SUBMISSION TO THE PRODUCTIVITY INQUIRY INTO A NATIONAL DISABILITY LONG-TERM CARE AND SUPPORT SCHEME

This submission has been prepared by Action for Tasmanian Autistic Children (**ATAC**).

ATAC starts from the premise that from the initial decisions that brought about the de-institutionalising of care for the disabled, all States adopted a policy of providing services to cater for the disabled which were based on a universal service model designed to fit all regardless of the type of disability involved. This has resulted in a model that fails to meet the specific needs of disabled people. Most tragically it fails those with intellectual disabilities.

It is self evident that the services required by the physically disabled are completely different to those needed by the intellectually disabled. The model adopted by State authorities, however, does not recognise this fact. Instead it concentrates only on offering respite services aimed at providing carers of the disabled with a break so that they can recuperate from the constant demands of caring for a disabled person. In so doing it totally fails the disabled, and particularly those with intellectual disabilities.

It is imperative therefore that this inquiry goes far beyond the establishment of an insurance scheme that will merely maintain and top up the present system which so manifestly fails to meet the needs of the intellectually disabled. Such a scheme is inevitably destined to spectacular failure. Without proper services to treat those with intellectual disabilities, the cost of lifetime care for these people will swamp the budgets of all governments.

This may appear to be an overly dramatic statement. However, once we examine what is occurring at the moment in our society, the truth of the present situation is inescapable. **ATAC**'s submission, for that reason, will focus on what is presently occurring in regard to the prevalence of **Autism Spectrum Disorder** within the community, and the failure of our society to adequately respond to what is a growing crisis in this area. We believe that an examination of what is occurring in this area clearly illustrates the disastrous path along which we are travelling.

THE PREVALENCE OF AUTISM SPECTRUM DISORDER

Australia

Data from Centrelink [1] show that more than 1% of Australian school age children have a diagnosis of Autistic Disorder or Aspergers' Disorder. *This data shows that the number of children diagnosed with Autism Spectrum Disorders (ASD) more than doubled compared to figures 5 years ago.*

In 2004 a peer-reviewed paper published data collected by the Australian Bureau of Statistics (ABS) for its Survey of Disability, Ageing and Carers (SDAC)[2]. This data showed that the number of Australians with ASD more than doubled in the five years from 1998 to 2003. *The number of Australians estimated to have ASD rose from13, 000 in 1998 to 30,000 in 2003.*

The rate of diagnosis for ASD has doubled every five years over a 20 year period. In the early 1990s the prevalence rate was said to be 1 per 10,000. Today the prevalence rate exceeds 1 in 100, *a 10 fold increase over a 15-20 year period.*

UK

There is no official register of people with autism in the UK. For this reason an accurate number of people with ASD is difficult to obtain. However, the National Autistic Society (NAS) estimates that the number of autistic children of school age is 1%.

This estimation is confirmed by the findings of a 2009 report [3] of rates in Cambridgeshire which found that school age children who were on the Special Education Needs Register approximated the 1% estimated by NAS i.e. 1 in 100.

The researchers followed this up by distributing surveys to parents in the shire's schools, and then diagnosed those children for whom parents reported concerns. When this process was complete, the actual number of children found to have ASDs was found to be 1 in 64, showing the estimates of the NAS to be conservative.

Again, what must be further factored in is the age of the school children surveyed, i.e. between 5 and 9 years at the time of the survey. If we apply the doubling that is now occurring every 5 years in the incidence of ASD, *the present rate of prevalence of children being born with ASDs in the UK may well be as high as 4%.*

USA

Similar increases have been reported in the USA[4]. A just published report from The Centre for Disease Control (CDC) (usa) found that 2 in 110 children aged 8 years in 2006 had an ASD. Increases in the various states ranged from 21% to 95%, with an average increase of 57%. This report raised for the first time the possibility that better diagnosis is **NOT** the only factor at work, and **that a real increase in the incidence of autism cannot be ruled out.**

The estimates in the Centre for Disease Control report were based upon children aged 8 in the year 2006, that is, to children born in 1998. If we apply the average increase that has generally occurred, namely doubling every 5 years, *then the prevalence rate of ASD in children being born today in the US would be 4 in 100 (4%).*

The CDC web site lists studies in Asia , Europe and North America which have identified individuals with an approximate prevalence of 0.6% to over 1%.

