Brussels, 24 March 2020

COST 036/20

DECISION

Subject: **Memorandum of Understanding for the implementation of the COST Action "Fostering and Strengthening Approaches to Reducing Coercion in European Mental Health Services" (FOSTREN) CA19133**

The COST Member Countries and/or the COST Cooperating State will find attached the Memorandum of Understanding for the COST Action Fostering and Strengthening Approaches to Reducing Coercion in European Mental Health Services approved by the Committee of Senior Officials through written procedure on 24 March 2020.

MEMORANDUM OF UNDERSTANDING

For the implementation of a COST Action designated as

COST Action CA19133
FOSTERING AND STRENGTHENING APPROACHES TO REDUCING COERCION IN EUROPEAN MENTAL HEALTH SERVICES (FOSTREN)

The COST Member Countries and/or the COST Cooperating State, accepting the present Memorandum of Understanding (MoU) wish to undertake joint activities of mutual interest and declare their common intention to participate in the COST Action (the Action), referred to above and described in the Technical Annex of this MoU.

The Action will be carried out in accordance with the set of COST Implementation Rules approved by the Committee of Senior Officials (CSO), or any new document amending or replacing them:

a. "Rules for Participation in and Implementation of COST Activities" (COST 132/14 REV2);
b. "COST Action Proposal Submission, Evaluation, Selection and Approval" (COST 133/14 REV);
c. "COST Action Management, Monitoring and Final Assessment" (COST 134/14 REV2);
d. "COST International Cooperation and Specific Organisations Participation" (COST 135/14 REV).

The main aim and objective of the Action is to comprehensively understand the mechanisms at the macro and individual level that lead to coercion and to find solutions to prevent coercion being applied in in hospital and community mental health services. This will be achieved through the specific objectives detailed in the Technical Annex.

The economic dimension of the activities carried out under the Action has been estimated, on the basis of information available during the planning of the Action, at EUR 64 million in 2019.

The MoU will enter into force once at least seven (7) COST Member Countries and/or COST Cooperating State have accepted it, and the corresponding Management Committee Members have been appointed, as described in the CSO Decision COST 134/14 REV2.

The COST Action will start from the date of the first Management Committee meeting and shall be implemented for a period of four (4) years, unless an extension is approved by the CSO following the procedure described in the CSO Decision COST 134/14 REV2.

TECHNICAL ANNEX

OVERVIEW

Summary
FOSTREN is an Action designed to establish a sustainable, multidisciplinary network of researchers and practitioners focused on reducing the degree to which mental health services use coercion in hospital and community mental health services. Many people receiving mental health care are subjected to coercive practices such as outpatient commitment in the community and physical restraint in hospital. Such practices can violate human rights and there is a growing international policy momentum to reduce reliance on them. Given the biopsychosocial complexity of mental health service delivery, successful initiatives in this area require sustained multilevel interventions which can be implemented effectively in the long term. Clinical practice in this area is extremely variable across Europe and relevant research activity is highly fragmented. The FOSTREN network will address these issues by enabling research and practice expertise to be exchanged in order to create an integrated framework for mental health service transformation.

The network objectives are: to advance understanding of successful interventions to reduce coercion within an implementation science paradigm by building a stable interdisciplinary network of European researchers and practitioners; and to apply this understanding by articulating and communicating best practice to key stakeholders responsible for mental health service delivery. This will be achieved through networking activities organized along four themes: risk factors; alternative interventions; outcomes & recovery; and implementation science. Key deliverables such as a framework for shared datasets and a coercion reduction implementation model will contribute to a pan-European effort to enhance human rights for vulnerable people with mental health problems.

Areas of Expertise Relevant for the Action	**Keywords**
● Health Sciences: Health services, health care research ● Sociology: Work and professions ● Psychology: Social psychology ● Clinical medicine: Psychiatry ● Other medical sciences: Databases, data mining, data curation, computational modelling for other medical sciences	● Coercion ● Mental Health ● Violence ● Organizational change

Specific Objectives
To achieve the main objective described in this MoU, the following specific objectives shall be accomplished:

Research Coordination
● To advance understanding of (1.1) the processes underlying the use of coercion and (1.2) successful interventions for reducing coercion in European mental health services by exchanging knowledge on activities in a multiplicity of service contexts (i.e. diverse countries, service levels/settings and levels of resource availability)
● To summarise current knowledge on the most effective methods for implementation / transformation of health services as it relates to the specific issue of reducing coercion in mental health services.

Capacity Building
● To build a stable interdisciplinary network of European researchers and practitioners in this area which includes participants from under-represented groups
● To apply the new understanding gained through exchange by setting Best Practice standards
● To communicate these standards to mental health policy makers and practitioners with recommendations for improving inpatient care and the experience of patients/service users.

TECHNICAL ANNEX

1 S&T EXCELLENCE

1.1 SOUNDNESS OF THE CHALLENGE

1.1.1 DESCRIPTION OF THE STATE-OF-THE-ART

The main aim of this Action is to establish a sustainable, multidisciplinary network of researchers and practitioners focused on reducing the degree to which mental health services use **coercion** in hospital and community mental health services.

Coercion occurs in this context when a person receiving mental health care (i.e. a patient or service user) is compelled through physical force or threat to accept care or treatment against their will[1]. It takes many forms in both community and hospital settings, comprising both legally constituted practices and informal strategies adopted by professionals and family and friends in crisis situations to manage violence, self-harm, suicide attempts, absconding and medication non-compliance. Its use varies widely across Europe. Many countries make extensive use of outpatient commitment, enforced medication and the option of compulsory admission to coercively manage patients in the community. Overt coercive measures within hospitals using physical force include enforced medication ('rapid tranquillisation'), mechanical restraint and/or seclusion in a locked room. **Coercion is unfortunately widespread:** over 40% of patients and 90% of staff in inpatient services have been involved in a coercion episode[2]. Certain disadvantaged groups of people (e.g. those with a schizophrenia diagnosis, those from ethnic minority communities or lower socioeconomic groups, people with a learning disability and elderly people) are more likely to be coerced than others[3].

For many reasons it is **imperative at this time to galvanise efforts to reduce these coercive practices.** The Council of Europe has recently (June 2019) unanimously adopted a resolution to "immediately start to transition to the abolition of coercive practices in mental health settings"[4]. Coercion often meets the criteria for inhuman or degrading treatment which contravenes the European Convention for the prevention of such acts[5]. Article 15 of the UN Convention on the Rights of Persons with Disabilities upholds the human right to freedom from torture or cruel, inhuman or degrading treatment or punishment[6]. In terms of international policy objectives, coercion in principle contravenes the objectives of the European Mental Health Action Plan 2013-2020[7] which stipulates in Objective 2 that people with mental health problems receiving services: "are citizens whose human rights (should be) fully valued, respected and promoted"; and in Objective 4 that they are "entitled to respectful, safe and effective treatment." At the social level, coercion is financially costly to health services and wider society[8]. At the individual level, coercion is dangerous and can severely damage the therapeutic relationship between staff and patients. On the ground, many patients, staff and service manager representatives argue that the time is right to implement new ways of working which minimise or eliminate coercion and enable collaborative care to become a reality.

