ADVANCED ASSESSMENTS LTD
Expert Witnesses & Psychologists

Dr Bernard Horsford
PhD, D Occ Psych, MBA, MSc, LLB, BA, Dip Ad Ed, Dip M, MAPM, MAE, FCIPD, C Psychol, MIoD, FIBC, AFBPSs
Chief Executive

Our ref: BIH/1964/2018
Your ref:
Date: As email

Dear Collegue

Re: Autism Diagnositc Assessment and Report by Chartered Psychologist

We are delighted to enclose an information pack about our comprehensive autism diagnostic assessments. We charge as standard fee for the assessment no matter how long it takes to complete the assessment. Most individuals complete the assessment within three to five hours, but some individuals take up to eight. We aim to provide a quality report and not rush you through the assessment process to ensure you find the diagnostic assessment enjoyable and engaging. Our diagnostic assessments are more comprehensive than other providers. In addition to the face to face assessment, we also include a preliminary assessment lasting 2 to 2 ½ hours.

We use gold standard tests in our diagnostic assessments and evaluate more areas of difficulty than most other providers of autism assessments. All our assessments are carried out by Chartered Psychologists to ensure that you have, the highest possible quality report available for the price. Because of the depth of analysis and skill, we bring to the evaluation of learning difficulty; we can identify autism which often is undetected by screening tests and by cheaper autism diagnostic assessments.

The majority of individuals choose a home based assessment; this is more comfortable for the individual. The cost of a home based assessment is just £1,200 if you need your report within four weeks. If you need your report within seven days, the fee is £1,800. If your home is not suitable for a home based assessment, you can come to one of our autism assessment centres. The additional fee for our London Assessment Centre is £95. The address of our London Autism Assesment Centre is Dr Bernard Horsford, Psychologist, Highgate Consulting Rooms, West Hill House, 6 Swain's Lane, London N6 6QS. You can get directions to our London autism assessment centre by Googling Dr Bernard Horford, Psychologist, London.

What will your autism diagnostic assessment report look like? What will the process involve?
I have attached an example autism diagnostic report, this should give you an idea of the tests that we use in the process and the depth of analysis and guidance we provide to ensure you get all the help you need to realise your full potential in education. Please note that we have since updated our style of reporting from the one in the attached example. If you need a autism assessment for use in legal or immigration proceedings, you will need to book an expert witness assessment of autism, these are charged at a higher fee.

How to book your full autism assessment or free initial call back
To book an assessment call my office on 020 8000078 or email my customer care team at wecare@advancedassessments.co.uk with the following information in the header of the email:

- Your name – telephone number – preferred booking date.
- Your name – telephone number preferred initial callback date and time

Your initial callback or preliminary assessment will take place after 18:00 hours on the evening of your choice. A psychologist will call you back to answer any detailed questions you might have after reading the information pack. Please let us know by return of email any dates and times when you are unavailable if your chosen date is not available. We only assess private clients for autism over the weekend.

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We cannot hold your preferred full autism assessment date without payment. If your chosen date is lost, we will transfer your booking to the next possible date or refund your booking fee if the next possible date is not suitable for you. It is therefore advisable to contact us by email or phone to confirm that you are making payment for your preferred date before you make payment.

Please make payment at least five working days before the face to face assessment. Five days notice is recommended because the psychologist assessing you will need to review your documents and carry out a telephone or video linked preliminary assessment with you to better understand your needs before the face to face assessment takes place. We will take a detailed developmental history in the preparatory assessment using the Autism Diagnostic Interview-Revised. The preliminary assessment takes place by phone, Skype, Face time or Google Hangouts. The preliminary assessment will take place at least two days before the face to face assessment. The preliminary assessment is not mandatory, but we strongly recommend it as it will allow the psychologist to better plan for the face to face assessment and reduce the amount of time needed in the face to face assessment. The face to face assessment will involve observation using the Autism Diagnostic Observation Schedule (Second Edition) and IQ testing. At the end of the face to face assessment, the assessing psychologist will have enough evidence to make an accurate diagnosis of autism. The psychologist will explain the findings of the diagnostic tests to you and allow you to ask any questions.

How to pay your autism diagnostic assessment fee.
You can pay the fee for the assessment by bank transfer to our bank account:
Advanced Assessments Ltd
Account Number: 14120135
Sort Code: 52-10-33
Bank: NatWest

Please include your name as a reference for the payment.

If you would like to pay by credit card, please advise us of this in your email we will send you an electronic PayPal credit card invoice from Sankofa Financial Services, who handle our credit card payments.

What you need to send before the evaluation takes place
When you have booked your assessment, please provide the following:

- If the individual being assessed is a child, copies of the last three years of your child's educational reports, exam results and any assessments carried out by the school.
- Any documentary evidence of difficulties you that you think might be attributable to autism.
- A written summary of the aspects of developmental history of the individual being assessed.
- Any other medical evidence to the diagnosis of autism.
- An indication of whether any other family members have autism (even in the extended family), this will be helpful to know.
- A signed copy of our Client Care Agreement.

If the individual being assessed has autism the report will allow they will able to gain a range of reasonable adjustments in education including extra time.

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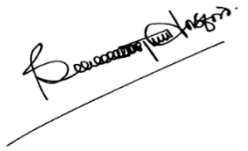
Thank you again for your enquiry, we look forward to working with you.

Kind regards

Yours faithfully



Dr Bernard Horsford
Chief Executive & Consultant Chartered Psychologist
Advanced Assessments Limited

Enclosures:

1. Sample Autism Assessment Report
2. Client Engagement Agreement
3. Privacy Policy

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Chief Executive

Example Autism Assessment Report

180 Piccadilly London W1J 9HF **T:** 0208 200 0078 **F:** 0208 200 0334
W: www.advancedassessments.co.uk
Registered Office: Africa House 21 Shorwell Road Nottingham NG3 7HG
Registered in England Number 3743892

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1. BRIEF CURRICULUM VITAE

1.1. Dr Bernard Horsford

1.1.1. I have over 25 years' experience in the psychological assessment of individuals. I was Managing Director of the largest specialist Mental Health Trust in Europe. I have particular expertise in the objective assessment of specific learning disabilities. My extensive experience includes advising leading personal injury lawyers, insurers, the Crown Prosecution Service, Treasury Solicitors Department, Central Government, HM Prison Service, the Probation Service, the Legal Services Commission, HM Courts and Tribunal Service, the Department of Health, NHS trusts and local authorities. As an expert in numerous cases, I have provided independent assessments of autism and specific learning disabilities. I sat on the Health Care Professions Council's Fitness to Practice and Education Panels for some years. I am a full member of the British Psychological Society's Division of Neuropsychology and a full member of the Association of Child Psychologist in Private Practice. In addition to this, I am an associate member of the British Psychological Society's Divisions of Child and Educational Psychology, Clinical Psychology, Forensic Psychology and a full member of the Division of Occupational Psychology. I hold membership of the Academy of Experts and the Expert Witness Institute. I have produced numerous expert reports.

2. SUMMARY OF CONCLUSIONS

2.1.1. This is an overview of the autism diagnostic interview which was carried out with Example's mother, Example, on 1st May 2016. The interview lasted for one hour and 50 minutes. My conclusions are that Example has high functioning autism. These conclusions are based on an analysis of all the clinical evidence, the Autism Diagnostic Interview - Revised (ADI-R), the Autism Diagnostic Schedule (ADOS-2) and the Wide Range Intelligence Test (WRIT) results. Additional analyses of the difficulties were carried out using the Clinical Assessment of Behaviour, (CAB) these proved negative. However, the results were likely to have underestimated Example's problem behaviour as his mother reports evidence of depression, and is reluctant to label Example as autistic. Assessment of Example's overall development using the Developmental Profile Three (DP3) found that apart from difficulties which are attributable to autism his development is normal.

3. FULL AUTISM DIAGNOSITIC ASSESSMENT

3.1. AUTISM DIAGNOSTIC INTERVIEW – REVISED

Background

Family Members/Family Medical and Social History

3.1.1. Example has a younger sister, Example. She displays no developmental difficulties. Example notes that Example's development was far quicker and followed a more normal pattern when compared to Example.

3.1.2. Example's mother, Example, is dyslexic and dyspraxic. She was diagnosed with dyslexia at the age of 18. She also has a brother who is dyslexic and dyspraxic. He could be autistic but yet does not have a formal diagnosis.

3.1.3. Example's father, Example, reports no developmental difficulties in his development. I do not have any information about developmental challenges in the paternal father's family.

Example's Education (School and Preschool)

3.1.4. Example has enjoyed some preschool placements. He attended Example Pre-school from February to July 2014. He also had a number of nursery placements which include a placement at Example Nursery from September to December 2014, Example Nursery from January to March 2015 and Example Nursery from March 2015 to present. During these placements, he has had an individual placement for children with limited speech. He has had an extended history of speech and language difficulties. These difficulties are referred to in the body of this report.

