No._____

IN THE SUPREME COURT OF THE UNITED STATES

SAMUEL TRELAWNEY HUGHES,

Petitioner,

v.

UNITED STATES OF AMERICA,

Respondent.

On Petition For A Writ of *Certiorari* To The United States Court of Appeals for the Ninth Circuit

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APPENDIX (VOLUME IV) – PRESENTED SEPARATELY UNDER S. CT. R. 14.1(i)

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subsequently issued local emergency orders and proclamations related to public gatherings.

(3) To date, hundreds of thousands of people within the Central District of California have been confirmed to be infected with COVID-19 and the number of those infected continues to rise, causing an emergency pandemic.

(4) In their continuing guidance, the Centers for Disease Control and Prevention and other public health authorities have suggested the public avoid social gatherings in groups of more than 10 people and practice physical distancing (within about six feet) between individuals to potentially slow the spread of COVID-19. The virus is thought to spread mainly from person-to-person contact, and no vaccine currently exists.

(5) On March 27, 2020, Congress passed the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act"), which authorized the Judicial Conference of the United States to provide authority to Chief District Judges to permit certain criminal proceedings to be conducted by video or telephonic conference.

(6) On March 29, 2020, the Judicial Conference of the United States made the appropriate findings as required under the CARES Act, finding specifically that "emergency conditions due to the national emergency declared by the President under the National Emergencies Act (50 U.S.C. § 1601, et seq.) with respect to the Coronavirus Disease 2019 (COVID-19) have materially affected and will materially affect the functioning of the federal courts generally."

(7) On March 29, 2020, the Chief Judge of this District also made the appropriate findings as required under the CARES Act, finding "that felony pleas under Rule 11 of the Federal Rules of

Criminal Procedure and felony sentencings under Rule 32 of the Federal Rules of Criminal Procedure cannot be conducted in person without seriously jeopardizing public health and safety. As a result, if judges in individual cases find, for specific reasons, that felony pleas or sentencings in those cases cannot be further delayed without serious harm to the interests of justice, judges may, with the consent of the defendant or the juvenile after consultation with counsel, conduct those proceedings by video conference, or by telephonic conference if video conferencing is not reasonably available." On June 26, 2020, the findings and authorizations in the Order of the Chief Judge No. 20-043 were extended by Order of the Chief Judge No. 20-080. C.D. Cal. Order of the Chief Judge No. 20-080, In Re: Coronavirus Public Emergency, Use of Video and Telephonic Conference Technology in Certain Criminal Proceedings, at 1 (June 26, 2020). The findings and authorizations were further extended on September 23, 2020, in Order of the Chief Judge No. 20-097. C.D. Cal. Order of the Chief Judge No. 20-097, In Re: Coronavirus Public Emergency, Use of Video and Telephonic Conference Technology in Certain Criminal Proceedings, at 1 (September 23, 2020).

(8) Through this order, I now find that the guilty-plea hearing and sentencing hearing in this case cannot be further delayed without serious harm to the interests of justice. My specific reasons are as follows:

a. On March 23, 2020, the Chief Judge of this District activated The Continuity of Operations ("COOP") Plan for the Central District of California, closing courthouses in this district to the public except for hearings on criminal duty matters. The COOP Plan was in effect through and including June 22, 2020.

b. On May 28, 2020, the Court adopted The Plan for Phased Resumption of Operations ("Reopening Plan"), outlining three different phases:

i. Phase 1 began on June 1, 2020. During this Phase, certain staff were permitted to return to this District's courthouses to prepare for limited in-court hearings.

ii. Phase 2 began on June 22, 2020. During this Phase, which remains ongoing, individual judges have the discretion to hold in-court hearings in any criminal matter. They may also continue to hold hearings by video and telephonic conference.

iii. The final phase of the Reopening Plan, Phase 3, will be implemented at a date to be determined. During this Phase, jury trials may resume. As a practical matter, however, this District is unlikely to conduct a substantial number of jury trials -- and reach its former capacity -- until several months after the implementation of Phase 3.

c. On April 9, 2020, the Judicial Council of the Ninth Circuit declared a judicial emergency in this District pursuant to 18 U.S.C. § 3174(d). The Judicial Council declared this emergency because, among other reasons, the Central District of California is one of the busiest judicial districts in the country.

d. As the Judicial Conference concluded, the exceptionally large number of cases pending in this District represents an emergency. A vacancy on a district court is generally considered an "emergency" if the court's "weighted filings" exceed 600 per judgeship. The Central District of California's weighted filings, 692 per judgeship (61 percent above the Conference standard), are high enough for each Judge's caseload to be deemed an

emergency. While the number of pending cases per judge has marginally decreased with the addition of the three recently-confirmed judges, the large number of pending cases will still constitute an emergency.

e. This District is authorized 27 permanent judgeships and one temporary judgeship, but has seven vacancies. Moreover, seven active district judges are eligible to take senior status or retire immediately.

f. While individual Judges currently have the discretion to hold in-person hearings in criminal matters, social distancing guidelines remain generally incompatible with in-person hearings. Many parties, including defendants, counsel, and court staff, are also unable or unwilling to attend in-person hearings due to legitimate safety concerns. And transporting detained defendants to these hearings may risk the spread of COVID-19 within detention facilities, and result in defendants being subject to quarantines upon their return to these facilities.

g. Given these facts, it is essential that Judges in this District resolve as many matters as possible via video teleconference and telephonic hearing. By holding these hearings now, this District will be in a much better position to work through the backlog of criminal and civil matters when normal operations resume.

(9) I therefore conclude that the guilty-plea hearing and sentencing hearing in this case cannot be further delayed without serious harm to the interests of justice. If the Court were to delay these hearings until it can be held in-person, it would only add to the enormous backlog of criminal and civil matters facing this Court, and every Judge in this District, when normal operations resume.

(10) The defendant consents to proceed with his guilty-plea hearing and sentencing hearing by video teleconference. Defendant also understands that, under Federal Rules of Criminal Procedure 32 and 43, as well as the Constitution, he may have the right to be physically present at these hearings. Defendant understands that right and voluntarily agrees to waive it and to proceed remotely by video teleconference. Counsel joins in this consent, agreement, and waiver.

(11) Based on the findings above, and my authority under § 15002(b) of the CARES Act, the guilty-plea hearing and sentencing hearing in this case will be conducted by video teleconference, if at the outset of such hearings, defendant makes a knowing and voluntary waiver of his right to an in-person hearing.

IT IS SO ORDERED.

October 23, 2020
DATE

Dale S. Fischer
THE HONORABLE DALE S. FISCHER
UNITED STATES DISTRICT JUDGE

Presented by:

/s/ Lauren Restrepo
LAUREN RESTREPO
Assistant United States Attorney

TRACY L. WILKISON
Acting United States Attorney
CHRISTOPHER D. GRIGG
Assistant United States Attorney
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Attorneys for Plaintiff
UNITED STATES OF AMERICA

UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, Plaintiff, v. SAMUEL TRELAWNEY HUGHES, Defendant.	No. CR 20-332-DSF STIPULATION REGARDING AMENDMENT TO THE PLEA AGREEMENT FOR DEFENDANT SAMUEL TRELAWNEY HUGHES

Plaintiff United States of America, by and through its counsel of record, the Acting United States Attorney for the Central District of California and Assistant United States Attorney Lauren Restrepo, and defendant SAMUEL TRELAWNEY HUGHES ("defendant"), both individually and by and through his counsel of record, Peter C. Swarth, after conversations with the United States Probation and Pretrial Services Office, hereby stipulate to the following amendments to the factual basis of the Plea Agreement for Defendant SAMUEL TRELAWNEY HUGHES ("Plea Agreement"), filed on October 21, 2020 (Dkt. 20):

1. The factual basis of the Plea Agreement is hereby amended as follows:

a. The following phrase is removed from page 8, lines 18-19: ", including the victims identified in the Indictment as Victims 1 through 10".

b. The following paragraph is removed from page 9, lines 17-21: "Defendant admits that he threatened the persons identified in the Indictment as Victims 1 through 10, as described in the Indictment, and that the factual allegations in Counts 1 to 23 of the Indictment with respect to defendant's conduct as to each of those victims are true and accurate."

2. The parties agree and stipulate to these amendments to the Plea Agreement. Defendant has read and discussed this stipulation with his attorney, understands the terms of this stipulation, and voluntarily agrees to those terms.

IT IS SO STIPULATED.

Dated: April 1, 2021

Respectfully submitted,

TRACY L. WILKISON
Acting United States Attorney

CHRISTOPHER D. GRIGG
Assistant United States Attorney
Chief, National Security Division

/s/ Lauren Restrepo
LAUREN RESTREPO
Assistant United States Attorney

Attorneys for Plaintiff
UNITED STATES OF AMERICA

Dated: ~~March~~ April 1, 2021

PETER C. SWARTH
Attorney for Defendant
SAMUEL TRELAWNEY HUGHES

Dated: ~~March~~ April 1, 2021

~~SAMUEL TRELAWNEY HUGHES~~
Defendant

TRACY L. WILKISON
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Attorneys for Plaintiff
UNITED STATES OF AMERICA

UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, Plaintiff, v. SAMUEL TRELAWNEY HUGHES, Defendant.	No. CR 20-332-DSF [PROPOSED] ORDER

For good cause shown, IT IS HEREBY ORDERED THAT:

The parties' Stipulation Regarding Amendment to the Plea Agreement for Defendant SAMUEL TRELAWNEY HUGHES, filed by the parties in this matter on April 1, 2021, is GRANTED.

DATE

HONORABLE DALE S. FISCHER
UNITED STATES DISTRICT JUDGE

TRACY L. WILKISON
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CHRISTOPHER D. GRIGG
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Chief, National Security Division
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Attorneys for Plaintiff
UNITED STATES OF AMERICA

UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, Plaintiff, v. SAMUEL TRELAWNEY HUGHES, Defendant.	No. CR 20-332-DSF ORDER

For good cause shown, IT IS HEREBY ORDERED THAT:

The parties' Stipulation Regarding Amendment to the Plea Agreement for Defendant SAMUEL TRELAWNEY HUGHES, filed by the parties in this matter on April 1, 2021, is GRANTED.

IT IS SO ORDERED.

DATED: April 5, 2021

Dale S. Fischer

Honorable Dale S. Fischer
UNITED STATES DISTRICT JUDGE

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Attorney for Samuel Hughes

UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, Plaintiff, vs. SAMUEL TRELAWNEY HUGHES, Defendant.	**CASE NO: 20-CR-332-01-DSF** DEFENDANT SAMUEL HUGHES' SENTENCING POSITION Date: November 15, 2021 Time: 8:30 AM Courtroom: 7D

To the Honorable Dale S. Fischer of the United States District Court for the Central District of California:

Defendant Samuel Hughes, by and through his attorney, Peter Swarth, hereby provides his position regarding sentencing. His position is based upon the attached memorandum of points and authorities, all matters of which the Court may properly take judicial notice, and on such further evidence as may be presented at or before the sentencing hearing.

Dated: November 1, 2021

Respectfully submitted,

*s/*_____

Peter Swarth

Attorney for Samuel Hughes

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SENTENCING POSITION

INTRODUCTION

Mr. Hughes is a British citizen with a documented life history of autism, which dates back to his early childhood. An innate neurological impairment, autism has rendered him unable to function in basic ways – e.g., he is unable to form friendships or hold employment. The autism prevented him from understanding the emotional impact that his threats would have on their subjects. His condition requires treatment in a supportive environment, after the significant period of incarceration that he has already served. These circumstances are further developed in this memo and are central here:

- The attached evaluation of psychologist Dr. Betty Jo Freeman explains the nature of Mr. Hughes innate cognitive limitations and sets forth the best prospects for his treatment. *See* Ex. A. As explained by Dr. Freeman, when Mr. Hughes' offense conduct is viewed in context of his autism, his wrongful words should be considered neither the product of ordinary free will nor a harbinger of physical violence.
- For the present offenses, per the Plea Agreement's Stipulated Request for Judicial Removal (Dkt. 20-1), Mr. Hughes will be deported to his home country of the United Kingdom, which provides the supportive environment that is most conducive to treatment – as shown by his life history. By contrast, Dr. Freeman's report explains that further incarceration would actually be *counterproductive* for Mr. Hughes.
- Mr. Hughes has already been in custody since June 2020 (i.e., in excess of 17 months prior to the sentencing hearing date), thereby providing punishment that is quite substantial, especially in light of his limited capacity.

In light of the foregoing, he should be deported as soon as possible to permit the most effective treatment, in the supportive surroundings of his home in the United Kingdom. Thus, any additional time in custody would be a sentence "greater than necessary." 18 U.S.C. § 3553(a).

Dated: November 1, 2021

Respectfully submitted,

s/

Peter Swarth
Attorney for Samuel Hughes

DECLARATION OF PETER SWARTH IN SUPPORT OF SENTENCING POSITION

I, Peter Swarth, declare as follows:

1. I make this declaration on personal knowledge and if called as a witness, I could and would testify competently to the facts set forth herein.

2. I am an attorney at law, licensed to practice in the courts of the State of California. I represent the Defendant, Samuel Hughes ("Mr. Hughes"), in this case (i.e., case no. 20-CR-332-01-DSF).

3. I make this Declaration in support of the sentencing position submitted on behalf of Mr. Hughes.

4. Attached hereto as Exhibit A is a true and correct copy of a report, concerning Mr. Hughes, which was prepared by Dr. Betty Jo Freeman.

5. Attached hereto as Exhibit B is a true and correct copy of a CV that I received from Dr. Betty Jo Freeman.

6. Attached hereto as Exhibit C is a true and correct copy of a report, concerning Mr. Hughes, which I received from Dr. Hildegard Schakel.

I declare under penalty of perjury under the laws of the State of California and the United States of America that the foregoing is true and correct, and that this declaration has been executed on November 1, 2021, at Los Angeles, California.

s/
Peter Swarth

EXHIBIT A

B. J. Freeman, Ph.D.
Licensed Clinical Psychologist, PSY 4826
Autism Spectrum and Related Developmental Disorders

PSYCHOLOGICAL ASSESSMENT

Patient: Samuel Hughes
Date of Birth: [redacted]

DATES OF EVALUATION: May 6, 2021; June 10, 2021; and June 30, 2021

TESTS ADMINISTERED
Wechsler Adult Intelligence Scale, Fourth Edition (WAIS-IV)
Social Language Development Test, Adolescent (SLDT-A) (partial)
Test of Problem Solving 2, Adolescent (TOPS 2)
Autism Diagnostic Observation Schedule, Second Edition (ADOS-2)
Incomplete Sentences Test, Adult Form
Beck Anxiety Inventory (BAI)
Beck Depression Inventory, Second Edition (BDI-II)
Adaptive Behavior Assessment System, Third Edition (ABAS-3)
Social Communication Questionnaire (SCQ)
Social Responsiveness Scale, Second Edition (SRS-2)
Behavior Rating Inventory of Executive Functioning, Adult (BRIEF-A)

ADDITIONAL SOURCES OF INFORMATION:
- Psychological report by Dr. Hildegard Schakel (10/29/2015)
- Review of police report (12/20/2019)
- Criminal complaint filed (07/10/2020)
- Review of letters to prosecuting attorney and FBI case agent (12/14/2020)
- Review of plea agreement (10/21/2020)
- Review of phone calls from Metropolitan Detention Center to various people
- Review of multiple letters from various dates related to this case.

