A Submission on Restrictive Practices

To the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability

Introduction

Autism Aspergers Advocacy Australia (A4) welcomes the interest of the Disability Royal Commission (DRC) in issues of people with disability including autistic people being subject to "restrictive practices".

The DRC's Restrictive Practices Issues Paper describes a "restrictive practice" as

> any action, approach or intervention that has the effect of limiting the rights or freedom of movement of a person.

Rights cannot be protected when they do not exist. Basically, Australian law fails to provide essential human rights for its jurisdiction. The issues paper recognises that

> The United Nations Committee on the Rights of Persons with Disabilities (CRPD Committee) has called on Australia to establish a nationally consistent legal framework for the elimination of restrictive practices, in all settings including the home. The CRPD Committee also called for this framework to protect all people with disability from psychotropic medication (medicine that can affect the mind, emotions and behaviour), physical restraint and seclusion under the guise of 'behaviour modification'. It also urged Australia to end the practice of detaining and restraining children with disabilities in any setting. The CRPD Committee expressed particular concerns about the use of solitary confinement for long periods.
>
> The Committee on the Rights of the Child has called on Australia to address the use of restraint and seclusion related to education, leisure and cultural activities.

The Australian Government's refusal to bestow internationally mandated rights on its citizens and others is a long-standing issue and the United Nations has complained about it repeatedly.

The High Court *Purvis vs NSW* precedent shows that Australian law does not protect the rights students with disability and "disturbed behaviour" to education or by extension any other human right associated with institutional support or services.

Concerns about "restrictive practices" have been raised before: Senate (Community Affairs Committee) 2015 inquiry into violence, abuse and

neglect against people with disability … was followed by Senate 2016 inquiry into "Indefinite detention of people with cognitive and psychiatric impairment in Australia".

The report says, "The committee is aware of a number of pending cases before the UN Disability Committee that relate to people with disability subject to indefinite detention". The Committee's report avoids the issue of Australia's ongoing refusal to enact the laws required of signatories to the UN Conventions.

Occasionally, the media latches onto a particular example of restrictive practices such as the infamous boy-in-a-cage example from the ACT, in 2015.

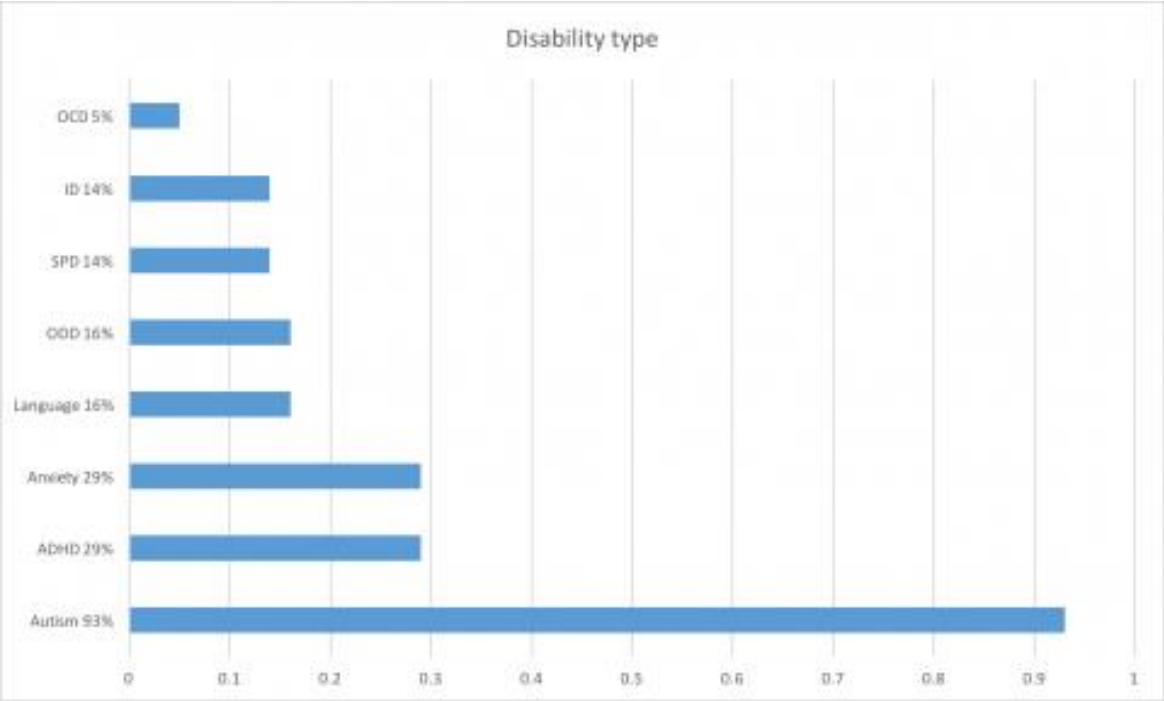
- Child reportedly contained in cage-like structure at ACT primary school
- Shock and sadness at 'cage' for Canberra school boy with autism: Ricky Stuart
- School cage disgrace: Eight staff reprimanded but not a single person sacked for building a steel enclosure to lock up an autistic boy
- Autism cage details emerge as United Nations investigates abuse of children
- On cages for autistic students: World Autism Awareness Day in Australia

There were many more media reports about this incident.