Personalised Timing

3.1.5. The Examples have always lived in their present house. When pregnant with her second child, Example was quite unwell. Example was very unsettled during this period. Example was aged three then. There had been no significant changes or incidents since the arrival of Example, Example's younger sister.

Diagnosis

3.1.6. His class teacher mentioned the possibility of Example being autistic (Mrs Example at Example Nursery in May 2015). She thought that Example may be autistic. She noticed that he was putting his hands over his ears in the classroom.

3.1.7. Autism was also mentioned by the speech and language therapist who has worked with Example for some time. She felt that he might be autistic.

Medication

3.1.8. Example currently has asthma. He takes Ventolin for this when it is needed. He has an inhaler for his asthma.

<u>Introductory Questions – General Overview of Example's Functioning</u>

3.1.9. Example, at times, can be seen as odd and quirky when he is compared to other children.

3.1.10. At times, he talks too much and interrupts the conversation. Sometimes he is not sure how to initiate conversations and interactions with others.

3.1.11. Example's parents note that he counts a lot. This is, of course, repetitive behaviour. He also spends hours playing astronauts. He is extremely interested in mathematics, science and how things work.

3.1.12. When things are changed this acts as a trigger for bad behaviour in Example, he becomes disruptive and uncooperative.

3.1.13. Example does not like weddings or parties. He will stand outside of them for 20 minutes to an hour before going in. It takes him about this time to feel comfortable and relaxed enough to go to the event.

Early Development

Onset of Symptoms

3.1.14. Example's symptoms became apparent when he was about 18 months to 2 years old. His speech was behind and his parent's spoke numerous times to the health visitor to a speech and language therapist because of his lack of expression.

First Symptoms to Arouse Parental Concern

3.1.15. Example's parents became concerned when he was around 18 months to 2 years because in comparison to other children he had a very limited amount of speech. He was also reluctant to go out. He had to be coerced to go out of the house.

3.1.16. As far as his speech was concerned, he only had use of a very limited amount of words that his family were able to recognise. Other individuals found much of Example's speech unrecognisable.

Onset as perceived with hindsight

3.1.17. In retrospect Example's estimates that Example first showed problems or difficulties in development or behaviour before his second birthday.

Major Milestone

First Walked Unaided

3.1.18. Example began walking between the ages of 14 to 15 months unaided.

Toilet Training

Acquisition of Bladder Control: Daytime

3.1.19. Example became toilet trained day and night after his third birthday. He was late in becoming effectively trained, but there were not significant issues with bedwetting.

Acquisition of Bladder Control: Night-time

3.1.20. Example first became dry at night when he was approximately three years old.

Acquisition of Bowel Control

3.1.21. Example first got full control of his bowels when he was approximately three years old.

Acquisition and Loss of Language/Other Skills

Age of First Single Words

3.1.22. Example was first able to use his first words meaningfully apart from mamma and dada when he was about 26 months old. This was following the intervention of a speech therapist. He had a number of sessions of speech therapy which were paid for privately. He was unable to say more than 20 words at the age of two years. Example was over 2.5 years before he could speak regularly and this was after the intervention of a speech therapist. At the age of 3.5 years, his speech remained limited and only family members understood what he said.

Age of First Phrases (If Ever Used)

3.1.23. Example was three and a half years old before he could utter a sentence that other people understand other than family members. At the age of three and a half years, he still had very limited speech or understanding of

speech other than to family members. Currently, new people that meet Example still do not fully understand him.

Loss of Language Skills

Loss of Language Skills after Acquisition

3.1.24. Example did not lose his language skills during the first years of life after he had learnt to talk.

General Loss of Skills

Loss of Skills (for at least three months)

3.1.25. There has never been a period of consistent loss of skills (although Example's behaviour may have varied at times).

Communication Functioning

Comprehension of Simple Language

3.1.26. When looking at how much language Example understands if his mother does not gesture, the following is noted. In response to a request Example can usually perform an unexpected action with an unexpected object; or could place an object other than something to be used by himself (such as boots or a toy), in an unexpected location in a different room ("Put the keys on the kitchen table").

Overall Level of Language

3.1.27. When considering whether Example uses at least three-word phrases; this includes spontaneous speech or echoed or stereotyped speech if they are used functionally, the following is noted:

3.1.28. Currently, Example has functional use of echoed, or stereotyped language that, on a daily basis, involves phrases of three words or more, which at least sometimes includes a verb and are comprehensible to other people.

Use of Other's Body to Communicate

3.1.29. When considering the abnormal use of another person as a kind of extension of Example's arm or body, for example the use of another person's hand to point, touch an object, or perform a task such as turning a doorknob to open the door, unscrewing a bottle top, or manipulating a zip or buttons. This behaviour, of course, will probably take place without any prior attempt to communicate the need or request, using other sounds or gestures. Thus, the physical contact is not to initiate a social approach, but rather to facilitate the completion of a task.

3.1.30. It is noted that Example makes regular use of another person's hand as a tool for gesture "for" himself.

3.1.31. For example, Example pointed and looked to the kitchen table for food. Example used his signs to tell you about a "train" or "plane" in the sky.

3.1.32. Example did not say the word up until he was about 3.5 years to 4 years old.

Articulation/Pronunciation

3.1.33. Looking at Example's pronunciation now, this was a little harder to classify. It is likely that he still has specific articulation difficulties such that some words are tough for strangers to understand until they get to know him. However, this was classified more conservatively when I analysed the results of the interview as the family seemed rather reluctant to accept the possibility that Example might have been autistic during the assessment. I, therefore, assumed that Example's symptoms were better than they were in reality and that he was understood better by family members because of difficulty with some words, but that he was mostly comprehensible to strangers at first encounter. I think this will make a microscopic difference to the classification of his symptoms as the analysis of the results of the ADI-R interview show that he has a definite diagnosis of them in any event and his total scores are well above the threshold for a diagnosis.

3.1.34. The family understand Example, but strangers need much help and will require reference back to the family as adults to know what Example says.

Stereotyped Utterances and Delayed Echolalia

3.1.35. Echolalia is defined as the non-hallucinatory use of repetitive speech patterns that are clearly odd regarding either stereotyped content, or then unsocial usage, or both. These include phrases that are interspersed into more normal speech itself; self-commentary on Example's actions, a repetitive return of emotive or upsetting interchanges, or routinized phrases used out of appropriate context. These do not include the repetitions that often occur with a typically developing child as part of play when phrased speech is just becoming well established, or for reassurance.

3.1.36. Example shows hardly any use of stereotype phrases or echolalia.

Social Verbalisation/Chat

3.1.37. The emphasis here is on defining social verbalisation/chat. The focus in representing social verbalisation/chat is on whether or not speech is used just to be friendly or social rather than to express needs or give some information. The focus of this question is the social approach, not social reciprocity, which is dealt with later on.

3.1.38. Example can make some social use of speech in response to the caregiver or to get attention with no other obvious motivation, but this is limited in frequency or range of context.

3.1.39. Example rarely engages in talk about a topic he is not interested in. If someone said to Example "It never stops raining", he would not say "Yes". He will then change the topic to something that he looks to talk about.

Reciprocal Conversation (within subject's level of language)

3.1.40. The emphasis on this item is the ability to facilitate the flow of conversation (i.e. to build on the other person's responses rather than the subject's ability to talk/chat). Example engages in occasional reciprocal conversation, but this is less frequent than average or limited in flexibility or topics.

Inappropriate Questions or Statements

3.1.41. The focus here is on socially inappropriate accurate utterances that reflect a lack of understanding or disregard of the social impact of such comments. These may consist of declarations that are intrinsically odd (for example, "How tall was Mr Brown when he was two?") or statements that are inappropriate because of their personal nature or about the situation. Repetition may contribute to the oddness, but it is not sufficient in itself.

3.1.42. There was only very rare use of questions or statements which were inappropriate to the setting. For example, Example might say "Why is that person in a wheelchair?"

Pronominal Reversal

3.1.43. The emphasis is on the consistent abnormal confusion of pronouns between the first and second or third person. It does not include "I/me" confusion as this is often a subculturally acceptable use.

3.1.44. Example exhibited no confusion between the first and second or third person after phrased speech with pronoun use established.

Neologisms/Idiosyncratic Language

3.1.45. Neologisms must be non-words and apparently particular, (for example "plin" for a freestanding piece of paper or fabric, or "mashuda" for triangles). The idiosyncratic language refers to real words/or phrases used or combined by the subject in a way that he or she could not have heard. These are used to convey specific meaning; they do not include conventional metaphors, differentiate unusual or truly idiosyncratic usages from frequent childish references to objects according to their function or as part of a shared game or a joke.

3.1.46. Example makes occasional use of neologisms and/or idiosyncratic words and phrases used consistently over a period.