From a rare disability affecting 1 in 25,000 in the 1980s to the 1 in 100 found today, ASDs have grown to the point where the CDC in the USA states that this year there will be more children diagnosed with ASDs than with **AIDS, DIABETES and CANCER combined.**

WHAT PROBLEMS HAVE BEEN CREATED BY THE ENORMOUS INCREASE IN THE INCIDENCE OF AUTISM?

Two years ago ATAC carried out research on the effect of the increase in ASDs on the disability budget in Tasmania. We found that more than 50% of the Tasmanian Disability Services Budget was spent in caring for people in group homes and assisted accommodation. We were able to ascertain that 80 to 85% of those in group homes had ASDs or some other intellectual disability.

Previously these people were held in Willow Court, a hospital that had a capacity for 400 permanent residents. Today the number of disabled in group homes and assisted accommodation exceeds this several times over.

We have been unable to quantify the number of children on the autism spectrum in State Care in Tasmania. However, thanks to the Tasmanian Commissioner for Children[5] we do know some of the costs. In criticizing the lack of training and qualifications of those working in the high needs rostered care system, the Commissioner revealed the cost of each child in this type of care to be $170, 000 <u>per annum</u> for what he described as 'glorified baby-sitting'. The annual cost for this service was $3.5 million. In addition there are many other autistic or intellectually disabled children living with foster parents as a further cost on the state.

Furthermore, State Budgets are significantly drained in other ways by people with ASDs and other intellectual disabilities. One of the most significant areas in which this occurs is in the area of criminal justice. The Secretary of the Prison Reform Group writing in the Hobart Mercury on February 10 2010 stated "… more than 70% of those who are in the criminal justice system have autism or some other form of intellectual disability."

ATAC is a small organisation operating in a small state. Our resources are limited, but we are confident that our analysis of Tasmania reveals a growing crisis that has the potential to cripple the State financially. We suggest that the

Commission needs to do similar research in all states to see if similar situations exist throughout Australia. We need to remember that the quadrupling of ASD diagnosis in the last 10 years is only just beginning to contribute to the long term care problem that already is becoming unmanageable.

If we go no further than adopting an insurance scheme designed to provide the same sort of services that currently exist for families with ASD, then the cost of long term care for people with ASD and other intellectual disabilities will bankrupt the scheme within 20 years.

HOW DID WE GET TO THIS CRISIS SITUATION?

When Australia de-institutionalised the care of the disabled, the problem of ASD was small, with a prevalence rate of only 1 in 10, 000. No special programmes were considered in this process as it was considered that the numbers of those with ASDs would be easily catered for in the general programmes set up for the disabled.

The rationale for this was based upon the small numbers of people with ASD in the community, and upon the little that was known at the time about ASD. A number of tenets underwrote this approach: -

- **AUTISM IS A RARE DISORDER**
- **NOBODY KNOWS THE CAUSES OF AUTISM**
- **EACH CHILD WITH AUTISM IS DIFFERENT FROM ALL OTHERS**
- **THERE IS NO ONE TREATMENT THAT SUITS ALL AUTISTIC CHILDREN**

What may have been acceptable at a time when so little was known about ASDs is not acceptable in today’s world. Yet these shibboleths dominate main-stream thinking in all State health and education authorities in Australia, and indeed the major Autism Associations in Australia. An autism industry has grown around these tenets, and this industry has the ear of Governments in Australia. It protects its position with vigour, and has not changed its stance in spite of vast strides in our knowledge of ASDs. For this reason alone we must examine the basis of its tenets, and determine if they are valid in light of what is known about ASD today.