REASON FOR REFERRAL: Samuel ("Sam") is a 32-year-old male with a diagnosis of Autism Spectrum Disorder. He is currently being held in the Metropolitan Detention Center on charges relating to sending inappropriate and threatening emails.

MEDICAL/DEVELOPMENTAL HISTORY: For a complete review of Sam's history, the reader is referred to the report by Dr. Hildegard Schakel completed in 2015 in England, where Sam was born and raised. Dr. Schakel's report was completed in order to determine if Sam had the ability to be gainfully employed.

It should be noted that Sam has reported being diagnosed at age six by Dr. Lorna Wing, one of the pioneers in the field of autism. Throughout his schooling including high school and college, he had a one-to-one tutor to help him with things he did not understand. Subsequent to his evaluation by Dr. Schakel in 2015, it was determined that Sam was not able to be gainfully employed.

Sam made an attempt to live on his own at a time when he was receiving his father's pension. (Of note: Sam's mother killed his father and is in a psychiatric facility.) At some point in 2019, Sam came to the United States. He began to go to meet-ups with other people for networking

purposes. According to Sam, he was attempting to lay the foundations for businesses that he was going to develop.

It is known that throughout his history, Sam has been on and off medications and in and out of psychiatric treatment. He has a long history of threatening to harm himself and of self-harm such as cutting on his arms. In her report, Dr. Schakel inferred that Sam's suicidal ideation were calls for help rather than true suicidal ideation.

As it is not possible to obtain Sam's educational and psychiatric records other than Dr. Schakel's report, the examiner contacted Sam's aunt, Norna Hughes, in order to obtain additional information regarding Sam's history. Ms. Hughes agreed to complete forms for the assessment. Ms. Hughes reported that Sam had been treated privately by a psychiatrist both in the United States and the United Kingdom.

While individuals with ASD may become involved with the criminal justice system at times, normally they are not violent crimes. But rather crimes related to their obsessions, as is the case here. As noted, Sam sees the threat as just words. It should be noted that Sam is extremely concrete and literal and this is documented throughout this report. To Sam's way of thinking, he wrote words but did not hurt anyone. He fails to grasp the concept that saying certain words and making threats are problematic in our society. This reflects the basic theory of mind deficit that persons with autism present with. Sam, in spite of his measured intelligence, does not understand that other people think differently than he does and that his behavior can have an effect on other people. This is a major factor in cases where people with autism exhibit criminal behavior.

In point of fact, a recent Swedish study (Lundstrom et al, 2014) examined the risk of violent offending in over 3000 individuals born between 1994 and 2004 and diagnosed with various neurodevelopmental disorders by child and adolescent mental health services. The study included 950 individuals with ASD. The study incorporated large control group conditions, including full- and half-siblings, in random population controls. Violent crime encompassed homicide, assault, arson, robbery, and sexual and other relevant crimes logged on the National Crime Register. Whereas ADHD emerged as a substantial risk factor for violent criminal behavior, there was no evidence that a diagnosis of ASD elevated risk for violent offending.

Ms. Hughes added that Sam is unable to learn from past experiences, and once he has adopted a position on something, he is unable to handle any discussion that contradicts or challenges his view. This is a direct result of the fact that Sam did not have appropriate treatment for his autism spectrum disorder. While in school, Sam had a one-to-one tutor. The focus was on Sam's academic skills. He has never had intervention for his social challenges and behavioral issues. As a result, as Ms. Hughes pointed out, once Sam has taken a position on something, he is unable to consider or accept any other point of view. In the instant case, Sam has adopted the view that he used only words with no intentions of being violent. (Sam's adoption of this view and his persistence in his view make it unlikely, in this examiner's opinion, that he would offend

violently). According to Ms. Hughes, whenever Sam has been in treatment he has benefited. However when the treatment stops Sam regresses. When Sam is in a supportive environment, as he was prior to coming to the United States, he is able to function fairly well. However, when he came to the U.S., with no supports in place for him, he was on his own with no knowledge or skills of how to interact in the real world. As a result, in his attempts to develop a social network, he became obsessive and did not know how to deal with his obsessions, and he had no support system to help guide him.

In the past, Sam has benefited from treatment by way of medicines and counseling. Ms. Hughes stated that she has seen improvement in Sam's confidence and functioning when he is in treatment and on medication.

Social Communication Questionnaire (SCQ)

The *Social Communication Questionnaire* is a screening instrument that helps to evaluate communication skills and social functioning in children/individuals who may have an autism spectrum disorder. The SCQ assesses both lifetime and current presence of behaviors typically associated with Autism Spectrum Disorder. The *Lifetime Form* focuses on the individual's entire developmental history, providing a Total Score that's interpreted in relation to specific cutoff points. This score identifies individuals who may have an autism spectrum disorder (and should be referred for a comprehensive evaluation using diagnostic specific measures such as the *Autism Diagnostic Interview, Revised* or the *Autism Diagnostic Observation Schedule*). The SCQ *Current Form* looks at the individual's behavior over the most recent three-month period, and produces results that can be helpful in treatment planning, educational intervention, and measurement of change over time.

Ms. Hughes was asked to complete both *Lifetime* and *Current* forms. (She completed the *Current* form based on the last three months that Sam was in England when she had close contact with him.) In both cases, scores were consistent in identifying behaviors associated with Autism Spectrum Disorder. Behaviors listed on the *Current* SCQ questionnaire that Ms. Hughes has observed in Sam include: asking socially inappropriate questions or making socially inappropriate comments; showing facial expressions inappropriate to a particular situation; preoccupations with particular interest that may seem odd to others; and deliberate self-injurious behavior. Much of the information provided by Ms. Hughes corroborates information in Dr. Schakel's report.

BEHAVIORAL OBSERVATIONS: Sam was seen over three sessions at the Metropolitan Detention Center in downtown Los Angeles. He presented as an alert, cooperative, adult male. Yet, while he was eager to talk with the examiner, he did not demonstrate the ability to engage in reciprocal conversational exchanges to build on the examiner's bids for discussion. He incorporated some nonverbal gestures with his vocalizations that were not coordinated with eye gaze. His social naïveté was evident during every task presented throughout the assessment. His comments about things were immature, much like a child's. Sam has many repetitive interests

and he tends to perseverate on anything that he perceives as wrong and talks about the same things over and over again. His inability to understand his situation is simply reflective of his lower level of functioning when it comes to social emotional issues.

As noted, Sam was very cooperative throughout the sessions. During one of the sessions, he appeared to have extremely pressured speech. He told the examiner that what he did was only "words," that he never did anything to harm anyone nor would he harm anyone. (Further behavioral observations are described in the ADOS summary below.)

PSYCHIATRIC SCREENING

Miller Forensic Assessment of Symptoms Test (M-FAST)

The M-FAST is a screening instrument used as one component of a complete psychological evaluation, to determine whether or not an individual has malingering psychiatric symptoms. The measure consists of seven scales, which operationalize response styles and interview strategies that have been shown to identify individuals who are feigning psychopathology. These scales include: Reported vs. Observed Symptoms (which allows one to see if the person is reporting the same behaviors that you are observing); Extreme Symptomatology; Rare Combinations; Unusual Hallucinations; Unusual Symptom Course; Negative Image; Suggestibility.

The examiner attempted to interview Sam using the M-FAST structured interview booklet. However, Sam took everything in the booklet in an extremely concrete way and it was not possible to obtain a valid score. He kept talking about things controlling his life in prison and he would not respond to the questions appropriately. Nevertheless, it is highly unlikely that Sam is feigning his autism symptoms. There was no difference between his reported and observed behaviors, and ASD has consistently been diagnosed across several examiners over a long period of time.

SOCIAL/EMOTIONAL SCREENING

Beck Anxiety and Depression Inventories (BAI, BDI-II)

The *Beck Anxiety Inventory* (BAI) is a screening instrument for anxiety in individuals ages 17 through 80 years. The individual is asked to respond to 21 items describing common symptoms of anxiety, indicating how much he/she has been bothered by that symptom during the past month, including today. The *Beck Depression Inventory, Second Edition* (BDI-II) is a self-rated scale that evaluates key symptoms of depression in adolescents and adults ages 13 through 80 years. The BDI–II also consists of 21 items. Each item lists four statements arranged in increasing severity about a particular symptom of depression. The individual is asked to rate their experience with symptoms listed over the preceding two weeks.

Both the anxiety and depression measures were used to screen Sam's current mental status. Results on the *Beck Anxiety Inventory* indicated "potentially concerning levels of anxiety." Sam rated the majority of anxiety symptoms listed as being typical for him; i.e., they "bothered him a lot" (a test response option). For example, he endorsed feeling numbness or tingling, wobbliness

in his legs, being unable to relax, fear of the worst happening, feeling dizzy or lightheaded, hand trembling, and feeling shaky or unsteady. He claimed "moderate" fear of losing control and "moderate" feelings of being scared and of feeling faint.

A similar pattern was seen on the *Beck Depression Inventory,* where Sam's responses indicate severe depression. Among others, he endorsed items that included: "I am so sad and unhappy that I cannot stand it;" "I feel the future is hopeless and things cannot improve;" "I feel I am a complete failure;" and "I don't get satisfaction out of anything anymore." He also endorsed an item referring to killing himself if he had a chance. However, according to Sam, he has no means of hurting himself while in prison.

Incomplete Sentences, Adult Form
In order to obtain a more subjective measure of how Sam perceives things, he was asked to complete this measure, which consists of a list of 40 partial phrases or incomplete sentences. The individual is asked to complete the phrases in ways that express his/her real feelings. Sam's responses were noted to be extremely immature. For example, he completed some of the *phrases* as follows: *The happiest time is* "when I get cats" and *If I were king* "I'd have my own land." Some of Sam's responses reflected his current circumstances and indicated feelings of being depressed; for example, on these phrases: *The future* "is mysterious" and *I sometimes wonder* "when I'll get out." He also reported his *greatest fear* is "criticism with a felony record."

COGNITIVE/ACADEMIC ASSESSMENT

Wechsler Adult Intelligence Scale, Fourth Edition (WAIS-IV)
The *Wechsler Adult Intelligence Scale, Fourth Edition* (WAIS-IV) was administered to assess Sam's intellectual abilities. The WAIS-IV measures cognitive ability in adults ages 16 to 90 using a core battery of 10 unique subtests that focus on four specific domains of intelligence: Verbal Comprehension, Perceptual Reasoning, Working Memory and Processing Speed. Each domain renders respective index scores with an average standard score of 100 and a standard deviation of 15. The composite of these four domain scores is used to determine the Full Scale IQ score, which also has a mean of 100 and a standard deviation of 15. Subtests in each domain have an average scaled score of 10 and a standard deviation of three scaled score points.

Sam shows a great deal of variability in his cognitive functioning, which is consistent with his diagnosis of autism spectrum disorder. Results on this measure are reported as follows:

Index/ *Subtests*	**Composite Scores** Scaled Scores	**Percentile Rank**	**True Score Range**	**Descriptive Classification**
Verbal Comprehension	**100**	**50%**	**91-106**	**Average**
Similarities	10			Average
Vocabulary	9			Average
Information	11			Average

B. J. Freeman, Ph.D.
Licensed Clinical Psychologist, PSY 4826
Autism Spectrum and Related Developmental Disorders

PSYCHOLOGICAL ASSESSMENT

Patient: Samuel Hughes
Date of Birth: [redacted]

(*Comprehension*)	(5)			Borderline
Perceptual Reasoning	**102**	**55%**	**96-108**	**Average**
Block Design	11			Average
Matrix Reasoning	10			Average
Visual Puzzles	10			Average
Working Memory	**131**	**98%**	**122-136**	**Very Superior**
Digit Span	16			Very Superior
Arithmetic	15			Superior
Processing Speed	**100**	**50%**	**92-106**	**Average**
Symbol Search	10			Average
Coding	10			Average
Full Scale IQ Score	**108**	**70%**	**104-112**	**Average**

On the Verbal Comprehension tests, Sam scored in the average range on *Similarities*, *Vocabulary* and *Information* subtests. However, when he had to process information and answer questions related to appropriate social behavior (on the *Comprehension* subtest), he scored in the borderline range. (It should be noted that the *Comprehension* subtest is not concluded included in the overall cognitive score.) It is clear that Sam has language processing problems which are not accounted for in his cognitive score.

In the Perceptual Reasoning domain, Sam scored in the average range on all three subtests, *Block Design, Matrix Reasoning* and *Visual Puzzles*, with little variability. In the *Working Memory* domain, Sam scored in the superior ranges indicating that he has good rote skills and good auditory and visual memory skills for recalling information. Sam's *Processing Speed* scores were also in the average range.

While Sam's overall IQ score falls in the average range, this score should be viewed with caution due to the amount of variability shown throughout the test.

Verbal Comprehension: The *Vocabulary* subtest measures the ability to acquire, retain and retrieve factual knowledge while providing definitions of single words of increasing complexity. The *Similarities* subtest is designed to measure verbal reasoning and concept formation, and requires the examinee to discriminate between essential and nonessential features of word pairs to apply abstract reasoning skills for concept formation. This subtest also involves auditory comprehension and memory. The *Information* subtest is designed to measure a general fund of knowledge on a broad range of topics also measuring the ability to acquire, retain and retrieve information learned. The *Comprehension* subtest measures verbal reasoning, conceptualization, verbal comprehension and expression, the ability to evaluate and use past experience, and the ability to demonstrate practical information.

PSYCHOLOGICAL ASSESSMENT

Patient: Samuel Hughes
Date of Birth:

Perceptual Organization: This domain assesses the discrimination, organization and interpretation of visually perceived material (e.g. pictures, patterns). The *Block Design* subtest measures the ability to analyze and synthesize abstract visual stimuli by reproducing block designs. The *Matrix Reasoning* subtest is a measure of nonverbal concept formation, visual perception and organization, simultaneous processing, visual motor coordination, learning, and the ability to separate figure ground and visual stimuli. The *Visual Puzzles* subtest measures visual spatial reasoning, whole part integration, and mental rotation. The examinee is required to choose which three of six puzzle pieces go together to match the presented figure.

Working Memory: The *Arithmetic* subtest measures cognitive flexibility to solve a series of orally presented arithmetic problems within a specific time period without the use of paper and pencil. This subtest involves mental manipulation and concentration, attention, short and long-term memory, numerical reasoning ability and mental alertness. The *Digit Span* subtest requires the examinee to repeat a series of numbers forward and backward and is designed as a measure of auditory short-term memory, sequencing skills, attention and concentration. The *Letter-Number Sequencing* subtest requires the examinee to repeat a sequence of numbers and letters, and recall the numbers in ascending orders and the letters in alphabetical order. This subtest also measures sequencing, mental manipulation, attention, short-term auditory memory, visual spatial imaging and processing speed.

Processing Speed: On these subtests, the examinee must coordinate and organize fine motor skills. The *Symbol Search* subtest requires the examinee to discriminate similar from dissimilar geometric forms and identify a positive or negative response accordingly. On the *Coding* subtest, the examinee must transcribe symbols to numbers based on a key by applying visual scanning, cognitive flexibility, visual motor coordination and visual perception to sustain attention and motivation across the items.

