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| **For the content use italics to mark the main title chapters. For example:**  **Ethics theory:**  Ethics is an inherent and inseparable part of clinical medicine [25] as the healthcare worker or clinician has an ethical obligation to benefit the patient, to avoid or minimize harm, and to respect the values and preferences of those using health services. Medical ethics have been present from the time of Hippocrates' oath. Modern medicine codes of ethics ensure physicians strive for the highest possible standards of ethical behavior [57].  **Beneficence, nonmaleficence, autonomy, and justice constitute the 4 principles of ethics.**  The principle of **beneficence** is the obligation of healthcare worker or clinicians to act for the benefit of the patient and supports a number of moral rules to protect and defend the right of others, prevent harm, remove conditions that will cause harm, help persons with disabilities, and rescue persons in danger. The principle calls for not just avoiding harm, but also to benefit patients and to promote their welfare.  **Nonmaleficence** is the obligation of a clinician not to harm the patient. This simply stated principle supports several moral rules − do not kill, do not cause pain or suffering, do not incapacitate, do not cause offense, and do not deprive others of the goods of life. The practical application of nonmaleficence is for the clinician to weigh the benefits against burdens of all interventions and treatments, to eschew those that are inappropriately burdensome, and to choose the best course of action for the patient. This is particularly important and pertinent in difficult end-of-life care decisions on withholding and withdrawing life-sustaining treatment, medically administered nutrition and hydration, and in pain and other symptom control. A physician's obligation and intention to relieve the suffering (e.g., refractory pain or dyspnea) of a patient by the use of appropriate drugs including opioids override the foreseen but unintended harmful effects or outcome (doctrine of double effect) [5, 43].  **Autonomy** is that all persons have intrinsic and unconditional worth, and therefore, should have the power to make rational decisions and moral choices, and each should be allowed to exercise their capacity for self-determination [22]. The principle of autonomy does not extend to persons who lack the capacity (competence) to act autonomously; examples include infants and children and challenges due to developmental, mental or physical disorder.  **Justice** is generally interpreted as fair, equitable, and appropriate treatment of persons. Of the several categories of justice, the one that is most pertinent to clinical ethics is distributive justice. Distributive justice refers to the fair, equitable, and appropriate distribution of health-care resources determined by justified norms that structure the terms of social cooperation [19].  **Confidentiality**  Clinicians are obligated not to disclose confidential information given by a patient to another party without the patient's authorization. An obvious exception (with implied patient authorization) is the sharing necessary of medical information for the care of the patient from the primary physician to consultants and other health-care teams.  **Informed consent** is the process in which a health care provider educates a patient about the risks, benefits, and alternatives of a given procedure or intervention. The patient must be competent to make a voluntary decision about whether to undergo the procedure or intervention [56].   1. ***Contextual factors associated with restrictive practice, seclusion, and restraint.***   Restraints and seclusions are restrictive interventions used in psychiatric inpatient units, including units for children and adolescents, when there is an imminent risk of harm to the patient or others [30]. These methods are controversial. Restraints have been associated with many adverse effects and put both patients and staff at risk of injury and death [Mohr WK. et al., 2002; Kersting XAK. et al., 2019; 41**;** 29]. In 1998, reports in the Hartford Courant revealed that 142 patients in the U.S. had died in the previous 10 years because of restraint [Weiss EM. et al., 1998; 64]. Many of these were children who had died of asphyxiation [Masters KJ., 2017; 37].  Legislation regarding coercive measures differs between countries [Mohr WK. et al., 2002; 41]. There is a movement towards less coercion and, as attitudes change, legislation revision follows. As an example, The Compulsory Mental Care Act in Sweden was recently updated, reducing the maximum duration of bed restraints for children from 4 h to 1 h and seclusions from 8 to 2 h [59].  Mechanical restraints are probably the least accepted containment measure and have been described as distressing and inhumane by Finnish adolescents [Chieze M. et al., 2017; 10]. In an American study, children and adolescents aged 12–15 reported that they associated fear, anger, and re-traumatization with the use of physical restraint [LeBel J. et al., 2005; 32].  