Does Autism Remain a Rare Disorder?

This belief that underpins present services available, namely that autism is a rare disorder, has been discredited by time itself. Yet the autism industry initially explained these increases by arguing that the apparent increase was brought about by a broadening of the definition of the spectrum. This broadening occurred in 1994, and any increase in incidence caused by this broadening should have shown up in the mid to late 90s. In fact there was a spike following the definition change, **but this can no longer explain the continued dramatic increase that continues 16 years later.**

As it became apparent that the argument that ASD was a rare disorder could no longer be sustained, the 'autism industry' moved to its next explanation, namely that it was the broadening of the definition of the spectrum **combined with** better diagnosis that created the increase in numbers of those with ASD. **ATAC** does not argue that this has not lead to some effect on the prevalence rates. **However** we do argue strongly that in no way can better diagnosis explain the increased prevalence in ASD that is now being recorded worldwide. The results of the Cambridge University study mentioned earlier would suggest that we are **still only diagnosing 50% of those affected.**

Does the cause of autism remain unknown?

This is the basis of the second claim made by the 'autism industry.' *To continue to espouse this as fact flies in the face of all the research that has taken place over the last few years.* Billions of dollars spent on detailed research, and the collaboration of scientist all over the world, will be wasted if this inquiry accepts this preposterous concept.

To do this the Commission would have to ignore the growth of gene banks and brain tissue banks, and the enormous research this has generated. The development of international collaboration of research bodies and the results of this research would need to be ignored. Even as this submission was being prepared the 7th IMFAR (International Meeting for Autism Research) is meeting in Philadelphia with 950 abstracts of research to be presented. The

International Society for Autism Research which organizes IMFAR also publishes a monthly journal, AUTISM RESEARCH.

The project to map the Autism Genome is underway, and received a considerable boost from the Obama administration in the US by means of its stimulus package.

While there is no magic ‘cure’ for autism on the horizon, we now know its cause. Genetic mutations occur in the areas of the brain that control the three main deficits in autism, namely communication, social interaction and narrow, restricted interests. Those genes in which these mutations occur produce the chemical neuro-transmitters that switch on the synapses that control the areas of the brain involved in autism.

A multitude of genes have now been identified as being implicated in these mutations. This fact means that it is unlikely that a specific drug will be found that can correct all the chemical imbalances involved. The major question remaining is whether the gene mutations that cause autism occur spontaneously, or whether there is an environmental factor involved.

Latest research published in the April 2010 Journal of Autism Research[6] suggests two types of inheritance involved with ASD. Most of these mutations occur in families with low autism risk, and are due to de novo mutations. The second type of inheritance occurs in families where there is a high risk of offspring developing autism, with dominant transmission approximating the expected 50% occurrence.

If this latest research is correct, it may explain the recent explosion in the prevalence of ASDs. If the de novo mutations are coming from recessive genes held by carriers who do not present as autistic, the build-up of people carrying these recessive genes has occurred over many years and has now reached a point where they are expressing at an ever-increasing rate.

The Centre for Disease Control in the US has now joined with Autism Speaks in an initiative to explore possible scientific opportunities in an international collaborative effort in autism epidemiology.

While there may be argument as to the cause of the gene mutations involved, there is no longer any doubt that they are the case of autism, and of many other intellectual disabilities encountered today.

Is each child with Autism is different from all others?

We need to examine this claim, and the claim that therefore each child needs a different treatment to other children on the spectrum.

It is a truism to state that all children are different, whether the child is autistic or non-autistic. What we need to know is exactly how each child's autism is differs from another's.

People with ASD have impairment in three areas, namely communication, social interaction, and interests, which are narrow and restricted when compared to the non-autistic child. Autistic people can differ in the **depth** of impairment in any or all of these three areas, but this does NOT lead to a conclusion that different treatments are required. As with any medical condition, the treatment regimen must be, and is, tailored to the severity of that condition.