SOCIAL LANGUAGE ASSESSMENT

Social Language Development Test, Adolescent

While Sam is well out of the age range for this test, it was used simply to obtain some measure of his social language skills. The *Social Language Development Test* is a standardized test of social language skills (in adolescents) that focus on social interpretation and interaction with peers. Tasks require the individual to take another person's perspective, make correct inferences, solve problems with peers, interpret social language, and understand idioms, irony and sarcasm. This measure is designed to identify atypical social language behaviors and determine how they compare to their typically developing peers. The examinee's language-based responses to portrayed, peer-to-peer situations are assessed through the use of photographs, scenarios presented verbally by the examiner and audio recordings.

Standard scores could not be computed as Sam is out of the age range for the test. However, it is possible to look at age equivalent scores to see a pattern of skills. Results are reported as follows:

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Subtests:	Age Equivalent Scores
Making Inferences	< 11 years 7 months (below norms)
Interpreting Social Language	< 11 years 7 months (below norms)
Problem Solving	< 11 years 7 months (below norms)

Only three of the subtests were able to be completed, as Sam became extremely anxious and would not perform the remainder of the tasks. As noted, he scored below the norms of the test on the *Making Inferences, Interpreting Social Language* and *Problem Solving*, indicating extreme delays in social problem solving skills, typical of ASD.

On the first subtest, *Making Inferences*, the examinee is asked to take the perspective of someone in a photograph and based on the context clues (facial expression, gestures, posture) say what the person is thinking. The comments must relate to the examinee's social perception of the nonverbal cues, including intensity of facial expression, posture and gestures. Sam had a great deal of difficulty reading nonverbal cues on this task. He was usually able to say what the person was thinking, but he was unable to identify the relevant visual clues that led him to his response.

The *Interpreting Social Language* subtest examines social metalinguistic skills. Questions are designed to tap a variety of skills that reflect how people communicate. On some tasks, the examinee must demonstrate an action and tell an appropriate reason or use for that action. On other tasks, the examinee is asked to give an example or definition of a conversational situation; or to interpret an idiom used in a short vignette. Sam is extremely concrete and literal in his thinking. He does not understand nonverbal cues and does not understand social language.
On the *Problem Solving* subtest, Sam was supposed to listen to a problem, describe the problem, propose a logical solution and say why his solution was a good one. However, he was unable to engage in this task and became very anxious trying to complete it. He had a great deal of difficulty coming up with a solution and stating a reason for using that solution.

Test of Problem Solving 2, Adolescent (TOPS 2)
The *Social Language Development Test* questions are much more socially-oriented and were very difficult for Sam. Thus, the examiner chose to use this measure to also assess Sam's problem-solving skills. The TOPS 2 is a measure of inferential reasoning and critical thinking abilities (normed for adolescents). Subtests assess the person's strengths and weaknesses in five specific critical thinking skill areas related to situations in and outside the academic setting. Test items are presented both verbally and in print to minimize possible auditory memory or reading deficiencies affecting test performance. A series of short paragraphs describing social situations are read aloud by the examiner and are followed by brief questions.

This measure involves reading a story and then answering questions about the story. Sam responded well to this type of structure. However, he had difficulty in all areas resulting in scores below the 11-year level, which is the bottom of the test. Sam has difficulty identifying problems and appropriate solutions. Results are reported as age equivalent scores, as follows:

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Tasks	Age Equivalent Scores
Making Inferences	< 11 years 6 months (below norms)
Determining Solutions	11 years 7 months
Problem Solving	< 11 years 9 months (below norms)
Interpreting Perspectives	< 11 years 6 months (below norms)
Transferring Insights	12 years 7 months

Sam is functioning like a young child in terms of problem-solving, inferential reasoning and critical thinking skills. The *Making Inferences* task asks the examinee to give a logical explanation about a situation, combining what he/she knows or can see with previous experiences and background information. On *Determining Solutions* the person is asked to provide a logical solution for some aspect of a situation presented in a passage. The *Problem Solving* task requires the person to recognize the problem, think of alternative solutions, evaluate the options, and state an appropriate solution for a given situation. It also includes stating how to avoid specific problems. *Interpreting Perspectives* looks at the person's ability to evaluate other points of view in order to make a conclusion. Finally, on the *Transferring Insights* subtest, the person is asked to compare analogous situations by using information stated in the passage.

SOCIAL COMMUNICATION/BEHAVIOR ASSESSMENT:

Autism Diagnostic Observation Schedule, Second Edition (ADOS-2), Module 4

Sam was administered Module 4 of the *Autism Diagnostic Observation Schedule* based on his age and verbal abilities. This is a measure of social communication and social behavior in older adolescents or adults with fluent speech and is used as a diagnostic indicator for Autism Spectrum Disorders. Items presented in the schedule provide a variety of opportunities for the participant to engage in typical social interactions of exchange. Based on the participant's social interaction, scores are derived to determine whether there are diagnostic indicators for Autism Spectrum Disorders.

In the area of language and communication, Sam used sentences in largely correct manner. He exhibited some speech abnormalities associated with an autism spectrum disorder. He did not exhibit immediate echolalia, but he did speak in a more formal manner than would be expected. He rarely offered information about his past history or feelings without the examiner asking him directly. He never asked the examiner for information about her thoughts or experiences, even when a press was given to do so. His reporting of events was entirely dependent on a question and answer format. Reciprocal conversation was limited as Sam would go off on tangents that the examiner could not follow, but there was little back and forth conversation. Sam used very few gestures, particularly descriptive and emphatic gestures.

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In the area of reciprocal social interaction, Sam did not use eye contact to regulate social interaction. There was little change in his facial expressions and his expression remained very flat throughout the assessment. Sam did not coordinate verbal language with nonverbal communication (eye gaze, gestures, facial expressions). He showed some enjoyment in his own actions within the context of the assessment. He communicated his own affect in terms of the fact that he was depressed. In a related activity, he did not comment on others' emotions and showed no insight into typical social situations and relationships or his role in them. (This is consistent with his behavior in the case against him.) The quality of Sam's social overtures was directly related to his own interests and not those of the examiner. He made some attempts to involve the examiner, but these were extremely limited. The quality of his social responses was somewhat awkward and difficult. Reciprocal social communication was also very limited. The overall quality of the rapport was extremely one-sided.

With regard to stereotyped or repetitive behaviors, Sam did not show unusual sensory interests, hand or finger mannerisms, or self-injurious behavior. He showed excessive interest and repetitive behavior. He is currently obsessed with the "fact" that he did nothing wrong. Overall results from this measure indicate substantial deficits in verbal and nonverbal communication, significant impairments in reciprocal social interaction, and repetitive, abnormal and stereotyped behaviors and restricted interests. Thus, taken in the context of a complete psychological evaluation, results from this measure are conclusive for a diagnosis of Autism Spectrum Disorder.

ADAPTIVE FUNCTIONING ASSESSMENT

Adaptive Behavior Assessment System, Third Edition (ABAS-3) (Adult Rating Form)
This measure was utilized to assess Sam's adaptive behavior and related skills in multiple skill areas and in comparison to chronological age. These skill areas encompass the practical, everyday skills required to function and meet environmental demands, including those needed to effectively and independently care for oneself and to interact with others. Five distinct forms are designed for the purpose of gaining critical insight into adaptive functioning from parents, teachers and adults alike. This form (ages 16-89) measures behaviors that range from those suitable for older teens to those suitable for adults. It may be completed as a self-report or by a parent or other adult who is familiar with the individual being rated. The ABAS-3 is utilized for evaluating levels of adaptive skills and specifying treatment goals for individuals with learning disabilities or other types of learning, behavioral, medical or psychological problems.

Sam's aunt was asked to complete this measure to assess Sam's daily functioning in specific adaptive skill areas in the home, community and work settings, when he was living in England. Specific behaviors and activities are rated based on how often Sam engaged in the behavior or performed the activity without help. Based on the information provided, scores on this rating scale are as follows:

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	Adult Rating Summary		
Domain/*Skill Areas*	**Composite Scores** Scaled Scores	**Percentile Rank**	**Qualitative Range**
Conceptual	**87**	**19%**	**Below Average**
Communication	8		Average
Functional Academics	14		Above Average
Self-Direction	4		Low
Social	**76**	**5%**	**Low**
Leisure	9		Average
Social	2		Extremely Low
Practical	**81**	**10%**	**Below Average**
Community Use	11		Average
Home Living	7		Below Average
Health and Safety	4		Low
Self-Care	7		Below Average
General Adaptive Composite	**81**	**10%**	**Below Average**

Sam's scores are significantly below what would be predicted from his cognitive potential. He shows a great deal of variability in his functioning and it is clear that he is unable to generalize skills learned in an academic setting and apply them to a social setting. The more important question on the ABAS-3 is not if the person is able to perform a skill, but rather does he actually engage in the skill and does he do so independently. Again, while Sam shows a great deal of variability in his social adaptive behavior, it is clear that he has had difficulty functioning in the real world.

The Conceptual domain encompasses four skill areas. The *Communication* area assesses the individual's speech, vocabulary, listening, conversation, and nonverbal communication skills. *Functional Academics* looks at the person's ability to perform basic academic skills such as reading and writing, and functional skills such as measuring, telling time, budgeting, managing money and balancing a checkbook. The area of *Self-Direction* looks at the individual's ability to make independent choices, exhibit self-control and take responsibility when appropriate.

The Social domain covers the areas of *Leisure* and *Social Skills.* This includes skills needed for engaging in and planning play/leisure time activities (e.g., initiating, following rules, trying new activities), and skills needed to interact socially, initiate and maintain friendships, express and recognize emotions, and assist others when needed.

The Practical domain covers four areas of daily living and self-help skills. *Community Use* looks at the individual's ability to function independently and get around in the community, including

shopping and using community resources. The *Home Living* area assesses the person's functioning inside the home, including cleaning, food preparation, performing chores and taking care of personal possessions. *Health and Safety* looks at the ability to protect one's own physical well-being and prevent and respond to injuries, including following safety rules, showing caution and safely using medicine when appropriate. The area of *Self-Care* assesses the person's ability to independently perform self-help activities such as eating, dressing, and taking care of personal hygiene. Finally, the *Work* section looks at the skills needed for holding a part-time or full-time job and for functioning successfully in that job, such as working with supervisors, completing work tasks in a timely manner, and following a work schedule.

SOCIAL SKILLS BEHAVIOR ASSESSMENT

Social Responsiveness Scale, Second Edition (Adult Other and Self-Report Forms)
The *Social Responsiveness Scale, Second Edition* (SRS-2) identifies social impairment associated with autism spectrum disorders and quantifies the severity of autism spectrum symptoms as they occur in natural social settings. The SRS-2 is a quantitative measure of impairment across a wide range of severity. This is important because even mild degrees of impairment can have significant adverse effects on social functioning. Total scores provide relevant diagnostic information, while subscale scores are useful in designing and evaluating treatment programs. These treatment subscales rate the individual's ability to recognize and interpret social cues; the person's reciprocal social communication skills, including expressive social communication; motivation for engaging in social interpersonal relationships, including elements of social anxiety, inhibitions and avoidance; and the level of stereotypical behaviors present that are characteristic of autism.

T-scores have a mean or average of 50 and a standard deviation of 10 standard score points. Scores of 59 or less are in the normal range; 60-65 indicate mild deficits; 66-75 is moderate; and 76 or higher is severe. Scores of 60-75 on any given subscale reflect deficits significant enough to warrant attention in treatment programs. Scores of 76 or higher are strongly associated with a clinical diagnosis of Autism Spectrum Disorder and suggest severe interference in everyday social interactions. If scores on two subtests differ by at least five *T*-score points (one-half a standard deviation), these may reflect significant differences for these areas and might result in differential treatment. Two additional subscales are compatible with the *Diagnostic Statistical Manual, Fifth Edition*. Scores on these subscales compare symptoms to the DSM-5 diagnostic criteria for autism spectrum disorder. Such comparisons help to clarify and determine whether the individual meets the most current diagnostic criteria for ASD.

Sam and his aunt, Ms. Hughes, each completed this rating scale with results as follows:

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	Self- Report		Ms. Hughes Report	
Subscales:	***T*-Scores**	**Behavior Rating**	***T*-Scores**	**Behavior Rating**
Social Awareness	78	Severe	83	Severe
Social Cognition	81	Severe	86	Severe
Social Communication	82	Severe	79	Severe
Social Motivation	84	Severe	71	Moderate
Restricted Interests/Repetitive Behaviors	>90	Severe	70	Moderate
Total Score:	**88**	**Severe**	**80**	**Severe**
DSM-5 Subscales:				
Social Communication & Interaction	85	Severe	82	Severe
Restricted Interests/Repetitive Behaviors	>90	Severe	70	Moderate

There was general agreement between the two reports regarding Sam's social behavior. Based on his self-report, results indicate severe deficits in his reciprocal social behavior that significantly interfere in everyday social interactions. However, while Sam recognizes his deficits intellectually, he is unable to correct them in real life. (This is typical of people with ASD.)

Sam has a great deal of difficulty recognizing and interpreting social cues appropriately. While Sam says he has little motivation for social interaction, his behavior reflects a different picture. He has a great deal of difficulty engaging in appropriate reciprocal social communication with others. He also endorsed a number of behaviors rated on this scale that are characteristic of autism and which clearly interfere with his ability to interact socially with others. Of particular note, Sam recognizes that he gets stuck on certain topics and cannot move forward. Scores on the DSM-5 subscales are consistent with the remainder of this psychological evaluation.

EXECUTIVE FUNCTIONING ASSESSMENT

Behavior Rating Inventory of Executive Function, Adult (BRIEF-A) (Self-Report)
The *Behavior Rating Inventory of Executive Function, Adult* is a standardized measure that captures views of everyday behaviors or self-regulation in adults, ages 18-90 years, associated with specific domains of executive functions. The BRIEF-A consists of equivalent Self-Report and Informant Report Forms, each having 75 items in nine non-overlapping scales, as well as two summary index scales and a scale reflecting overall functioning. This scale can serve as a screening tool for possible executive dysfunction, as an index of the ecological validity of clinic-based assessments, and as an indicator of individuals' awareness of their own self-regulatory function, particularly when both forms are used. The Self-Report Form provides an understanding of the individual's perspective with respect to their own difficulties in self-regulation - information that can be critical to the development of interventions. Determining the

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degree to which the individual is aware of their executive dysfunction can be helpful in gauging the level of support required.

On the BRIEF-A nine aspects of executive functioning are assessed within two broad domains or indexes: The *Behavioral Regulation Index* reflects the individual's ability to maintain appropriate control over one's thoughts, behaviors and emotions; and the *Metacognition Index* reflects the ability to manage one's attention and problem solving. Individual aspects evaluated include: selecting appropriate goals for a particular task; planning and organizing approaches to problem solving; blocking out distractions and refraining from acting impulsively or acting inappropriately in one's environment; holding information such as goals or plans in mind over time; flexibly altering one's behavior and/or problem-solving strategy when necessary; and monitoring one's own behavior for mistakes as well as for its effect on others. Executive functions are also responsible for regulating emotional responses, thereby allowing for more effective problem solving and more successful interpersonal relationships. The *Global Executive Composite* incorporates all subscale scores and is a summary measure of the individual's overall functioning.

Scores on the BRIEF-A have a mean (average) of 50 and a standard deviation of 10 points. T-scores provide information about the individual's scores relative to the scores of respondents in a standardized population. The higher the T-scores, the more impaired the individual is in executive functioning. T-scores at or above 65 should be considered as having potential clinical significance.