In interviews with psychiatric nurses in Ireland, restraint and seclusion were interpreted as a last resort in the management of client’s aggression and violence [Moran A. et al., 2009; 42]. The nurses experienced significant emotional distress when compelled to engage in the interventions and, to get through the incidents, the nurses appeared to suppress their distressing emotions. The harsh nature of these interventions also conflicted with the caring aspects of the nursing role. In a recent systematic review, nurses viewed coercive measures as undesirable but necessary to maintain safety on psychiatric wards [Doedens P. et al., 2020; 15]. They also expressed a need for less intrusive interventions.  The staff offered several suggestions for improving restrictive measures. Similarly, both patients and staff identified the importance of support following the use of a restrictive measure such as restraint or seclusion. Patients felt ignored and neglected during restraint or seclusion, which intensified the distress experienced during the event. Following the event, patients reported receiving no emotional support or explanation and were left with resentment towards staff, which damaged the patient–staff relationship. A recent report from the UK Care Quality Commission highlighted that staffing and time pressures are a hindrance to staff being able to spend time building relationships with patients [8]. Interestingly, where staff were unable to spend time providing emotional support to patients, patients perceived this as being ignored, leading to increased tensions and a disconnect between patients and staff. The tensions in the staff–patient therapeutic relationship and the importance of having an appropriate ratio of patients to staff has been identified in other international in-patient contexts [Bak J. et al., 2015; 3].  Use of seclusion and restraint was most strongly associated with involuntary admission status and, in the case of seclusion.  The most commonly occurring contextual factor for prolonged restrictive interventions was risk of harm to others:  • younger age.  • prolonged seclusion.  • prolonged mechanical restraint.  • diagnosis.  • symptoms.  • cognitive function  • global functioning  • therapeutic alliance  • attitudes toward medication.  • insight.   1. ***Motivations behind behaviours that challenge abnormal behaviour to infant, child, and adolescent mental health.***   Violence prevention begins in early childhood with violence-free discipline [Kashala E et al. 2005; 28]. Limiting exposure to violence through media and video games may also help because exposure to these violent images [e.g., Reiss, 2013; Russell, Ford, Williams, & Russell, 2016; Yoshikawa, Aber, & Beardslee, 2012; 52; 55; 65] has been shown to desensitize children to violence and cause children to accept violence as part of their life [Ballarotto G. et al. 2018; 4]. School-age children should have access to a safe school environment [Oladeji BD et al. 2010; Cimino S. et al., 2018; Cerniglia L. et al. 2010; 48; 11; 9]. Older children and adolescents should not have access to weapons and should be taught to avoid high-risk situations [Eaton NR et al, 2010; Hannigan LJ, 2017; 17; 23], (such as places or settings where others have weapons or are using alcohol or drugs) [APA, 2018b; 2; Reiss, 2013; 52], and to use strategies to defuse tense situations [Levy S, 2022; 33].    Fig. 1. Theoretical model of risk behaviour factors. (Bozzini A. et all. 2021; 7)   1. **Coercive and restrictive practice.** 2. “Coercive practices” has been explained as making someone do something they don’t want to do or stopping someone doing something they want to do. 3. “Cohesion” is used as shorthand for all the restrictive interventions listed in the box across the page. There are other practices on this spectrum which people experience as restrictions or restraint: psychological coercion and manipulation, and withdrawal of care, resources and/or information. They are not ‘interventions’ because they are not methods that that staff are expected or allowed to use but can occur where there is a coercive or controlling ward culture. 4. “Restrictive interventions” include observation, seclusion, manual restraint, mechanical restraint, and chemical restraint which may include rapid tranquillisation. These are all deliberate acts that restrict someone’s movement or freedom to take control of a dangerous situation or to end or reduce danger to the person concerned or others. Acts like these all have the potential to violate the person’s human rights.  * Physical   Any direct physical contact where the intention is to prevent, restrict, or subdue movement of the body (or part of the body) of another person. (Positive and proactive care and Mental Health Act Code of Practice)   * Mechanical   The use of a device to prevent, restrict or subdue movement of a person’s body, or part of the body, for the primary purpose of behavioural control. (Positive and Proactive Care and Mental Health Act Code of Practice)   * Chemical   The use of medication which is prescribed and administered for the purpose of controlling or subduing disturbed/violent behaviour. This does not include where it is prescribed for the treatment of a formally identified physical or mental illness. (Positive and proactive care) Rapid tranquillisation is the use of medication to calm or lightly sedate an individual to reduce the risk of harm to self or others and to reduce agitation and aggression. (Code of Practice) The Code of Practice says it may include oral medication or injections; It refers to an injection given if oral medication is not possible or appropriate and urgent sedation with medication is needed. Both are clear that oral medication should always be considered first. Use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed.   1. Seclusion   The supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others.   * Work out common triggers - this could be in the environment, or with certain people. * Find ways to help the person express themselves. * Help the person to feel happy and spend time doing the things they enjoy. * Develop simple coping strategies to reduce stress, such as controlled breathing or counting. * Stay alert and try to anticipate problems. * Create a strong support network of family, friends, and professionals if necessary.   The terms ”coercion” and ”coercive practices” are used to refer to both forceful persuasion and/or compulsion of a person – which emphasizes forceful action – due to an actual or perceived mental health condition [Szmukler G., 2015; 60]. The definition of “coercive measures” includes formal coercion, such as actions limiting freedom of movement (restraint, seclusion), involuntary hospitalization, and forced treatment [Hem MH, Gjerberg E, Husum TL et al, 2018; 24]. Coercive measures, defined as any measure applied “against the patient's will or in spite of his or her opposition” [59].  Restrictive practices are typically broken down into categories such as physical, chemical, mechanical, environmental, seclusion, psychosocial or psychological [1]. Restrictive practices refer to a range of measures. Physical and chemical restraint (e.g., rapid tranquillisation) aim to restrict movement or control behaviour in an emergency [Vedana KGG, da Silva DM, Ventura CAA, Giacon BCC, et al. 2018; 63] and seclusion is intended to isolate and reduce sensory stimulation to calm the patient and ensure everyone is safe from harm [Meehan T, et al, 2004; 39]. Physical restraint involves direct physical contact between persons where force is positively applied against resistance, either to restrict movement or mobility or to disengage from harmful behaviour displayed by an individual [40]. Restraint is defined as any manual method, physical, material, or equipment that immobilizes or reduces the ability of a patient to freely move his or her arms, legs, body, or head. Physical restraint can be defined as any device, material, or equipment attached to or placed near a person's body and which cannot be controlled or easily removed by the person and which deliberately prevents or is deliberately intended to prevent a person's free body movement to a position of choice and/or a person's normal access to their body parts [Retsas AP, 1998; Gowda GS, Lepping P, Noorthoorn EO, 2018; Raveesh BN, Lepping P, 2013; 54; 21; 51] The most common examples of physical restraint include bedside rails, tucking very tightly in sheets, limb ties, straps, belts [Danivas V, Lepping P, Punitharani S, 2016; 14].  Chemical restraint involves the use of medication to restrain. It differs from therapeutic sedation in that it does not have a direct therapeutic purpose but is primarily employed to control undesirable behaviour. Chemical restraint is more difficult to measure because the administration of a psychotropic drug (e.g., an antipsychotic) does not necessarily equate to it being used as a restraint. Studies have reported the prevalence of use of drugs associated with chemical restraint [Dunbar P, McMahon M, Durkan C, 2022; 16]. Mechanical restraint is defined as the immobilization of a person through the application of mechanical devices that cannot be easily controlled or removed to prevent free movement of their body [Bleijlevens MH, Wagner LM, Capezuti E, 2016; 6]. In clinical practice, MR is considered an emergency procedure for patients exhibiting potentially dangerous behaviour associated with psychiatric illnesses who have failed to respond to less restrictive interventions [Fugger G, Gleiss A, Baldinger P, 2016; 20]. Environmental restraint involves buildings designed to limit people's freedom of movement, including locked doors, electronic keypads, double door handles, and baffle locks. Regardless of who the health professionals tasked with making decisions about PR use might be, the setting in which this might take place, or the elements that might exert an influence, decision-making in clinical practice should include the following five elements: (1) awareness and definition of the problem; (2) determination of the goal; (3) assessment of alternatives; (4) implementation; and (5) evaluation [Evans D. 1990; 18].  