3.1.47. He makes up names and has made up a name for a teddy bear. If you say to Example what is the name of that teddy, he will give it a real name. He will call it a sound like “um ah!” for instance.

Verbal Ritual

3.1.48. When deciding whether verbal rituals are present, the focus was on the degree of predictability and the context and sequence, as well as the compulsive quality of the speech. The emphasis is on thick sequences of utterances that are said as if the subject feels pressure to complete them in a particular order. The subject is imposing an order on what he or she says and may, also, pose particular restrictions on the verbal responses/utterances of others. I excluded verbal rituals that occur solely as part of a bedtime routine.

3.1.49. Using this definitional framework, Example was found to have a tendency to say things in a ritualised way or to require others to do so, but there is no indication that this is compulsive, and regularly stops if he is asked to do so.

Intonation/Volume/Rhyme/Rate

3.1.50. This item refers to unusual qualities of prosody or the paralinguistic sound of the subject speech such as evidenced in intonation, volume, rhyme, or rate. I have not included colloquial phrases or indectives here.

3.1.51. When using this definition, it can be seen that Example’s speech showed one or other of the abnormalities that I have considered above, but not apparently particular and no interference with intelligibility.

3.1.52. Example has a delay when he speaks. I felt his speech was quite flat.

Current Communicated Speech

3.1.53. This item refers to semantic and grammatical complexity within a sentence in non-echoed utterances. This is a summary code to assess how well the subject uses his or her language to communicate.

3.1.54. Example has some communicated use of words (for example, words regularly used to communicate, with or without an abnormal element), but somewhat restricted in frequency or context.

3.1.55. Example's speech appears to be "odd". It is fixated on small particular points. In conversation, he can be unusual in that he gets very interested in a particular point and will not move from it. He is very interested in how a particular thing works – for example a doorbell or telling people how it works if he knows.

Pointing to Express Interest

3.1.56. This item is strictly concerned with unprompted pointing that is used as a spontaneous communication to express interest or to show something at a distance, rather than as a means of obtaining some object. Pointing must be social and the subject must initiate it. Furthermore, the pointing must be objects that are within sight, but that are some distance away. Pointing at books, or pointing as a learned response to questions, is explicitly excluded from this item. Also excluded is pointing that is used as a means of obtaining some object. For the pointing to be not counted it must involve coordinated eye gaze with the other person, as described above.

3.1.57. Example was found to point spontaneously at objects at a distance with a finger to express interest, using coordinated eye gaze to communicate.

3.1.58. Example would point at things around himself, for example, "lampposts". He can point out different ones en route to the nursery. He will also identify which lampposts have screws missing out of them. On Dial-a-Ride buses, he said that buses had seatbelts.

Nodding

3.1.59. This item was intended to determine if the subject currently uses or has ever used the conversational gesture of head nodding to communicate "yes" should have occurred in several different situations, but may have decreased in frequency as the subject learnt to speak.

3.1.60. Example will consistently nod spontaneously.

Headshaking

3.1.61. This item is intended to determine if the subject currently uses or has ever used the conventional gesture of headshaking to communicate "no". Headshaking should have occurred in several different situations, but may have decreased in frequency as the subject learned to speak.

3.1.62. Example shakes his head to mean no. He consistently shakes his head spontaneously.

Conventional/Instrumental Gestures

3.1.63. Instrumental gestures are spontaneous, culturally appropriate, deliberate hand or arm movements that convey a message by their former social signals. They exclude purely emotional signals (such as hand to face in embarrassment or shrinking with fear); demonstrations; and instances of touching or pulling someone to gain their attention or show them something. Also, they exclude mannerisms such as touching the face or scratching. All gestures must be/have been used over a period of three or more months to be coded positively. Often it is useful in helping informants to remember gestures to focus on how the subject directed their attention or used other modes of communication.

3.1.64. Example displays an appropriate and spontaneous use of a variety of conversational or instrumental gestures.

Attention to Voice

3.1.65. The focus here is on whether the subject shows an orienting response when spoken to and not whether she or he complies with what is said. The orienting response should consist of an automatic looking to the sound, as calling the subject's name or standing very close to him or her.

3.1.66. Example does not consistently appear to pay attention (for example, he might look up briefly, but little-sustained attention), but sometimes responds to what is said or responds on occasion only to affirm loud voice. This was evidenced in the current period and also evident when Example had turned four and therefore can be classified as mostly abnormal.

3.1.67. For 50% of the time one might get a response and in the other 50% of the time, Example fails to respond. He "can appear quite zoned out". His parents were worried he had a hearing problem. He had five separate hearing tests, but Example was scared of the test and did not want anybody to put anything in his ears. However, his hearing is fine.

Spontaneous Imitation of Actions

3.1.68. The emphasis here is on automatic imitation of a range of non-thought individual behaviours, actions or characteristics of another person. They exclude imitation of film/TV characters.

3.1.69. Example exhibits spontaneous imitation of a varied range of non-thought actions, at least some of which are incorporated into play outside the context of the observed behaviour of the imitated person. This has always been the case.

Imaginative Play

3.1.70. Imagination is defined as pretend play that implies the formation of mental images of things not present. The focus here is on the child's creative and varied use of actions or objects in play to represent his or her own ideas.

3.1.71. Example will make occasional, spontaneous pretend actions or highly repetitive pretend play (which may be frequent) or only part that has been taught by others.

3.1.72. His mother notes him as being quite repetitive. He will play firefighter for example for hours at a time. He will also play space astronaut for hours at a time. He has a fascination with emergency services. In contrast, he is very reluctant to play pretend games with other children.

Imaginative Play with Peers

3.1.73. The focus here is on the spontaneous, creative sharing of imagination among children, incorporating both the subject's ideas and those of other children. The level of creativity may be simple, so long as it is socially interactive, spontaneous, and varied. The subject's only play is with his siblings. I was particularly careful to differentiate well-practice routines from spontaneous, flexible play, also distinguish play that is highly structured "for" the subject by the sibling from play in which she or he showed some initiative.

3.1.74. Example showed some participation in pretend play with other children, but not truly reciprocal and/or pretending is very limited in variety.

3.1.75. Play is quite often on Example's terms only. He likes to take the lead in play when pretending. His play is restricted in that much of it focuses on roles in the emergency services and outer space.

3.1.76. He will be reluctant to participate in play if it is play of a game suggested by another person. Example will often complain to his mother that he has played no games while at the nursery. His mother would ask him if he played there.

Social Development and Play

Direct Gaze

3.1.77. This includes the subject's use of direct eye gaze to communicate his or her response to others.

3.1.78. Example exhibited normal reciprocal direct gaze used to communicate across a range of situations and people.

Social Smiling

3.1.79. This is defined as spontaneous smiling directed at a variety of people, including smiling back at someone, smiling at him or her during an approach and smiling in response to what someone does or says to him or her.

3.1.80. There was some evidence of smiling while looking at people, but Example's smiling was not reciprocal; he might for example only smile at his parents or only smile on request, or only smile in odd situations or odd ways.

Showing and Directing Attention

3.1.81. The purpose of this item is to determine how and in what circumstances the subject directs other's attention to toys or objects in which she or he is interested. The focus is on spontaneous directing.

3.1.82. Example shows objects regularly by bringing things to his parents and directing his or her attention, with no obvious motive other than sharing.

Offering to Share

3.1.83. This item is concerned with unprompted, non-routine offers to share a range of different objects with other people.

3.1.84. Example demonstrated frequent spontaneous, and different offers to share different sorts of objects (for example, toys, comforters) with other people.

Seeking to Share Enjoyment with Others

3.1.85. The aim of this item is to determine whether the subject attempts to share his or her enjoyment with things that give him or her pleasure with others, with no other apparent motive than sharing.

3.1.86. Example makes frequent attempts across a variety of contexts to direct several other people's attention to things that he enjoyed or has done well (he does this with more than one parent).

3.1.87. He repeatedly tells his parents that he is excited.

Offering Comfort

3.1.88. This is defined as spontaneous unprompted gesture, touch, vocalisation or offer of an object (for example, a blanket). It also includes a change in facial expression directed to someone who is sad, ill, or hurt, and an attempt to help him or her feel better.

3.1.89. Example flexibly and spontaneously offers comfort in a range of circumstances and ways, for example, by gesture, touching, or vocalisation, or offers of objects (for example, blanket); this includes a change in facial expression.

Quality of Social Overture

3.1.90. The focus of this item is on the quality of social intentionality when seeking help, not on the number of contexts in which social approaches occur.

3.1.91. Example consistently uses coordinated eye gaze with accompanying vocalisation in typical situations when motivated to communicate.

3.1.92. Example will repeatedly shout rather than talk. He can be very impatient.

Range of Social Expressions Used to Communicate

3.1.93. The focus here is on facial expressions used to communicate, not just those associated with the experience of emotions. A normal range of emotions, even in a very young child, could be expected to include several more subtle facial expressions used communicatively, including surprise, guilt, disgust, interest, amusement and embarrassment as well as joy, anger, fear, and pain.