Sam was asked to complete the BRIEF-A Self-Report Form. Results are as follows:

Index/Scale	**T-Score / Percentile**	
Inhibit	78	98%
Shift	83	>99%
Emotional Control	83	>99%
Self-Monitor	81	99%
Behavioral Regulation Index	**88**	**>99%**
Initiate	84	>99%
Working Memory	85	>99%
Plan/Organize	83	99%
Task Monitor	79	>99%
Organization of Materials	63	93%
Metacognition Index	**83**	**99%**
Global Executive Composite	**88**	**>99%**

Based on the responses provided, Sam appears to recognize difficulties in his executive functioning in multiple areas. However, as noted, he is unable to translate this knowledge into real life behavior changes. Specifically, Sam describes himself as having a great deal of difficulty

inhibiting impulsive responses; adjusting to changes in routine, activities or task demands; modulating or controlling his emotions appropriately; keeping track of or being aware of the effect his behavior has on others; initiating tasks or activities without prompts and independently generating ideas; keeping information in mind for completing tasks (working memory); planning and organizing appropriate sequential steps to carry out a task or activity (problem solving approaches); and monitoring his performance during and after completing tasks.

SUMMARY: Samuel ("Sam") is a 32-year-old male with Autism Spectrum Disorder referred for updated assessment of cognitive and social adaptive functioning. Based on a review of records, developmental history, cognitive evaluation, adaptive level of functioning, *Autism Diagnostic Observation Schedule,* behavior observations, and relative's report, this evaluation is consistent with prior diagnostic impressions and continues to indicate a DSM-5 diagnosis of Autism Spectrum Disorder. Overall, Sam's behavior throughout this assessment is consistent with previous evaluations (by review of records). At this time, he continues to present with behaviors and patterning of skills on current cognitive testing and observation consistent with his diagnosis of Autism Spectrum Disorder.

Results of all testing are consistent with his history and indicate that Samuel functions below average in terms of his social adaptive skills while scoring in the average ranges on cognitive tests administered. He has significant expressive and receptive language and language processing difficulties. Results from measures of social communication, the ADOS-2, *Social Language Test* and *Test of Problem Solving*, indicate that Sam demonstrates significant social disabilities in communication, perception and reciprocation. In light of these impairments, his skills are notable for significant social distortion, social naïveté and a lack of social judgment and insight. His primary social skill is one of being talkative. However, he does not recognize how his behavior affects others. Results indicate that Sam needs direct instruction with regard to social skills (e.g., perception, reciprocity and insight). Sam has difficulty identifying problems and appropriate solutions, and he is unable to understand the consequences of his behavior.

Sam presents with disordered thinking, which is associated with Autism Spectrum Disorder. As noted, he is socially naïve and misinterprets his current situation. He is extremely concrete and literal, and often misreads social signals as he does not have a good grasp of appropriate social cues or social behavior. As a result he has engaged in very inappropriate behavior in contacting women. Sam is not always able to anticipate or interpret the intentions of others. He has obsessions and preoccupations and lacks insight into the effect his behavior has on others. Further, he lacks awareness and understanding of possible outcomes of his behavior. He has difficulty regulating his emotions, and has poor impulse control, sensory processing issues and difficulty reading and interpreting nonverbal behaviors.

ASD: Autism spectrum disorders are a group of neurodevelopmental disorders that reflect deficits in the way the brain develops over time. These result in specific deficits in both social communication and repetitive behaviors. People with autism spectrum disorder frequently are

unable to read cues from other people and often are concrete and literal. Sam has not received appropriate intervention to overcome his very significant social deficits associated with his autism. Furthermore, he does not respond to environmental cues and often misunderstand what is expected of him.

Current literature supports the fact that Autism Spectrum Disorder is not correlated with violence. In point of fact, individuals on the autism spectrum are more likely to be victims rather than perpetrators. Studies indicate that people with autism spectrum disorders are less likely to commit crimes than those without autism spectrum disorders. Brewer and Young (2015) reviewed all of the studies in crime and autism spectrum disorders and concluded the diagnosis of ASD by itself does not provide a greater likelihood of involvement in criminal activity relative to a non-autistic person. When frustrated, Sam writes emails in which he expresses his frustrations.

It is important to note that Sam does not have a past history of violence as far as the examiner is aware. Many of Sam's threats involve something happening to the person, but they do not always involve *him* directly making things happen. Nonviolence is consistent with what we know about persons on the autism spectrum in general and is consistent with what we know about Sam's past behavior, in spite of his inappropriate messages.

In this examiner's opinion, due to the effects of his Autism Spectrum Disorder on the way in which Sam's brain works, specifically his marked deficits in social perceptions and reciprocity, Sam's ability to understand what he is doing and appreciate the way in which the reader of his messages is interpreting them, is extremely impaired.

Sam may perceive that if he writes something down, he no longer has to think about it. In Sam's mind, he uses "words" to get rid of the thought. It is clear that Sam does not understand the consequences of writing the type of messages he wrote. To his way of thinking, if he has difficulty getting his mind off things, if he were to write it down, it would help him. This would be his way of getting things off of his mind. His messages are repetitive in nature and generally all reflect his perception of being rejected.

Features of autism spectrum disorder relevant to criminal actions: Individuals with ASD are particularly impaired in social intelligence that can lead to involvement with the criminal justice system. Criminal activity associated with ASD can be divided into two broad domains (1) deficits in theory of mind abilities, and or (2) abnormal repetitive narrow interests. Theory of mind refers to the ability to understand and predict the behavior of another person. Sam's lack of an ability to do this led to his misinterpretation of people's response to his notes. Sam presents with significant deficits in his ability to recognize that another person has a different emotional, cognitive response to a shared event. Due to his ASD, Sam suffers from an inability to read the necessary interpersonal clues telling him to disengage from a social encounter. This has led to his writing repetitive messages.

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Human beings have a natural tendency to construct their view of the world from all of their experiences; that is, they pull together all of their experiences, process the information and look for the big picture. People with ASD, like Sam, lack these normal human experiences in critical aspects of their lives including their social, moral, and physical environments. This can lead to criminal behavior as it did in Sam's case because of his excessive preoccupation with highly focused, internal interests while ignoring the social consequences, including legal sanctions.

Sam's behavior in connection with his crimes can be explained by his autism spectrum disorder. Consistent with many individuals with ASD, Sam was unable to properly process and interpret the verbal and nonverbal cues of his victims, much less understand their emotional response to his messages. To him, they were just words. He obsessively pursued his special interest with his victims and failed to recognize the consequences of his behavior. His ability to compartmentalize events in his life is both abnormal and a symptom of his ASD. Because of his ability to compartmentalize parts of his life, he failed to recognize the consequences of his behavior.

Samuel's ASD and overall difficulties relating to others socially also created difficulties in several other areas. For example, he had problems differentiating his own actions from those of others, he often misinterpreted what he saw or heard, and he functioned very poorly in unfamiliar environments. (Being in America was a new environment for Sam where he had no supports.). The combination of Sam's neurological and social deficits as well as his lack of intervention for appropriate social skills and lack of a structured supported environment resulted in his criminal behavior.

In 2004, Frith introduced the concept of weak central coherence theory, which is the process that involves the natural tendency of human beings to construct their view of the world as a rich and unified theory of their past experiences. Many people with ASD, however, such as Sam, lack normal human experiences in critical aspects of their lives, including their social, moral and physical environments. Thus, individuals with deficits in central coherence may engage in criminal behavior because of their excessive preoccupation with highly focused internal interests, while ignoring social consequences including legal sanctions

Silva, et al (2005) proposed that deficits in internal coherence (seeing the big picture) and associated compartmentalizing (putting each experience in a separate compartment in his mind) characteristics of individuals with ASD predispose them to develop a psychological niche for the growth of inner preoccupations. Such fixations, if left unchecked by normal awareness of social morays and constraints, may lead to maladaptive fantasies, as in Sam's case. These deficits appear to be dramatically highlighted in crimes associated with a person's repetitive behaviors. As discussed in more detail above, the inability of individuals with ASD to mentalize also places them at risk for engaging in behaviors that may be unwelcome by others. (Haskins and Silva, 2006).

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Autism Spectrum Disorder and threatening behavior: It is not uncommon for persons with autism spectrum disorder to lash out at others when they become frustrated. This often takes the form of written threats, as in this case. In order to understand this behavior it is important to understand typical development. Children, as they develop, will often lash out at parents when they are upset. For example, when their wishes are thwarted, such as not being allowed to do something, they may often respond with saying "I hate you" to their parents. This is an attempt by young children to learn to control their own environment, which is largely controlled by the parents. This behavior is commonly seen in schools as children mature. As children continue to mature, they develop other ways of expressing their anger and frustration. They learn appropriate problem-solving skills and behaviors that are more socially acceptable.

The majority of individuals with ASD who make threatening statements have no intention of following through. It frequently represents a response to a frustrating situation and represents a response of a young child. It is often the person's way of attempting to control a situation in which they feel powerless. As previously noted, there are no data that show people with autism are more violent than other people. What we see in adults with ASD is a social immaturity and value to develop appropriate social and problem-solving behaviors that persist into adulthood. However, in addition, in this day and age, threats are heavily influenced by social media and television. People on the autism spectrum often do not understand that they have committed an offense. They do not understand that their words (such as "I'm going to stab you") have significant meaning to other people. They don't understand how other people will react to this. What appears to be antisocial behavior in the "regular" world is typically a manifestation of the autistic person's misunderstanding of social norms and how to function in the world.

Research shows that once people have written down their threats, they move on. They put the issue in a separate "compartment" and it has very little impact on their behavior. Sam clearly does not understand that he has committed an offense that people find threatening and inappropriate. Sam has learned no other way to control his emotions and feelings and has not developed mature problem-solving skills because of his lack of intervention. This is clear and discussed throughout this report. It is this examiner's opinion that Sam's threatening messages should be viewed as the response of a young child without appropriate social skills, rather than a real threat.

DIAGNOSES: Results from this evaluation substantiate that Samuel meets the *Diagnostic Statistical Manual, Fifth Edition*, 2013 (DSM-5) criteria for 299.0 Autism Spectrum Disorder requiring substantial support for social communication and social interaction, and restricted, repetitive behaviors; without intellectual impairment; and with language impairment (*language processing, pragmatics*). Rule out anxiety and depression.

With regard to the diagnosis of ASD, Sam meets the following DSM-5 criteria:

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A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history:

1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation, to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions. [*examiner observation, review of records, aunt's report*]

2. Deficits in nonverbal communicative behaviors used for social interaction; ranging, for example, from poorly integrated- verbal and nonverbal communication, to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication. [*observation, review of records*]

3. Deficits in developing, maintaining and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts, to difficulties in sharing imaginative play or in making friends; to absence of interest in peers. [*observation, review of records, aunt's report*]

Severity Level 2: Requires substantial support for marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; reduced or abnormal responses to social overtures from others; and decreased interest in social interactions.

B. Restricted, repetitive patterns of behavior, interests, or activities as manifested by at least two of the following, currently or by history:

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases). [*examiner observation, review of records, aunt's report*]

2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same foods every day). [*examiner observation, review of records, aunt's report*]

3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests). [*examiner observation, review of records, aunt's report*]

4. Hyper-or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement). [*review of records, aunt's report*]

B. J. Freeman, Ph.D.
Licensed Clinical Psychologist, PSY 4826
Autism Spectrum and Related Developmental Disorders

PSYCHOLOGICAL ASSESSMENT

Patient: Samuel Hughes
Date of Birth:

Severity Level 3: Requires very substantial support for inflexibility of behavior, extreme difficulty coping with change, or other restricted/repetitive behaviors that markedly interfere with functioning in all spheres; great distress/difficulty changing focus or action.

C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).

D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay.

RECOMMENDATIONS:

In this examiner's opinion, Sam needs a highly structured residential treatment facility where his severe social-emotional deficits can be addressed. Prison would not address these issues and would thus make it more likely that Sam will reoffend.

If I can provide any additional information, please do not hesitate to contact me at 310-440-8543.

B. J. Freeman, Ph.D.
Professor Emerita of Medical Psychology
UCLA School of Medicine

EXHIBIT B

UNIVERSITY OF CALIFORNIA, LOS ANGELES **UCLA**

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SANTA BARBARA · SANTA CRUZ

CURRICULUM VITAE

Betty Jo Freeman, Ph.D.
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California License CA PSY 4826

EDUCATION

Mercer University, Macon GA	B.A.	1962-1966
Southern Illinois University, Carbondale IL	M.A.	1966-1968
Southern Illinois University, Carbondale IL	Ph.D.	1968-1969

PROFESSIONAL TRAINING

Southern Illinois University, Carbondale IL	Research Assistant (Animal Learning Lab)	09/66 – 06/67
Southern Illinois University, Carbondale IL	Research Assistant (Operant Conditioning Lab)	08/67 – 08/69
Southern Illinois University, Carbondale IL	Teaching Assistant (Introductory Course, Psychology)	09/67 – 06/68
Southern Illinois University, Carbondale IL	Teaching Assistant (Introductory Course, Psychology)	01/69 – 06/69
Southern Illinois University, Carbondale IL	Teaching Assistant (Advanced Course, Psychology)	03/69 – 06/69

PROFESSIONAL EXPERIENCE

Veterans Administration Hospital Pittsburgh PA & Nashville TN	Research Associate	09/69 – 09/71
University of Pittsburgh, Pittsburgh PA	Instructor (part-time)	09/69 – 12/69
Fisk University, Nashville TN	Instructor (part-time)	09/70 – 06/71
Fisk University, Nashville TN	Assistant Professor, Psychology	09/71 – 09/72
Johns Hopkins University Medical School & John F. Kennedy Institute, Baltimore MD	Postdoctoral Fellow, Dept of Pediatrics	09/72 – 09/73
University of Baltimore, Baltimore MD	Instructor (part-time)	01/73 – 06/73
University of California Los Angeles School of Medicine, Los Angeles CA	Assistant Professor in Residence Dept of Psychiatry & Biobehavioral Sciences	09/01/73 – 06/30/80
University of California Los Angeles School of Medicine, Los Angeles CA	Associate Professor in Residence Dept of Psychiatry & Biobehavioral Sciences	07/01/80 – 06/30/86
University of California Los Angeles School of Medicine, Los Angeles CA	Professor in Residence Dept of Psychiatry & Biobehavioral Sciences	07/01/86 – 06/30/03
University of California Los Angeles School of Medicine, Los Angeles CA	Emerita Professor	01/01/04 – present

PROFESSIONAL ACTIVITIES – Lectures and Papers Presented

"Role of reinforcement frequency in producing contrast effects on a multiple schedule of positive reinforcement." Presented to Eastern Psychological Association, Atlantic City NJ. 1970 (Abstract)

"Differential rearing effects on positively and negatively motivated behavior." Presented to Eastern Psychological Association, New York City NY, 1971 (Abstract)

"Activity as a function of chronic administration of morphine in rats." Presented to ASPET Meetings, University of Vermont, Burlington VT. 1971 (Abstract)

"The application of procedures for the development of complex stimulus control in testing auditory deficits in young retarded children." Presented to Eastern Psychological Association, Washington, D.C. 1973 (Abstract)

"Failure to obtain condition suppression in humans when timeout from positive reinforcement is the aversive event." Presented to American Psychological Association; Montreal, Canada. 1973 (Abstract)

"The reinforcing effects of photic stimulation upon the behavior of autistic and retarded children." Presented to Western Psychological Association Meetings, San Francisco CA. 1974 (Abstract)

"Extinction of a phobia of physical examination in a seven-year-old mentally retarded boy." American Psychological Association Meeting; New Orleans LA. 1974 (Abstract)