There is preliminary evidence that some organisational interventions can be effective in reducing coercion in the short term when implemented as part of a research study[9,10]. Much of this research is from outside Europe and does not focus on sustained adoption of interventions over long time periods. The context and underlying reasons for using coercion are multifaceted and implementing effective novel methods and procedures into everyday clinical care over the long term is extremely challenging. Mental health services are uniquely and irreducibly complex environments with a range of competing and often contradictory forces operating within them. The patient as an individual receiving mental health services is subject to a range of influences and is in part constructed as a 'social entity' by them. These influences include the social and cultural environment, the medical and legal environment[11], the built environment and the organizational environment of the service delivering care. Any successful intervention must take these various environments into account when redesigning services to minimise or eliminate coercion. It is misleading to isolate certain factors without taking the overall context in which they occur into account. This necessitates a holistic approach as this is the best way to do justice to the complexities involved in the reduction of coercive practices in a variety of situations.

The critical point is that currently adequate knowledge is lacking about:

A) **which interventions to reduce coercion work;**

B) in which situation/organisations they work; and

C) how they can be adopted into policy and practice in the long term.

For society at large and in mental health care services especially, to help service users/patients and health care staff, researchers have to investigate what kind of intervention and implementation methods for these interventions work best for different cultural and social environments. Alternatives to coercion do exist, have varying degrees of evidence to support them and need to be moved from 'proof of concept' to at-scale implementation. Knowledge on how to achieve this would allow us to systematically choose interventions and implementation methods that would achieve the best possible treatment outcome for each specific service user / organisation.

At the moment, there is undoubtedly **a dynamic and productive European research effort into ways of minimising coercive practice** which could be drawn upon to transform mental health services if it was effectively coordinated and its findings were successfully implemented into practice[12]. However, this European research effort is *very fragmented* with most studies running in one country (and, indeed, usually just one locality within that country) and focusing on one discipline or aspect of coercion. Whilst they may fortuitously have wider ramifications, these studies usually address purely local needs and priorities or, at best, they may be linked to a national research programme. They tend to be pragmatic and detached from broader theoretical considerations. They run in different countries simultaneously but independently with little interaction between researchers. Whilst many countries register coercion events as they occur and thereby create large local or even national routine datasets, the comparability of these datasets as the basis for international comparisons has not yet been fully explored. More fundamentally, there are also significant linguistic and definitional variations when comparing practices across countries which need to be addressed through a drive toward terminological clarity and consistency. This fragmentation along several dimensions makes it impossible to understand the huge variability of coercion rates between countries (and often between services within the same country) as the basis for effective implementation of suitable interventions[3,13].

Moreover, the resources available for mental health research in many countries are relatively modest, and even within the H2020 framework programme, only limited funding has been made available for this topic. As mentioned by COST-action 16102 (European Network on Individualized Psychotherapy Treatment of Young People with Mental Disorders), there is a shortage of specialist research centres and cross-cutting structures (shared databases, cohorts, technical platforms, etc.) in this area, while the existing entities have relatively low visibility so that many researchers are not aware of their existence. Similarly, the H2020 funded project ROAMER (Roadmap for Mental Health and Wellbeing Research in Europe) shows that the evidence base in mental health needs to be strengthened and the gap between research and implementation needs to be closed. This can only be achieved if research is defragmented and more disciplines are integrated into mental health research including the reduction of coercion.

In addition, the variety of health care systems in different countries implies that research requires sustained and integrative coordination to ensure that the resulting knowledge can be readily implemented across COST countries and sectors. This COST Action therefore aims at magnifying the impact of the currently un-coordinated European research efforts on reducing coercion in mental health care. FOSTREN will bring research groups together in order to purposively exchange knowledge, collectively determine the current state-of-the-art, identify gaps and needs in currently fragmented research efforts, develop research guidelines, and collaborate on current and future projects. It will also strengthen the external validity of past, current and future research in this area. The activities in the Action will help avoid duplication and waste of resources. FOSTREN thus would facilitate research collaboration and pave the way for consortia and common databases in the longer term across COST countries and beyond to be developed.

1.1.2 DESCRIPTION OF THE CHALLENGE (MAIN AIM)

This COST action FOSTREN will enable researchers from across Europe to address challenges faced by the field as a whole in an efficient and systematic way. In particular, the main challenge for researchers in the field of reducing coercion is **how to design and conduct high quality intervention studies,** including **synthesising results** and **assessing** the **mechanisms for effectively implementing sustained changes** in the organizations involved. Such knowledge will have important implications for the allocation of resources and organization of mental health care across COST countries. Therefore, the Action's main challenge is to comprehensively understand the mechanisms at the macro and individual level that lead to coercion and to find solutions to prevent coercion being

applied in hospital and community mental health services. Currently two core elements to this challenge have been identified.

I) ***The Variation Issue:*** that the services provided in mental health care across Europe vary widely, and this complicates the transfer and generalisation of research on underlying mechanisms and effective implementation within a European dimension;

II) ***The Fragmentation Issue:*** research is fragmented across different disciplines and levels of focus (e.g. single clinic vs multinational; fundamental vs. applied).

I) **The Variation Issue:** mental health services have developed very differently across Europe. We see different stages of professionalisation in services in terms of staffing (competence and volume) and specialisation (e.g. high security wards, forensic psychiatry). Of particular interest is diversity in the division of responsibility between mental health services and the criminal justice system. Anecdotal evidence indicates that there are also substantial differences in the degree to which national policy makers acknowledge the issue of coercion as a problem in mental health, the standards of services available, and the degree to which different types of coercive and non-coercive measures are applied in handling conflict. These differences in themselves call for international collaboration and so far the consequences of these differences are not well understood. The challenge therefore is to calibrate and standardise methodologies for mental health research and for synthesis of results while addressing the international, social and cultural context. In particular those contexts which result in mental health disparities, with special reference to under-researched groups such as at-risk, disadvantaged, or marginalised populations, need to be taken into account e.g. economic inequality, life-styles, population well-being, effects of public and economic policy and ethnicity.

II) **The Fragmentation Issue:** overcoming fragmented research is essential. Research activity in this area is largely conducted in national 'silos' with little connection between studies in different countries sharing the same objectives. The results from interventions on local levels and the findings from multinational studies in a wide variety of disciplines, e.g. psychology, sociology, nursing, psychiatry, implementation research, need to be integrated with relevant theoretical models. The **challenge** lies in **bringing the different strains of research together**. The sharing of results generated by ongoing research from all these areas and on all these levels is needed to provide in-depth understanding of how to avoid coercion and how to implement these measures in the hospital and community setting. It will also lead to initiation of a network that will disseminate guidelines and recommend adjustments to current regulations across Europe where needed.