These are all deliberate acts that restrict someone’s movement or freedom to take control of a dangerous situation or to end or reduce danger to the person concerned or others. Acts like these all have the potential to violate the person’s human rights [64].  The following are the general principles followed for the use of restraints [47]:   1. The safety and dignity of the patient must be ensured. 2. The safety and well-being of staff is also a priority. 3. Prevention of violence is key. 4. De-escalation should always be tried before the use of restraint. 5. Restraint is used for the minimum period. 6. All actions undertaken by staff are appropriate and proportional to the patient's behaviour. 7. Any restraint used must be the least restrictive, to ensure safety. 8. The patient must be closely monitored, so that any deterioration in their physical condition is noted and managed promptly and appropriately. Mechanical restraint requires 1:1 observation. 9. Only appropriately trained staff should undertake restrictive interventions, to ensure the safety of patients and staff. 10. **Legislation and national guidelines.**   The legislation, which regulates various issues related to violence against children and women, covers various legal acts.   1. United Nations convention on the rights of the child [27]   In 1989 something incredible happened. Against the backdrop of a changing world order world leaders came together and made a historic commitment to the world’s children. They made a promise to every child to protect and fulfil their rights, by adopting an international legal framework – the United Nations Convention on the Rights of the Child. Contained in this treaty is a profound idea: that children are not just objects who belong to their parents and for whom decisions are made, or adults in training. Rather, they are human beings and individuals with their own rights. The Convention says childhood is separate from adulthood, and lasts until 18; it is a special, protected time, in which children must be allowed to grow, learn, play, develop and flourish with dignity. The Convention went on to become the most widely ratified human rights treaty in history and has helped transform children’s lives.  The Convention has inspired governments to change laws and policies and make investments so that more children get the health care and nutrition they need to survive and develop, and there are stronger safeguards in place to protect children from violence and exploitation. It has also enabled more children to have their voices heard and participate in their societies.  Despite this progress, the Convention is still not fully implemented or widely known and understood. Millions of children continue to suffer violations of their rights when they are denied adequate health care, nutrition, education, and protection from violence. Childhoods continue to be cut short when children are forced to leave school, do hazardous work, get married, fight in wars, or are locked up in adult prisons. And global changes, like the rise of digital technology, environmental change, prolonged conflict, and mass migration are completely changing childhood. Today’s children face new threats to their rights, but they also have new opportunities to realize their rights.  The hope, vision, and commitment of world leaders in 1989 led to the Convention. It is up to today’s generation to demand that world leaders from government, business, and communities end child rights violations now, once and for all.   1. European Union convention on Human Rights   The European Convention on Human Rights (ECHR) is an international human rights treaty between the 47 states that are members of the Council of Europe (CoE) - not to be confused with the European Union. Governments signed up to the ECHR have made a legal commitment to abide by certain standards of behaviour and to protect the basic rights and freedoms of people. It is a treaty to protect the rule of law and promote democracy in European countries. The European Convention on Human Rights (ECHR) was formally drafted by the Council of Europe in Strasbourg during the summer of 1949. Over 100 members of parliament from across Europe assembled to draft the charter. The United Kingdom was the very first nation to ratify the convention in March of 1951 [26].  The ECHR came into full effect on the 3rd of September 1953. It was intended to be a simple, flexible roundup of universal rights, whose meaning could grow and adapt to society’s changing needs over time. Not only were ordinary people to be protected from abuse by the state, but duties were to be placed on those states to protect individuals. It has been hugely important in raising standards and increasing awareness of human rights across CoE member states, and beyond.  