RACGP

Royal Australian College *of* General Practitioners

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RACGP submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability

Issues paper: Restrictive practices

September 2020

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The Royal Australian College of General Practitioners

The Royal Australian College of General Practitioners (RACGP) thanks the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (the Commission) for the opportunity to provide a submission to the *Restrictive practices issues paper*.

The RACGP is Australia's largest general practice organisation, representing over 41,000 members working in, or towards, a career in general practice. Each year, general practitioners (GPs) provide more than 154 million general practice services to more than 24 million Australians.

The RACGP has previously contributed submissions to the Royal Commission, including:

- Healthcare for people with cognitive disability issues paper[1]
- Emergency planning and response issues paper[2]
- Submission to the Royal Commission Terms of Reference[3]

The role of the GP

GPs are most often a person's first point of contact in the health system. GPs provide patient-centred, comprehensive, longitudinal care for patients and work to ensure they receive the necessary support outside of the general practice.

Even when other health professionals are providing support to a person with disability, many people with disability have other health issues which require care from GPs and their teams. Therefore, GPs are intrinsically involved in disability work and often have a strong and ongoing relationship with people who have a disability.

GPs also play a key role in the prevention, detection and support for patients with disability who may be experiencing abuse and violence. Through this long-term relationship, GPs are particularly cognisant of the signs of abuse and neglect that a person with disability may exhibit, including being subject to restrictive practices from family, carers or other services providers (e.g. schools, hospitals, in a group home or aged care setting). The RACGP provides guidance to GPs who may have a patient with disability who they suspect, or know, is subject to abuse and violence.

- *RACGP Abuse and Violence: working with our patients in general practice* (10th ed) - Chapter 10.2 - People with disabilities - specifically provides guidance around the identification and management of people with disability who are subject to abuse and violence[4].

- *RACGP Aged care clinical guide* (the Silver book) - Part B - Abuse and violence of older people - provides guidance on abuse that may occur in an aged care setting or with elderly patients living at home[5].

1. Definition of restrictive practices

Referring to Question 1: What are restrictive practices? Does the explanation in this paper need to change?

The *Restrictive practices issues paper* provides a comprehensive and thorough explanation. The RACGP recommends the changes below for consideration by the Commission.

1.1 Use of restrictive practices as a last resort

The RACGP recommends the explanation further emphasises the decision to apply a restrictive practice should only be made as a last resort.

It is important that a person's autonomy is respected at all times. It is imperative that people with disability are empowered, encouraged and feel safe to make their own decisions and choices. A restrictive practice should only be applied after careful consideration and after all other alternatives have been exhausted.

1.2 Highlight passive and less recognised restrictive practices

Passive forms of restrictive practices that may go unrecognised include:

- *Set rules for all residents of a home*, such as enforced set meal and bed times, that do not allow for individual autonomy, needs and circumstances
- *Intentional or unintentional restriction of social interaction*, where residents do not have access to a range of stimulating activities, may have limited opportunities for social interaction with other people, and may suffer boredom as a result.

2. Restrictive practices in general practice and in other healthcare settings

In response to:

- *Question 2: What types of restrictive practices are applied to people with disability? Are certain types of restrictive practices more common than others?*
- *Question 4: Where or in what circumstances are restrictive practices used?*
- *Question 5: Why are restrictive practices used?*

GPs may encounter restrictive practices outside of their clinic, within a visit to a care facility, or a group home. There are instances where GPs may be required to use a restrictive practice in the GP clinic. As an example, to administer necessary care (usually in the setting of administering a required vaccination or taking blood for a test, where it is important that the patient remains still), or if the person is at immediate risk of harming themselves or other people. In such circumstances, GPs will have to carefully consider whether the benefits of the health intervention outweigh the potential emotional harm of the restrictive practice.

Restrictive practices that are commonly seen or used within healthcare settings include:

1. Medication and chemical restraints
2. Physical restraints
3. Environmental restraints

2.1 Medication and chemical restraints

Why this is used

- *As a last resort harm reduction strategy*, because within the context of an emergency crisis, the presenting challenging behaviour may potentially result in harm to the person themselves, to staff, or to other members of

the public. If a person is unresponsive to other non-restrictive behavioural strategies, medication may be administered in order to settle the person, and subsequently de-escalate the situation.