1.2 PROGRESS BEYOND THE STATE-OF-THE-ART

1.2.1 APPROACH TO THE CHALLENGE AND PROGRESS BEYOND THE STATE-OF-THE-ART

FOSTREN aims to carry the state of the art forward by addressing the two issues described above. While the ultimate ambition is to reduce coercion in mental health care across Europe and beyond, the Action's goal is to enable this by structuring research methodologies, outcomes and programmes, and by **bringing together evidence-based interventions with implementation research**. It thus aims to both foster promising new interventions with preliminary research evidence and to strengthen those with a more developed research evidence base by evaluating the key implementation issues.

Constructing a co-ordinated programme (Issues I & II): in line with ROAMER's suggestion, the methodologies and approaches needed for comprehensively understanding the mechanisms that lead to coercion and for finding solutions to prevent it, must be drawn from a broader range of methodologies: qualitative and observational research, clinical trials, surveys, participatory action research, register-based studies, systematic reviews etc. It must be achieved with an awareness of the extensive variation in social contexts and mechanisms operating in both community and hospital coercion. By creating consensus across Europe, this variety of methods will all be applied synergistically to the different environments that affect the patient (and staff), and thus together they can contribute significantly to the goal of reducing and perhaps ultimately eliminating the use of coercion in European mental health services. A central goal of FOSTREN is therefore to address this complexity and the interrelationships of these factors by bringing a broad selection of experts from relevant fields together in a single network of knowledge exchange and mutually supportive research trajectories.

Supporting successful methods of implementation (Issue II): over the past 15 years, a number of new interventions aimed at changing how mental health care teams operate based on a vision of 'zero restraint' have been developed and tested. Despite their success in reducing coercion and its associated economic costs at the organisational level, these interventions are not implemented to a degree that would change practice in each country at a significant scale. FOSTREN aims to disseminate these promising interventions through its network, while in addition supporting implementation researchers to exchange research methods and results with a broader network of researchers. The aim is to facilitate the transition from novel intervention testing to broad-scale implementation across institutions and countries.

Ensuring evidence-based best practice is embedded into everyday care (Issues I & II): a new approach to healthcare can be judged to be successfully implemented when there is evidence that it has been adopted by healthcare staff in their everyday practice in a wide range of services over a sustained period of time. This must match the needs of the patient and requires effective monitoring of ongoing practice. However healthcare staff and managers are often not updated on the latest or most applicable evidence-base regarding the reduction of coercion. Moreover, when healthcare staff and managers are aware of the evidence, they struggle to implement the changes into their own organisations and every-day work practice. Therefore, coordinated efforts are needed to disseminate the existing knowledge, and to stimulate implementation research to exchange their methods and results across different countries and disciplines. All such initiatives must take into consideration the variability in financial resources available for mental health services in different regions of Europe and thus adapt recommendations to fit with what is feasible in each setting[14].

1.2.2 OBJECTIVES

1.2.2.1 Research Coordination Objectives

*Objective 1: to **advance** understanding of (1.1) the processes underlying the use of coercion and (1.2) successful interventions for reducing coercion in European mental health services by exchanging knowledge on activities in a multiplicity of service contexts (i.e. diverse countries, service levels/settings and levels of resource availability).*

Understanding of the relevant processes will be achieved by exchanging knowledge and results from ongoing projects with empirical, theoretical and methodological activity in four main areas each with a dedicated Action Work Group (WG)**: Risk Factors for Coercion** (WG1), **Alternative Interventions** (WG2), **Recovery & Outcomes** (WG3) and **Implementation Science** (WG4). These four areas are interlinked and rely on interdisciplinary activity at the levels of policy, practice and research and the results from them will be exploited and disseminated beyond the network by an additional Work Group (WG5).

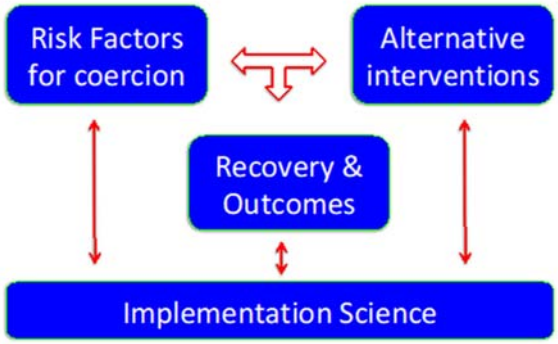

Figure 1: interrelationship of the four topic Work Groups

Improved understanding of factors leading to use of the various forms of coercion will be achieved at both the individual/clinical and the social/contextual levels (WG1) by sharing data on empirical testing of risk assessment tools (individual level) and factors explaining coercion rates (social level) in different countries. This empirical sharing will be enhanced through theoretical debate relating to the relationship between risk assessment and risk management in acute situations, and to the relationship between the treatment perspective and the dangerousness perspective in compulsory admissions and compulsory pharmacological treatment. If understanding of these factors is improved, it will enable earlier intervention which is likely to be less coercive and thus the use of alternative interventions will be facilitated. Identification of best practice when implementing interventions at the organisational, team or individual level can be achieved within the Action again by sharing data on current practice and novel interventions. The refinement of social and psychological theories underpinning treatment resistance, human aggression and conflict will enable a wider range of less coercive or non-coercive interventions

to be considered as alternatives (WG2). Nonetheless, some conflict and coercion is likely to continue occurring in mental health services in the medium term and those involved need to be effectively supported post-incident. Likely outcomes post-incident will include psychological (e.g. emotional responses), social (e.g. need to withdraw from services) and economic (e.g. taking sickness absence) impacts amongst both practitioners and patients and models for recovery and repair of therapeutic relationships will be considered (WG3). Within the Action, sharing data on the epidemiology of these various health consequences and the effectiveness of alternative interventions will enable the identification of predictors of successful prevention which will be fed through dissemination activities into future support programmes.

*Objective 2: to **summarise** current knowledge on the most effective methods for implementation / transformation of health services as it relates to the specific issue of reducing coercion in mental health services.*

Underpinning these three elements will be an additional Work Group focused on sharing models of effective organisational change and intervention implementation based on co-creation of strategies by patient and staff stakeholders (WG4). The most relevant, yet generic models from a range of health care specialities will be selected, considered and adapted for the mental health care setting. Further adaptation will enable tailored best-practice implementation packages for each of the other three WG topics. The Action will prioritise transferring theory, best practices and research results into changing practice in services 'on the ground'. Ideas and evidence generated in the ongoing projects within the other WGs will be reformulated in terms of barriers and obstacles to implementation within mental health services in participating countries.