The creation of the ECHR led to the establishment of the European Court of Human Rights (ECtHR). It was set up in 1959 and is based in Strasbourg, France. The Court exists to safeguard the ECHR, providing a forum for people who believe their rights have been denied, allowing them to have their cases heard. Judgements of the Court legally bind countries to stand by its rulings. The resulting case-law makes the Convention a powerful ‘living instrument’, whose decisions have influenced the laws and practices of governments across Europe [26].   1. EU strategy on the rights of the child 2021   A new comprehensive EU policy framework to ensure the protection of rights of all children, and secure access to basic services for vulnerable children.  The EU Strategy on the Rights of the Child has been developed for children and with children. Children should have access to information provided in a child friendly way so they can clearly know what their rights are and, in this case, what the EU plans to do for them. The child friendly versions of the strategy were co-designed by children and present the information in a digestible way for their readers. Children advised on the language, images and examples used in the leaflets. Moreover, the child friendly version of the strategy is accessible for visually impaired readers and can be accessed using assistive devices and technology. Every child in Europe and across the world should enjoy the same rights and live free from discrimination and intimidation of any kind. In the EU Strategy on the Rights of the Child, the Commission addresses persisting and emerging challenges and proposes concrete actions to protect, promote and fulfil children’s rights in today’s ever-changing world [58]. No policy regarding children should be designed without their voices. Thanks to the efforts of leading child rights agencies and organisations, both the Strategy on the Rights of the Child and the European Child Guarantee benefitted from the input of more than 10,000 children. Their views were collected through an online questionnaire and other forms of consultations. The principal report following this consultation process was launched on 23 February 2021 at an online event with children.   1. In Republic of Bulgaria, the main ones are: 2. The Law on Protection from Domestic Violence and the Regulations for its Implementation.   On March 16, 2005, the Bulgarian Parliament adopted the Law on Protection against Domestic Violence (LPADV). The impetus for the Law came almost ten years earlier in 1997-99 through a joint project of the Bulgarian Gender Research Foundation (BGRF) and The Advocates for Human Rights (The Advocates). In 1996, after conducting extensive research, The Advocates published a report on domestic violence as a human rights abuse, entitled Domestic Violence in Bulgaria (March 1996). This report was followed by further legal research by both organizations on domestic violence in Bulgaria and the gaps in Bulgarian legislation. During 2000-2002, a group of BGRF and other attorneys began work on a draft domestic violence law [State Gazette [SG] 2005, No. 33; 50]. Domestic violence remains a widespread problem in Bulgaria. A 2006 report estimated that one in four women in Bulgaria are subject to domestic violence. According to a 2007 report, 40% of Bulgarians knew a woman victim of physical violence. The problem is compounded by other factors, such as weak criminal laws for punishing offenders, policies that prioritize the [62] offender’s right to property over a victim’s safety, and traditional views that domestic violence is a private matter. A majority of Bulgarians agree that a woman’s right to be free from violence is more important than preservation of the family or the offender’s right to live in his home. In one survey, sixty-eight percent of Bulgarians supported the idea of temporarily removing the offender from the family [59].  The LPADV creates a remedy for victims of domestic violence in Bulgaria by allowing them to petition the regional court for protection [State Gazette [SG] 2005, No. 29; 34]. It defines domestic violence as any act or attempted act of physical, mental or sexual violence, as well as the forcible restriction of individual freedom and privacy [LPADV, SG 2005, No. 27, § 2; 34].  To warrant protection under the law, the violence must have occurred within one month of the petition6 and between the following persons: current and former spouses; current and former cohabitants; persons with a child in common; [LPADV, SG 2005, No. 28, § 1; 35]; ascendant and descendants (e.g. parent/child); siblings; relatives within two degrees; guardian/foster parent and child relationship [LPADV, SG 2005, No. 29, § 2; 36].   1. The Child Protection Act and the regulations for its implementation.   