The use of coercive measures in child and adolescent psychiatry practice in the Children's Clinical University Hospital, Riga, Latvia – a 10-year audit study

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Background. The use of coercive measures is still a part of the child and adolescent psychiatry practice, aimed to resolve the highest risk situations, but in itself bearing risks of being traumatizing to the patient, so it needs constant scrutiny and audit. This is the first clinical audit study that has been carried out looking at the use of coercive measures in child and adolescent psychiatry in Latvia.

Aim. To evaluate the use of coercive measures (types of measures used, reasons for coercion) in patients receiving inpatient psychiatric care in the Clinical University Hospital between 2013 and 2022.

Methods. A retrospective study was conducted using Children's Clinical University Hospital Child psychiatry clinic inpatient medical records and data from restraint and seclusion registries and protocols. IBM SPSS v.26 was used for statistical analysis.

Results. The total number of events of coercion between the years 2013 and 2022 was 237. In 149 (62.9%) cases, restrained and secluded patients were male. The most used coercive method was mechanical restraint with soft bandages (96.2%, N=228), while isolation was used only in 3 cases (1.3%). The mean duration of mechanical restraint was 50 minutes. Boys tended to be restrained for longer periods than girls (55 vs. 41 min on average). The most common reasons for the use of restraint were aggression (78.5%, N=186); psychomotor agitation/psychosis (48.1%, N=114); autoaggression (43.9%, N=104); damaging hospital property (14.3%, N=34); necessity to administer medication (7.2%, N=17). Boys were significantly more likely to be restrained due to psychomotor agitation/psychosis (p=0.000), while girls were more likely to be restrained due to autoaggression (p=0.000). The medication most often used for pharmacological restraint were i/m diazepam (32.1%, N=76) and i/m olanzapine (21.5%, N=51). The patients' parents were informed about the event of restraint straight after the event in only 14.8% of cases (N=35), which can be partially explained by the majority of cases of restraint being carried out in patients coming from out-of-home care (56.1%, N=133).

Conclusion. Most of the cases of seclusion and restraint that happened in the Children's Clinical University Hospital Child psychiatry clinic in a 10-year period were carried out according to existing normative regulations, but there is still a need for improvement to ensure the best possible standard of care for psychomotorly agitated, aggressive and autoaggressive patients.

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