1.2.2.2 Capacity-building Objectives

*Objective 3: to **build** a stable interdisciplinary network of European researchers and practitioners in this area which includes participants from under-represented groups*

As stated above (1.1.1), European researchers are highly productive in this area, but the overall effort is fragmented into separate national or local research programmes. The activity required to produce the deliverables listed in 4.1.2 below will require intensive communication within a coherent network. A key priority within the Action is to build research capacity relating to this topic in under-represented groups**.** It is clear from previous *ad hoc* networking attempts in this area that researchers vary in their capacity to gain financial support to attend international research meetings. While this is true for all research topics, it is a particular problem for those working with the issues of mental health and coercion which are relatively stigmatised topics with a low priority in many countries and zero priority in some. Resources for the Action will be used to support researchers from all participating countries but special efforts will be made to support particular categories of researchers: women, Early Career Investigators (ECIs) and those from countries with a relatively underdeveloped research infrastructure for mental health. ECIs will be encouraged to be involved in all working activities of the five WGs. A number of short-term scientific missions (STSMs) will be arranged and a specific proportion of these will be allocated to the researchers from these groups (see 4.1.1 below).

*Objective 4: to **apply** the new understanding gained through exchange by setting Best Practice standards;* and *Objective 5: to **communicate** these standards to mental health policy makers and practitioners with recommendations for improving inpatient care and the experience of patients/service users.*

A key feature of the Action is the integration of *scientific knowledge with practical application in real world settings.* Many of the participants in the Action combine research activity with a commitment to clinical work so are skilled in seamlessly integrating research and practice in this way. A number of communities of end-users are identified below (3.2.2) including practitioners directly delivering care and policy makers who plan strategic services. Representatives from both practice and policy communities will participate in the Action and will be targeted for dissemination as it proceeds. In each of the four topic WG areas there is the potential to apply the understanding gained through Objectives 1 and 2 by, for instance, adopting the best-performing risk assessment tools, adopting less coercive interventions, incorporating the effective components of post-incident support packages into national practice and adopting successful strategies for implementing clinical guidelines.

2 NETWORKING EXCELLENCE

2.1 ADDED VALUE OF NETWORKING IN S&T EXCELLENCE

2.1.1 ADDED VALUE IN RELATION TO EXISTING EFFORTS AT EUROPEAN AND/OR INTERNATIONAL LEVEL

The network will draw together leading researchers and prominent practitioners from across Europe to enable the exchange of ideas and formulation of statements on best practice accompanied by models of effective implementation of such best practice into routine care. Efforts to change mental health services in Europe towards a position where coercion is minimized or even eradicated requires coordinated activity in terms of evidence synthesis, implementation of new practices and organizational change (i.e. improved service delivery). Driving a shift away from coercion towards genuinely collaborative care needs a sustained and coordinated effort in and between each of these domains. The systemic insularity of current research seriously limits the degree to which excellence in the three domains can be identified and shared between academic and clinical stakeholders (including patients/service users and their families), especially in countries where mental health services receive very limited resources.

The FOSTREN network will provide the infrastructure and mechanisms for this to be overcome. Intensive efforts to systematically synthesise evidence, articulate best practice and initiate evidence-based organizational change are currently highly clustered in a small number of European countries. National and local projects within and beyond these clusters are conducted with little awareness of similar activity elsewhere. The network will directly address this fragmentation by enabling the results of these efforts to be shared amongst researchers, practitioners and other stakeholders. Evidence synthesis may draw on research from a range of countries in these small research-intensive clusters but the degree of implementation of evidence-based practice (EBP) into services is variable even within the clusters themselves. International knowledge-sharing and spread of EBP innovations beyond the clusters is virtually non-existent in this area.

The network will be open to a diverse range of stakeholders. The primary interface will be between researchers and practitioners (defined as health care professionals at all levels from direct clinical care to senior management). Connecting these two groups will enable a stimulating dialogue in which novel academic ideas can be tested out against the realities of clinical practice across levels of service (e.g. forensic, acute) in different countries. Clinicians will pitch ideas for new ways of working which can be considered for formal evaluation by researchers. Input from patients/service users individually and their families directly or via representative organisations will be facilitated as well to create a three-way exchange and to ensure the often-competing perspectives of staff and patients/service users on coercion are captured. In addition to this primary interface, communication will be facilitated between hospital and community staff who work with patients at different points on their care pathway. Furthermore, the inclusion of policy makers and representatives of Small Medium Enterprises (SMEs) in the network will enable specific expertise and political-contextual factors to be considered.

Each of the COST networking tools will be deployed to facilitate these exchanges (see also 4.1.1). Regular meetings of the Action Management Committee (MC) and WGs will bring together these stakeholder representatives around a table to share knowledge and experiences. Training schools will enable ECIs, health care professionals and patient-advocates to work together for a focused period of time on a specific set of skills which will enhance their capacity to address the problem in their home organisation. Short Term Scientific Missions (STSMs) organised between Action members will support the same stakeholders individually to learn about the realities of clinical care in other countries and local solutions that have been adopted to address the issue of coercion. Finally, the dissemination plan (see 3.2.2) will include several conferences at which a wide range of interested parties can engage in discussion with the network members and other event participants to spread knowledge more broadly.

The work of the Action fits with the aims of several UN Sustainable Goals[15] (Goal 3: Good Health & Wellbeing; Goal 5: Gender Equality; Goal 10: Reduced Inequalities). It's objectives are also aligned with the World Health Organization Quality Rights Initiative[16] and, as mentioned above, it will support delivery of the objectives of the European Mental Health Action Plan 2013-2020[6] . It will furthermore support the work of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)[17] which defines some coercive mental health care practices as forms of torture and the UN Subcommittee on the Prevention of Torture and Other Cruel, Inhuman or

Degrading Treatment or Punishment which states that “Restraints, physical or pharmacological, are forms of deprivation of liberty and, subject to all the safeguards and procedures applicable to deprivation of liberty, should be considered only as measures of last resort for safety reasons.”[18]. The network will build upon the efforts made to reform mental health services and improve the protection of human rights of persons with mental disabilities by the EU Joint Action on Mental Health and Wellbeing (2013-2016). This involved 27 Member States and led to the approval in 2016 of the European Framework for Action on Mental Health and Wellbeing[19] which urges Member States to update their legislation in accordance with the principles established in the Convention on the Rights of People with Disabilities. It also advocated promotion of a coordinated transition towards community-based care, ensuring the improvement of quality of care and the protection of human rights across all parts of the system. The work of the Action will also align with that of the EU Compass for Action on Mental Health and Wellbeing[20] network that has developed the monitoring and implementation of human rights and recovery oriented mental health policies and services in Europe.