This Act shall govern the rights of the child; the principles and the measures for child protection; the state and municipal bodies and their interaction in the process of performing child protection activities, as well as the participation of legal entities and natural persons in the said activities [New, SG No. 36/2003; 45]. The state shall protect and guarantee the basic children's rights. In all spheres of public life for all groups of children in view of the age, social status, physical, health and mental development, as providing appropriate economic, social, and cultural environment, education, freedom of expression and security.   1. Provisions on the Bulgarian Family Code and the Criminal Code.   Family Code envisages three property regimes between the spouses – statutory property (community) matrimonial regime, statutory separate matrimonial regime, and a contractual regime. The Family Code shall regulate the relations based on marriage, kinship, and adoption, as well as custody and guardianship [53].  Family relations shall be settled in accordance with the following principles:   * protection of marriage and the family by the state and society. * gender equality. * voluntary nature of matrimony. * special protection for children. * equal treatment of those born in wedlock, out of wedlock and adopted. * respect for the personality of the family. * respect, care, and support among family members.  1. The Anti-Discrimination Act etc.   This Law shall regulate the protection against all forms of discrimination and shall contribute to its prevention [31].  The purpose of this Law is to ensure for every person the right to:   * + equality before the law.   + equality of treatment and of opportunities for participation in the public life.   + effective protection against discrimination.  1. Any direct or indirect discrimination on the grounds of sex, race, nationality, ethnic origin, citizenship, origin, religion or belief, education, opinions, political belonging, personal or public status, disability, age, sexual orientation, marital status, property status, or on any other grounds, established by the law, or by international treaties to which the Republic of Bulgaria is a party, is forbidden. 2. Direct discrimination shall be any less favourable treatment of a person on the grounds, referred to in paragraph (1), then another person is, has been or would be treated under comparable circumstances. 3. Indirect discrimination shall be to put a person, on the grounds referred to in paragraph (1) in a less favourable position in comparison with other persons by means of an apparently neutral provision, criterion, or practice, unless the said provision, criterion or practice have objective justification in view of achieving a lawful objective and the means for achieving this objective are appropriate and necessary. 4. National child protection strategies are also important, for the prevention of violence against children and women and other acts.   The development of children and the protection of their rights is a national priority requiring a concentration of resources, constant political and public attention, and maximum coordination of policies. The National Strategy on the Child is a political document which defines the priority areas and activities for improving the welfare of the children in Bulgaria. The Strategy has been adopted in compliance with Art. 1, para. 3 of the Child Protection Act (CPA) and is based on the main principles stipulated in the Convention on the Rights of the Child of the United Nations (UN).  The European Commission (EC) has adopted actions for the development of a Single European Strategy on the Rights of the Child, as well as administrative provision of the new policies. Thus, the European Union (EU) has clearly identified the support for the rights of the child as a separate subject requiring specific action.  The state policy on the child has been implemented based on the National Strategy on the Child adopted by the National Assembly, based on the principles of the Child Protection Act. In compliance with the National Strategy, the Council of Ministers has adopted a National Programme for Child Protection. These documents are based on the principles aiming to ensure the best interests of the child and protection of the rights of all children in Bulgaria, by uniting the efforts of all institutions involved in the planning and implementation of the activities [61; 49].   1. The Republic of Bulgaria is also bound by several international and European conventions, treaties, and other acts in the field, which are of a mandatory nature.  * National Committee on International humanitarian law.   National Committees on International humanitarian law exist in 112 states worldwide and in 20 out of 27 Member States of the European Union. Their main functions is to support the State-parties in the implementation of the Geneva Conventions of 1949 and their Additional Protocols. The International Committee of the Red Cross (ICRC) advises and encourages the creation of National Committees on IHL [46].   * Expert working groups within the NC on IHL   Decree No. 35 of the Council of Ministers of February 28, 2019, provided the possibility to establish expert working groups as part of the NC on IHL to bring expert support to the Council’s activities on various subjects in the field of IHL. At its first meeting, the NC on IHL decided to set up an expert working group to review the compliance of Bulgarian legislation with the international treaties in the field of IHL in areas such as: protection of humanitarian and health personnel, provision of medical care in emergencies, including natural disasters, regulated use of methods and means of war, protection of cultural property, natural environment protection, etc. [12].  As a result of the Review, an assessment of the national measures for implementation of IHL, as well as the measures that need to be undertaken to bring national legislation in compliance with international treaties, was conducted. The Expert Working group included a wide range of experts from government agencies, independent institutions, representatives of the academic sphere and the non-governmental sector; as well as other experts with expertise in the field of IHL [13].   1. **13 steps before restraint.**  * Control yourself – act calm and confidently. Show no fear. Have slow and gentle movements. * Delimit – separate yourself from other people at risk. Maintain distance. * Clarify – ask what’s happening, use open questions. Orient patient to time, place, and person. * Resolve – request politely, don’t command, be flexible, negotiate, compromise. * Respect and empathy – show interest, concern and interested tone of voice. Don’t yell or shout, show sincerity. * Be able to check that the patient’s airway and breathing are not compromised. * Be able to monitor vital signs. * It must be assumed that a person has capacity go give their informed consent unless assessed as otherwise. * Avoid prolonged physical intervention/immobilisation longer than 10 minutes. * Risk assessment of the circumstances * If necessary, request assistance from security or the Police * Ensure that the restrained persons’ head and neck are appropriately supported and protected, airway and breathing are not compromised, and vital signs are monitored. * For safety reasons during a restraint, it is only permissible to hold/apply pressure to the person’s limbs. Avoid applying pressure to the neck, thorax, abdomen, back or pelvic area. * Avoid restraining person on the floor. In rare cases where the restrained person needs to be held in a face down prone position this should be for the shortest possible time to bring the situation under control.  1. The patient must be informed of the type of restraint, why it is being used and the requirements for discontinuing the restraint. 2. Communicate clearly. 3. Safety is paramount. 4. Wait until you have enough resources present that nobody is going to get hurt. (Including the patient.) 5. Have a plan. 6. Assign a team leader. 7. Have a plan B. (Know your exit.) 8. Protect the patient’s airway. 9. Consider sedation if the patient is still fighting after restraint. 10. Pay close attention to any patient who suddenly becomes quiet and compliant. 11. Here are a few restraint errors to avoid: 12. Don’t give the patient ideas. 13. Don’t use arm locks, leg locks, face down restraint, hog tie or sandwich restraint techniques. 14. **Quality standards in child psychiatry.**   Basic provisions:   1. Child psychiatry is a medical discipline with the object of diagnosis, treatment, and prevention of mental disorders in children and adolescents. 2. Basic principles of children's psychiatric health care are regionality, focus on the child and parents, commitment of parents in the diagnostic-treatment process, collaboration with non-medical institutions working with children, diagnosis, and treatment in the **least restrictive** environment for the child, child-psychiatric multidisciplinary team. 3. Child psychiatric health care includes pre-hospital and in-hospital care. 4. In pre-hospital care, child psychiatric health care is provided by family doctors, psychiatrists, and child psychiatrists ets. 5. The child-psychiatric hospital departments are a department for child-adolescent mental health, a psychiatric department for children up to 12 years old, a psychiatric department for adolescents /13-18 years old/, a rehabilitation department. 6. Child-psychiatric hospital health care is provided by regional dispensaries for mental illnesses, child-adolescent psychiatric hospitals, university child-adolescent psychiatric clinics and, under certain conditions, psychiatric hospitals [38].   Basic divisions:   1. Hospital child-psychiatric health care - includes the following mandatory organizational principles of disclosure - territorial separation from adult wards, separation of boys from girls, provision of a day dining room and study room, access to laboratory and instrumental tests and medical consultations. 2. Child or adolescent rehabilitation departments - they are disclosed in child-adolescent psychiatric hospitals and university child-adolescent psychiatric clinics that they are territorially separated and have separate staff. |

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