- *To provide necessary care* in the circumstances of a healthcare setting, where a person may exhibit challenging behaviours, in-patient admission may be unsuitable and can be distressing for the person in crisis.
- To help facilitate management of the person and their initial presenting problem at home, where they feel most comfortable.
- *As a short-term measure for the patient* to 'bridge the gap' until they can access non-pharmaceutical options. There are currently long wait times for behavioural specialist appointments to address ongoing patient issues such as challenging behaviours and crises. These medications may only be prescribed as a short-term measure until the patient can see a specialist who can put together a non-restrictive treatment plan going forward.

Problems that arise from use of medication as a restraint

- Improved behaviour may be mistakenly linked directly to prescribed medication. This may occur if a person with disability has been prescribed a medication, and their behaviour subsequently improves. The treating clinician should be aware of the person's baseline behaviours, and ensure adequate follow-up and monitoring following the initiation of any medications to manage behaviour. Medication should not be part of routine care as this may result in unnecessary harms if not required.
- Inappropriate medication use can result in unnecessary risk of adverse side effects on the person taking the medication. This can have long-term implications for the person's health, for example, weight gain as a result of taking antipsychotic medication, and adverse interactions with other medications which may be upsetting and/or harmful. Good communication, including thorough clinical notes between the treating team is essential.
- *Oversedation* may make the person less responsive to non-pharmaceutical behavioural management techniques, and experience respiratory depression or arrest.

Regular reviews, appropriate documentation, monitoring effects, and adjustment or deprescribing will ensure medication is not unnecessarily prescribed and risk of harms to the person is reduced.

2.2 Physical restraints

When this is used

Physical restraints may be used when the person is at immediate risk of hurting or endangering themselves or others, and are likely to be used more for younger people with disability, and those with mental health conditions.

Why this is used

- *For harm reduction* when the person is presenting with challenging behaviours and are at immediate risk to themselves or others.
- *To administer healthcare* such as for necessary procedures or tests. As an example, restriction of movement may be required to maintain an upright posture to prevent aspiration. In such situations, the benefits of the healthcare intervention have to be carefully weighed up against potential harms from the restriction.

Problems that arise from use of physical restraints

- *Direct physical harm* can occur as people may sustain injury from trying to escape the restraint. Indirect physical harm, such as increased weight gain, obesity and/or cardiovascular disease as a result of lack of exercise may be sustained over a longer term.

- *Psychological harm* including fear, anxiety and phobia could result from the use of physical restrictive practices. A person may also lose trust and confidence in the person applying the restriction, who may be a close family member or carer.

2.3 Environmental restraints

When this is used

Environmental restraints involve changes to the surrounding environment to reduce dangers that could be encountered, or to soothe challenging behaviours. These restraints are more commonly used for people with intellectual disability and dementia.

Why this is used

- *For harm reduction* where items that can pose a danger to the person or other people are removed or locked. This could involve the use of locks and gates at a residential care facility. Environmental restraints are also used for indirect harm reduction such as creating a calm environment to soothe potential challenging behaviours, with intent of preventing a crisis.

- *For behaviour control,* for example, withholding technology such as iPads to ensure the person gets adequate rest at night, or encouraging the use of technology to ensure the person is entertained, while carers complete other necessary tasks.

Problems that arise from use of environmental restraints

- Removes autonomy and the ability for the person to make decisions for themselves. In a group setting, blanket restrictions impact the autonomy of other people who live in the premises, who do not require the restrictions.

3. Frequency, circumstances and other factors that contribute to the use of restrictive practices

In response to Question 3: How often are people with disability subjected to restrictive practices?

The frequency and circumstances in which a restrictive practice is used is difficult to accurately ascertain as it is dependent on intertwined and multilayered contributing factors:

- how a restrictive practice is defined, and whether it includes more passive forms of restrictive practices

- the severity of the disability / condition

- the type and severity of the challenging behaviour, and whether the behaviour poses immediate risks to the person or others around them, the environment in which the person is in, and whether there are any immediate dangers in the environment

- the availability and accessibility of non-restrictive alternatives.