Beyond policy, the Action will amplify the work of existing national networks in this area such as the Restraint Reduction Network[21] and complement a number of H2020-funded mental health projects in terms of integrating research and practice (PROMENPOL), capacity building and international co-ordination (ROAMER), improving service design and delivery (COFI), strengthening links between high and middle income countries (EMERALD), improving community care (RECOVER-E), empowering patients (UPSIDES), improving clinical decision making (CEDAR) and exploring routes toward successful organisational change (COLAB). The Action will also complement a number of other completed and running COST Actions without duplicating their work. These include IS1302 (Towards an EU research framework on forensic psychiatric care), IS1206 (Femicide across Europe) and IS1107 (European Network for Conflict Research (ENCoRe). Contact will be made with the Chairs of relevant running Actions to discuss the desirability of joint meetings and joint working. Contact will also be made with the relevant H2020 projects at an early stage of the Action to discuss liaison with relevant projects. Notwithstanding all of these links, however, the focus of this Action will be distinctive because of the emphasis on coercion in mental health services and improved care for this vulnerable group of patients.

2.2 ADDED VALUE OF NETWORKING IN IMPACT

2.2.1 SECURING THE CRITICAL MASS AND EXPERTISE

The proposed network consists of key leading researchers and practitioners in the area of coercion reduction from 16 countries across Europe. The Action will remain open to new members who approach the network, and will actively encourage participants who address gaps in terms of geography, knowledge or expertise. The key experts on this topic across Europe are well-known through academic publications and interaction at relevant conferences as well as their engagement with human rights bodies and organisations e.g. the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). An initial group has been identified and all have contributed to the drafting of this proposal. Their contacts and knowledge will be drawn upon to identify additional participants in a snowballing process. Critical mass will be achieved through collective participation of these key participants in network meetings and their collective knowledge will be pooled and interrogated through effective facilitation of these meetings. Specific attention will be given to the issue of geographical distribution to ensure participation of experts from countries outside of the research-intensive clusters and from those with relatively low expenditure on mental health services. This will contribute to improved equity of knowledge and leadership across Europe which is a key goal of the network. All Action members will contribute to the dissemination plan to maximise impact beyond academia and beyond the network by running activities in their own country and in other network member countries where their expertise is relevant.

2.2.2 INVOLVEMENT OF STAKEHOLDERS

Given the complexity of the mental health service environment in which coercion occurs, a wide range of stakeholder groups will be represented in the network. Prominent **researchers** with expertise in theory development and evidence production will be a core component of the network and will be engaged in positive dialogues with the other stakeholders. **Practitioners** involved in delivering mental health services and leading clinical teams which implement coercive practices will be encouraged to share their experiences of routine care and the potential obstacles which must be overcome to achieve organisational change. Organisations representing **patients/service users** who have been subjected to coercion will be invited to describe and evaluate the lived experience of coercive practice, its

psychological consequences and potential solutions. Those involved in **policy development** at the national level will be urged to consider the proposals for service improvement and consider them in the context of national political and economic priorities. Each of these stakeholder groups will be integral to the overall network and will be represented on the MC and within the WGs.

2.2.3 MUTUAL BENEFITS OF THE INVOLVEMENT OF SECONDARY PROPOSERS FROM NEAR NEIGHBOUR OR INTERNATIONAL PARTNER COUNTRIES OR INTERNATIONAL ORGANISATIONS

Not applicable as all proposers are located within COST countries.

3 IMPACT

3.1 IMPACT TO SCIENCE, SOCIETY AND COMPETITIVENESS, AND POTENTIAL FOR INNOVATION/BREAK-THROUGHS

3.1.1 SCIENTIFIC, TECHNOLOGICAL, AND/OR SOCIOECONOMIC IMPACTS (INCLUDING POTENTIAL INNOVATIONS AND/OR BREAKTHROUGHS)

The FOSTREN network is an international implementation research collaboration linking countries with relatively restricted access to financial resources for high-quality mental health services to partners in other European countries with greater resources and expertise in implementing organizational change. The network is designed to provide excellent value for money by maximising the impact that can be achieved through reasonable and feasible levels of input.

Current research projects all aim to improve the evidence base for clinical practice when working with and delivering services to people with mental health problems. The Action would enable a coordinated pan-European approach in this area, which would ultimately inform and enhance relevant European policy and practice. Patient/service user engagement in the delivery of mental health services will be enhanced through the collaborative/interactional stance of the Action participants. The immediate benefit of the Action will be to enhance communication and understanding between participants representing a wide range of European countries with varying degrees of expertise in minimising coercion effectively. As noted above, certain countries and certain units in participating countries are recognised as international centres of excellence and dissemination from these centres could begin at an early stage in the Action. The long-term benefits of the Action would be a common understanding across Europe of best practice in research and clinical activity relating to violence and coercion in mental health services. This understanding is a necessary condition for further 'real world' impact through underpinning improvements in healthcare delivery and patient-staff interactions. The framework of standards produced in the consensus statements (see 4.1.2 below) would serve as a model for researchers and practitioners in developing new services and improving existing ones. Following this model should lead to reductions in both the amount of coercion in mental health settings with the concomitant benefits outlined above in terms of reduced financial, personal and social costs.

The Action network will have significant scientific impact through activity in the domains of evidence synthesis, implementation of new practices and organizational change. New knowledge will be generated on coercion risk factors, alternatives to coercion and outcomes & recovery through evidence reviews conducted by each WG. For example evidence on collaborative approaches to working with service users in understanding how conflict situations arise and can be avoided at various stages will be integrated and conceptualised in terms of implementation barriers and facilitators. These approaches might include value reflection exercises, improved de-escalation techniques and improved crisis resolution in the community. This will be supplemented by examining the potential for constructing shared datasets relating to coercion and alternative practices, including adapting current dataset structures to ensure consistent data capture. Theoretical and methodological innovations will be achieved through clarification of key terminology and exchange of ideas about cutting-edge research methodologies as appropriate to each topic.

The following **socioeconomic** impacts will be achieved through the work of the network:

- *Improvements in the functioning and sustainability of health systems*: managing conflict in mental health services through coercion is inherently wasteful of human and financial resources. The high rates of iatrogenic injury associated with implementing these dangerous, physically demanding

interventions lead to significant additional costs for health organisations because of the frequent need for treatment of both staff and patients/service users and sickness absence amongst staff. It is estimated that work place injuries cost about USD5000 per event on average and can amount to 2% of a hospital's entire budget[22]. Lower costs are incurred when less- and non-coercive interventions are adopted. Novel or reactivated psychological trauma can also intensify existing distress and illness for patients and lead to staff absenteeism, sickness absence and contractual resignation. Some staff seek financial compensation from their employer for occupational injury and legal costs can also be incurred when patients or their advocates sue for reparations. The damage to therapeutic relationships following coercion can throw up serious barriers between staff and patients including withdrawal and disengagement from contact thus diluting the effectiveness of services and prolonging admission periods. Despite a lack of evidence for effectiveness, outpatient coercion requires lengthy and costly legal processes and other administrative costs. All of these effects have serious economic consequences for health services and redirect financial resources away from therapeutic patient care and models for reducing them will be produced by the Action.