Despite promises from politicians and governments that this was an "isolated incident", there are many similar examples: see *Boy with autism locked in*

'cage', NSW school being investigated and a short list of recent "isolated incidents" (from 2015).

A report to the United Nations shows that most of the documented case of restraint in schools relate to autistic students.



In relation to autistic people, A4's recent submission indicates a high likelihood of 9 in 10 autistic adults have not been diagnosed. It is very unlikely that their autism would be diagnosed/recognised in Australia's mental health and forensic/penal systems so their treatment by these systems is typically uninformed and inappropriate, and frequently involves unsatisfactory restrictive practices.

The issues paper says:

> Restrictive practices can be used across Australia, as a last resort, to prevent or protect people from harm. This includes a perceived risk of harm. This may include preventing or protecting an individual or others from behaviours referred to as 'challenging behaviours' or 'behaviours of concern'.

We contest the suggestion that restrictive practices are used only "as a last resort". Too often, restrictive practices are the preferred or go-to strategy; no other strategy is even considered.

In addition to the terms 'challenging behaviours' or 'behaviours of concern', we see the term, *disturbed behaviour*, used in *the Disability Discrimination Act 1992*. Authorities at times use the terms violent, aggressive, problem or unwanted behaviour. Clinicians sometimes refer to dysfunctional behaviour.

Phrases like distressed or frustrated behaviour, or non-verbal communication are more accurate, informative and appropriate.

Many autistic people make enormous efforts to restrain their own behaviour in their efforts to fit into their communities[1]

US research found that few young autistic adults live independently[2]. Autistic adults are more likely to have limited or restrained living experiences than other people, or even people with disability generally. While we lack data in Australia, A4 feels it sees a similar situation in Australia.

Choices around restrictive practices are difficult; they involve balancing safety with learning and independence. Generally, we accept that young children need to be restricted from risky conduct where they do not appreciate the risk and/or the potentially bad consequences. As they develop, they are given increasing responsibility for their risk-taking. Attitudes to risk-taking vary considerably between people responsible for supporting adolescents and adults with developmental delay. Decisions are rarely black-and-white.

Issues of drug treatment (medication) or chemical restraint are very complex. Some drugs are quite effective in helping people with mental illness improve their life experience. Other people do not like the drugs they are prescribed. This is much more complicated when a person's autism limits or reduces their ability to express their preferences, or possibly in some cases to understand their options.

Any discussion of restrictive practices must reference *the Association for Behavior Analysis International's Position Statement on Restrain and Seclusion*. It's guiding principles are:

- The welfare of the individual served is the highest priority
- Individuals (and parents and guardians) have a right to choose, and
- The principle of least restrictiveness.

Questions from the Issues Paper

This section responds to the questions in the Issues Paper (downloaded from the DRC web page).

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

The short description given for "restrictive practices" in the Issues Paper avoids many of the difficulties that need to be recognised and addressed.

Practices that restrict people in various ways are far more common that the description given. The process of being part of a community impose substantial restrictions on what we do and how we act. Most people act in the interests of their community and balance their individual preferences against social norms. Different people make different decisions so the rules, the restrictions of our behaviour varies between individuals. For example,

[1] See https://www.sciencedaily.com/releases/2019/07/190723190851.htm
[2] See https://www.disabilityscoop.com/2013/09/03/few-autism-independently/18647/

some people always obey pedestrian lights and other regard them as "advisory".

Adults restrict what they allow children to do often claiming safety reasons, but many restrictions are about social compliance. Restrictions vary with the age of a child, where they are and who is involved in supervising the child. Rules are often inconsistent which makes them hard to learn.

"Restrictive practices" are used for varied reasons. The reasons generally given for imposing restrictive practices include:

- Keeping people safe
- Not knowing what else to do
- Teaching social rules
- Punishment.

Other reasons that are denied or rarely acknowledged include laziness, incompetence (not using alternatives), exerting power over others and cruelty.

Sadly, it is incorrect to claim that restrictive practices are a "last resort"; they are frequently used well before that situation is reached.