3.1.94. Example shows a somewhat limited range of expression, and he sometimes comes across as rather stilted and exaggerated in his mannerisms.

3.1.95. Example was also somewhat limited in facial expression, and was stilted and exaggerated in manner when he was four years old and this is most abnormal.

Inappropriate Facial Expressions

3.1.96. Inappropriate social expressions are those that indicate emotions incongruent with the situation such as laughing when someone is upset or hurt, or laughing or crying for no discernible reason.

3.1.97. Example's expressions are almost always appropriate to mood, situation and context.

3.1.98. He does seem to follow others, but it does appear at times that he is laughing because of others, not because he is following the joke. The speech therapist has pointed this out to Example's parents.

Appropriateness of Social Responses

3.1.99. The focus of this item is on the subject's response when adults other than parents attempt to interact with him or her in every day, but non-routine situations.

3.1.100. Example makes some clear positive responses and interactions, but he is not consistent. This was clearly present when he was at the age of four and this is most abnormal.

3.1.101. He can ignore people at times and Example can be unsure what to do and will look for guidance from his parents. Example often needs prompting to say hello and goodbye to people. This is something that Example's parents do not have to do with his younger sister.

Table 1: Favourite Activity/Toys

Favourite Activities	Favourite Toys or Objects
Playing with the hose in the garden	Fire engines
Scooter	Train track
	Fireman Sam toys
	Astronaut toys
	Paw Patrol

3.1.102. Initially, Example was the worst child in the class. Now he is the best in rugby and football. He follows directions to the tee.

3.1.103. He becomes very upset if he thinks he is missing a session. For example, if he is ill, his parents have to tell him that the nursery is closed or otherwise Example will be distraught.

3.1.104. Example needed to have the whole set of firefighter, astronaut and Paw Patrol toys. If a new blue light services toy comes out, Example will want it.

3.1.105. He will spend ages telling his parents what new vehicle or toy he needs.

Initiation of Appropriate Activities

3.1.106. This item concerns how the subject spontaneously keeps him or herself occupied and involved in a range of non-odd and non-repetitive activities when not supervised or directed.

3.1.107. Example takes up a range of appropriate play activities, without prompting or organising by other people.

Imitative Social Play

3.1.108. The focus of this item is on the child's reciprocal participation as both leader and follower in early games that require imitation and coordination of simple actions. Ball games are not included in this definition.

3.1.109. There is some to and fro (that is, reciprocal) social play, but this is limited in amount, duration, or context in which shown (for example, only plays peekaboo or pat-a-cake with his parents).

3.1.110. While Example did happily play peekaboo, he did not like any group activity. Example always had difficulties in his toddler group; he would keep himself to himself in the room. However, he does seem to tolerate social play a little better now.

Interest in Children

3.1.111. The focus on this item is on Example's interest in watching and interacting with other children who are the same age.

3.1.112. Example often watches other kids and sometimes makes an apparent effort to approach them or get their attention.

Response to approaches of other children

3.1.113. The aim here is to determine the subject's response when other children approach him or her and whether his reply constitutes an effort keep an interaction going.

3.1.114. Example sometimes is responsive to other children's approaches, but his response is limited, somewhat unpredictable, or only to a sibling or playing with an only child.

3.1.115. Example has issues "initiating" approaches to other children when they have approached him. In the past, he has "frowned" at them. He does this less now, but can do it from time to time.

Group Play with peers

3.1.116. The focus is on the subject's participation in groups of other children in spontaneous games or activities. Co-operation must involve the subject attending to his or her peers and modify his or her behaviour that clearly demonstrates spontaneous, flexible, interactive play. Chasing and ball games should be included only if spontaneous, flexible and interactive.

3.1.117. Example enjoys "parallel" active play (jumping on a trampoline or falling with others during ring-a-ring-a-roses), but little on co-operative play.

3.1.118. He prefers to play with individual children. He will often choose to sit out if there is more than one child.

Friendships

3.1.119. For the purpose of this item, friendships are defined as a selective, reciprocal but between two people of approximately the same age who

seek each other's company and share activities and interests. Example has one or more relationships with a person in his age group with whom he shares non-stereotype activities of personal variety. He sees them outside a prearranaged group (such as a club); and with whom there is positive reciprocity mutual responsiveness.

Social Disinhibition

3.1.120. Social disinhibition refers to behaviour that is not appropriately modulated accordingly to the social expectations in the subject's sub-cultural environment. Such disinhibition may arise from a variety of causes, but the aim here is to ask about that which stems from a lack of awareness of social cues.

3.1.121. Example demonstrates a definite lack of appreciation and social cues, context, or requirements: he lacks normal social inhibitions and in times behaves in socially awkward ways: fails to modulate behaviour according to social context.

3.1.122. Example picks his nose always when under pressure. He also walks around with no clothes on and will open the door in this state to his friends. His parents used to try to explain that his friends find this uncomfortable.

Interests and behaviour

Unusual preoccupations

3.1.123. An unusual preoccupation is defined as an interest that is odd or particular in quantity – that is unusual in its intensity and lack of social features – and which is repetitive or stereotyped in one or more of its features or elements.

3.1.124. Example has an unusual preoccupation that does not interfere with significant activities of family life or does not cause social impairment.

3.1.125. His occupation is with the emergency services, firefighters in particular. He has interests in other things such as a metal detector.

Circumscribed interests

3.1.126. Circumscribed interests are defined as a pursuit that differs from ordinary hobbies in its intensity: its circumscribed nature (i.e.): it may involve a high level of expertise, but this remains unusually focused and has not developed into broader contexts of knowledge): it's non-social quality (maybe shared with another individual similar circumscribed interests, but not as part of a specialised club or association): and its relative non-progression or development over time (that is, the interest persists, but does not form the basis of a building up of shared or used expertise). It differs from an unusual preoccupation in that it lacks a building up of shared or used knowledge). It differs from an "unusual preoccupation" that it requires a building up of shared or used knowledge. It differs from an "unusual preoccupation" that it lacks particular or odd content. Circumscribed interests are unique in their qualities, but not their content.

3.1.127. Example exhibited circumscribed interests that do not cause substantial interference with social functioning, but which does constrain or intrude upon Example's or his family's activities.

3.1.128. Example has a circumscribed interest with fire engines and the emergency services.

Repetitive use of objects or interests in parts of objects

3.1.129. This item involves sections of a stereotyped or repetitive nature that are non-functional and require a focus either on parts of objects or on a stage of an object that is clearly separate from that which is ordinarily accepted.

3.1.130. Example demonstrated little or no repetitive use of objects.

Compulsions/rituals

3.1.131. The emphasis of this item is on fixed sequences that are performed as if the subject feels to complete them in a particular order. Compulsions may also include having to place particular objects in exact positions or relationships in space, such as opening all doors to a certain angle or turning all lights off. The compulsion with lights differs from repetitive use of objects (in that the subject insists that several lights must remain off, rather than carrying out a repetitive action of flicking lights off and on).

3.1.132. Compulsions differ from difficulties with changes in that they have a sequence; also, in a ritual or compulsion, the subject is imposing order on events, rather than responding to a perceived change. A subject who needs to lay her or his napkin out flat and place her or his spoon on it before she or he will eat could be regarded as having a ritual. Whereas, a subject who is upset she or he is given a different napkin would be considered under "difficulties with minor changes in subject's routines or personal environment".

3.1.133. Bedtime routines are explicitly excluded from this item because they occur so commonly in typically developing children.

3.1.134. Example has one or more activities that he has to perform in a particular way; Example appears to be under marked pressure or becomes extremely anxious or distressed if this activity is disrupted; the degree of compulsive quantity intrudes upon family life or causes definite social impairment to Example.

3.1.135. Example could not be rushed; everything has to be done in order, with timed warnings given to Example ten minutes before his parents leave, and then five minutes, et cetera. The mornings are relatively calm, if Example is rushed, he will become upset.

Unusual sensory interests

3.1.136. Unusual sensory interests are defined as the unusually strong seeking of stimulations from the basic sensations of sight, touch, sound, taste or smell that are dissociated from meaning. The focus is on the extent to which the normal interests disturbs or replaces "normal use" of the object.

3.1.137. Example has no unusual sensory interests currently and he has never displayed any unusual sensory interests.

Undue general sensitivity to noise

3.1.138. The focus needs to be predicable, generally increased sensitivity to everyday sounds, such as household appliances or traffic, rather than a reaction to sudden, harsh, or unexpected noise such as thunder or a loud speaker. Not the idiosyncratic responses to highly specific sounds.

3.1.139. Example demonstrates particular sensitivity to noises to the extent that Example's distress/disturbance about certain noises interferes with family or household routines.