"Intellectual assessment of autistic children." Invited lecture to UCLA Extension Course, Autism: Diagnosis, Current Research and Management, Los Angeles CA. 1975

"Parents as paraprofessionals." Invited lecture to UCLA Extension Course, Autism: Diagnosis, Current Research and Management, Los Angeles CA.1975

"Effect of long time-out durations on behavior of the autistic child." Presented to Western Psychological Association Meeting; Sacramento CA. 1975 (Abstract)

"The effects of response contingent vestibular stimulation on the behavior of autistic and retarded children." Presented to Western Psychological Association Meeting, Los Angeles CA. 1976 (Abstract)

"Evaluation and treatment of autistic children at the UCLA- NPI." UCLA Symposium presented to the American Association of Psychiatric Services for Children. 1976 (Abstract)

"Assessment and evaluation: Implication for school and home management." Invited workshop presented to the National Society for Autistic Children, Los Angeles CA. 1976

"An overview of behavior therapy with children." Invited lecture to the American Academy of Child Psychiatry Second Annual Review in Child Psychiatry, Santa Monica, CA. 1977

"The effects of number of stimuli on rate of discrimination learning in autistic children." Presented at the Western Psychological Association Meetings, Seattle WA. 1977 (Abstract)

"Concurrent extinction programs for self-injurious behavior in a mentally retarded child." Presented at Western Psychological Association Meeting, Seattle WA, with Fred Frankel. 1977 (Abstract)

"The advocate and the diagnostic and evaluation system." Invited paper at the Symposium "Advocacy and Autism," University of Kansas, Lawrence KS. 1977

"Diagnostic approaches in differentiating autism from childhood schizophrenia." Invited workshop to the Continuing Care Service Section, Department of Health, Burbank CA. 1977

"Behavioral correlates of the syndrome of autism." Paper presented at the American Psychological Association, San Francisco CA. Aug 1977 (Abstract)

"Diagnosis and objective behavioral observational scale, DSM III proposals." Invited participant in Symposia

"The syndrome of autism: An update of diagnosis, research and advocacy," American Academy of Child Psychiatry, Houston TX, with Ed Ritvo. Oct 1997 (Abstract)

"Objective diagnosis of autism." Invited workshop presented at Harbor Regional Center (California Dept of Developmental Services), Torrance CA. Dec 1997

"Behavioral correlates of the syndrome of autism: Objective diagnosis." Workshop presented to the American Association of Psychiatric Services for Children, Washington, D.C. Nov 1977 (Abstract)

"Behavioral diagnosis of the syndrome of autism." Invited keynote speaker, Long Beach National Society for Autistic Children, Long Beach CA. Oct 1977

"Behavioral approach to diagnosis and treatment of emotional disorders of infancy." Jan Invited lecture, Child Psychiatry Seminar, Harbor General Hospital, Torrance CA. Jan 1978

"Objective diagnosis of the syndrome of autism." Invited panel participant, presented at Louisiana State University, Baton Rouge LA, with Ed Ritvo. Feb 1978

"Behavior observation scale: Assessing the similarities and differences among autistic, mentally retarded and normal children." Paper presented at Western Psychological Association Meeting. April 1978 (Abstract)

"Establishing the diagnosis of autism: Medical, psychological and behavioral examination." Workshop for "Syndrome of autism: Medical and educational management," sponsored by the American Academy of Child Psychiatry and Wayne County Intermediate School District, Detroit, MI. April 1978

"Differential diagnosis of the syndrome of autism." Workshop for "Syndrome of autism: Medical and educational management," sponsored by the American Academy of Child Psychiatry and Wayne County Intermediate School District, Detroit, MI. April 1978

"Medical and behavioral management of the syndrome of autism." Workshop for "Syndrome of autism: Medical and educational management," sponsored by the American Academy of Child Psychiatry and Wayne County Intermediate School District, Detroit, MI. April 1978

"The Syndrome of Autism: Medical and educational management." Ritvo, E., Freeman, B. J., & Greiner, J. (Co-Chairpersons), Workshop sponsored by the American Academy of Child Psychiatry and Wayne County Intermediate School District, Detroit, MI. Apr 1978

"Behavioral correlates of the syndrome of autism." Invited panel participant, "Current research in autism." American Association of Mental Deficiency." Denver, CO, with Dr. Fred Frankel. May 1978 (Abstract)

"The Behavior Observation Scale." Paper presented to the American Psychological Association annual meeting. Toronto, Canada. Aug 1978. (Abstract)

"Current research in autism: Behavior, cognitive and language." Invited lecture for "Symposium on Autism and Childhood Psychosis." Dept of Psychiatry, University of Nebraska, Omaha NE. May 1978

"The UCLA-Neuropsychiatric Institute Program for Autistic Children." Invited lecture for "Symposium on Autism and Childhood Psychosis." Dept of Psychiatry, University of Nebraska, Omaha NE. May 1978

"Assessment and treatment of the syndrome of autism." Invited workshop, Touhaven Project, Gaylord MI. Sept 1978

"Objective diagnosis of the syndrome of autism." Paper presented at the American Association of Psychiatric Services for Children annual meeting, Atlanta GA. Nov 1978 (Abstract)

"Psychological assessment of children with the syndrome of autism." Invited workshop, Dept of Psychiatry, University of Alabama Medical School, Birmingham AL. Nov 1978

"Diagnosing the syndrome of autism." Invited lecture, Dept of Special Education, University of Texas, Austin Tx. Feb 1979

"Age as a factor in discriminate analysis among autistic, mentally retarded, and normal children." Paper presented at Western Psychological Association Meeting, Honolulu HI. 1980 (Abstract) Also reprinted by ERIC, Princeton NJ.

"I.Q. as a factor in the behavior of autistic, mentally retarded and normal children." Paper presented at the Western Psychological Association Meeting, Honolulu, 1980. (Abstract) Also reprinted by ERIC, Princeton NJ.

"Diagnosing the syndrome of autism." Invited lecture at Harbor General Hospital, Los Angeles CA. Feb 1980

"The Behavior Observation Scale for autism (BOS): Factor analysis of behaviors." Paper presented to the American Psychological Association, New York NY. 1980 (Abstract) Also reprinted by ERIC, Princeton NJ.

"Evaluating autistic children." Invited workshop for Illinois and Missouri National Society for Autistic Children. St. Louis MO. 1980

"The Behavior Observation Scale: Frequency analysis." Paper presented to the American Psychological Association, Los Angeles CA. 1981. (Abstract) Also reprinted by ERIC, Princeton NJ.

"Social relatedness in autistic children." Paper presented to the American Psychological Association, Los Angeles CA, with Ilene Tonick. 1981 (Abstract)

"Behavioral assessment of the syndrome of autism: A quantitative review of autistic behaviors." Invited paper, UCLA Child Psychiatry Academic Colloquium, Los Angeles CA. May 1981

"Evaluating autistic children." Invited workshop, Southwestern Society for Autistic Children; San Diego CA. October 1981

"Diagnosis and treatment of problems in early childhood." Invited workshop, 8th Annual Regional Conference, "Teaching and Treating Children, Adolescents and Parents", University of Las Vegas, NV. March 1982

"DSM-III and childhood diagnoses." Invited workshop, California Dept of Mental Health, San Diego CA. March 1982

"Behavior management: Decreasing behaviors." Invited lecture, Residential Services Specialist Program, Westside Regional Center (California Dept of Developmental Services), Los Angeles CA. December, 1981. Also 1982, 1983, 1984

"Psychological assessment of severely handicapped children." Invited lecture, Rowland Unified School District, Los Angeles CA. Sept 1982

"Effects of fenfluramine on the behavior of autistic children." (1982 - 1984)

1. Invited speaker, Sutton Foundation, Orange County CA. Nov 1982
2. Invited speaker, National Society for Autistic Children, Riverside County CA. March 1983
3. Invited speaker, National Society for Autistic Children, Ventura County CA. April 1983
4. Invited speaker, California Society for Autistic Children, Sacramento CA. May 1983
5. Keynote speaker, Canadian Society for Autistic Children, Toronto, Canada. May 1983
6. Keynote speaker, National Society for Autistic Children Annual Meeting, Salt Lake City UT. July 1983
7. Invited speaker, National Society for Autistic Children, Los Angeles CA. Sept 1983
8. Invited speaker, National Society for Autistic Children, Long Beach CA. 1984
9. Invited speaker, Washington Society for Autistic Children, WA. 1984

"Assessment and treatment of syndrome of autism." Residential Services Specialist Program. North Los Angeles Regional Center, February 1983, March 1984, March 1985.

"Genetic factors in autism." Invited speaker, National Society for Autistic Children Annual Meeting, Salt Lake City UT, July 1983.

"Diagnosis and treatment of autism." Invited Lecture. Grand Rounds, Department of Child Psychiatry, University of Southern California, April 1983.

"Pervasive developmental disorder and schizophrenia." Invited lecture, American Academy of Child Psychiatry Annual Review, Los Angeles CA, May 1983.

"Behavioral assessment of the effects of fenfluramine on autistic children." Paper presented to the Western Psychological Association Meeting, San Francisco CA April 1983. (Abstract)

"Assessing effects of fenfluramine on behavior in 15 autistic children." Paper presented to the American Psychological Association, Los Angeles CA, August 1983. (Abstract)

"Behavioral assessment of the syndrome of autism." Paper presented to the American Academy of Child Psychiatry, October 1983.

"Genetic contributions to the syndrome of autism." Invited address. Western Psychological Association Meeting, April 1984.

"Diagnosis of the syndrome of autism." Workshop, Coast Mental Health, 1984.

"Stability of cognitive and linguistic scales in autism." Paper presented to the American Academy of Child Psychiatry, 1984.

"Effects of fenfluramine of 14 outpatients." Presented paper, American Academy of Child Psychiatry, 1984.

"Psychological evaluation of untestable children." Invited lecture, Lanterman State Hospital, October 1984.

"Sequential and simultaneous processing in autistic children." Paper presented to the American Psychological Association, August 1985.

Stability of cognitive-linguistic scales in Autism" Mental Retardation Research Center Grand Rounds, Jan 1985

"Differential diagnosis of autism" Workshop presented at the Autism Training Center, Marshall University, Huntington, West Virginia, April 1985. (CME credits)

"Recent research in the syndrome of autism." Invited lecture, Autism Training Center, Marshall University, Huntington, West Virginia, April 1985.

"Familial autism: Psychometric assessments of first-degree relatives." Paper presented to American Academy of Child Psychiatry, San Antonio TX. October 1985.

"Cognitive Assessment in Autism" and "Prognosis in Autism". Invited Lectures. New Orleans LA. Dec 1985.

"Relationship of WISC-R and Vineland ABS Scores in Autism," Invited Lecture, National Society for Children and Adults with Autism Conference, Washington, D.C., July 1986.

"Diagnosis and Treatment of Autism", Invited Lecture. Autism Society of America, San Diego CA. May 1987.

"Diagnosis and Treatment of Autism", Invited Lecture. Behavior Therapy and Learning Center, Long Beach CA. July 1987.

"Diagnosis and Assessment of Autism," Invited Lecturer
- West Virginia Autism Society, Autism Center Workshop, October 1987.
- Orange County Severely Handicapped Conference, Sept. 1987, Sept. 1988.

"Diagnosis of Autism" (1987-1991) Invited Lecturer:
- University Affiliated Program, UCLA/NPI, Los Angeles CA, 1987 & 1988.
- La Mirada Unified School District, La Mirada CA, June 1988.
- California Program Specialists, Special Education, Long Beach CA, March 1988.
- South Central Los Angeles Regional Center, July 1988.

Invited Workshops & Inservices:
- Agency for International Development, Guayaquil, Ecuador, July 1988
- Autism Society of America, San Francisco CA (UCSF) May 1989.
- Seattle Autism Society, Seattle WA, October, 1989
- Autism Conference, Oakland CA, January 1990.
- DDIP Program/UCLA, February 1990.
- Autism Conference, Newport Beach CA, March 1990
- Autism Society of America, Los Angeles CA, April 1990.
- Autism Conference, University of California San Francisco CA, May 1990.
- San Gabriel Valley Regional Center, Covina CA, July 1990.
- Canyon Hills School District, Canyon Country CA, January 1991.
- Alhambra School District, at UCLA-NPI, May 1991.

Conference Presentations:
- Westside Regional Center, Los Angeles CA April 1989.
- Autism Society of America, Long Beach/San Gabriel Regional Center, April 1989
- National Autism Society of America, Buena Park CA, July 1990.

- Inland County Regional Center, October 1990.
- Autism Society of America, Ohio, November 1990.
- Parent/Professional Meeting, Autism Society of America, Orange County Chapter, Feb. 1991
- Autism Society of America, Long Beach Chapter, February 1991.
- Canyon Hill School, April 1991.
- Parent/Professional Meeting, ASLA, Whitney High School, April 1991.

"Assessment of Functional Skills in Autism", Jay Nolan Center Saturday Program, Whitney High School, Los Angeles CA. November 1987, November 1988

"Assessment of Severely Handicapped Children", Invited Lecture, University of Southern California, February 1988.

Population Prevalence, Sibling Risk and Recurrence Risk Estimates of Autism", Paper presented, International Congress of Psychology, Sydney Australia, September 1988.

"A New Basis For Genetic Counseling In Autism", Paper presented, American Psychiatric Association 142nd Annual Meeting, San Francisco CA, May 6-11, 1989.

"Genetics and Autism" Paper presented at World Congress of Biological Psychiatry, Jerusalem, Israel. March 1989.

"Diagnosis and prognosis in persons with mild autism", paper presented, Autism Society of America, Buena Park CA, July 1990.

"Prospective Longitudinal Study of Autism", paper presented, Autism Research Symposium, Snowbird UT August 1990.

Diagnosis and Assessment of High Functioning Autistic Children", Educational Inservice Workshop, Tacoma School District, Tacoma WA, July 5-7, 1990.

Diagnosis and Assessment of High Functioning Autistic Children", Educational Inservice Workshop, Tacoma School District, Tacoma WA, July 5-7, 1990.

"Diagnosis and Assessment of High Functioning Autistic Children", Conference presenter, California Association of Behavior Therapists, San Francisco CA, March 8, 1991.

"Assessment and Treatment of Autism", Workshop presented, Department of Pediatrics - University of Timisoara, Romania, April 12-20, 1991.

"The Stability of Cognitive and Behavioral Parameters in Autism: A 12-year prospective study" Paper presented at 38th Annual Meeting of the American Academy of Child and Adolescent Psychiatry, Oct 16-20, 1991.