Most people restrict their own behaviour in order to fit into their community. Some people like (or need) to test some of the boundaries. And some people deliberately flout the rules, perhaps to convince themselves that they are special or to get attention.

Some people simply do not understand the rules or that the rules exist. And some people struggle to learn or comply with rules. For example, some people find it difficult to learn not to masturbate in public places or where they are visible to the public. This is considered an "unwanted" or "challenging behaviour" and is likely to result in restrictive practices, but masturbation is quite normal behaviour as long as it is done in private.

Enormous care is needed in distinguishing the difference between medication and chemical restraint. The descriptions currently in use need improvement. People with disability and other disability representatives must be major partners in all work on making this clearer distinction.

Imposition of restrictive practices must only be allowed when it addresses problems in an appropriate, informed and effective manner. Otherwise, it is abuse, punishment and/or cruelty.

Question 2: What types of restrictive practices are applied to people with disability? Are certain types of restrictive practices more common than others?

Sadly, we cannot really answer this question because we do not have much data. We have no faith in data collection processes in education settings, health settings, in relation to the NDIS or other parts of the disability service sector. We have no faith in disability data from the penal system and even less faith in anything said about autistic people in the legal and penal system.

We are aware that all the types of restraint listed in the Issues Paper are in regular use.

We also see examples of fatal or near-fatal restraint; see 'Courtney had a knife out in public but she didn't deserve to die' and Police who shot teen made 'good choices' to protect themselves, Commissioner says.

We see children denied access to schools and parts of schools. For many autistic people, having access to essential services like mental health services restricted or denied is part of their existence.

In the ACT, the Standing Committee on Education, Employment and Youth Affairs, in its report on Youth Mental Health in the ACT, recently reported that:

> 3.44 The Committee heard reports of autistic youth and their parents report being turned away from mental health services, such as CAMHS, because "we don't treat people with autism".
>
> > Routinely, autistic youth who present with anxiety, trauma or depression are denied mental health services for those conditions because of their autism. In the past, CAMHS had a strong interest in autism but now the service excludes many, possibly all known, patients known to be autistic. Many autistic youths with mental illness have nowhere else to go to get the mental health services they need. It seems this is a staff decision rather than an actual policy.

and stated:

> 3.48 The Committee was disappointed to hear accounts of autistic youth with mental health challenges in Canberra being refused support or receiving inappropriate treatment in the mental health system. The Committee highlights the urgent need for training of mental health professionals to effectively assist in the treatment of autistic youth suffering mental health challenges.

While the DSM-5 regards autism spectrum disorder as a neurological disorder (the DSM-IV regards autism as a "developmental disorder"[3]), the ACT Government considers autism to be a behavioural or conduct disorder. Apparently, there is considerable confusion over whether autism is a psychosocial disability. Mostly, autism gets omitted from a category when it comes to issues of addressing clinical needs.

The ACT Committee also reported:

> 3.42 Professor Julian Trollor (head of the Department of Developmental Disability Neuropsychiatry within the School of Psychiatry at the University of NSW) gave evidence before the Disability Royal Commission, raising concerns that autistic people:

[3] "developmental disorders" get special mention in the *NDIS Act 2013*. The NDIS usually omits autism from its "developmental disorder" category.

- are not being treated inside the health and mental health system and also not being addressed outside the health sector – autistic people just miss out everywhere on many of the services and supports they need;
- have a right to health services under Article 25 of the *Convention on the Rights of Persons with Disabilities* but that goal is not being met;
- have high mortality rates including suicide; and
- have high rates of undiagnosed, untreated and/or poorly managed illness.

This is not just an ACT issue, Professor Trollor's evidence indicates that this denial of essential services to autistic people is a national issue.

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

Most autistic individuals are constantly subjected to restrictive practices. Many who are severely affected by their autism are given daily chemical restraints to moderate behaviour once they reach puberty or adulthood.

Many autistic students and adults are segregated at times. It is better if they learn to withdraw to their safe/quiet space when they want, when they feel stressed rather than being forcefully separated from others.

Some autistic students separate themselves one or more times each day. Others may be comfortable just knowing they have the option to withdraw but rarely do so.

Question 4: Where or in what circumstances are restrictive practices used?

Autism is pervasive; it is always part of an autistic person. Autistic people are often engaged in some behaviour that some others consider dysfunctional. Restrictive practices are applied to address what is regarded as dysfunctional behaviour.

So restrictive practices are likely to be applied to autistic people at any time.

Many young autistic children are routinely held in cages if they are considered likely to abscond. Abscond is a term that can describe a child's attempts to find things that interest them, to escape environments that cause them discomfort, or various other motivations.

Some families lock their doors and windows routinely so their autistic child cannot abscond from their family home.