Where autistic children do differ is in the number of co-morbid conditions they experience alongside their autism. It is this fact that causes the complexity in treating each case of autism. Many other medical conditions have a common etiology with autism, and this complex set of inter-relationships needs to be explored.

1. It is estimated that 70-80% of people with ASDs have some degree of mental retardation. However, there are people with autism at the higher end of the spectrum who display no retardation, and this clearly points

to the fact that retardation itself is separate from the condition itself. There are many people who suffer mental retardation who are not autistic. This clearly demonstrates that mental retardation is a co-morbid condition, not an intrinsic element of ASD.

2. It is estimated that between 30% and 40% of autistics have epilepsy. Epileptic seizures are the largest cause of premature death in people on the spectrum. Recent research[7] reveals that in the up to 40% of autistics who never speak, one of the major causative factors is epilepsy. Yet no state in Australia automatically gives an EEG to a child diagnosed with autism. The insidious policy of testing ONLY for autism during diagnosis has resulted in this sorry state of affairs. Subsequently, the necessary expertise in dealing with and treating children with ASDs and epilepsy does not exist.

3. It is estimated that 40% to 60% of autistics also have ADHD as a co-morbid condition. Again, recent research[8] has shown that children with both ASD and ADHD are four times more likely to bully than other children (adhd). This group also had higher rates of bullying than those children who were either autistic or who had ADHD. And again, both these disorders need their own separate treatment. By using one diagnosis alone, there are potentially long lasting and damaging effects on the child concerned.

4. Gastro-intestinal symptoms occur in 45% of children with autism.[9] It is now known that one of the genes implicated in autism plays a role in the gastro-intestinal system. Once again, because it is not treated as a separate co-morbid disorder, but instead considered to be wholly a part of autism, parents are left without help to discover and deal with this problem on their own. Just how much this contributes to the anger levels of a child on the spectrum can be imagined.

5. Up to 70% of children with ASD are estimated to have nervous disorders including depression. If these are not treated, these children as they grown older can slip into full blown mental disorders. Untreated,

children with nervous disorders find their narrow interests can slip over into OCD.

6. Dyspraxia is endemic in children with autism, but because it is regarded as an aspect of their autism, and not as a co-morbid condition, many autistic children are never treated for their dyspraxia.

There are many rarer genetic disorders such as Tuberous Sclerosis which are co-morbid with autism, and it is the mix of these co-morbidities that makes each case of autism appear different. We can treat the autism and we must also treat the co-morbidities.

Two things are abundantly clear. Firstly there is a potential for autism to completely overwhelm government budgets. **THE AUTISM GROWTH THAT IS PRESENTLY BEING EXPERIENCED WILL CREATE A POTENTIALLY GREATER CRISIS THAN THE CRISIS IN AGED CARE, AND WILL CONTINUE TO GROW LONG AFTER THE AGED CARE CRISIS HAS PASSED.** Secondly, the present policies and programmes available for people with autism which are limited and which do not meet the needs neither of the people they supposedly are designed to help nor the community as a whole, are themselves a major contributing factor to the crisis now facing us.

Can this situation be turned around?

ATAC believes it can, but we also believe that the initial stages of tackling this crisis will be very expensive. There is however, no viable alternative. There are teenagers in group homes who will need to be in care for the rest of their lives, there are those who, as a consequence of the inadequate care being provided at the moment, are in the process of breaking down. The turnaround of unqualified carers and teacher aides providing a form of respite, with no real education being provided, has left every state in the country short of suitably qualified people who can turn this situation around. It will not happen overnight.