"Stability of Cognitive and Behavior Factors in Autism"

1. American Academy of Child Psychiatry, San Francisco, October 1991 (Abstract)
2. IDEA Conference, California Autism Society, May, 1992
3. Autism Society of America, July 1992

"Diagnosis, Assessment and Current Research of the Syndrome of Autism." (1991 - 1995)

1. Long Beach/San Gabriel Valley Autism Society, January 1991
2. Northern California Association of Behavioral Analysis, March 1991
3. Grand Rounds, University of Timisoara Medical School, Romania, April 1991
4. Los Angeles Autism Society, April 1991
5. American Academy of Child Psychiatry Update Course, June 1991
6. Santa Rosa Autism Society, October 1991
7. South Central Los Angeles Regional Center, October 1991
8. Ohio Autism Society, October, 1991
9. Florida Autism Society, Ft. Lauderdale FL, February 1992
10. Kaiser Department of Pediatrics, Grand Rounds, March & July 1992
11. Children's Hospital, Department of Pediatrics, Grand Rounds, January 1992
12. Issues in Early Child Development, Contemporary Forums, San Diego CA, June 1992
13. Autism Society of Canada, Calgary, May 1992
14. San Diego, Nursing Update, CME Course, June 1992
15. Tennessee Autism Society, February 1993

16. Anaheim School District, January 1993
17. Breakfast Club, UCLA, March 1993
18. Saddleback Unified School District, March 1993
19. Fullerton Child Guidance Center, March 1993
20. ABC Unified School District, March 1993
21. Grand Rounds, Long Beach Memorial Hospital, April 1993
22. Ladera Heights School District, April 1993
23. Kaiser Mental Health, May 1993
24. Kaiser, Whittier, May 1993
25. AACP Update Course, Los Angeles, June 1993
26. Autism Society in Toronto, Canada, July 1993
27. Autism Society of America (ASA), January 1994
28. UCLA, Psychiatry Across the Lifespan, January 1994
29. San Gabriel Autism Society, February 1994
30. South African Autism Society, Capetown, RSA, March 1994
31. California School Psychologists, March 1994
32. Long Beach Autism Society, March 1994
33. Whittier Autism Society, March 23, 1994
34. Los Angeles Autism Society, May 19, 1994
35. Fiesta Educativa, Los Angeles, May 20, 1994
36. California Autism Society, Newport Beach, May 21, 1994
37. Torrance Memorial Hospital, June 1, 1994
38. Simi Valley Autism Society of America, June 17, 1994
39. Parents of Adults with Autism, Los Angeles, August, 1994
40. California Nursing Association, Orange County, February 1995
41. Washington Autism Society of America, Seattle, March 1995
42. Autism Society of America, San Diego, March 1995

"Cognitive and Social Emotional Development in Romanian Orphans." (1992)

1. International Conference on Infant Studies, May 1992, Miami FL, with S. Kaler, PhD (Abstract)
2. Romanian/American Academy of Science, June 1992, with S. Kaler, PhD (Abstract)
3. American Psychological Association, August 1994 with S. Kaler, PhD (Abstract)

"Autism: Where we've been and where we are going." Keynote Address, Autism Society of America, Las Vegas, July 1994

"Early Intervention and Development in Autism" Invited Address, University of North Carolina, May 1995.

"Autism: Making the Diagnosis" Presentation Conference, The Association of Child Development, Specialists Fall Meeting, Los Angeles CA, October 1993

"What Physicians Need to Know About Autism" Presentation, Conference, 4th Annual Educational Workshop in Hawaii; Autism Society of Hawaii; UAP Resource and Technical Assistance Project on Autism; Hawaii Medical Association; Hawaii Psychiatric Medical Association and The American Academy of Pediatrics-Hawaii Chapter, Honolulu, Hawaii, August 3, 1994.

"Unraveling Autism, Asperger's Syndrome and PDD", Keynote Speaker at Multidisciplinary Conference, Autism, Asperger's Syndrome & Pervasive Developmental Disorders; Greater Phoenix Chapter of Autism Society of America, & Developmental Pediatric Education, Scottsdale, AZ, April 1995

"Psychological Assessment of Autistic Children", Presentation, A Workshop on Understanding Autism, Morongo Unified School District, Yucca Valley CA, April 1995

"Diagnosis and Treatment of Autism" (Workshop and Conferences, Invited Speaker, 1995 – 1997)

1. Greater Long Beach/South Bay Autism Society, May 1995
2. American Academy of Child and Adolescent Psychiatry, Beverly Hills, June 1995
3. The Autism Consortium of the Ralph J. Baudhuin Oral School of Nova-Southeastern University, Fort Lauderdale FL, September 1995
4. Long Beach Unified School District, Long Beach, November 1995

5. Los Angeles County School Nurses Association, Los Angeles, CA January 1996
6. Bellflower Unified School District, Bellflower CA, January 1996
7. California School Nurses Organization, Fresno CA, February 1996
8. Greater Anaheim Special Education Local Plan Area (SELPA), Buena Park CA, October 1996
9. Autism Society of California and the East Bay, Alamo CA, April 1996
10. Santa Barbara County SELPA, Santa Barbara CA, May 1996
11. San Francisco Bay Area Autism Society of America, San Francisco CA, May 1996
12. Harbor-UCLA Department of Psychiatry, Los Angeles CA, August 1996
13. ABC Unified School District, October 1996
14. UCLA First Annual Review of Psychiatry, October 1996
15. Region X, Fort Worth, TX and Region XI, Dallas, TX, November 1996
16. Special Education and Law, Los Angeles, March 1996
17. Steve Kaufman & Associates, Culver City CA 1996
18. Sonoma County Special Education Conference, December 1996
19. Riverside County School District, Riverside CA, January 1997
20. University Affiliated Program, UCLA, January 1997
21. Metra Health, Long Beach, January 1997
22. Dept. of Mental Health, Bell Gardens, CA, January 1997
23. Alaska Statewide Special Education Conference, Anchorage AK, February 1997
24. Fourth Annual Big Sky Summer Institute, Bozeman MT, June 1997
25. Contemporary Forums, Anaheim CA, October 1997
26. Georgia State Education Conference, April 1997
27. Bellflower Community Action Board, CA, February 1997
28. Continuing Education Lectures, Professional Psychiatry Seminars, 1997-2004

"Autism: What Current Research Tells Us"

1. "Creating California's Future," State Conference on Special Education, October 1996
2. Invited Address, Illinois Center for Autism, October 1997
3. Special Education Conference, Anaheim CA, October 1997
4. Invited Address, "Working to Solve the Problem," Calgary Canada, May 1997

"Cooperation between Parents and Professionals"

1. Invited address, International Autism Conference, Skive Hallerne Denmark, Nov. 1996
2. Invited address, Autism Society of America, Orlando FL, July 1997

"Questions Parents Should Ask Before Beginning a Treatment" (Invited Address)

1. International Autism Conference, Skive Hallerne Denmark, Nov. 1996
2. Parents Helping Parents, San Jose CA, January 1997
3. Future Horizons, Nashville TN, November 1997

Autism Diagnosis, Interventions, Prognosis; "Expanding Our Boundaries" Third Annual Psychologist Conference, Los Angeles County Office of Education Workshop, Burbank CA, February 1996

Feature Presentation: "Questions to Ask When Looking for Services"; Conference: "Stairway to Change" Autism Treatment Services of Canada, Sydney, Nova Scotia, Canada, May 1996

"Evaluating Cognitive and Social Early Intervention Programs"; Early Social and Cognitive Development in Autism, 16th Annual TEACCH Conference, Presentation: Chapel Hill NC, May 1996

"Autism: What's In & What's Out" Autism Treatment Services of Canada, Victoria, British Columbia, May 1966

"Asperger's Syndrome: Diagnosis and Treatment"

1. Sunrise Seminars, The H.E.L.P. Group, July 1996
2. California Autism Society State Conference, May 1997
3. 1st Annual Learning Disorder Symposium, The H.E.L.P. Group, UCLA/NPI, September 1997
4. UCLA's 2nd Annual Review of Psychiatry, October 1997
5. North County ASA Conference, San Diego CA, May 1998
6. Autism Society of America, Long Beach CA, February 2000
7. Grand Rounds, UCLA-NPI, May 2000

8. Autism Spectrum Disorder Conference, Autism Partnership, January 2001
9. The H.E.L.P. Group, Los Angeles CA, October 2002
10. U.E.S. Lecture, UCLA, Los Angeles CA, February 2003

"Early Intervention: A Range of Models" (Panel Chair); Autism Society of America Annual Meeting, Milwaukee, WI, July 1996, Orlando 1997

"Diagnosis and Treatment of Autism" (1997 – 1998)
1. Fulton County Schools, Atlanta GA February 1997
2. Ventura County Schools, Ventura CA, May 1997
3. North Center Georgia GLRS, October 1997
4. Georgia Learning Centers, Macon, Albany and Statesborg GA, December 1997
5. Grand Rounds, Santa Rosa Memorial Hospital, Santa Rosa CA, January, 1998
6. Foothill SELPA Parent Conference, Burbank CA, March 1998
7. Iowa Autism Society Conference, April 1998
8. PDD/IDA, Houston TX, May 1998
9. Los Angeles Unified School District Psychologists, May 1998
10. Florida Associates of School Psychologists, Orlando FL, November 1998

"Diagnosis and Treatment of Autism" (2001-2002)
1. Minneapolis Autism Society, Minneapolis Minnesota, May 2001
2. Workshop, Autism Society of America National Conference, San Diego CA, July 2001
3. Workshop, Harbor Regional Center, March 2002
4. Workshop, University of South Florida, Tampa FL, July 2002

"Autism Spectrum Disorder: What does the future hold?"
1. Treatment Services of Canada, Calgary and Alberta, May 1997
2. West Coast Special Education Conference, Anaheim CA, November 1997

"Autism: A Biological Disorder" and "How to manage the managed care maze." Dual lecture, (Co-presenter) UCLA, August 1997

"Guidelines for Evaluating Treatment Programs for Autistic Children"
1. Orange County Interagency Autism Group, Huntington Beach CA, September 1997
2. Iowa Autism Society Conference, April 1998
3. Tennessee Assoc. for Administrators in Special Educ. Conference, Gatlinburg TN, Dec. 1998
4. Special Education Attorneys Conference, Orlando FL, December 1998
5. West Orange County Consortium for Special Education, Orange County CA, May 2001

"Autism: Clues to Recognition and Tips for Managing Behavior in the Office" Nursing Issues in Ambulatory Pediatrics,' Contemporary Forums, October 1997

"Diagnosis and Assessment of Autism Spectrum Disorder: What We Know"
1. Governor's Conference: Partners in Prevention, San Diego CA, February 1998
2. Workshop, San Luis Obispo SELPA, San Luis Obispo CA, September 2002

"Results of a Twenty Year Longitudinal Study of Persons with Autism"
1. California Autism Society, Conference, March 1998
2. Grand Rounds, UCLA-NPI, February 1999

"Common Behavior Problems in Autistic Disorder" Iowa Autism Society Conference, April 1998

"Evaluating the Efficacy of Intervention Programs for Autistic Children"
1. The Child with Autism, Contemporary Forums, Anaheim CA, April 1998
2. Autism Society of America Annual Conference, Reno NV, July 1998
3. Contemporary Forums: The Young Child with Special Needs, New Orleans LA, May 2001

"Diagnosis and Assessment of Autism and Related PDD: Developing an Effective Early Intervention Curriculum" Workshop, Autism Treatment Services of Canada, Vancouver, B.C., May 1998

"Treatment of Autism: A Range of Options" Panel Chairperson, Autism Society of America Annual Conference, Reno NV, July 1998

"Romania's Institutionalized Children: A Longitudinal Study of Cognitive and Socio-Emotional Development" co-presenter with Dr. Sandra Kaler, 10th Annual Sigma Theta Tau, International Meeting, Utrecht, Netherlands, July 1998

"Diagnosis and Current Research in Autism" Workshop: Autism Treatment Services of Canada, Quebec. Oct 1998

"Autism: What We Know" (1999 – 2005) (updated annually)

1. Grand Rounds, Kaiser Permanente, Dept. of Pediatrics, Woodland Hills CA, Jan. 1999
2. Autism Society of Southern Illinois, Bellfield IL, March 1999
3. Autism Society of Tucson, Tucson AZ, March 27, 1999
4. LRP National Meeting, San Francisco CA, April 24, 1999
5. Update in Child Psychiatric, Los Angeles CA, June 1999
6. CME Panel, Oxnard CA, September 1999
7. Autism Conference, University of California at Santa Barbara, September 1999
8. UCLA Psychiatry Review Course, Los Angeles CA, October 15, 1999
9. Foothill SELPA Parents Conference, Burbank CA, October 16, 1999
10. University of Hong Kong, November 1999, 2000, 2001
11. UCLA Department of Neurology, Los Angeles CA,, 1999
12. Autism Partnership, Seal Beach CA, January 12, 2000
13. Covina SELPA, Covina CA, January 25, 2000
14. Jewish Bureau of Education, Temple Sinai, Los Angeles CA, March 2000
15. Autism Society of Vancouver, Vancouver, B.C., March 2000
16. Alabama State Dept. of Education, Birmingham, March 2000; Montgomery, Feb 2001; Mobile, July 2001
17. Loyola-Marymount College, March 2000
18. Texas State Dept. of Education, Dallas and South Padre Island TX, April 2000
19. North Counties Autism Society Conference, San Diego CA, May 2000
20. Austin Unified School District, Austin TX, May 2000
21. PacificCare Health Services, Woodland Hills CA, June 2000
22. Long Beach Unified School District, Long Beach CA, August 2000
23. Conference, co-presented with Autism Partnership, Toronto, Canada, November 2000
24. Administrative Law Judges Conference, Santa Barbara, CA, November 2000
25. Orange County SELPA, Anaheim CA, September 2000 and January 2001
26. Vista School District, Vista CA, January 2001
27. University of Judaism, Los Angeles CA, April 2001
28. Autism Society Conference, Minneapolis, MI, May 2001
29. Huntington Beach School District, Huntington Beach CA, May 2001
30. Florida Department of Education, State Conference, June 2001
31. San Diego State University, San Diego CA, May 2000
32. Special Education Summer Academy, Alabama State Dept. of Education, Mobile, May 2001
33. State Dept. of Education, Council for Administrators & Special Education Autism Conference, Orlando FL, June 2001
34. Regional Center of Orange County, Orange CA, October 2001
35. Jewish Bureau of Education, Stephen S. Wise Temple, Los Angeles, CA April 2001, 2002
36. State Department of Education, Columbus IN, April 2002
37. Department of Education, Key West FL, May 2002

"Role of Normal Development in Development of Treatment Programs"

1. Autism Partnership, Seal Beach CA, July 2000 and Hong Kong, November 2000
2. Autism Partnership, Joint Conference, Long Beach CA, January 2001
3. Autism Society of America National Conference, San Diego CA, July 2001

"Diagnosis of Autism/PDD: An Update" Contemporary Forums: The Young Child with Special Needs Conference, New Orleans LA, May 2001

"Autism & Pervasive Developmental Disorders: Assessment, Differential Diagnosis & Treatment"

1. Autism Partnership, A Two-Day Workshop, Toronto Canada, October 2000
2. Professional Psych Seminars: Los Angeles, Pasadena & San Rafael CA, March-April 2001
3. Autism Partnership, Two-Day Workshop, Seal Beach CA, June 2001

"Autism & Pervasive Developmental Disorders: Assessment, Differential Diagnosis & Treatment; Professional Psych. Seminars: Emeryville, Los Angeles, Costa Mesa & Pasadena CA, Oct-Dec 2002

"Asperger's Syndrome or High Functioning Autism"
1. National University, Vista CA, February 2002
2. Autism Society of Long Beach, Long Beach CA, March 2002
3. State of Department Education, Columbus, Indiana, April 2002

Interventions for Children with Autism; Workshop, San Luis Obispo, County Education, January 2002

"Etiological Biological findings and implications for treatment in Autism Spectrum Disorder" (ASD)
1. Contemporary Forum, The Young Child with Special Needs, New Orleans, May 2001
2. Autism Partnership, Seal Beach, California, June 2001
3. Conference, Toronto, Canada, October 2001
4. Conference, University of Hong Kong, November 2001 (Invited address)
5. State Department of Education, Honolulu, Hawaii, February 2002 (Invited address)