Many families find their autistic child's behaviour in public to be "difficult". Families choose whether or not they take their child to the supermarket with them. Often, autistic children have outings restricted or they may be restrained while they are out.

There are many reports of restrictive practices applied to autistic students in schools.

Some autistic adolescents and adults have been brought to the attention of police when they are out in public. And some police severely exacerbate

challenging behaviour, then follow up with strong physical restraint. Sometime police call an ambulance and demand chemical restraint.

Encounters with police are known to leave autistic people traumatised and unwilling (or refusing) to venture out or try to socialise.

Some autistic people end up in hospital or mental health facilities where they are physically and chemically restrained.

We do not know the level of chemical restraint used on autistic people in group homes or disability accommodation. We expect that the levels are excessive.

Question 5: Why are restrictive practices used?

There are many answers.

- As a go-to strategy to address distressed or frustrated behaviour
- Ignorance or unaware of appropriate approaches
- Because there was no appropriate plan in place
- Nothing else that they tried was seen to work
- Cruelty or revenge.

Question 6: What are the effects of restrictive practices?

Some restrictive practices can result in physical injury.

Restrictive practices usually result in psychological damage or trauma; at the very least, stress and anxiety … perhaps depression, mental illness and suicidal ideation. All of this results in poor health and reduced lifespan.

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

> A. How is the use of restrictive practices on people with disability of different age, sex, gender identity, sexual orientation and race different? Are restrictive practices used on them at higher rates?
>
> B. How is the use of restrictive practices on First Nations people with disability different? Are restrictive practices used on First Nations people with disability at higher rates?
>
> C. How is the use of restrictive practices different for culturally and linguistically diverse people with disability different? Are restrictive practices used on culturally and linguistically diverse people with disability at higher rates?

We lack data to really answer this question.

Presumably, the NDIS Quality and Safeguards Commission will be able to answer these questions if they collect their data appropriately.

We know that indigenous Australians are subject to restrictive practices of incarcerated at substantially higher rates. We expect low diagnosis rates

means that indigenous Australians are denied properly informed support planning.

We expect autistic Australians are subject to restrictive practices at substantially higher rates than the rest of the population, except possibly people with dementia.

Question 8: Does the use of restrictive practices lead to further violence and abuse, neglect and exploitation of people with disability? If so, how?

A4 understands that behaviour science answers this question.

If the "restrictive practice" removes a "reinforcer" then there is usually an "extinction burst" … understandably. This is because a person's behaviour was rewarded/reinforced. The person still wants the outcome (reinforcer). If they want something and do not get it, they usually try again. Inevitably, their problem behaviour escalates.

When their "challenging behaviour", which is their established means of communicating that they want something, results in a restrictive practice, then their increasing requesting (increased "challenging behaviour") results in increased restrictive practices.

Behaviour science offers a range of strategies for tackling this complex chain of behaviour, reducing the need for, frequency or degree of restrictive practice used.

As to the how, we have seen behavioural clinicians examine challenging behaviour to identify:

1. The antecedent to the behaviour, that is what are all the things that come before a behaviour,
2. The nature of the behaviour itself and what it involves, and
3. The consequence of the behaviour, especially the outcome (reinforcer) for the behaviour.

Basically, each of these offers an opportunity for change. For example, if a person does not want to be somewhere (the context is that they leave somewhere they do not want to be), then not taking them there removes the "antecedent". If they break things, then removing things that break means the behaviour is eliminated. If they are provided a more preferred reinforcer and a different way to request it, then they can get a better outcome and the old reinforcer disappears from their preferences.

Notice, that most of these strategies do not involve the use of restrictive practices.

The use of restrictive practices may be to interfere with an established pattern of behaviour or while a person learns a replacement communication and behaviour. This should mean that the use of restrictive practices decreases measurably.

Question 9: Are current approaches to restrictive practices effective? This may include laws, policies, principles, standards and practices.

A. Are there any gaps in the current approaches?

B. If so, what are the impacts of these gaps?

Current approaches to restrictive practices for autistic people are relatively ineffective. Mostly they increase or escalate distressed behaviour and frustration.

As behaviours of concern get worse, families often withdraw their autistic family members to the family home where they work out what to do by trial and error. It is often a damaging and inefficient process. The outcomes are variable.

Laws and penalties for law breaking do not work for people who do not cognitively understand laws.

For people who understand, law may work if the laws make sense and warrants respect. Australian law does not protect the rights of people with disability. Schools teach autistic children from a very young age that laws and rules do not protect them, that laws, policies, principles, standards and rules will be ignored or used against them. They are taught that the truth is irrelevant, what matters most is who is the best liar.

As we have indicated above, the primary gap is the lack of properly registered behavioural clinicians.