Wherever possible, people with challenging behaviours should have access to non-pharmaceutical, proactive, positive, and individually tailored behavioural approaches. These approaches should best fit their disability and specific circumstances, with a process to monitor and adjust these approaches over time. There is currently little data or research within the Australian context regarding the use and prevalence of restrictive practices for people with disability.

3.1 How a restrictive practice is defined

How the restrictive practice is defined is important. For example, a locked gate at a facility, where people may be at risk of walking onto a nearby road despite being told not to, may be necessary to ensure safety. Subtle practices may be

required to avoid use of physical, and potentially more traumatic, restrictive practices. For example, ensuring the availability of a quiet room or space for people who are sensitive to sounds to avoid a crisis where a more restrictive approach may need to be taken.

3.2 The type of disability

The frequency of use of restrictive practices is likely to be influenced by the type of disability, the severity of the disability and/or the resulting challenging behaviours.

- *People with intellectual disability and autism* may be more likely to exhibit challenging behaviours that may be subject to restrictive practice.
- *Specific developmental disabilities* may be subject to restrictive practices, such as food restriction for a person with Prader Willi syndrome.
- *People who are non-verbal* may be subject to restrictive practices, particularly if they do not have strong advocacy from family, or their family may not be educated on appropriately managing challenging behaviours.

3.3 Availability of accessible alternatives

Availability of non-restrictive alternatives, such as appropriate support experts may affect how frequently a restrictive practice is used. Long wait times for specialist support and other non-pharmaceutical approaches may result in restrictive practices being used more often, as a desperate and reactionary measure. In addition, time is required to draw up an appropriate management plan, train and brief staff, and await placement in a suitable environment after the initial assessment. This gap between initial crisis and specialist behavioural support is often exacerbated in rural and regional areas where there is often shortage of appropriately skilled professionals.

A person with disability, without a specific psychiatric diagnosis, may lose support from public mental health services. The person is then left without high level specialist support, leading to increased challenging behaviours and/or a crisis.

3.4 Staff, carer and family burnout

Reduced staffing numbers, staff turnover and burnout may affect how often a restrictive practice is used for people with disability and challenging behaviours. If family, carers, and/or staff do not have the adequate skills, support or staffing numbers to effectively manage challenging behaviours, restrictive practices are more likely to be used. Without adequate resourcing and support, family, carers and/or staff are also likely to experience fatigue and burnout, and use restrictive practices such as physical and medical restraints, as a desperate last resort.

3.5 Allow safe community interaction

Restrictive practices may be required to keep the person, and other people around them, safe when they access the community. It is important that wherever possible, people with disability have the freedom to interact and be included within the community, maintaining their quality of life and mental wellbeing. Depending on the nature of the challenging behaviours exhibited, some restrictions may be required to access the community safely.

3.6 In emergency situations

Restrictive practices may be used as a result of behavioural outbursts, crises and other challenging behaviours, where the person, or other people in their immediate vicinity, may be at risk of harm, and non-restrictive practices have been unable to successfully manage those risks. In these cases, the least restrictive option should be used. Once implemented, the effect of the practice should be monitored and reviewed, and only continued if shown to be effective, and if no other options are available.

3.7 Routine care

Restrictive practices may end up entrenched in 'routine care' in the care of people with severe disabilities and behavioural conditions, and in Residential Aged Care Facilities (RACFs).

Practices may be first initiated within a crisis situation and continued as a matter of routine care.

3.8 Carers

Some form of restrictive practices may be routinely used by carers who:

- may be less well-educated about disability;
- may not have the skills to manage particularly complex and challenging behaviours;
- have people supporting them who have concerns about a repeat situation;
- are less supported or are experiencing burnout due to staff shortages and shortage of appropriate specialists.

Restrictive practices may be an easier solution in these circumstances, in place of more inclusive, but energy intensive strategies. It is important to ensure reviews are conducted by treating health professionals or qualified staff to ensure use only when absolutely required.