The present totally inadequate system needs urgent reform. A model needs to be adopted that does not place the onus on families to look after their autistic children with only the assistance of untrained respite carers. Further, it is imperative also that a new, enlightened model to meet the needs of children with ASDs in the school system must be developed, not the present situation where these children are left to the care of teacher aides who have no professional educational qualifications. It is makes a mockery of the principles of equitable educational opportunities for the disabled when children with the most demanding needs and the most difficult to educate receive the least qualified care.

WHAT IS THE KEY TO RESOLVING THE PRESENT DISASTROUS SITUATION AND PROVIDING A SYSTEM WHICH WILL ADDRESS BOTH THE NEEDS OF THE INTELLECTUALLY DISABLED AND PROVIDE A LONG TERM REDUCTION OF COSTS TO THE COMMUNITY?

We must cease training our children for a dependent life in care, and must instead transform their opportunities by the introduction of **quality early intervention programmes using properly trained and qualified professionals to educate our children.** In this way by using professional programmes which offer proper training, we will enable children with ASD to become self-reliant, to live independently and with dignity. Further, we must be far-sighted enough to understand that the initial high costs of setting up such a system will be rewarded over and over again by the huge reduction in the $millions spent by government on long term permanent care.

Every expert on autism is in agreement that the earlier in a child's life that an intervention programme is put into place, the better the result for the child. In a child's early formative years preschool, the brain's plasticity is at its greatest and is most receptive to learning. An autistic child who is developing at half the rate of a normal child is by age 2 one year behind a non-autistic child of the same age. The task of getting this child to develop at a normal rate, and close the gap in development is much easier than it is if this task does not commence to the age of six. By that age the autistic child is three years behind his peers, and the brain is already far less flexible than it was at the age of 2 years. If we fail to address the needs of children with ASDs until this late point in their development, the process of meeting their needs becomes a considerably longer and more costly task.

To be able to commence intervention as early as 18 months to 2 years of age, children must be screened early. No government in Australia, either State or Federal, has such a screening programme in place. Yet there are simple and inexpensive screening tools already widely available and in use elsewhere. The Modified Childhood Autism Test (M-Chat) is over 95% accurate, and simple and relatively cheap to implement. Child Health Nurses, GPs and Paediatricians could quickly apply this test at 18 and 24 months. The American Pediatric Society has just recently recommended that this procedure be adopted.

That screening is not done in any State in Australia signals clearly that there is no intention on the part of government authorities to discover the true size of the problem that autism presents, let alone addressing the problem of autism itself. This is a foolhardy position. Being an ostrich not only does not send the immediate problem away, but it prevents those with their heads in the sand from finding solutions to the greater problem.

If on the other hand governments face the reality of the present situation, they can make decisions which will prevent the looming catastrophe. Using M-CHAT will allow children red-flagged by screening to be sent to specialized clinics dealing with autism. The clinics should be placed in all major hospitals. Properly trained staff at these centres could test and diagnose autism, and co-morbidities could be tested for by geneticists, experts in epilepsy, in gastro-intestinal disorders and nervous disorders. In this way, individual treatment programmes can be developed for each child with autism.

These services should be covered by Medicare, at minimal cost to the parents; just as all other treatments for medical conditions are covered.

While screening and autism clinics are relatively simple things to introduce, they require extensive training of professionals if they are to be effective. Today it is estimated that 84% of children with autism have phobias about medical procedures. This is because of their previous experience of prior procedures – forcible restraint when required to give blood for testing, needles being stuck in mouths when dental work is required, strange incomprehensible hats with wires placed on their heads, etc etc. We desperately need a medical profession that is ‘autism-aware’ and ‘autism friendly’.

Proper diagnosis and treatment and control of existing co-morbidities, **must** be followed by placement in quality early intervention programmes. The failure to provide these procedures **and** the necessary intervention programmes is the root of present day problems. This failure is then compounded by an education system that utterly abandons the needs of those children with ASDs.

Integration policy today is a catastrophe for children with autism.