- *Greater health equity and additional societal benefits*: mental health services overall receive less funding than those providing physical treatments and parity of esteem and funding must be achieved. Furthermore, at the individual and service level, it is well established that certain groups in society are more likely to be subjected to coercion than others. Privately funded mental health services in all countries are less likely to use coercion than those providing services to people without sufficient resources to pay for their own care. Research indicates that even within the apparently 'level playing field' of publicly funded services themselves certain sociodemographic characteristics are associated with greater exposure to coercion and fewer opportunities for access to 'talking therapies'. Low economic status and membership of certain ethnic or racial groups are key risk factors for coercion even when other risk factors are controlled for. Addressing coercion therefore has the potential to enable all mental health care recipients to gain fairer access to collaborative care.

- *Availability to healthcare providers and policy makers in order to facilitate transferability*: the network will adopt a principle of openness which will be enshrined in its outputs and deliverables. Dissemination to all relevant stakeholder groups will be prioritized. Strenuous efforts will be made to effectively communicate the findings and the final implementation strategy to mental health staff, patient groups, and service managers at all levels and also to policy makers.

- *Wider social inclusion and reduction of stigma:* the experience of mental health problems is associated with stigma amongst the wider society leading to exclusion, prejudice, hostility and discrimination which only serve to exacerbate the primary problems of fear, distress and confusion. With very few exceptions these additional burdens are not inflicted on those with physical health problems. It is likely that national and regional policy makers who are involved in facilitating the project and staff inspired by the potential improvements in the patient experience could act as catalysts for wider social change and reduced stigma across European societies.

3.2 MEASURES TO MAXIMISE IMPACT

3.2.1 KNOWLEDGE CREATION, TRANSFER OF KNOWLEDGE AND CAREER DEVELOPMENT

Knowledge creation and transfer: the FOSTREN network will be multidisciplinary and multiagency with a particular emphasis on facilitating exchange between academic, clinical and policy experts. As part of its core emphasis on implementation as well as shared knowledge, the network will maintain a continuous focus upon contributing to a new wave of innovation in mental health services at any one of several points on the health care innovation pathway from 'feasibility' to 'adoption'[23]. Such innovations may be primarily theoretical and/or conceptual and thus will contribute by stimulating new ways of thinking about overlooked or challenging problems. Other innovations will involve sharing knowledge about specific new interventions and implementation models which aim directly to improve mental health services and the well-being of patients. An awareness of the need for continuous innovation in the neglected area of mental health will be emphasised. Key questions for innovators will be addressed by the network at network meetings. Answers to these questions will enable a good grasp of the relevant context for understanding coercion and how innovations might be successfully embedded into practice. The questions include:

- How does the health system work in each participating country?

- What are the existing systems and patient needs?
- Which organisations and stakeholders are involved in the innovation pathway in each country?
- What are the outcomes that are important to patients?
- How would a package or recommended approach emerge from the network impact on the care pathway and resources required?
- What are the relevant regulatory and procurement systems?

Career development: career development of ECIs and mental health practitioners will be a core focus throughout the life of the Action with the aim of maximising individual potential to make the most of employment opportunities long-term. For ECIs this is in line with the European Charter for Researchers. A senior member of the network will have designated responsibility for designing and monitoring this aspect of the overall activity and will ensure it is an agenda item at all relevant network meetings. The relevant research and transferable skills will be acquired and enacted primarily through STSMs designed specifically for ECIs. Each network member will consider its potential contribution to these in terms of specialist training reflecting their particular areas of expertise for individual ECIs. STSMs hosted by academic organisations and SMEs will provide an opportunity to learn specific skills distinctive to the host and suitable for the ECI. STSMs hosted by health care organisations will be managed in a way that enables the ECI to observe, reflect upon and (where appropriate) enact key skills in the clinical setting. Consortium meetings will also be a forum for exchanging best practice on preparing ECIs for future employment and for ECIs to support each other in developing the necessary skills. All training will be delivered within an equity framework to ensure equal access to opportunities for learning regardless of gender and other personal characteristics and circumstances. An awareness of gender as a dimension of the coercion experience for patients will be considered throughout. Both female and male ECIs will be expected to reflect upon their assumptions about gender and any impact these might have on their behaviour and that of others.

3.2.2 PLAN FOR DISSEMINATION AND/OR EXPLOITATION AND DIALOGUE WITH THE GENERAL PUBLIC OR POLICY

The FOSTREN network will have a key part to play in fostering information exchange between existing research and development (R&D) communities, both regarding the network itself and how existing work can inform the project's activities. The dissemination activities aim to promote the results as swiftly and effectively as possible to benefit the whole community and to avoid duplication of R&D efforts.

A network Dissemination Manager will be appointed to lead and facilitate the activities regarding dissemination, communication and replication throughout the project. To target the plans for dissemination and replication of results to the different stakeholders across nations and regions, these activities will be updated regularly to ensure the project will be in line with novel developments, and to incorporate lessons learned.

Strategy for knowledge management and protection: all FOSTREN participants will be expected to commit to a general principle of disseminating the outcomes of their ongoing research to the network and to the public domain as broadly as possible, to enable faster implementation of positive results. There will be substantial exchange of ideas within the network and particularly between Work Groups. In Years 1 and 2, time within consortium meetings will be devoted specifically to aligning frames of reference, different measurement parameters etc. At the beginning of the Action, a webspace for filesharing will be created to facilitate dissemination of information within the consortium. This webspace can be made accessible, in full or partially, for sharing information with partners outside the network. The appointed Dissemination Manager will ensure, within a framework for handling both knowledge and documents, that all published information has been screened for potential ethical sensitivity and GDPR compliance. He/she will also be responsible for producing a protocol governing Intellectual Property Rights (IPR) management within the network by the end of Year 1 as part of the Communication and Dissemination Plan (see 4.1.2).

*Dissemination to the broader public***.** to create a platform through which the consortium can disseminate the public results of the FOSTREN network, a targeted Action **website** will be launched with an identified manager. This will provide an information point for the work of the network itself, including details of partners, objectives, work areas, interim and final results and working papers, public deliverables, webinars etc. Moreover, the website will have a section for related fields of work, e.g. links to other

projects, services, collaborative efforts relevant to each part of the Action. There will be several sections for the specific regions targeted in FOSTREN, in their own language(s) and with information that will specifically target the broader public, but also with some targeted at stakeholders in those regions. The consortium will create **a network factsheet** at the start of the project, incorporating general network information, information about the challenges the Action addresses, and the potential for future exploitation. This will be updated after each plenary meeting, to provide stakeholders with an overview of how the project results have progressed and how the results may affect policies to decrease coercion in mental health care in Europe and beyond. Media releases are planned for the countries where the network is active, first to announce the project and later to create awareness on this topic and to update the general public on the project results. Moreover, to promote the significance and results of the network, the consortium will investigate the availability of resources to produce promotional **video** material explaining the need for the network and (preliminary) results in layperson's terms including the wider European and global scope. Video material will be released on the project's website, but also through other social media if this is deemed effective for the Action's purpose of creating more outreach.