3.9 Demographic differences in the use of restrictive practices

Restrictive practices may be used more often in certain demographics:

- *Gender* – Males who display aggressive or disruptive behaviour.
- *Age* - physical restrictive practices are more likely to be used in children.
- *Aboriginal and Torres Strait Islander people* - the unique challenges faced by Aboriginal and Torres Strait Islander people is addressed in Section 6.
- *Culturally and linguistically diverse people* - Understanding of what causes a disability can vary greatly across cultures and within families. People providing support need to be informed and mindful of how this impacts a person with disability, while still being culturally sensitive and responsive. Previously experienced trauma or torture and complex mental health issues[7] may influence reaction and distress to the use of restrictive practices. Lack of access to translation and interpreter services, for both people with disability and their family and/or carers, including after-hours services, is a barrier to providing appropriate support[7].

4. The effects of restrictive practices

Referring to Question 6: What are the effects of restrictive practices?

While harmful effects may result from the use of restrictive practices, well-applied restrictive practices make an important difference in the person's quality of life, allowing them safe access to the community. A clear rationale is required for restrictions, with careful monitoring of its implementation, and regular assessment for the duration of the restriction.

4.1 Harmful effects

- *Harms from inappropriate use of medication* as discussed in **Medication and chemical restraints**
- *Loss of freedom* by limiting the range of activities that a person can undertake. This limits their self-determination and ability to develop good decision-making skills. Loss of freedom can impact negatively on a person's wellbeing and mental health.

- *Cause harm to relationships* between the person and their carer and/or family. These are relationships where trust is paramount, as the person with disability may rely heavily or solely on carers and/or family for care. Some restrictive practices may isolate the person from family, partners, friends, and other close social relationships. They may not have opportunities to interact in the community, and to develop new relationships.

- *Physical harm* as discussed in **Physical restraints.** Physical restraints can result in physical harms to the person, or long-term health problems, such as weight gain, obesity or cardiovascular disease because of limited movement.

- *Psychological harm* can include fear, anxiety and phobia, feelings of isolation, low mood and depression.

4.2 Beneficial effects

Well-applied restrictive practices enable people with disability to access the community in a safe and comforting way, tailored to their individual needs and circumstances, making an important and positive difference in a person's quality of life.

- *Harm prevention* strategies prevent harm to the person, and/or people around them.

- *Providing a sense of structure* to the person can be mentally calming, improving their health and wellbeing by allowing access to the community, albeit with restrictions (as opposed to no access to the community at all).

- *Restrictive practices required for the person to undergo health procedures* provide short or long-term benefits.

- *Preventive strategies* help protect family and carers from burnout, provide them with improved mental health and ability to help the person and others they care for.

5. Gaps (and subsequent impacts) in current approaches to restrictive practices

The introduction of restrictive practice legislation was necessary due to previously excessive use of both physical and chemical restraints, and to ensure accountability for any service providing for people with disability. However, the legislation needs to be implemented in conjunction with appropriate and targeted supports to eliminate underlying reasons for inappropriate restrictive practices.

Gaps and subsequent impact in current approaches to restrictive practices:

- *Shortage of highly skilled professionals* who can implement non-pharmaceutical behavioural approaches and strategies. Availability of these professional services are essential to decrease long wait times. Funding made available for these services through implementation of the National Disability Insurance Scheme (NDIS), has resulted in increased demand on an already overburdened system. Increased funding and incentives should be provided to train and encourage more professionals to work in this area.

- *A broad shortage of medical professionals* trained and experienced in managing challenging behaviours, particularly those experienced in working with patients with developmental disability and challenging behaviours.

- *Skilled staff shortage in disability and aged care* as a result of deregulation of these services. There is currently a shortage of staff (including accommodation support staff and house supervisors) with the specialist skills and knowledge to respond appropriately to complex and challenging behaviours. Insufficient training with limited supervision, insufficient remuneration and unstable, casualised work with high levels of turnover are contributing factors that may result in staff feeling unsupported and suffering from burnout. This negatively impacts on care provided to people with disability, and may result in increased use of restrictive practices. Upskilling staff should include training, management support and a career structure. House supervisors within supported accommodation should have similar levels of training to that required of nursing staff.