3.1.140. Example did not like sitting at toddler groups. The teacher stated that he was putting his hands over his ear in the classroom. He was the only child at the funfair walking around with his hands over his ears.

3.1.141. On the steam train, again he was the only child who seems to enjoy having his hands over his ears. Example hates the vacuum cleaner, his mother daily battles to use it. When he hears emergency sirens, he sometimes puts his hands over his ears. Example does not like his sister crying, he will ask her to be quiet and will put her hands over her ears.

Abnormal, idiosyncratic, negative response to specific sensory stimuli

3.1.142. To meet the criteria for coding, the subject's response must be predictable; be specific to some identifiable and particular sensory stimulus (or group of stimuli), the idiosyncratic; and involve some form of negative, emotional reaction other than fear (often it involves anger or marked irritation). Thus, general distress in relation to very loud noises is excluded, as are negative reactions to environmental change.

3.1.143. Example shows predictable, normal, idiosyncratic, negative responses to one or more stimuli, but his reaction is mild or controllable so does not give rise to avoidance or any interference with ordinary life.

3.1.144. When his sister cries, he will "ask her to be moved" and hold his hands over his ears.

Difficulties with minor changes in subject's routines or personal environment

3.1.145. This item concerns marked adverse reactions to a variety of small changes in how, where, or when the subject carries out daily activities. These changes must be small. They do not include moving house, changing home, or the other major transition that would be expected to affect any subject. The emphasis for this item is with an unusual degree of upset or insistence on maintaining the original condition if a minor aspect of the subject's routine is changed.

3.1.146. Example shows definite, unusual reactions to minor changes in his routines, causing resistance or distress/or family going to extraordinary lengths to avoid changing major aspects of Example's routine or to prepare Example for significant changes; but no substantial interference in family life is present.

3.1.147. Example likes to have things done in a particular sequence. He is very reluctant to wear new shoes; they have to be left out for weeks for him to look at or buy the same pair, a size bigger. However, if you told him they were new, he would be upset. He does not like the old ones to be thrown away; he would become quite upset when they are thrown away. He is not happy to wear shorts or socks with sandals and it would take some weeks to persuade him to wear them.

Resistance to trivial changes in the environment (not directly affecting the subject)

3.1.148. This item concerns the subject's marked difficulty with minor or insignificant changes in aspects of the environment that have had no direct effect on him or her, for example, the position of ornaments, the orientation of the telephone, or clothes worn by people other than the subject. The emphasis is on the subject's unusually negative reaction to these changes.

3.1.149. Example showed particular, unusual reactions to trivial changes in the environment, causing marked distress or causing his family to go to unusual lengths to avoid trivial variations in the environment or to prepare Example for such minor changes; but no substantial interference in family life.

3.1.150. For example, if there were a toy that was moved from the toy shop, which might, for instance be in the lounge to the bedroom, this would cause significant upset. One year later, Example is still asking his mother to move this back to the lounge; Example was quite distraught at the time.

3.1.151. Another example is where his mother changed the lampshade in the lounge, one year later, Example is still asking his mother to put the lampshade back. Additionally, the family have changed their car, two years later, Example is still asking about the old car.

Unusual attachment to objects

3.1.152. An attachment is defined as a significant interest and dependence on a particular object that the subject carries around with him or her. The focus here is on attachments to unusual objects, that is, not the soft, cuddly blankets or stuffed toys used by most children. The strength of the attachment is determined by how difficult it is for the subject to separate from the object and whether its position intrudes into the subject's or family's life. The behaviour of unusual attachment must have lasted three months, but this may or may not have involved the same object throughout.

3.1.153. Example showed attachment to an unusual object that causes significant distress on separation or causes his family to ensure the object is always

readily available for him because of anticipated distress; occasional interference with activities is also apparent.

3.1.154. Example has ten teddy bears at the end of the bed. He has mentioned these to his parents at least forty to fifty times when his parents forgot them last time when they went on holiday.

Hand and finger mannerisms

3.1.155. Hand and finger mannerisms of the type covered by this item typically involve rapid, voluntary, repetitious movements of the fingers and hands, often but not always within the line of the subject's vision. Nail biting, hair twisting or thumb sucking is not included. Clapping is not a hand mechanism, nor are the non-specific overflow movements seen in movements in toddlers when they are excited. If the hand and finger mechanisms only occur during whole body movements, this would be classified as other complex mechanisms or stereotyped body movements (and this would not include rocking).

3.1.156. Example does not currently display any hand and finger mechanisms, and he has never displayed such mechanisms.

Other complex mannerisms or stereotyped body movements (isolated rocking is not included)

3.1.157. The focus here is on complex, stereotypic, voluntary, whole - body movements, such as arm waving while rocking up onto tiptoes.

3.1.158. Example has never demonstrated complex mannerisms or stereotyped body movements that have lasted for more than three months.

Gait

3.1.159. The focus is on unusual ways of walking – particularly tiptoeing or bouncing that are not clearly associated with a physical handicap.

3.1.160. Example has a normal gait.

Aggression towards caregivers or family members

3.1.161. This item is concerned with episodes of aggression within the family, including with caregivers, of sufficient severity and/or frequency to constitute a significant cause for concern.

3.1.162. Example shows definite physical aggression involving hitting or biting, but no use of implements.

3.1.163. Example's current behaviour is good, however, if there is a change/disruption, he will become upset, shout, scream or on the odd occasion hit. Behaviour might be exhibited every two weeks to every month.

3.1.164. When Example's mother was pregnant and unable to look after him, he hit and bit her. Family members were looking after Example at the time.

3.1.165. For a whole term at Nursery, he would hit every day, and the nursery asked for him to be referred about his behaviour.

Aggression towards to non-care givers or non-family members

3.1.166. This item constitutes a direct parallel to aggression towards caregivers or family members and is different only in so far as the aggression is directed to individuals who are not care givers or family members. It includes aggression towards both peers and adults.

3.1.167. Example exhibits mild aggressive only (threatening without physical contact, or behaviour that might represent just unduly rough play or momentarily provoked lashing out).

3.1.168. He is settled in school and there have been no reports over the past six months of hitting. However, this was not the case earlier. He can still "grrr!" His aggression seems to be directed to children that he is mainly friends with. He is quite kind to his sister. She does get the odd cherish from him.

Self-injury

3.1.169. Self-injury is a deliberate self-directed aggressive act (for example, biting the wrists, banging the head) that results in tissue damage and occurs over a period of at least three months.

Example exhibits no current signs of self-injury.

Hyperventilation

3.1.170. Hyperventilation involves episodes of rapid, deep, repetitive breathing in situations other than those that elicit panic.

3.1.171. Example exhibits no signs of hyperventilating.

Faints/fits/blackouts

3.1.172. The focus here is on episodes involving an unexpected change in the level of consciousness with or without falling or jerking movements of the limbs.

3.1.173. Example exhibits no evidence of faints or blackouts.

3.1.174. When Example was between eight to twelve months old, there was no babbling; he would be quite happy to sit for extensive periods on his own for thirty minutes to one hour. He did not cry.

3.1.175. Example is the Example's first baby so they did not notice the above as being unusual. However, they now recognise that this was the first signs of some developmental abnormality. His sister is exactly the opposite to Example.

3.1.176. By the age of one to two, he became reluctant to leave the house. His speech was very limited; he did not like joining groups. He became much more reliant on his parents and needed to be with his parents rather than other people.

Age when abnormality first evident

3.1.177. Where it is clear that the behaviour was abnormal by the age of three years, the respondents are questioned only on the earlier age to assess the likely time that the abnormalities were first evident. If the account so far suggests that the subject was normal up to three years, then the focus should be on the subject when they were aged three to determine if development is normal at that age, and then explore earlier ages.

3.1.178. This assessment is made on the assessing psychologist use of all the available information from the interview.

3.1.179. In my judgement, Example was abnormal in the first three years, and the quality of his behaviour/social relationships/communications are strongly indicative of autism at that age.

3.1.180. At Example's third birthday party, he did not want to go into the hall. He spent an hour watching programmes; he only enjoyed the last hour of his birthday party with other children. He exhibited very little speech at the time. Although he was feeding, he was toileting late after his third birthday. He currently does not dress and he is nearly four.

Interviewers judgement on age when developmental abnormalities were probably first manifest

3.1.181. From a consideration of the evidence that I have seen from a variety of sources independent of the respondent's mother, Example Example, and including evidence from the school, speech and language therapist and my clinical observations, I would assess Example as first displaying abnormalities when he was significantly younger than thirty-six months. I would estimate that these abnormalities were probably evident within the first twelve months of Example's development.