The impacts are that autistic people are denied access to many benefits of community that are their rights under international law, but not protected by Australian law. Many autistic Australians live distressed, tragic and traumatised lives because they are subject to inappropriate and unnecessary restrictive practices.

Young children who abscond are usually subject to restrictive practices. Absconding is seen as a behaviour of concern. But the reasons children abscond vary. Some children seek to escape a situation or environment; other children are explore seeking activities and places they like better, and some are rewarded/reinforced by the social engagement and attention that ensues from absconding.

A child who absconds when they are bored or under-engaged sends a clear message, that "I need better engagement". Rather than approaching absconding as a "behaviour of concern", it should be approached as functional communication that the support for the child needs to engage the child more.

Autistic adults who abscond are usually more challenging than children because the reinforcers are complex and patterns are entrenched.

Appropriate approaches to absconding address a person's purpose for absconding rather than treating absconding as a "behaviour of concern".

Restrictive practices are more likely when addressing a behaviour of concern rather than the causes and purposes of a behaviour.

The knowledge and understanding to best address behavioural issues is much more complex than is generally recognised. Similarly, the techniques for addressing behaviour are very powerful so they need to be used very carefully. This probably means that serious behavioural methods should be carefully managed by professional clinicians, not just anyone who feels they can have a go or who is ordered to do what they can by their employer.

In Australia, most behaviour support for autistic people falls to the family. Few families access the specialist professional behavioural clinicians, because:

- no one advises them that they can or should get professional clinical behavioural support,
- they cannot access the behavioural support they need (very few professional behavioural clinicians are trained and offering services, especially for adults, in Australia's workforce), and
- usually they cannot afford to pay for professional behavioural support.

Question 10: In what circumstances may restrictive practices be needed?

A. What rules and safeguards should be apply?

B. Should the same rules apply to all people?

Restrictive practices may be needed to keep a person safe. We often restrain a child unexpectedly who wants to run onto a busy road or does something that puts them in physical danger.

Preferably, when a person puts themselves repeatedly at risk, we start to expect the behaviour. Then a behaviour plan should be implemented to reduce the risk with little or no restrictive practice needed.

If the rule is that restrictive practices should be minimised, then the same rule should apply to all people. The general rule should require that the response should be appropriate and best practice based on the individual and the circumstance.

Any rules that relate to and individual's specific behaviours must address both the context and the individual need. Every rule needs to be appropriate for the individual and the circumstance.

Question 11: How can the use of restrictive practices be prevented, avoided or minimised?

A. What needs to change in laws and polices?

B. What needs to change in the community and within organisations?

C. What are the barriers to this change?

Restrictive practices must be measured and monitored in order to identify that they are reduced, prevented, avoided or minimised.

In relation to laws, the basic or underlying issue for people with disability in Australia is that Australian law does not protect or ensure their human rights. The United Nations has repeatedly identified this issue.

Most Australian governments are yet to recognise that their laws and policies do not address the needs of autistic Australians. Only the Victorian Government has an autism plan, and it is not funded.

Most disability policies ignore or exclude the needs of autistic citizens so we can expect that abysmal outcomes for autistic Australians will continue.

State and federal education departments need to recognise that they are not addressing or meeting the education needs of autistic students. Health departments, and especially mental health departments, need to recognise that autistic people experience substantial mental illness, trauma and suicide and their needs must be recognised and addressed.

The community needs to understand that autistic people are not rorters and scammers and their political leaders claim/advise; instead, they need to respect that autistic people are different and that is OK, usually much better than OK.

Many people feel that anyone who is not like them is a threat or a problem. Their rejection or fear of difference becomes a barrier to inclusive community.

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

In general terms, alternatives to restrictive practices include:

a) Do nothing – which is especially appropriate when a review/reassessment finds that a perceived behaviour of concern is not really an issue or is not a sufficient concern to "deserve" a restrictive practice.
b) Teach functional communication – when a "behaviour of concern" is functional communication, it is usually best to improve communication through better carer understanding and practicing (and generalising) communication skills.
c) Change or remove antecedent – basically, change the environment that results in a behaviour of concern.
d) De-escalation – everyone can practice calming or withdrawal in less stressed settings so that they can reduce or escape stressful situations before getting to a behaviour of concern.
e) And many more techniques …

The first step to finding an alternative to restrictive practice is to understand fully (or better) the purpose of the "behaviours of concern".

When the purpose of a "behaviour of concern" is to communicate or request some outcome, such as "I don't want to be here", "I don't like that person" or

"I want a biscuit", it is often better to teach a more acceptable way to communicate.

When "behaviour of concern" is to communicate "I feel frustrated" we may need to understand why an autistic person is frustrated on this occasion. Even better would be to recognise (or help them communicate) earlier that they are becoming stressed or frustrated and address their frustration before they escalate to a "behaviour of concern".