- *Shortages of mental health support services,* including insufficient staff and support for Community Treatment Orders for those with mental illness. Shortages result in a reduction of support and case management of mentally unwell patients, with a poor enforcement of the Community Treatment Order. People with disability and unstable mental illness subsequently do not receive the support and treatment required, with the increased likelihood of restrictive practices being used.

- Following the introduction of the NDIS, some people had applications for NDIS community services declined, and subsequently lost access to their existing case workers and support services. This resulted in a destabilising of their conditions, increasing the likelihood of restrictive practices being used and/or scheduled.

- *Available education to support health professionals on restrictive practices*, skills to assess the risk versus the benefit of using a restrictive practice, and alternatives that can be used. Education on medico-legal considerations of using a restrictive practice in the administration of healthcare, and how the legal system interprets restrictive practices is also important.

- *Poor system access for voluntary admissions for mental health services* due to a caseload that is already heavy and with stretched resources. The limited access to affordable psychiatric services results in the person more likely to experience a destabilisation of their condition, and in potential use of restrictive practices.

- *The need for clear sector-specific protocols* in the behaviour management of people with disability which clearly state when restraint is and is not appropriate.

6. Aboriginal and Torres Strait Islander people with disability

In reference to Question 7: Is the use of restrictive practices different for particular groups of people with disability? If so, how?

The prevalence of disability is higher in Aboriginal and Torres Strait Islander people than in the general population[8]. They are more likely to experience multiple barriers to care, including racism, socioeconomic disadvantage, substance misuse disorders, and intergenerational trauma (relating to the Stolen Generation and/or systemic racism). These barriers can result in disability, or compound the disadvantage in accessing care as a person with disability. Culturally appropriate health services need to be provided with support, funding and empowerment to develop appropriate health interventions that are effective for their community.

Fetal Alcohol Spectrum Disorder (FASD) is a disability with particularly high incidence, resulting in impulsive behaviours, and may lead to use of restrictive practices. Understanding of FASD and access to appropriate support and care is required in the community, as these challenging behaviours may lead to interactions with the criminal justice system and incarceration. There should be accountability for and adherence to restraint protocols that are used.

7. Rules and safeguards that should be applied in the use of restrictive practices

In reference to Question 10: In what circumstances may restrictive practices be needed? A. What rules and safeguards should be applied? B. Should the same rules apply to all people?

Additional rules and safeguards need to be applied to ensure restrictive practices are not being used unnecessarily or excessively. Considerations when analysing and monitoring the use of restrictive practices include:

- *Assessment of the person's current quality of life*, and if improvements can be made as to how the person has been cared for and treated;

- *Adequate and appropriate access to behaviour support* and if this has been implemented accordingly;

- *Assessment of the interpersonal and physical environment* to determine environmental factors that can make the situation or challenging behaviour worse;

- *Access to an expert medical practitioner* who has experience in managing the person's disability, and consideration of the need for interdisciplinary support.

Different sectors may require different protocols that they are required to act to, but assault laws should apply to all people.

Other suggestions for consideration include:

- *Undertaking regular audits of disability services and RACFs,* with enforcement if negative findings are found.
- *The implementation of real time prescribing systems* that would alert to risky combinations of prescribed medications. This is particularly important if a person with disability sees a number of health professionals.
- *Further academic research* should be undertaken into best practice to support people with disability, according to their disability and/or condition. This research should include how to best reduce risks, and primary prevention strategies to reduce the likelihood that behaviour escalates to needing use of restrictive practices.

8. Preventing, avoiding, minimising restrictive practices

In reference to Question 11: How can the use of restrictive practices be prevented, avoided or minimised? A. What needs to change in law and policies? B. What needs to change in the community?

8.1 Changes in law and policies

Legislation and clear policies as guidance on practices are important, however, they do not address the root causes of the use of inappropriate or excessive restrictive practices. As addressed in **Section 5**, existing systemic gaps result in restrictive practices being used more often or excessively than is necessary, with detrimental impact. Gaps need to be addressed in conjunction with any relevant legislation.

As previously articulated in **Section 3**, there are circumstances where the use of restrictive practices is inevitable. Carers need to be protected from people who may present with violent behaviours that place surrounding people at risk. This is important to prevent burnout and high turnover, which may discourage people from working in the sector.