Special isolated skills

3.1.182. In this part of the interview, I focused on particular skills or abilities that the subject may or may not have. These skills were compared to the subject's overall level of functioning and how this functioning compares to the

general population. For example, a child with mental retardation who could only multiply three figure numbers in his or her head could not apply this skill of computational ability. If she or he could implement the skill in real life situations, they would be coded as having isolated competence/knowledge which is above the subject's general level and above the normal populations level of ability and is used meaningfully (i.e. genuine talent or ability used adaptively, such as performing music for others enjoyment or participating in age-appropriate children's hobbies such as model/building or computer programming); peers recognise the subject as having exceptional skill.

3.1.183. If the isolated skill that is generally out of keeping with the subject's general level of skill or ability, but not above population norms then the assessing psychologist would code this as isolated competence/knowledge that is definitely out of keeping with the subject's general level of ability, but not above general population norms.

3.1.184. Example exhibited no special isolated skills in relation to visio-spacial abilities (in puzzles, jigsaws, shapes, patterns).

3.1.185. However, Example displays isolated skills/knowledge which is generally above his general level of ability and above the general population's average level. These skills are not used functionally or meaningfully to any marked extent (for example, a pre-school who can read without comprehension or a calendrical calculator. His memory for detail is accurate as it is of dates and timetables).

3.1.186. Example has no special isolated skills about musical ability or drawing skills. He currently has a separate skill in relation to reading (for example, early sight reading) and this is currently out of keeping with Example's general level of ability, but not above general population norms.

3.1.187. Finally, with respect to computational ability (for example, mental arithmetic) Example displays isolated skills/knowledge which is definitely

above his general level of ability and above that of the general population's normal level, but is not used functionally or meaningfully to any extent. He has previously demonstrated this skill and, it is currently present.

Concluding Comments

Overall assessment

3.1.188. I asked Mrs Example whether there were other aspects of Example's behaviour that were of particular concern for him. She indicated that his coordination can be appalling. He struggles to put his shoes on and has only just recently managed to pull his shirt over his head. He has just started to climb on the climbing frame but has been very hesitant in the past. He does not like weddings, birthdays or any events. He has to sit outside until he is comfortable to go in.

3.1.189. My overall assessment is that Example has a definite diagnosis of autism. His scores is on the Autism Diagnostic Interview – Revised, confirmed that assessment. His scores on three of the four diagnostic categories were above or at cut-off level. I deal with these scores and the overall diagnostic criteria for autism below.

A: Qualitative abnormalities in reciprocal social interaction.

3.1.190. Example scored ten in this category. The sub-elements making up the group are a failure to use non-verbal behaviours and regulate social interaction, inability to develop peer relationships, lack of shared enjoyment, and lack of social reciprocity. The cut-off score was ten and so his score is just above the diagnostic level.

B: Qualitative abnormalities in communication.

3.1.191. This item consists of a lack of or delay in spoken language and failure to compensate through gesture. Analysis of the results show that Example's mother did not consider him to have diagnostically significant delays in this area. However, this does not fit well with the other clinical evidence. This is probably because this is her first child, and she had no real basis for comparison. The parents themselves apparently genuinely love Example,

and I would hypothesise that their failure to recognise items on this part of the diagnostic criteria may well be due to their reluctance to accept that Example may well be autistic.

3.1.192. The next item is a lack of varied spontaneous, make-believe or imaginative social play. This is followed by relative failure to initiate or sustain conversational interchange. The final item within this element is stereotyped, repetitive or idiosyncratic speech.

3.1.193. When the qualitative abnormalities in communication are considered overall, Example's scores on this element of the diagnostic criteria fall slightly below the cut-off score of eight. The score calculated was six, however, as indicated above, I believe that this is an underestimation of the severity of Example's symptoms.

C. Restricted, repetitive and stereotyped patterns of behaviour.

3.1.194. This item is made up of encompassing preoccupation or circumscribed pattern of interest. Apparently, compulsive adherence to non-functional routines or rituals. Stereotyped and repetitive motor mechanisms. Finally, preoccupation with parts of objects or non-functional elements of the material.

3.1.195. Example's score in this category of items was five compared with a cut-off score of three.

3.1.196. The final group in the diagnostic criteria is an abnormality of development evident at or before thirty-six months.

3.1.197. Example's scores in this category total five against a cut-off score of one. There is therefore superb evidence overall that Example has a diagnosis of autism.

3.1.198. My conclusions about this diagnosis are confirmed by a detailed analysis of Example's behaviour using the Autism Diagnostic Observation Schedule 2 (ADOS-2).

Table 2: Summary of Example's ADI-R Interview -

A: Qualitative Abnormalities in Reciprocal Social Interaction

Codes are "Most Abnormal 4.05.0"for all items in A1 to A4 (except 31, 58, and 65).

			Code Score	
A1:	**Failure to use nonverbal behaviors to regulate social interaction**			
	Direct Gaze	(50)	0	0
	Social Smiling	(51)	2	2
	Range of Facial Expressions Used to Communicate	(57)	1	1
			Total A1	3
A2:	**Failure to develop peer relationships**			
	Imaginative Play With Peers	(49)	1	1
	Interest in Children	(62)	0	0
	Response to Approaches of Other Children	(63)	1	1
	Group Play with Peers (score if 4.0 to 9.11 years)	(64)	2	
	OR (score either 64 or 65, depending on age of subject)			2
	Friendships (score if 10.0 years or older)			
	"Most Abnormal 10.0 - 15.0"	(65)	0	
			Total A2	4
A3:	**Lack of shared enjoyment**			
	Showing and Directing Attention	(52)	0	0
	Offering to Share	(53)	0	0
	Seeking to Share Enjoyment With Others	(54)	0	0
			Total A3	0
A4:	**Lack of socioemotional reciprocity**			
	Use of Other's Body to Communicate (Score "Ever")	(31)	3	2
	Offering Comfort	(55)	0	0
	Quality of Social Overtures	(56)	0	0
	Inappropriate Facial Expressions (Score "Ever")	(58)	0	0
	Appropriateness of Social Responses	(59)	1	1
			Total A4	3

A Total = A1 + A2 + A3 + A4 **A Total (cutoff = 10)** 10

B: Qualitative Abnormalities in Communication

Codes are "Most Abnormal 4.05.0"for all items in B1 and B4.
B2(V) and B3(V) codes apply only for verbal subjects (Item 30 = 0), using "Ever"codes.
Only B1 and B4 codes apply for nonverbal subjects (Item 30 = 1 or 2).

		Code	Score
B1: Lack of, or delay in, spoken language and failure to compensate through gesture			
Pointing to Express Interest	(42)	0	0
Nodding	(43)	0	0
Head Shaking	(44)	0	0
Conventional/Instrumental Gestures	(45)	0	0
		Total B1	0
B4: Lack of varied spontaneous make-believe or social imitative play			
Spontaneous Imitation of Actions	(47)	0	0
Imaginative Play	(48)	2	2
Imitative Social Play	(61)	1	1
		Total B4	3

Verbal Subjects Only:

B2(V): Relative failure to initiate or sustain conversational interchange			
Social Verbalization/Chat	(34)	1	1
Reciprocal Conversation	(35)	1	1
		Total B2(V)	2
B3(V): Stereotyped, repetitive or idiosyncratic speech			
Stereotyped Utterances and Delayed Echolalia (Score "Ever")	(33)	0	0
Inappropriate Questions or Statements (Score "Ever")	(36)	0	0
Pronominal Reversal (Score "Ever")	(37)	0	0
Neologisms/Idiosyncratic Language (Score "Ever")	(38)	1	1
		Total B3(V)	1

Verbal Total = B1 + B2(V) + B3(V) + B4	**B(V) Total (cutoff = 8)** 6
Nonverbal Total = B1 + B4	**B(NV) Total (cutoff = 7)** .

Interviewer's impressions and circumstances of the interview

3.1.199. An audio recording was not made of the interview, but an audio recording was made of the assessment using the ADOS-2.

3.2. **AUTISM DIAGNOSITC OBSERVATION SCHEDULE - 2**

Table 4: Module 3 ADOS-2 Algorithm — Example

SOCIAL AFFECT (SA)		**Code Score**	
Communication			
Reporting of Events	(A-7)	2	2
Conversation	(A-8)	0	0
Descriptive, Conventional, Instrumental, or Informational Gestures	(A-9)	0	0
Reciprocal Social Interaction			
Unusual Eye Contact	(B-1)	0	0
Facial Expressions Directed to Examiner	(B-2)	0	0
Shared Enjoyment in Interaction	(B-4)	0	0
Quality of Social Overtures	(B-7)	1	1
Quality of Social Response	(B-9)	1	1
Amount of Reciprocal Social Communication	(B-10)	2	2
Overall Quality of Rapport	(B-11)	2	2
	SA Total		**8**
RESTRICTED AND REPETITIVE BEHAVIOR (RRB)			
Restricted and Repetitive Behaviors			
Stereotyped/Idiosyncratic Use of Words or Phrases	(A-4)	0	0
Unusual Sensory Interest in Play Material/Person	(D-1)	2	2
Hand and Finger and Other Complex Mannerisms	(D-2)	2	2
Excessive Interest in Unusual or Highly Specific Topics/Objects	(D-4)	2	2
	RRB Total		**6**
	Overall Total 14 (SA + RRB)		

Classification/Diagnosis

ADOS-2 Classification: *autism*

Overall Diagnosis: _____High Functioning Austism_____

ADOS-2 Comparison Score: 8

Level of autism spectrum-related symptoms associated with this Comparison Score: *High*

Summary of discrepancies between the informant's description and the observer information

3.2.1. As indicated above, the major differences are that these parents appear to be somewhat overprotective of Example.

3.2.2. I fear that they will have some difficulty coming to terms with a diagnosis of autism and may well benefit from counselling or contact with relevant support groups such as the National Autistic Society. I have no reason to doubt the sincerity of the information provided by the respondent mother. Both parents seem very reluctant to label Example as autistic. They fear that this may well impact on his experiences in education in the long term.