Dissemination with and to patients/service users: the network will identify patient/service user organisations to approach and seek help with dissemination of the Action results to the relevant interest groups. Existing links with organisations such as Mental Health Europe[24] will be drawn upon to enable this to be achieved effectively. A communiqué will be issued to patient/service user organisations, politicians and health-oriented patient/service user's organisations and bodies where they exist in the countries that are represented in the network. The International Conference on Alternatives in Mental Health (INTAR) will also be approached for support in this aspect of dissemination.

Dissemination to the scientific domain: the scientific dissemination activities will consist of scientific publications and participation at scientific events, as well as contributing to online discussions. FOSTREN will prioritise open access to all scientific publications i.e. any peer-reviewed journal article from the work of the Action will be openly accessible and free of charge. Due to the current operating conditions of some of the major journals that are relevant for FOSTREN's dissemination strategy, some articles might be delayed for open access but will then at a later stage become available through the Action's public website. Scientific journals to be targeted include: *The Lancet, BMC Health Service Research, The British Journal of Psychiatry* (known as *BJPsych*), *Psychiatric Services* and the *International Journal of Nursing Studies*. (IJNS). **Participation at scientific events** will also allow collection and evaluation of feedback from specific scientific audiences in order to improve the impact of the Action. Conferences, symposia etc. where patients/service users are significantly involved, e.g. INTAR, will be prioritised. Other suitable events include the European Congress on Violence in Clinical Psychiatry (2021, 2023); Restraint Reduction Network Conference (annually 2020-24); International Association of Forensic Mental Health Services Annual Conference (annually 2020-24), the International Crisis, Coercion and Intensive Treatment in Psychiatry (CCITP) conference and conferences organised by the World Association of Social Psychiatry and the European Association of Social Psychiatry.

4 IMPLEMENTATION

4.1 COHERENCE AND EFFECTIVENESS OF THE WORK PLAN

4.1.1 DESCRIPTION OF WORKING GROUPS, TASKS AND ACTIVITIES

Based on the problem-definition and on the state of the art in current and existing research, the following scientific programme will be implemented. The scientific programme is grounded in the objectives of the Action and will evolve along the four identified research themes that are crucial for the successful reduction of coercion in mental health services across Europe. Each theme will be addressed by one of the Work Groups and will contribute to the overall objectives of the Action (1.2.2 above). The main tasks and activities which will be designed to address these objectives are as follows.

Work Group 1: Risk Factors for Coercion*:* this Work Group will examine *risk factors relating to coercion at both the macro and individual levels.* The Action will therefore enable the systematic collection of information and comparison of clinical practice in this area and the social and legal context that may influence such practices. This will make it possible to compare risk assessment practices in different European countries and, where data are available, the variability of social factors (e.g. urbanicity) which might be relevant to decisions about risk management. With regard to **macro-level factors**, the WG will collate evidence from the existing European literature on the association between social, structural and legal factors and coercion rates in hospitals and the community and examine

potential explanations for their variability. Depending on the quality of available research, this may involve systematic identification, analysis and meta-analytic aggregation of data from individual studies to enable robust conclusions to be drawn. With regard to **individual factors**, the WG *will gather and disseminate information on violence prediction instruments such as the Brøset Violence Checklist (BVC) and coercion experience measures such as the MacArthur Admission Experience Survey, MacArthur Leverage Interview and Perceived Coercion Scale.* The spread of these and other instruments will increase knowledge of contexts within which coercion is exercised and experienced and enhance standardisation in data collection across countries. In addition to these activities and in line with Action Objective 5, the WG will promote knowledge among practitioners and policy-makers about the reliability, validity and clinical utility of the various risk assessment tools, and what the various statistical research findings mean for everyday clinical practice. This will be achieved by producing a document containing an explanation of the most important statistical measures and methodological issues in judging risk management studies accompanied by 'real-life' examples as part of the consensus statement. The WG will meet twice a year on average (see Gantt Chart 4.1.4 below). Its members will identify suitable research or clinical staff to engage in **three STSMs** (one per year in Years 2-4, up to 12 weeks duration with 1 host each) during which academic and practice-based knowledge of coercion risk factors will be exchanged with partners beyond the originating institution. The WG will also organise a **Training School** in Year 2 in which one member will host all Action participants and enable dialogue with experts in research methodology and/or clinical practice.

Work Group 2: Alternative Interventions*:* this working group will explore and examine opportunities to facilitate a shift away from reliance on coercion in hospital and community services. An organisational perspective will be adopted which views decisions by individual staff in the context of broader organisational factors which facilitate or obstruct less coercive measures. Therefore, in accordance with the overall Action objectives, an overview of the known interventions currently in use will be obtained as a precursor for further discussions. In addition, the Europe-wide implementation of key organisational programmes designed to minimise and eliminate the use of coercion will be mapped. *Where data are available, both elements (coercion and its alternatives) will be examined in the context of broader organisational factors* such as the service policy on aggression and violence, team staffing levels and education, user perceptions and user involvement, effective team working, staff attitudes towards patients, funding resource availability and ward/team culture and climate. The WG activities will follow the same broad pattern as WG1. It will meet twice a year on average, manage **three STSMs** on this specific topic and organise a **Training School** (in Year 2).

Work Group 3: Outcomes and Recovery*:* Until coercion can be eliminated entirely, its consequences must still be managed. There is scope for significant improvement both in how patients/service users and staff are supported after coercive incidents and what can be learned from reflecting on such incidents. For patients in particular a trauma-informed approach is required which recognises that exposure to coercion often evokes memories of exposure to previous traumatic events within and beyond mental health services. Members of this WG will *systematically collate information on the effects of coercion exposure on patients and staff* across all participating countries. Predictors of a poor outcome in terms of impact and sickness absence will be calculated where possible and, conversely, protective features will also be identified. Models of best practice for supporting post-incident recovery amongst patients and re-entry to work for staff in individual countries will be gathered. They will then be thematically analysed to develop a consensus of international recommendations. The WG activities will again follow the same broad pattern as WG1. It will meet twice a year on average, manage **three STSMs** on this specific topic and organise a **Training School** (in Year 3).

These three Work Groups will contribute to the delivery of those aspects of key Action deliverables relating to their topic through focused activity during network meetings, ongoing liaison between meetings and STSMs. These key deliverables (see 4.1.2) are the mapping exercise report (D3), glossary (D5), dataset framework (D6), state-of the art reviews (D7) and consensus statements (D9). A member of each WG will be appointed to lead on preparation and delivery of each of these deliverables from that group.