Recent Advances in treatment on Autism; UCLA 7th Annual Review of Psychiatry and Psychopharmacology Update, October 2002

"Asperger's Syndrome and/or High Functioning Autism: An Update" UCLA 8th Annual Review of Psychiatry and Psychopharmacology Update, October 24, 2003

"Assessment and Treatment of Asperger's Syndrome"
1. Workshop, San Diego County SELPA, San Diego CA, February 2003
2. Los Angeles Department of Mental Health, Los Angeles CA, May 2003

Current Treatment for Autism; University of Hong Kong, Hong Kong, November 2002, December 2003

"History of Treatment of Autism: An Update" UCLA, Los Angeles CA, October 2002

Update on Treatment in Autism
1. Grand Rounds, Steamboat Springs Hospital, Steamboat Springs CO, March 2003
2. Conference on Developmental Disabilities, Montana State University, Billings MT, Oct. 2002

"Assessment and Treatment of Autism Spectrum Disorder (ASD)"
1. Psychopharmacology Lecture, UCLA, Los Angeles CA, October 2002
2. Bangkok Thailand, November 2002
3. San Diego County SELPA, San Diego CA, October 2003
4. Grand Rounds, UCLA, Harbor CA November 2003
5. Grand Rounds, Torrance CA, November 2003
6. University of Hong Kong, December 2003

Current Therapies for Autism Spectrum Disorder; Regional Center of Orange County, Orange CA, Oct. 2003

Current Treatment of Autism Spectrum Disorder
1. Harbor Regional Center, Torrance CA, September 2002
2. FEAT Conference, Torrance CA, June 2003
3. Autism Spectrum Therapies, Los Angeles CA, September 2003

"Autism Spectrum Disorders: Identifying Behaviors that Impact Education" San Diego County of Education Psychologists, San Diego, CA, October 2003

"Diagnosis of Autism Spectrum Disorder" Workshops for Las Virgenes Unified School District: Pre-school, Feb. 2004, Oct. 2004; School Age/ High School, November 2004

"Diagnosis of Autism Spectrum Disorder" Autism Partnership Workshops: Singapore, March 2004; Hong Kong, June 2004

"Appropriate Programs for Children with Autism Spectrum Disorders: Do the Professionals Agree?" Co-Presenter, LRP National Institute on Legal Issues of Educating Individuals with Disabilities, Orlando FL, May 2004.

"Educational Programs for Children with Autism: Do the Professionals Agree?"; Co-Presenter, LRP Annual Conference, Orlando FL, May 2004.

Asperger's Syndrome: An Update; Grand Rounds, Harbor-UCLA, September 2004, Norwalk-La Mirada School District, September 2004

"Evaluating Children With Autism: Everything a Parent Should Know" Parent Conference, UCLA, Nov 2004

CONFERENCE PRESENTATIONS/INVITED LECTURES (2005-present)

"Alternative Treatments for Autism: What is the Science?" Invited Workshop, Autism Partnership, Seal Beach, CA, January 2005

"Autism Spectrum Disorders" Workshop, Los Angeles Unified School District, Los Angeles, Feb. 2005

"Alternative Treatments for ASD: Fact or Fiction?" Invited Lecture, Contemporary Forums, Las Vegas, NV, May 2005

"Overview of Teaching Methods for Children with ASD" Autism Society of America, Los Angeles Chapter; Parent and Professional Conference; Los Angeles CA, May 2005

"Practical Strategies for Parents & Teachers" Autism Society of America, annual Parent-Professional Conference, Los Angeles CA, May 2005

"Early Detection of ASD" Invited Lecture, Contemporary Forums, Las Vegas, NV, May 2005

"Assessment and Identification of Children with Autism Spectrum Disorder"
1. Invited Lecture, California State University at Northridge (CSUN), April 2005
2. Invited Lecture, Los Angeles Unified School District, February 2006

"Impact of Autism Spectrum Disorder on Classroom Behaviors"
1. Los Alamitos Unified School District, April 2005
2. Lee University, Cleveland Tennessee, July 2005

"Autism Spectrum Disorder: What We Know" Conference: ASD in the Year 2005; Lee University, Cleveland TN, July 2005

"Early Diagnosis of Autism in Young Children: What Does the Research Tell Us?" Workshop, University of Leeds; Leeds England, Sept. 2005

"Autism Spectrum Disorder in Adults: Facilitating Independence" (Invited Address) Montana Dept. of Public Health and Human Services; Butte MT, November 2005

"Identifying Effective Treatments for Autism"
1. Manchester England, September 2005
2. University of Westminster, London England, October 2005
3. Tokyo Japan, January 2006

"Assessment and Identification of Children with Autism Spectrum Disorder" Invited Lecture: Long Beach Assoc. of School Psychologists, April 2006

"Identifying Effective Treatments for Autism" Invited speaker, Young Child with Special Needs Conference; Las Vegas NV, May 2006

"Update on Causes of ASD: Real, Suspected & Discredited"; Young Child with Special Needs Conference; Contemporary Forums, Las Vegas NV, May 2006

"Early Diagnosis of Autism" (Invited Lectures) Autism Partnership seminars: Seal Beach CA, Jan 2006; Singapore, June 2006; Hong Kong, June 2006

"Diagnosis and Treatment of Children on the Border: Asperger's Syndrome and Variants of ASD" Two-day Workshop; Autism Partnership; Singapore, June 2006

"Autism Spectrum Disorder: What is the Role of ABA Therapy?"; "Autism Spectrum Disorder in Adults: Facilitating Independence" and "Educating Children with Asperger's: What Should Be in the IEP?" Invited speaker, multiple presentations. Autism Society of Iowa, Des Moines Iowa, October 2006

"Normal Development and Diagnosis of Autism Spectrum Disorder" Staff Inservice, Las Virgenes Unified School District, Calabasas CA, September 2007

"Psychological Assessment in ASD: What Do Cognitive Tests Tell Us?" and "Diagnosis of Autism Spectrum Disorder 2007: What We Know, What We Don't Know" Invited speaker. Annual NATTAP Conference (Network of Autism Training & Technical Assistance Programs), Columbus OH, Sept. 2007

"Alternative Treatments for ASD: What is the Science?" Autism Partnership Workshop, St. Louis MO, Nov 2007

"ASD: What We Know" Panel discussion; Special Needs Network, Los Angeles CA, April 2008

"Diagnosis of Autism Spectrum Disorder: 2008"; "ASD in Adolescent & Adult Years: What to Expect" and "How to Meaningfully Integrate Children with ASD into a Typical School" Invited speaker, Autism Partnership Three-day workshop, Hong Kong. Sept 2008

"It Can Be Done: Translating Evidence Based Research into Educational Programs for Children with Autism" Invited Panel, Co-presented with Dr. Ron Leaf, Dr. Joanne Foland & Ms. Glenda McHale; annual NATTAP Conference, Columbus OH, November 2008

"Model for Training and Diagnosis of Autism Spectrum Disorders" and "Children on the Border: To Diagnose or Not to Diagnose" Invited speaker, NATTAP Conference, Columbus OH, November 2008

"Diagnosing Autism Spectrum Disorders, 2008" and "ASD Kids on the Border: When to Diagnose" Autism Partnership, Two-day seminar; December 2008

"Update on Treatment for Autism Spectrum Disorders: What We Know 2009" Long Beach Autism Society of America, Long Beach CA; April 2009

"Educating Children with Autism" - Part I: Role of Assessment & Part II: What Should Be In the IEP? Invited speaker, Los Angeles Families for Effective Treatment (L.A. FEAT), May 2009

"Diagnosis and Treatment of Milder Variants of ASD: Kids on the Border" Invited speaker, Minnesota Autism Society Parent Conference, Minneapolis MN, May 2009

"Autism Spectrum Disorders: What We Know 2010" Charles Drew University of Medicine & Science, Los Angeles CA; Mental Health Research Conference, October 2010

"Guide for Supporting Asperger's & Higher Functioning Individuals" Special Needs Network, Los Angeles CA; Parent seminar, April 2011

"Understanding My Child's Assessment: What Do Test Scores Mean?" L. A. FEAT, Hermosa Beach CA; Parent meeting, May 2011

Diagnosing Autism Spectrum Disorders/ASD 2011: What We Know" & "Educating Children with ASD: What Should Be in the IEP" Antelope Valley SELPA, Palmdale CA; Two-day Staff Inservice, May 2011

Panel Discussions: DSM-5, co-presenter with Dr. Pegeen Cronin, & Autism: Disparity in Diagnosis, California Science Center, May 2012

"Educating Children with Autism" and "Infantile Autism to Autism Spectrum Disorder: A 40-year Journey" Montgomery, Alabama Oct 2013

Autism Spectrum Disorder: Characteristics That Affect Learning in the Classroom and "Infantile Autism to Autism Spectrum Disorder: A 40-year Journey" - University of Georgia, The Bionic Educator Conference Series: Autism "Answers," Nov 2013

Autism Spectrum Disorder in 2014: An Update, Alabama CASE Spring Conference, Montgomery, AL Feb 2014

DSM-5 Panel Discussion, co-presenter with Dr. Pegeen Cronin, Tools for Transition Conference, Special Needs Network, Apr 2014

Issues in Diagnosis & Assessment of ASD, 2016, Presenter, Center for the Advancement of Behavior Analysis (CABA) Conference, Autism Partnership Foundation, Seal Beach CA, April 22, 2016.

Panel Discussion, The IEP: Best Practice for ASD; Tools for Transition Conference, Special Needs Network, Los Angeles CA, April 2017

Normal Development & Early Diagnosis; Presenter, Autism Partnership, Seal Beach CA, May 2017

Diagnosing Autism Spectrum Disorders in 2018; Presenter, Learning Rights Center, Los Angeles CA, June 2018

PUBLICATIONS

1. Meltzer, D., & Freeman, B. J. (1969) Some parameters affecting performance in fixed interval schedules. Psychonomic Science, 17, 129-131.
2. Freeman, B. J. (1971). The role of response-dependent reinforcement in the production of behavioral contrast on a multiple schedule. Learning and Motivation, 2, 138-147.
3. Meltzer, D., & Freeman, B. J. (1971) Maintenance of response summation under conditions of minimal stimulus intensity. Psychonomic Science, 22, 287-288.
4. Freeman, B. J., & Ray, O. S. (1972) Strain, sex and environmental effects on appetitive and aversive learning tasks. Developmental Psychobiology, 5, 101-109.
5. Herman, S. J., Freeman, B. J., & Ray, O. S. (1972) The effects of multiple injections of morphine sulfate on shuttle-box behavior in the rat. Psychopharmacologia, 26, 146-154
6. Freeman, B. J. (1972) Behavioral contrast: Reinforcement frequency or response suppression? Psychological Bulletin, 79, 347-356. (Theoretical treatise)
7. Freeman, B. J., & Leibowitz, J. M. (1974) Response facilitation as a function of a short timeout stimulus in a condition suppression paradigm. Psychological Reports, 35, 67-72
8. Freeman, B. J., Leibowitz, J. M., & Linseman, M. A. (1974) A study of an operant procedure: Testing auditory deficits. Mental Retardation, 12, 14-17.
9. Freeman, B. J., & Pribble, W. (1974) Elimination of inappropriate toileting behavior by over correction. Psychological Reports, 35, 802
10. Caul, W. J., Freeman, B. J., & Buchanan, D. (1975) Effects of differential rearing conditions on heart rate conditioning and response suppression. Developmental Psychobiology, 8, 63-68
11. Buchanan, D., Caul, W. J., & Freeman, B. J. (1975) Effects of differential rearing conditions on stress induced ulceration. Developmental Psychobiology, 8,
12. Freeman, B. J., Ritvo, E. R., & Miller, R. (1975) An operant procedure for teaching children to answer questions appropriately. Journal of Autism and Childhood Schizophrenia, 5, 169-196.
13. Freeman, B. J., Graham, V., & Ritvo, E. R. (1975) Reduction of self-destructive behavior by over correction. Psychological Reports, 137-446.
14. Black, M., Freeman, B. J., & Montgomery, J. (1975) The effect of four different environments on the play behavior of autistic children. Journal of Autism and Childhood Schizophrenia, 5,361-371.
15. Freeman, B. J., Roy, R. R., & Hemmick, S. (1976) Extinction of a phobia of physical examination in a 7-year-old mentally retarded boy. Behavior Research and Therapy, 16,63-64.
16. Freeman, B. J., Somerset, T., & Ritvo, E. R., (1976) Effects of long timeout durations on disruptive behavior of autistic children. Psychological Reports, 38,124-126.
17. Colman, R., Frankel, F., Ritvo, E. R., & Freeman, B. J. (1976) The effects of fluorescent and incandescent illumination upon repetitive behaviors in autistic children. Journal of Autism and Childhood Schizophrenia, 6,157-162.
18. Frankel, F., Freeman, B. J., Ritvo, E. R., Carr, E., & Chikami, B. (1976) Relationships of photic stimulation on operant behavior in autistic and retarded children. American Journal of Mental Deficiency, 6,32-40.
19. Freeman, B. J., Frankel, F., & Ritvo, E. R. (1976) The effects of response contingent vestibular stimulation on the behavior of autistic and retarded children. Journal of Autism and Childhood Schizophrenia, 6,353-358.

20. Freeman, B. J., Moss, D., Somerset, T., & Ritvo, E. R. (1977) Thumb sucking in an autistic child overcome by over correction. Journal of Behavior Therapy Experimental Psychiatry, 8, 211-212.

21. Freeman, B. J. (1977) The syndrome of autism: The problem of diagnosis in research. Journal of Pediatric Psychology, 4,142-145. (Theoretical Treatise)

22. Freeman, B. J., Ritvo, E. R., Guthrie, D., Schroth, P., & Ball, J. (1978) The behavior observation scale. Journal of the American Academy of Child Psychiatry, 17,576-588.

23. Frankel, F., Freeman, B. J., Ritvo, E. R., & Pardo, R. (1978) The effect of environmental stimulation upon the stereotyped behavior of autistic children. Journal of Autism and Childhood Schizophrenia, 4, 389-394.

24. Freeman, B. J., Guthrie, D., Ritvo, E. R., Schroth, P., Glass, R., & Frankel, F. (1979) Behavior observation scale: Preliminary analysis of the similarities and differences between autistic and mentally retarded children. Psychological Reports, 44, 519-524.

25. Needleman, R., Ritvo, E. R., & Freeman, B. J. (1980) Objective language criteria and the diagnosis of autism. Journal of Autism and Developmental Disorders, 10, 389-398.

26. Freeman, B. J., Schroth, P., Ritvo, E. R., Guthrie, D., & Wake, L. (1980) The behavior observation scale for autism (BOS): Initial results of factor analysis on 89 children. Journal of Autism and Developmental Disorders, 10, 343-346. Abstracted (1982) International and Interdisciplinary Documentation and Information on Rehabilitation Research.

27. Freeman, B. J., & Ritvo, E. R. (1980) The behavior observation scale for autism. International Journal of Rehabilitation Research, 3, 254-346.

28. Freeman, B. J., Ritvo, E. R., Schroth, P., Tonick, I., & Wake, L. (1981) Relationship of frequency of behavior to I.Q. in autistic, mentally retarded and normal children. American Journal of Psychiatry, 138. Also abstracted (1981, June) Psychiatry Digest and (1981 November) ERIC.