If a carer needs a restrictive practice, perhaps to ensure safety, then they might have practiced a number of lesser restrictive practices, so they have a range of less restrictive strategies for varied situations.

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

Focus on restrictive practices leaves out the issue of exclusion, such as school exclusion or suspension, as another inappropriate response to distressed or frustrated behaviour. School exclusion/suspension is restricted access to education.

Autistic students experience high levels of school exclusion. School exclusion is a frequent response to distressed or frustrated behaviour and could be considered a restrictive practice.

Without proper regulation of behavioural clinicians we can only expect inadequate and inappropriate services is all settings. People cannot expect and do not get professional clinical services.

The gross lack of training, the lack of required qualifications and experience in behaviour support, or in medical supports for restrictive practices demand that the Commonwealth Government develops, together with stakeholders, an appropriate workforce for this sector.

Behaviour Management

Australia's record in behaviour management is unacceptable. In Australia, anyone can claim to provide behaviour support services or to advise on behaviour management.

A4 is very concerned that many people believe services listed as offering Behaviour Support on the NDIS provider list[4] are professional; the NDIS even describes them as "registered". As far as we know, no qualification or experience is required to appear on the list.

Formal registration of behavioural clinicians or specialists in Australia is essentially non-existent. The NDIS Quality and Safeguards Commission is developing its approach for the NDIS context[5] but it still has a very long way

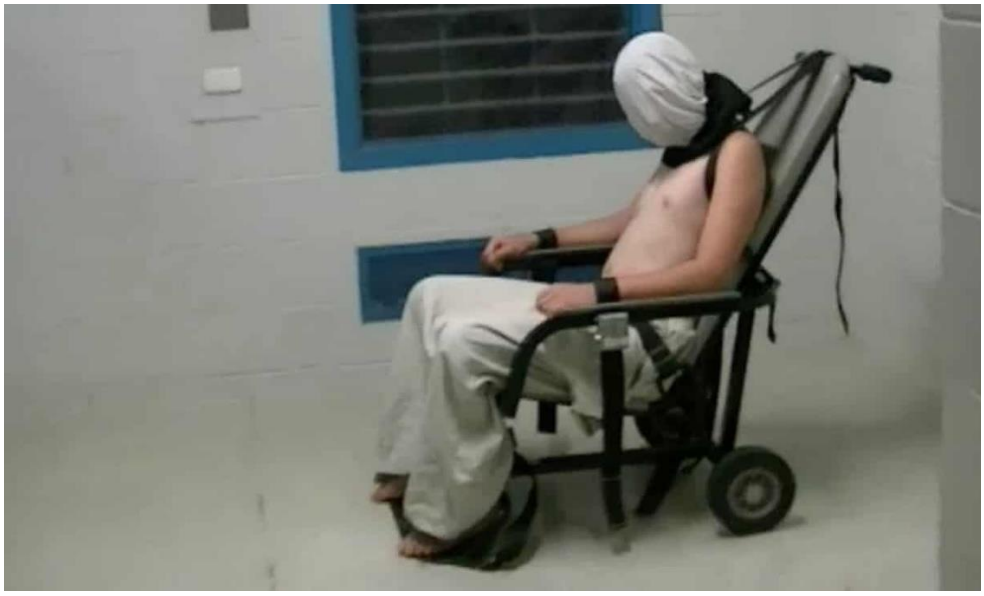
[4] Download from https://www.ndis.gov.au/participants/working-providers/find-registered-provider

[5] https://www.ndiscommission.gov.au/providers/registered-provider-requirements

to go. We are not aware of any stakeholder consultation at this stage so we have no confidence that an appropriate registration model will be developed.

Psychologists who register with the Australian Psychological Association do not have an option to declare an interest in behaviour/management/support.

The case of Dylan Voller a few years ago is a lesson in the conduct of behaviour management in Australia. We saw a young man severely restrained in a Behaviour Management Unit (BMU) at the Don Dale Centre with no behavioural clinician in sight.



In schools, non-clinical psychologists (who are themselves not qualified to *deliver* behaviour supports) and other even less qualified people advise or instruct teachers in management of student behaviour. Often, teachers instruct classroom assistants. Any value there was in the original message is lost in through the chain of transmission. Clear there is no accountability or responsibility for behaviour management is Australian schools.

Many behaviour management practices are like adding peppermints to a soda bottle; they take volatile situations and escalate them, especially when police are involved, see here for example.