Work Group 4: Implementation Science**:** the focus of this WG will be on *processes which underpin effective implementation of the findings from the other three WGs*. Knowledge on best practices, however robust, is of little use if it is not adopted by mental health services across Europe as much as is feasible. Recent decades have seen the development of understanding on the facilitators and obstacles to embedding evidence-based innovations into routine health care. This understanding has led to the design and testing of mechanisms which can maximise the facilitators and overcome many of the obstacles to changing practice. These generic mechanisms will be examined by the WG and tailored

to the specific context of coercion in mental health care in hospitals and the community. An overall implementation model will be formulated based on this analysis and bespoke implementation packages for different contexts (e.g. high vs. low resource services) in the three WG areas above will be drawn from this overall model. Elements of these packages will be shared with staff in selected countries for feedback on feasibility, acceptability and clinical utility. The WG will meet twice a year as above and organise a **Training School** (in Year 4). The 3 **STSMs** in this WG will be shorter and more varied (up to 12 weeks with 3 hosts, 4 weeks per host) to enable implementation experts to visit and exchange views with as many participating organisations as possible and to get a sense of key implementation issues. This Work Group will appoint a task leader and use its network activities to develop the over-arching implementation model (D8) and will also produce specific deliverables relevant to its focus (mapping exercise report, D3, and state-of-the-art review, D7).

***WG 5: Dissemination and Exploitation of New Understanding*:** this WG will focus on dissemination and exploitation of the results of the project. An action website (D1) will be set up, including details of all Action members, ongoing activities and key documents. A communication and dissemination plan (D2) will be drawn up and will be updated to activate and streamline the communication and dissemination activities of the partners. The Work Group will organise three conferences (state-of-the-art, midway and end-of-Action) with published proceedings (D4) to which each of the other WGs will contribute speakers and co-ordination support. The WG will also plan several smaller workshops in the first 18 months with all WGs to enable an understanding of each other's language and background. To overcome the previous fragmentation and poor integration of research results and findings, WG5 will also organise workshops and meetings to integrate the different parts and draw conclusions between the results achieved in the WGs within the field as a whole. This activity is continuous throughout the project, ensuring quality control and an on-going conversation between the partners and the countries and/or approaches they represent.

4.1.2 DESCRIPTION OF DELIVERABLES AND TIMEFRAME

In summary, the following deliverables will be produced during the Action (see also Gantt chart, 4.1.4).

D1: Action website (Month 6): the Action website will be hosted and maintained by the lead applicant's institution to enable additional members to be aware of and join the Action. It will include details of all Action members, ongoing activities and key documents.

D2: Communication and Dissemination plan (Month 6): this will set out the strategy for liaison between network members, work groups and external stakeholders.

D3: Mapping exercise report (Month 18): an overview of databases, key datasets and ongoing research in each of the WG's will be produced. Each participant will provide a description of recently completed and ongoing projects, the main datasets held by the team and the main theoretical and methodological approaches adopted by them.

D4: Conference proceedings (Months 19, 36 and 48): all presentations at each of the three conferences will be published in a proceedings booklet to be made publicly available via the website.

D5: Glossary (Month 24): a glossary of terms and concepts relating to coercion and related phenomena will be produced as a vital step away from the subjectivity of these phenomena which currently contributes to widespread individual and cultural variations in the usage of terminology and impedes effective communication.

D6: Framework for establishing combined datasets and toolbank (Month 24): where existing datasets and findings are consistent across research teams the metadata for each will be identified and the scope for linking across datasets will be investigated.. Two main types of data collection instruments will be used: basic routine data collected by hospitals (e.g. registers of staff sickness absence, registers of the use of coercive interventions) and validated scientific measures. In addition a repository of public-domain structured instruments used in services across Europe relating to coercion will be compiled, stored and linked to the website for ease of access.

D7: State of the art reviews (Month 36): summary statements of the state-of-the art of research and clinical practice in each of the WG-areas, including comparative findings across countries will be produced. These will be targeted at various stakeholder groups (e.g. policy makers to improve decision making) and will underpin the consensus statements (D9 below).

D8: Implementation model (Month 42): an overarching model for addressing implementation barriers and embedding best practice will be articulated with case examples tailored to a selection of national contexts.

D9: Consensus statements (Month 46): each WG will produce a statement of best practice recommendations based on consideration of Action data, current literature and consensus meetings (e.g. Delphi technique). Statements will integrate specific knowledge on each topic with awareness of likely implementation issues (D8) drawn from WG4. These will include a number of proposed implementation packages tailored specifically to a range of contexts (e.g. high and low resources) providing guidance on how best practice principles in the consensus statements might best be introduced into practice.

D10: Annual / final report (Months 12, 24, 36 and 48): a report summarising activities and outputs for each year will be produced and collated at the end of the Action in a final report.

4.1.3 RISK ANALYSIS AND CONTINGENCY PLANS

Description of Risk **(Likelihood / severity)**	**Proposed mitigation measures**
Linguistic differences in cross-national activities based on written text and spoken language (high/moderate)	Access to high-quality translation services
Lack of suitable and available ECI candidates for STSMs (low/high)	Re-advertisement for recruitment up to month 24
Insufficient annual progress by Work Groups (low/moderate)	Ongoing monitoring and support
Withdrawal of key partner (low/high)	Suitable replacement to be found and co-opted using established networks
Non-delivery of key deliverables from the first half of the project (low/high)	If necessary, the project plan will be adjusted
Failure of consensus on what is relevant or achievable in quality control standards (moderate/moderate	Close consultation between consortium members in developing the material
Disagreements over intellectual property (low / moderate)	Early and continuous liaison by Dissemination Manager with consortium members in preparing the protocol
Inadequate dissemination to the specific target groups (low / moderate)	Early and continuous liaison by Dissemination Manager with consortium members in preparing outputs
Research fields remain fragmented; project participants have difficulties overcoming their disciplinary boundaries / hampered interdisciplinarity (low / high)	Additional and targeted meetings to facilitate and streamline interdisciplinary dialogues and developing a shared frame of understanding

4.1.4 GANTT DIAGRAM

WG	Year	1				2				3				4			
	Quarter	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
1.1	WG1 Meeting																
1.2	STSM 1																
1.3	STSM 5																
1.4	STSM 9																
1.5	Training school 1																
2.1	WG2 Meeting																
2.2	STSM 2																
2.3	STSM 6																
2.4	STSM 10																
2.5	Training school 2																
3.1	WG3 Meeting																
3.2	STSM 3																
3.3	STSM 7																
3.4	STSM 11																
3.5	Training school 3																
4.1	WG4 Meeting																
4.2	STSM 4																
4.3	STSM 8																
4.4	STSM 12																
4.5	Training school 4																
5.1	Management Committee																
5.2	State of the art conference																
5.3	Midway conference																
5.4	End of Action Conference																
D1	Website																
D2	Communication & Dissemination Plan																
D3	Mapping exercise report																
D4	Conference proceedings																
D5	Glossary																
D6	Dataset framework / toolbank																
D7	State of the art reviews																
D8	Implementation model																
D9	Consensus statements																
D10	Annual / final report																

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