3.2.3. I have advised that it is far better that they accept a diagnosis of this as this will allow those who educate Example to make the necessary reasonable adjustments that they are required to do as a matter of good practice and to comply with the provisions of the Equality Act 2010.

4. Underlying Ability (WRIT Results)

4.1.1. Example was assessed using the Wide Range Intelligence Test. The following results were found:

Table 5: Example's IQ Scores

	SUM OF SCORES	IQ	PERCENTILE	95% CONFIDENCE INTERVAL
VERBAL (Crystallised)	216	109	73	102 – 115
Visual (Fluid)	244	127	96	117 – 132
General IQ	460	120	91	113 – 125

4.1.2. The Wide Range Intelligence Test (WRIT) represents a new direction for ability measures because it delivers a psychometrically sound product with great efficiency. The WRIT contains subtests that have historically been shown to correlate with overall intellectual ability. The first broad dimension is verbal (crystallised) intelligence which effectively is a measure of verbal information, acquired skills and knowledge, each highly dependent on an individual's exposure to formal academic training, Western culture and the English Language. The second broad dimension is visual (fluid) intelligence. The visual (fluid) intelligence is a measure of abilities that are novel, more visually mediated and/or less culturally influenced.

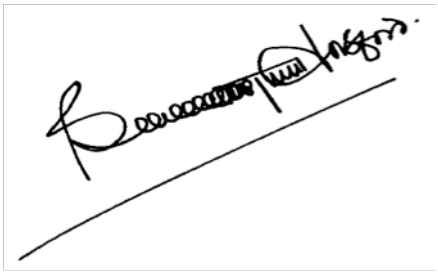
4.1.3. The WRIT provides index scales related to specific areas of cognitive functioning: Verbal or crystallised intelligence and visual or fluid intelligence. The full-scale score provides an overall summary score that estimates an individual's general level of intellectual functioning.

4.1.4. Example received a composite score on the verbal IQ scores of 109, which placed his verbal (crystallised) IQ in the average range. His overall IQ score of 120 indicates that he has superior intellectual abilities. The subtest scores are as follows:

Table 6: Example's IQ Subtest Scores

	RAW SCORE	STANDARD SCORE	PERCENTILE
VERBAL SUBTESTS			
Verbal Analogies	13	121	92
Vocabulary	9	95	37
VISUAL TESTS			
Matrices	16	135	99
Diamonds	10	109	73

4.1.5. He performed better on the non-verbal tests than verbal tests when his scores overall were considered. However, there were wide variations within the subtests. With Example's highest score being on the matrices test. He has strong abilities with logical reasoning tasks such as those, which he completed in the Matrices subtest.



Dr Bernard Horsford, MBA, O Occ Psych, LLB, BA, DipAdEd, DipM, MAPM, MAE, MEWI, Chartered FIPD, FIC, AFBPsS, Chartered Psychologist

Advanced Assessments Limited

27 MAY 2016

ADVANCED ASSESSMENTS LTD
Expert Witnesses & Psychologists

Client Engagement Agreement 2018

Terms and conditions for private client assessments for educational, occupational and therapeutic assessments that have not been commissioned for the use in court proceedings and will not be used in court proceedings.

Private Client Terms & Conditions

ADVANCED ASSESSMENTS LTD

TERMS AND CONDITIONS FOR

DYSLEXIA, DYSPRAXIA, AUTISM, ADHD & MENTAL HEALTH ASSESSMENTS

Advanced Assessments Ltd believes that its services should be positive experiences, providing, wherever possible, answers to questions and suggestions on how to move forward. As explained in Advanced Assessments Ltd leaflets, assessment, screening and consultation exercises are key elements of understanding an individual's strengths and difficulties and planning appropriate action. The focus of the overall process is always the individual and it is this person's interests that will be put first. In order to obtain a balanced picture it is helpful to have background information from home, schools, employers, etc. However, no contact will be made with any outside agencies without prior approval and, as explained in our data protection statement, no information will be released without prior approval.

The following Terms and Conditions are designed to describe fully the operation of Advanced Assessments Ltd's services and to minimise the potential for misunderstanding.

Advanced Assessments Ltd will:

1)

a. arrange a suitable assessment, screening or consultation for the client[1] with a Chartered Psychologist[2]

b. arrange an assessment, screening or consultation for the client that is relevant to the reason for referral and within the area of Advanced Assessments Ltd's expertise as described within its website.

c. when suitable to do so, request completion of suitable questionnaires covering background information and, when appropriate, request additional information from relevant agencies relating to the reason for referral.

d. ensure that when a client is individually assessed, he/she will receive provisional, verbal feedback from the assessor immediately after the assessment session.

e. provide reports in approximately four weeks unless an expedited free has been agreed in which case the assessment will be returned within seven days. Individual assessments will highlight the client's cognitive strengths and weaknesses, offer advice on appropriate learning and coping strategies, and give information on sources of appropriate teaching and advice/support etc, where relevant. When appropriate, reports will be circulated to both purchasers and clients

f. arrange for assessments and screenings to be performed in a suitable assessment room (when taking place in Advanced Assessments Ltd's premises)

g. will compete a Form 8 if instructed to, the fee for completion of Form 8 is £300 and does not form part of the fee for the assessment.

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1 A 'client' being assessed can be an adult, young person or a child. Where the client being assessed is a child, i.e. under the age of 16 years, the client's parent(s) will usually be considered as the client for the purpose of confirming to these Terms and Conditions. Young persons aged 16-17 are entitled to the same duty of confidence as adults. Therefore, their parents should explain and discussed with them in advance the reason for the assessment, and obtain their agreement to proceed within the conditions of the above Terms and Conditions. However, it should be noted that children of any age who have the capacity and understanding to make decisions about their own treatment are also entitled to a duty of confidence and to decide whether their personal information

should be disclosed to a third party. Where children do not have the requisite capacity and understanding, decisions to pass information may be taken by a person with parental responsibility in consultation with the professional assessor involved. A client can also be the purchaser of Advanced Assessments Ltd's services. See Section 6.

2 In exceptional circumstances, psychologists under supervision with conditional chartered status may be allocated

g. provide waiting area facilities at its main centres[3]. However, clients should note that Advanced Assessments Ltd office staff cannot be held responsible for the supervision of children on Advanced Assessments Ltd premises while their parents are receiving post-assessment feedback

h. try to conform as much as possible to clients' own terms and conditions and related instructions. In particular cases, individual agreements or contracts will be made

2)

a. provide the client being assessed or screened with suitable literature on Advanced Assessments Ltd's where appropriate

b. attend to any queries about reports as quickly as possible that arise after the assessment. However any such queries will be chargeable at our normal professional rate of £200 per hour plus VAT.

3)

a. in all of its dealings, conform to UK law concerning the processing and storage of information, employment and civil rights of the client being assessed[4]

4)

a. enable and support its teachers and consulting psychologists to apply their professional codes of conduct/ethics at all times when engaging with their clients

b. monitor and maintain acceptable standards of quality from its personnel and consulting psychologists

c. arrange for educational and psychological assessments, screening and consultations to be performed only by appropriately qualified personnel or Chartered[5], independent psychologists, respectively.