Crucially, we must recognise the difference when an autistic person withdraws voluntarily from a situation that is stressful for them, from when

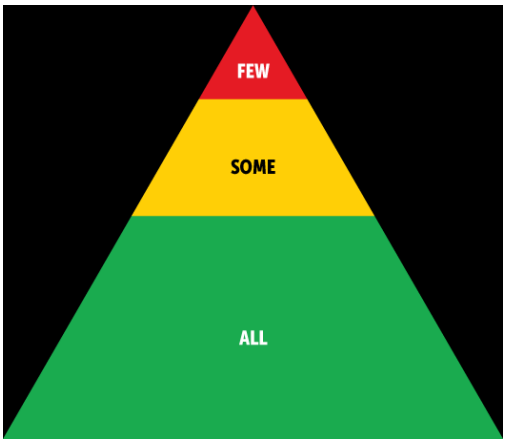
an autistic person is forced into seclusion. Providing a withdrawal space is an essential support, withdrawing appropriately is a skill. Forcing an autistic person into seclusion is a restrictive practice.

ABA vs PBS

Applied Behaviour Analysis (ABA) is the clinical application of behaviour science. Information about ABA is available from the international Behaviour Analysis Certification Board (see https://www.bacb.com/). While the Board's website does not define ABA, it is generally described as "the practice of applying the psychological principles of learning theory in a systematic way to alter behavior" or the professional and clinical application of behavioural science.

Some people see Positive Behaviour Support (PBS) as an alternative approach.

The Association for Positive Behavior Support say that PBS combines behavioural and biomedical science. This makes PBS a team approach since no one is qualified to practice both biomedical and behavioural science clinically. They also say that "Positive behavior support is a community based approach".



In the USA, the U.S. Department of Education, Office of Special Education Programs and Office of Elementary and Secondary Education supported the National Technical Assistance Center on Positive Behavioral Interventions and Supports (PBIS). The PBIS model uses a 3-tiered approach to behaviour support in schools.

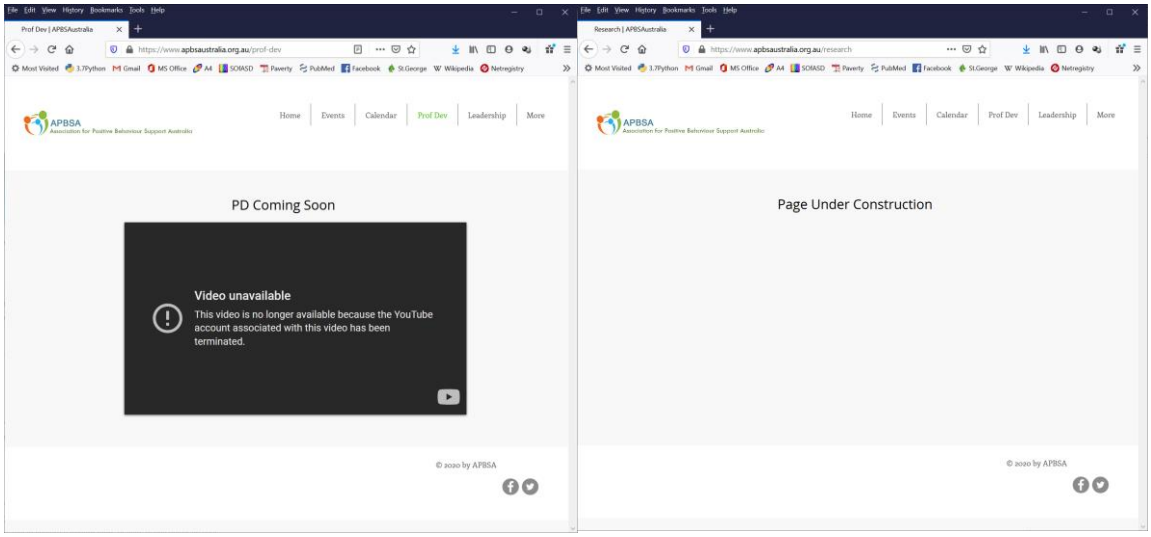
Some authors say that the goals of ABA and PBS are similar except that PBS has a "defining feature" about "implementation of support within organizational systems that facilitate sustained effects"[6] but ABA seems more focused on the needs of an individual and less constrained to institutional settings.

Commentary on the difference between ABA and PBS says that "There are numerous definitions of PBS" and notes that "most of [the PBS] emphases have long been accepted features of mainstream ABA".

An Association for Positive Behaviour Support may be emerging in Australia, but it is in its early days.