Where a restrictive practice has been used, it is important to assess whether the physical or interpersonal environment contributed to the challenging behaviour, and how strategies and actions can be implemented to prevent the challenging behaviour from occurring in the future. However, the law should always ensure that people with disability are protected from the use of overly excessive and unjustifiable force or restraint.

8.2 Changes in the community and within organisations

The RACGP proposes the following changes be considered within the community and in organisations to help prevent, avoid, or minimise restrictive practices.

- *Appropriate accommodation support*. This currently tends to be crisis driven, with people being placed in the first available service which may not necessarily be the most appropriate. Accommodation support most able to meet individual needs minimises the use of restrictive practices.
- *Increased support and funding to meet NDIS needs* includes building services around the particular and individual needs of people with disability, in a timely manner to prevent the current long wait times for these services.
- *Increased training and education* is required to address skill shortages and support existing staff to better address and prevent challenging behaviours using non-restrictive methods. Information provided for health professionals to assist in understanding of behaviour management strategies, including alternatives to

restrictive practices, how the disability service system is structured, and what is and is not appropriate according to the various health settings and interventions.

- *Increase staff remuneration* in services such as disability care and RACFs. These can be challenging positions and require long working hours. Appropriate remuneration will reduce burnout and turnover and attract suitably trained staff, increase staffing levels and support. Cost is a key barrier to implementing these changes, often including the lack of investment in training and cost-cutting in service delivery.

9. Alternatives to restrictive practices to prevent or address behaviours of concern

In reference to Question 12: What alternatives to restrictive practices could be used to prevent or address behaviours of concern?

In most cases, restrictive practices will be used in conjunction with other strategies. Alternatives to restrictive practices that could be implemented in order to prevent or address challenging behaviours include:

Non-pharmaceutical positive behaviour approaches should be the cornerstone of behaviour management. These approaches ensure provision of appropriate physical and interpersonal environments tailored to best fit the person's individual needs. Access to well-planned and well-implemented non-pharmaceutical positive behaviour approaches is a fundamental right for people with challenging behaviours.

Provide more training and support for staff and carers on how to best manage challenging behaviours, particularly for staff in more isolated settings with less access to external supports. Ongoing evaluation of services will ensure staff receive adequate training and restrictive practice use is monitored and reviewed. Carers and families of people with challenging behaviours should also receive education and support.

Increase availability of crisis-response services, as the current delays in seeing an appropriate behavioural specialist, and delays in receiving treatment can result in entrenched challenging behaviours. Deeply entrenched behaviours are more difficult to manage and treat, and affect the health and wellbeing of the person. Where possible, planning, implementation and reviews should be adequately funded prior to restrictive practices being instituted.

10. Other comments

In reference to Question 13: Have we missed anything? What else should we know about restrictive practices?

Emphasise the shift in attitude required from carers and care-providing organisations. This is a balance between stronger emphasis on dignity, freedom of choice, equal human rights and respect for the patient, and the need of carers to be safe and adequately supported. This issues paper should highlight the importance of carers and care-providing organisations in understanding restrictive practices, and recognising when restrictive practices are in place.

Restrictive practices required for safety of the person and those around them. For example, a person may have a history of undoing their seat belt when travelling by car, and despite the best efforts of family, carers or staff, they require the use of a seat belt lock. The term 'restrictive practices' in some of these instances may be an over-reach.

The use of psychotropic medications should be monitored. Each case of why the medication was prescribed, and subsequent effects (both benefits and any side effects) should be monitored and documented.

Access to high quality health care needs. People with disability require access to high quality healthcare as the rest of the population. Support should be provided for access to preventive health information and assistance with behaviours causing short or long-term harm (such as smoking or drinking alcohol), and recognition of the drivers of these behaviours.

The RACGP looks forward to continuing to contribute to the Royal Commission into Violence, Abuse, Neglect, and Exploitation of People with Disability. Should you have any questions or comments regarding the RACGP's submission to the *Restrictive Practices issues paper*, please contact Mr Stephan Groombridge, e-Health and Quality Care Manager, on 03 8699 0544 or Stephan.groombridge@racgp.org.au

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