School starting age for the general population is 5 years of age. At this age it is deemed that a child has reached the development milestones which will equip her/him to succeed in the complexities of school life, both social and educational. However, in a society where the problems of the autistic child are not addressed, today’s autistic child is compelled to attend school **PRIOR** to reaching these developmental milestones. Many are still wearing nappies, an estimated 40% are unable to communicate, and even the highest functioning lack the social skills necessary to survive in our overcrowded classrooms and schools.

NO AUTISTIC CHILD SHOULD ENTER MAINSTREAM SCHOOLING UNTIL THEY HAVE UNDERGONE QUALITY EARLY INTERVENTION TO BRING THEIR DEVELOPMENT AND SKILLS TO A LEVEL WHERE THEY ARE ABLE TO COPE AND RECEIVE AN EDUCATION.

This cannot be seen as unfairly discriminatory in favour of the child with autism. **ATAC** strongly argues that the present system which forces children into schools before they are adequately equipped with the necessary skills to allow education and well-adjusted social interaction is **cruel, and denies children on the spectrum their basis right to education.**

There is a window of opportunity for children with autism who are diagnosed by the time they reach two years of age, 3 years prior to reaching school age. If they are able to access appropriate intensive intervention programmes at this time, they are able to function and learn within the normal classroom.

This complete change in the approach to autism within our community is indisputably enormously expensive in its initial stages. It will mean that a new system will need to built from the ground up in an environment where past practices have left us with a costly legacy of the state funding people in long term permanent care. These people will still need to receive care, at the same time as that the new systems costs will have to be met.

Savings will come, but only with time. Previous unsound decisions by governments to take the cheapest option, regardless of the personal cost to those in need of government assistance, have been based on the advice of bureaucrats who have had no understanding of autism, and whose short sighted self interest has bequeathed us an inheritance that we simply will not be able to sustain, either socially or in terms of overwhelming financial cost to the public purse, in the mid to long term.

The demands of a change in government direction unquestionably have implications for major change through many areas of the community. The need for intensive early learning centres throughout Australia will mean that our universities will have to provide the training necessary for those who staff them, including psychologists and other professionals. There simply is not sufficient trained staff available to address the current situation, let alone deal with long term needs. The present system of respite care being provided by insufficiently trained staff will have to be replaced by highly trained autism therapists so that these centres can work at an optimal level. Professional case managers who have expertise in autism will need to be trained.

The expense of such a re-organisation demands the implementation of only tried, tested, and substantiated programmes . These programmes must be scientifically validated; evidence based; peer reviewed; and <u>not</u> reliant merely on anecdotal evidence. Any programme that does not adhere to the strictest and most rigorous of standards cannot form part of this system. It is for these reasons that **ATAC** strongly supports the use of the one intensive intervention programme that can meet these criteria, which moreover been able to publish consistent success over a period of 40 years. Applied Behavioral Analysis (ABA) is the only early intensive intervention programme which meets the rigorous standards needed to justify public spending of this nature. **ATAC** further argues that any other programme considered for use must meet the same criteria and indeed be measured against ABA.

It is for this reason that we strongly oppose the Eclectic Programmes supported by most of the Autism Industry. These programmes have been tested against ABA many times and found to be significantly less effective in their outcomes.[10] No government could justify the type of expenditure a new system demands if it was to be based on such unproven programmes.

ATAC accepts the view of Geraldine Dawson PhD, Chief Science Officer of Autism Speaks, expressed in her annual report. Here she submits that the way forward for autism appears to be a combination of ABA programmes and drug therapy to work on the plasticity of the brain.

CONCLUSION

ATAC is aware that the views held by our organisation, and expressed in this submission, will not find favour with many so-called experts. Many of these themselves involved themselves in the ‘autism industry’ and have a strong vested interest in maintaining the myths that permeate present mainstream thinking. We strongly believe that this Commission needs to check for itself the facts **ATAC** has outlined in this submission concerning the prevalence rates of autism today, and its frightening rate of growth. You will hear the same arguments from so-called experts that have been trotted out for over 20 years. You must ask yourself why these arguments persist when the prevalence rate is now rising to a point where it is threatening to overwhelm the health budgets of State governments. You need to determine whether they are in fact based in self interest rather than in the public good.