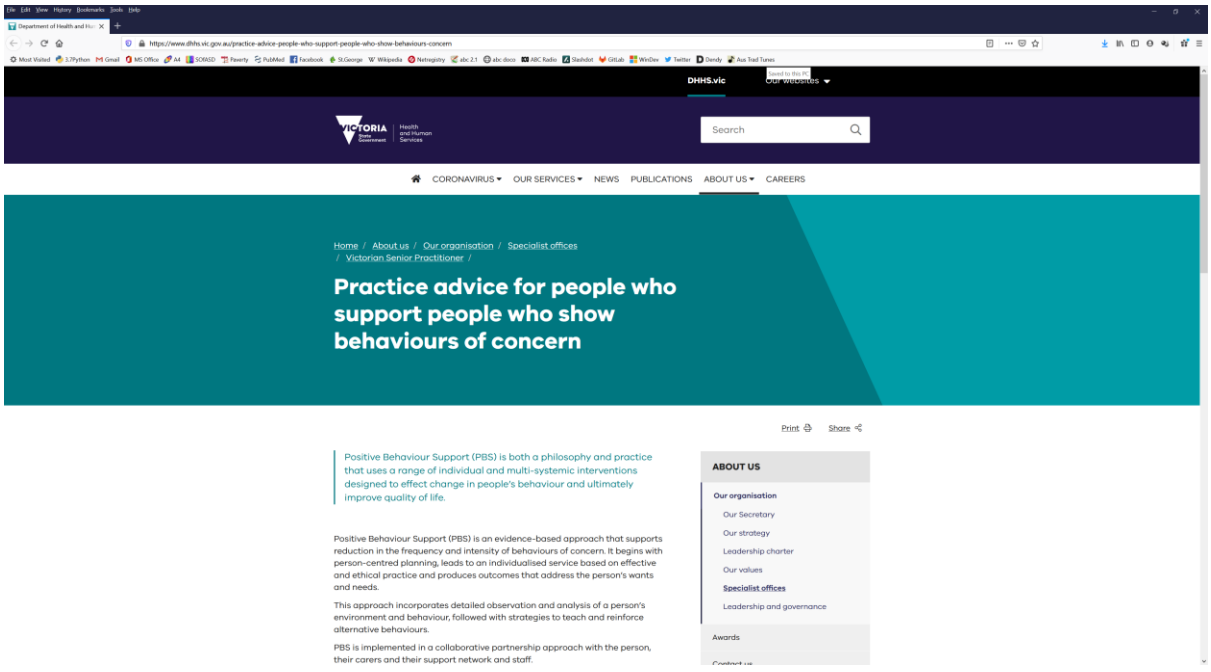
---

6 https://www.google.com.au/books/edition/Handbook_of_Positive_Behavior_Support/TW8go24dqDkC



Their emphasis seems to be focussed on ~30 hours of school for 40 weeks of the year rather than on the holistic 24/7 needs of an autistic individual and the pervasive nature of their condition. And the high needs of PBS Tier-3 students, the few at the top of the PBS triangle, are not adequately addressed. This approach does little or nothing to address their out-of-school needs. It rarely involves registered behavioural clinicians for its Tier-3.

The Victorian Department of Health and Human Services declared that "PBS is now recognised worldwide as the best practice for responding to behaviours of concern" though they do not provide a basis for their claim.



The Association for Behaviour Analysis Australia is also an emerging organisation for ABA practitioners in Australia including internationally registers Board Certified Behavior Analysts (BCBA) practicing in Australia.

Other Restrictive Practices

While we hear less about it these days, we need vigilance about medical restraints like frontal lobotomies and reproductive sterilisations.

Many people with disability are economically and financially restricted. The Commonwealth Government's illegal Robotdebt scheme was a massive example of exploitation and abuse of the most vulnerable people including people with disability.

Suggestions

Australia needs:

1. Much clearer distinction between medication and chemical restraint needs to be co-developed with people with disability.
2. formal recognition and professional registration for behaviour support clinicians.
3. Data describing the need for and outcomes related to behaviour supports for people with disability.
4. A plan to ensure the behaviour support workforce meets the demand for behaviour support services in the disability sector.
5. Specific attention to recognising and addressing health, especially mental health, needs of autistic people.

About Autism Aspergers Advocacy Australia

Autism Aspergers Advocacy Australia (A4) is the national grassroots advocacy organisation providing systemic advocacy[1] for autistic people[2] and others (family members and partners) living with ASD.

A4 aims to represent the varied views of its members at the federal/national level. A4 does not represent a particular view; it aims to represent the views of its members. There are issues where the ASD community has a range of (conflicting?) views; issues where there is no consensus view. In such cases, A4 tries to recognise, respect and represent the range of views it finds in the ASD community. When views about an issue vary, A4 does not choose sides; instead, A4 makes it clear to Government (and others) that there are varied views in the ASD community.

A4 is a member of the *Disability Australia Consortium:* see National disability representative organisations. A4 works with the *Australian Federation of Disability Organisations* (AFDO) on wider disability issues at the federal level. A4 is a member of the *Australian Autism Alliance*.