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3 Waiting facilities cannot be guaranteed at all outposts

4 In particular, the Data Protection Act 1998, Equality Act 2010 and Article 8, (right to private life) Human Rights Act 1998

5 Psychologists under supervision of a chartered status may be allocated

5)

Advanced Assessments Ltd reserves the right to accept a referral, terminate it, or not or not circulate a report, if:

a. the referral appears to be outside its area of expertise

b. there is an apparent conflict of interest between relevant parties

c. if any relevant parties are in or intend to be in, dispute

d. Advanced Assessments Ltd's reputation is or could be, compromised

e. Where the report commissioned is going to be used in proceedings or contemplated proceedings, and the party commissioning the report has failed to commission instruct Advanced Assessments Ltd as an expert witness at its normal professional rate.

f. there are current legal or tribunal proceedings that may be affected by Advanced Assessments Ltd's involvement

g. it cannot provide the report in the time required

h. the fee has not been paid at the required time

i. the staff member or psychologist decides to terminate his/her involvement for any just reason

j. the client being assessed fails to comply with any of the conditions in (7) below and where such failure could compromise the validity of the assessment

k. the relevant Questionnaire/Authorisation Form(s) (and Letter of Instruction where appropriate) have not been signed by the appropriate person(s) and returned to Advanced Assessments Ltd.

l. in the case of termination or non-acceptance of a referral or non-circulation of a report, under sub-clauses a, b, c, d, e, f, h, i, and k above, and if a fee has already been received, the administrative and assessment fees shall not be returned.

m. if the client cancels, postpone or rearranges the assessment less in less than seven working days' notice the full fee will be not be refunded.

6)

The commissioner/purchaser (if not the client being assessed) **will:**

a. complete and return relevant Advanced Assessments Ltd questionnaires, or other pertinent information, when requested to do so

b. use reports for the sole purpose of attending to the needs of the client being assessed

c. Pay the full fee for the report if it decides at any stage not to wait for the final report.

d. not use or circulate any report for any other purpose than for what it is intended

e. pay fees, when requested to do so by Advanced Assessments Ltd and agree to pay the full fee for appointments cancelled in less than five working days without or notification of prior warning or good cause, will result in loss of the agreed fee[6]

f. respect the confidential status of reports and conform to the regulations of the Data Protection Act 1998, the General Data Protection Regulations and our Privacy Policy.

g. agree with the client being assessed, in advance of the assessment, the reason for referral to Advanced Assessments Ltd and obtain the client's agreement to proceed with the assessment

h. agree with the client being assessed, in advance of Advanced Assessments Ltd's involvement, the arrangements for distribution of reports.

i. disclose all material facts that might lead to the assessment being more complicated than that usual in good time, such as advising if it is suspected that the individual being assessed has multiple learning difficulties.

j. agree to the client being assessed being provided with a confidential report that will not be circulated to other people without his/her agreement

7)

The client being assessed will:

a. be punctual for the assessment

b. co-operate fully with all requirements of the assessment process

c. confirm with the assessor assessing if any confidential information is given verbally or on Advanced Assessments Ltd's questionnaires should not be divulged within reports

d. inform the assessor if he/she has received an assessment in the past that may have a bearing on the assessment to be performed

e. inform Advanced Assessments Ltd prior to the assessment of any personal health or other factors that may influence the assessment to be performed

f. bring with them any prescription spectacles needed to see fine details when working with materials at a table

g. complete and return relevant Advanced Assessments Ltd questionnaires or other pertinent information when requested to do so

h. arrange for assessments and screenings to be performed in a suitable room this needs to be free from noise and have a table or desk where two people can sit and two chairs.

i. not use or circulate the report for any other purpose than for what it is intended

j. unless funded by a third party, pay the fee when requested to do so by Advanced Assessments Ltd and agree to pay the full fee for appointments cancelled or postponed without notification of prior warning or good cause

k. respect the confidential status of the report and conform to the regulations of the Data Protection Act 1998, the General Data Protection Regulations and our Privacy Policy.

l. where applicable, agree with the commissioner/purchaser of the assessment, in advance of the assessment, the reason for referral to Advanced Assessments Ltd and give their written agreement to proceed with the assessment

m. make full and frank disclosure of all material facts before instructing Advanced Assessments Ltd.

n. where applicable, agree with the commissioner/purchaser of the assessment, in advance of the assessment, the arrangements for distribution of the assessment report

o. agree to all of the above terms and conditions

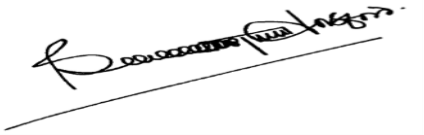
I agree to all of the above terms and conditions

Signed

Name:

Date:

Signed



Dr Bernard Horsford
For and on Behalf of Advanced Assessments Ltd

6 Advanced Assessments Ltd prefers that payment be made via one paying agent only.

Advanced Assessments Ltd - Privacy Notice

This Privacy Notice sets out how we protect your 'data' (personal details and records) we do this to comply with the General Data Protection Regulation or GDPR (Europe) and The Data Protection Act 2018 (UK). A summary of how GDPR is being implemented, why confidential information is held and how this is protected can be found by visiting: https://ico.org.uk

It is assumed that by engaging in this assessment or service, you are consenting to records being kept. For the avoidance of doubt, we (or those who instruct us) might ask you to sign a consent form. If we believe you lack capacity or if you are a child we might seek consent from an appropriate adult.

- Keeping records is an essential component of healthcare, which helps in understanding how best to help and forms the basis of any reports needed. We usually keep your records for any of the following reasons:
    - Preventative or Occupational Medicine.
    - Legal defence necessary for the establishment, exercise or defence of legal claims whenever courts are acting in their judicial capacity.
    - Where the data subject has given explicit consent.
    - Research.
    - Where it is necessary to protect the vital interest of the data subject or some other person where the data subject is physically or legally incapable of giving consent.
    - Employment relationship.
    - Where a data subject has already put information in the public domain.
- Confidentiality is maintained at all times (i.e. your information is not shared) unless there are *exceptional* circumstances such as risk to yourself or others. If believe you or a child is at risk other services such as your GP or police may be contacted without your consent, as this is a professional obligation. Please see The British Psychological Society, Generic Professional Practice Guidelines www.bps.org.uk
- We operate a system of peer review and supervisor review, where we believe that it would be helpful for a peer or supervisor to review the content of a report or therapeutic session we will obtain your consent.
- Consultation notes and questionnaires will be held for varying lengths of time depending on the content (and then carefully disposed of). For example:
    - Some records might be held indefinitely if there were any issues of concern that could lead to a police investigation in the future.
    - Where there is a legal obligation to hold those records to report our transactions to HMRC, we will hold those records for seven years.
    - Mental health records are subject to special legislation, e.g. children's records are kept until age 26 and adult records for eight years after the last contact with the service Www.gov.uk/government/publications/records-management-code-of-practice-for-health-and-social-care
- All information recorded on paper will be securely stored in a locked filing cabinet, and if this has to be transported outside of the office, great care will be taken in other premises and likewise locked in a filing cabinet
- Confidential digital information will be stored in a secure cloud service offering high levels of security.
- Confidential information sent via the internet will be encrypted and password protected, the password may be sent separately by text message.
- Letters sent by surface mail, e.g. to GP's will be marked Confidential.
- All electronic devices (e.g. computers, laptops and phones) and used to access stored information will themselves be password protected. Disc's drives will be encrypted.
- The right of access called a 'subject access request' or SAR can be made for

the data we hold, but there may be an administration charge if all records are requested, as these may be 'excessive'. These will be provided within one calendar month of the request being made.

- Where we carry out psychological tests and assessments, we work within the British Psychological Society's Statement on the Conduct of the Psychologists providing Psychometric Expert Evidence to Courts and Lawyers. Under these guidelines, it is not possible to disclose some of our records to you. We cannot disclose certain test information under these guidelines, or where disclosure would amount to a breach of a trade secret.
- Where a request is made by a *bona fide* data subject (the data subject might be an organisation or individual), we will require proof of identity in the form of:
    - a current passport,
    - a driving licence; or
    - a birth certificate.

  And also one of these:

    - a recent bank statement dated within the last the months (with full address); or
    - a recent utility statement dated within the last three months (with full address).
- We might ask records to be collected in person from our office and for the data subject to bring the original identification documents with them. Please also provide a certificate of true likeness of the documents from the Post Office identity checking service. If records are sent by post, they can only be sent to the registered address which is proved by the identity documents.
- In the event of death or incapacity of any medical professional in Advanced Assessments, arrangements have been made for records to be held by a named professional colleague who will continue with the above obligations.
- We do not process your information outside of the EEA.
- Where you are under a statutory or contractual obligation to provide your data, this will be set out in the letter of instruction from the lawyers involved in your case, the court or by your employer.
- We do not use automated decision making in processing your data.
- You have the right to withdraw consent and ask us to delete the data that we hold on you. If you have not provided consent, we will not retain your data unless we were lawfully obliged to.
- This Privacy Notice will be subject to review, as needed or annually by 25 May each year.
- Advanced Assessments Ltd is registered with the Information Commissioner's Office (ICO), and you have the right to complain how we process your data to the ICO.

Enquiries can be made by contacting the Data Controller in writing:

Tamsin Beeby

Data Protection Officer
Advanced Assessments Ltd
180 Piccadilly
Mayfair
London W1J 9HF

Email: tamsin.beeby@strategic-enterprise.com
Secure email: tamsin.beeby@experts.cjsm.net