The Commission should demand they be provided with figures gathered by State and Territory Governments on the numbers of people with intellectual disabilities who are housed in group homes or who are in rostered care. On the numbers of children in foster care and are wards of the state who also have intellectual disabilities. On the amount of disability respite money spent on people with intellectual disabilities. You should ask those organisations who run homeless youth refuges how many of their clients have intellectual disabilities.

You should ask how many of those in the Youth Justice System, or prison inmates, have intellectual disabilities.

An examination of this data will convince you of the high cost of our failure to address the needs of the intellectually disabled.

Will the number of those with autism now stabilize?

To answer this question two facts need to be considered.

1. The inquiry by the British Parliament into adult autism found that 70% of adult autistics never have a significant relationship. The implications of this are clear. For the prevalence rate of autism, a genetic problem, to be increasing at the pace it is, it must be carried by a wide distribution of

people carrying recessive genes, but not expressing them. For this reason, the rate will not stabilize, but will build up and increase.

2. There is emerging evidence that autism in females expresses differently than it does in males. Female obsessions, for example, are different, and may manifest in obsessions about body image, hence express themselves as anorexia and bulimia. If this proves to be true, we can expect a further large increase in prevalence, as at present female rates of autism are about a quarter that of male rates. This new evidence needs to be factored into our understanding of the rate of increase of autism within the community.

While **ATAC** supports the proposal for a disability insurance scheme, we caution that this scheme can only be successful if we **discontinue** the present practice of providing one service for all children with disabilities. The option of ignoring the special needs of those with intellectual disabilities is no longer viable. It may be that this inquiry should consider an initial scheme to fund intellectual disabilities and allow the present funding to be continued for those disabled who are not intellectually challenged. Then, as over time the savings from this new approach begin to emerge, the two schemes can be merged into one insurance scheme that will fund both.

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[1] **Presented at the APAC '09 Conference Sydney**

[2] **ATAC has taken this analysis of Australian prevalence rates from an article by Bob Buckley, printed in A4 Update, February 2010, Volume 8, Number 2**

[3] **Prevalence of Autism in Cambridgeshire, UK, Professor Baren-Cohen of the Autism Research Centre at Cambridge University, published in the British Medical Journal**

[4] **Prevalence of Autism Spectrum Disorders – Autism and Developmental Disabilities Monitoring Network, United States, 2006 (Dec 18, 2009**

[5] **Press Release from Commissioner for Children Tasmania, 29 June 2009**

[6] **Kristina Brady et AL, Volume 3, Number 2, April 2010 Autism Research**

[7] **THESIS: Speech and Language Dysfunction in Childhood Epilepsy and Epileptiform EEG Activity, University of Gothenberg (Sahlgrenska Academy)**

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[8] **Guilermo Monteo PhD, Senior Researcher at Rochester NY based Children's Institute**

[9] **Autism Treatment Network**

[10] **Various sources**

i) Dita A Zacher, Eather Ben Itzchok, Anna-Lea Rabinovich, Eli Lahat, '<u>Changes in autism core symptoms with intervention'</u> published in Science Direct, 2006

ii) Jane S Howard, Colleen R Sparkman, Howard G Cohen, Gina Green, Harold Stanislaw, published in Research in Developmental Disabilities 2005, pp 26, 359 – 383

iii) Sven Eikeseth, Tristram Smith, Erik Jahr, Sigmund Elderik, <u>Intensive Behavioural Treatment at School for 4 – 7 year old Children, A 1 Year Comparison Controlled Study,</u> published in Behaviour Modifications, Volume 26, Number 1, June 2002