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Aggressive and violent behaviour are major public health problems. In particular, the association with mental illness has been controversial and supported by some but not all research.[1,2] The display of aggressive or violent behaviour depends on a combination of factors relating to intrinsic and distal processes including the person, the environment and his/her social networks. This association with mental illness may in part drive public negative perceptions and stigmatisation of the mentally ill and the mandated imposition of treatment against further risk of interpersonal violence.

Coercion, defined as "compelling a person who is receiving mental health care ... through physical force or threat to accept care or treatment against their will"[3] appears to be indispensable in the management of aggressive behaviour and may be used in up to 8% of inpatients in mental health services. As recently as 2016, a Europe-wide report indicated that many mentally ill patients remained incarcerated in psychiatric institutions and patient testimonies told of physical and chemical restraint and segregation, all of which are examples of restrictive interventions.

Specific population groups such as people with intellectual and developmental disabilities are more likely to be subject to such restrictions. National UK data indicate that coercion took place in 13% (or over 10,000 incidents) of inpatients with intellectual disabilities and/or autism in a 3 month period in 2019 though the number of incidents declined substantially by 2021.[4.]

Application of restraint in its various forms has a harmful impact on staff and patient wellbeing and may even lead to death in some cases, so there is widespread concern about the continuing use of such practices[5]. An increasing interest from self advocates, their families, researchers and clinicians internationally has led to greater scrutiny of coercive practices. Substantial research has provided an evidence base and risk assessment tools to assist mental health professionals in predicting risk of future violence[6]. At the same time, a number of strategies have been described which, if implemented, can reduce or prevent violence and aggression, such as risk management, de‑escalation, staff training, post‑incident debriefing and review. However, many of the studies that report them suffer significant methodological limitations, including lack of theoretical underpinning, single site delivery, poor reporting of fidelity and of the active ingredients that are likely to be effective.

The multi-country EUNOMIA study[7] funded by the European Commission examined coercion in the treatment of the mentally ill across jurisdictions. The recommendations for good care ranged from informing patients about the reasons for admission and its duration; protecting patients' rights; encouraging the involvement of family members; improving the communication between community and hospital teams to developing training courses for involved professionals on the management of aggressive behaviours.

In England, the NICE Guideline 10 (2015)[8], sets out the pathway for anticipating and managing aggressive behaviour taking a person-centred approach. The guideline emphasises the importance of recognition of early signs of aggressive behaviour, the positive approach to promoting care and treatment and the skilled response in using coercive strategies. In this respect, patient involvement in Shared Decision Making[9] in mental health care is related to successful application of management strategies.

A potentially under-utilised approach which has been explored in a few studies is involving patients in their own risk assessment[10]; however, a recent audit report in one service showed that uptake is lower than expected[11]. Further, the characteristics of the inpatient environment merit attention as a ward designated as locked space or incorporating a seclusion area affects the frequency of use of coercion. The design of hospital facilities for people with mental illness has also been the focus of research as it is shown to induce violence and prohibit prosocial interaction. Drab and poorly maintained wards, *inter alia*, can add to the sense of frustration and alienation following admission ("originating domains") and give rise to "flashpoints" when violence may be displayed[12]. Therefore, giving due consideration to the built environment of inpatient facilities and how it could be used to support recovery is critical in the holistic management of aggressive behaviour and the reduction of coercive practices.

Following the tradition of scientific collaboration, dissemination of good practice and involvement of service users' perspectives in order to improve care, the EViPRG and FOSTREN collaborations were formed to bring together clinicians and researchers who study coercion in its various forms. By exchanging such knowledge in the multiplicity of service contexts across Europe, both organisations are committed to understanding the processes underlying the use of coercion in order to reduce it. These interdisciplinary networks are important in the delivery of education and training to psychiatric inpatient staff and in fostering access to arms-length bodies and policy makers, thus contributing to the promotion of recovery and reintegration of mentally ill patients in society[13]. Multiple avenues that encompass intervention development, staff upskilling and greater utilisation of the lived

experience of patients are urgently needed to tackle the multiple factors which contribute to the perpetuation of coercion in inpatient mental health settings and to enhance experience of mental health care.

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