29. Freeman, B. J., Tonick, I., Ritvo, E. R., Guthrie, D., & Schroth, P. (1981) Behavior observation scale for autism (BOS): Analysis of behaviors among autistic, mentally retarded and normal children. Psychological Reports, 49, 199-208.

30. Freeman, B. J., & Ritvo, E. R. (1981) The syndrome of autism: A critical review of diagnostic systems and follow-up studies and the theoretical background of the behavior observation scale. In J. Gillian (Ed.), Autism: Diagnosis, instruction, management and research. Springfield, IL, Charles C. Thomas.

31. Geller, E., Ritvo, E. R., Freeman, B. J., & Yuwiler, A. (1982) Preliminary observations on the effect of fenfluramine on blood serotonin and symptoms in three autistic boys. New England Journal of Medicine, 307, 165-169.

32. Freeman, B. J., & Ritvo, E. R. (1982) The syndrome of autism: A critical review of diagnostic systems and follow-up studies and the theoretical background of the behavior observation scale. In J. Steffen & P. Karoly (Eds.), Autism and Severe Psychopathology. Lexington, MA: D. C. Heath, Co. (Theoretical treatise).

33. Freeman, B. J., & Schroth, P. (1983) The development of the behavior observation scale (BOS). Behavioral Assessment, 5, 394-405

34. Yuwiler, A., Geller, E., Boullin, D., Ritvo, E. R., Rutter, M., and Freeman, B. J. (1983) A re-examination of serotonin efflux by platelets in autism. Journal of Autism and Developmental Disorders.

35. Frankel, F., Simmons, J. Q., Freeman, B. J., & Frichter, M. (1983) Stimulus selectivity in autistic, retarded and normal children. Journal of Child Psychology and Psychiatry, 24

36. Funderburk, S. J., Carter, J., Tanguay, P., Freeman, B. J., & Westlake, J. (1983) Potential steroid hormone teratogens in autistic and schizophrenic children. Journal of Autism and Developmental Disorders, 13, 325-332.

37. Ritvo, E. R., Freeman, B. J., Geller, E., & Yuwiler, A. (1983) Effects of fenfluramine on 14 autistic outpatients. Journal of the American Academy of Child Psychiatry, 22, 549-558. Also abstracted (1984, June) Intelligence Reports in Psychiatric Disorders.

38. Ritvo, E. R., Freeman, B. J., Yuwiler, A., Geller, E., Yokota, A., Schroth, P., & Novak, P. (1984) Study of fenfluramine in outpatients with the syndrome of autism. Journal of Pediatrics, 105, 823-828.

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43. Freeman, B. J., Needleman, R., & Ritvo, E. R. (1985) Stability of language and cognitive scales in autism. Journal of the American Academy of Child Psychiatry, 24, 459-464.

44. Freeman, B.J., Lucas, J.C., Forness, S.R., Ritvo, E.R., (1985) Cognitive processing of high-functioning autistic children: Comparing the K-ABC & WISC-R. Journal of Psychoeducational Assessment: 4, 357-362. Abstracted (1986) Eric Clearinghouse, Ann Arbor, MI

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49. Ritvo, E.R., Creel, D., Crandall, A.S., Freeman, B.J., Pingree, C., Barr, R. Realmuto, G., (1986) Letters to the Editor: Retinal Pathology in autistic Children: A Possible Biological Marker for a Subtype? Journal of the American Academy of Child Psychiatry, 25, 1:l37.

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51. Ritvo, E. R., Mason-Brothers, A., Jensen, W. P., Freeman, B. J., Mo, A., Pingree, C., Petersen, P. B., & McMahon, W. M. (1987) A report of one family with four autistic siblings and four families with three autistic siblings. Journal of the American Academy of Child and Adolescent Psychiatry, 26, 339-341.

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71. Ritvo, E.R., Ritvo, R., Yuwiler, A., Brothers, A., Freeman, B.J., and Plotkin, S. (1993) Elevated daytime melatonin concentrations in Autism: A Pilot Study. European Child and Adolescent Psychiatry, 2:75-78.

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74. Kaler, Sandra R., Freeman, B J (1993) An Analysis of Environmental Deprivation: Cognitive and Social Development in Romanian Orphans. Journal of Child Psychiatry and Psychology, 35, 769-781.

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76. Freeman, B.J., Del'Homme, M., Guthrie, D. and Zang, F. (1999) Vineland Adaptive Behavior Scales scores as a function of age and initial IQ in 210 autistic children. Journal of Autism and Developmental Disorders. 29, 5:379-384

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78. McDougle, C.J., Scahill, L., McCracken J.T., Aman, M., Tierney, E., Arnold, E., Freeman, B.J., Martin, A., McGough, J.J., Cronin, P., Posey, D.J., Riddle, M.A., Ritz, L., Swiezy, N.B., Vitiello, B., Volkmar, F., Votolato, N.A. and Watson, P. (2000) Child and Adolescent Psychiatric Clinics of North America, 9:201-224.

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NON-EXPERIMENTAL ARTICLES, REVIEW ARTICLES AND BOOK CHAPTERS

1. Freeman, B. J., & Ritvo, E. R. (1976) Cognitive Assessment. In E. R. Ritvo, B. J. Freeman, E. M. Ornitz, and P. Tanguay (Eds.), Autism: Diagnosis, Current Research and Management. Holliswood, NY: Spectrum Publications.

2. Freeman, B. J., & Ritvo, E. R. (1976) Parents as Paraprofessionals. In E.R. Ritvo, B.J. Freeman, E.M. Ornitz, and P.Tanguay (Eds.), Autism: Diagnosis, Current Research and Management. Holliswood, N.Y.: Spectrum Publications.

3. Freeman, B. J. (1976) Evaluating Autistic Children. Journal of Pediatric Psychology, 1, 18-21.

4. Ritvo, E. R., & Freeman, B. J. Definition of the Syndrome of autism. Journal of Autism and Childhood Schizophrenia, 8, 162-167.

5. Ritvo, E. R., & Freeman, B. J. (1977) NSAC definition of the syndrome of autism. Journal of Pediatric Psychology, 4, 148.

6. Ritvo, E. R., & Freeman, B. J. (1978) National Society for Autistic Children definition of the syndrome of autism. Journal of American Academy of Child Psychiatry, 17, 565-675.

7. Freeman, B. J., & Ritvo, E. R. (1978) Diagnostic and evaluation systems: Helping the advocate cope with the "state of the art." In J. Budde (Ed.), Advocacy and Autism. Lawrence, Kansas: University of Kansas Press.

8. Ritvo, E. R., & Freeman, B. J. (1977) Current status of biomedical research in autism. Journal of Pediatric Psychology, 4, 149-152.

9. Freeman, B. J. (1978) Appraising children for mental retardation. Clinical Pediatrics, 17, 169-173; (1979) Reprinted in Human Growth and Development, Special Learning Corporation.

10. Freeman, B. J., & Ritvo, E. R., 1985. Assessment and treatment of specific disabilities: Autism/schizophrenia I. Invited chapter to appear in D. M. Doleys, T. B. Vaughan, & M. L. Cantrell (Eds) Assessment and treatment of developmental problems. New York: Spectrum.

11. Ritvo, E. R., Rabin, K., Yuwiler, A., Freeman, B. J., & Geller, E. (1978) Biochemical and hematologic studies of children with the syndrome of autism, childhood schizophrenia and related developmental disabilities: A critical review. In M. Rutter & Schopler (Eds.), Autism: A Reappraisal of Concepts. New York: Plenum.

12. Freeman, B. J. (1982) Diagnosing the syndrome of autism. Journal of Psychiatric Disorders and Treatment, 4, 99-105. (Selected for Category 1 medical credits).

13. Freeman, B. J., & Ritvo, E. R. (1984) The syndrome of autism: Establishing the diagnosis and principles of management. Pediatric Annals, 13, 285-295.

14. Ritvo, E. R., & Freeman, B. J. (1984) A medical model of autism: Etiology, pathology and treatment. Pediatric Annals, 13, 298-305.

15. Freeman, B.J. (1993) Diagnosis of the syndrome of autism: Update and guidelines for diagnosis. Infants and Young Children, 6, 1-12.

16. Freeman, B.J. (1994) The Syndrome of Autism: Questions Parents Ask. Autism Society of America. Reprinted (Nov 2000) Ohio State Department of Health.

17. Freeman, B.J. (1994) The Advocate Interview. The Advocate, Autism Society of America.

18. Freeman, B.J. (1995) Diagnosis of the syndrome of autism: Update and guidelines for diagnosis. Infants and Young Children, excerpted in: Caregiver Education guide for Children with Developmental Disabilities (supplement).

19. Freeman, B.J., (1997) Guidelines for evaluating intervention programs for autistic children. Journal of Autism and Developmental Disabilities, 27, 641-651. Reprinted (1998) Autism Society of America; and UCLA Pediatric Update (1998).

20. Freeman, B.J., (1998) Diagnosis of Autism: Questions Parents Ask. Caregiver Education Guide for Children with Developmental Disabilities. Gaithersberg, MD: Aspen Publications. Reprinted (1998) Pediatric Patient Education Manual. Gaithersberg, MD: Aspen Publications; and Vanderbilt University Training Manual. Reprinted (2000) Ohio Department of Health Training Manual. Reprinted (2001) Pediatric Patient Education Manual, Aspen Publications.

21. Freeman, B.J. (2001) Technology Assessment Report on Comprehensive Programs for the Treatment of Children with Autism. Exceptional Parent (Invited Article)

22. Freeman, B.J. and Cronin, P. (2000) The Autism Epidemic: Better Detection and Awareness. (Invited Article) Autism-Asperger's Digest, 1, 21-22

23. Letter to the Editor (2001). Journal of Autism and Developmental Disorders. Apr 2001, 31:2, 249-250.

24. Freeman, B.J. and Cronin, P. (2002) Diagnosing Autism Spectrum Disorders in Young Children: An Update. Infants and Young Children, 14, 1-10 (invited article)

25. Freeman, B.J., Cronin, P., Candela, P. (2002) Asperger's Syndrome or Autistic Disorder: The Diagnosis Dilemma. (Invited article) Focus on Autism and Developmental Disabilities, 17:3, 145-151.

26. Freeman, B.J., Guidelines for Evaluating Intervention Programs (checklist); Questions to Ask Regarding Specific Treatment. Original publication 1997: Journal of Autism and Developmental Disabilities, 27, 641-651. Partial reprint: Parent to Parent: Information and Inspiration for Parents, Jessica Kingsley Publishers, London England (October 2003)
27. Freeman, B.J., (2005-In Press) Alternative Treatments for ASD: Fact or Fiction? In Leaf, R., Taubman, M. and McEachin, J. (Eds), It Has To Be Said.
28. Freeman, B.J., (2005-In Press) Evaluating Treatments for ASD: Questions Parents Need to Ask. TAD
29. Freeman, B J and Van Dyke, M; (2006-In Press) Invited commentary: Are the majority of children with ASD mentally retarded?, Focus on Autism and Other Developmental Disabilities, 21: 2, 86-88.
30. Freeman, B. J., (2007) Alternative Treatments for Autism Spectrum Disorder: What is the Science? In Leaf, R.B., McEachin, J. & Taubman, M., Sense and Nonsense: It Has To Be Said. New York, NY: Different Roads to Learning.
31. Freeman, B.J., (2015) Crafting Connections: Contemporary applied behavior analysis (ABA) for enriching the social lives of persons with Autism Spectrum Disorder. By Autism Partnership: M Taubman, Ph.D., R B Leaf, Ph.D., and J McEachin, Ph.D.
32. Freeman, B.J., Cronin, P. (2017) Handbook of Social Skills and Autism Spectrum Disorders: Assessment, Curricula and Intervention. Leaf, J. (Ed); Springer Publishing, New York, NY.

BOOKS

1. Drash, P.W., & Freeman, B J. (1973) Behavior modification, behavior therapy and operant conditioning: A bibliography of books in print from 1900-1972. Baltimore: Behavioral Information and Technology.
2. Ritvo, E. R., Freeman, B. J., Ornitz, E. M., & Tanguay, P. (Eds.) (1976) Autism: Diagnosis, current research and management. Holliswood, NY: Spectrum.
3. Freeman, B. J. (Guest Ed.) Journal of Pediatric Psychology on Autism.
4. Freeman, B. J., & Ritvo, E. R. (Guest Eds.) Pediatric Annals, April 1984.

BOOK AND TEST REVIEWS

1. Freeman, B. J. (1980) Advances in clinical child psychology III. Journal of Autism and Developmental Disorders, 10, 254-257.
2. Freeman, B. J. (1985) Review of child behavior checklist [Accession number: AN 0906-2912, Buros Institute Database (Search Label MMYD)]. Bibliographic Retrieval Services, Inc. (BRS)
3. Freeman, B. J. (1985) Review of Wechsler Preschool and Primary Scale of Intelligence. [Accession number: AN 0903-0234, Buros Institute Database (Search Label MMYD)]. Bibliographic Retrieval Services, Inc. (BRS).

LICENSES AND CERTIFICATES

Licensed Psychologist, State of California PSY 4826 (October 1976 - Present)

HONORS

- Individual Achievement Award, Autism Society of America, 1990
- Professional of the Year, California Autism Society, 1996
- Professional of the Year, Villa Esperanza School (Voted by parents) March 1999
- Westside Regional Center, 2000
- Vista School District, 2000
- North County Chapter, Autism Society of America, 2000
- North Coastal Consortium for Special Education, 2001
- Autism Society of America, 2001
- Long Beach/South Bay ASA 2002
- Special Needs Network, Women of the Year – Autism Vanguard Award, 2014
- Lifetime Achievement Award, Autism Partnership, 2019

UNIVERSITY COMMITTEE SERVICE

- Quality Assurance Committee, Child Psychology and Partial Hospitalization (UCLA)
- Psychology Training Committee, From 1987 to Present (UCLA)
- Academic Senate Committee, 1988 to Present
- Dual Dissertation Committees (Co-chair of one) Department of Psychology/UCLA) 1992-Present
- Post-doctoral Research Trainee, 1993 – present (UCLA)
- Developmental Disabilities Advisory Board, UCLA, 1999-2000
- Dissertation Committees, 2005-2006 (UCLA)
- Dissertation Committee, Claremont Colleges, 2006

PROFESSIONAL SOCIETY MEMBERSHIPS

- Child Clinical Psychology Division of American Psychological Association (Charter Member)
- Society for Pediatric Psychology International Committee, National Society for Autistic Children
- Panel Professional Advisors, Autism Society of America
- American Psychological Association
- Autism Society of America

EDITORIAL BOARDS

- Associate Editor, *Focus on Autism and other Developmental Disabilities*, 2000-Present
- *Handbook of Autism and Pervasive Developmental Disorders*, 2002
- Handbook of Autism, California Department of Developmental Disabilities, 2002-present
- Autism News of Orange County, 2004 – present
- TAP Magazine (*The Autism Perspective*) 2005 - present

EDITORIAL SERVICES TO SCHOLARLY PUBLICATIONS (since last evaluation)

- Journal of Autism and Developmental Disorders (3 manuscripts)
- Journal of American Academy of Child and Adolescent Psychiatry
- Journal of Consulting and Clinical Psychology
- Analysis and Intervention in Developmental Disabilities
- Archives of General Psychiatry (2 manuscripts)

COMMUNITY SERVICE ACTIVITIES - Evaluations, Consultations, Panels

- Long Beach Society for Autistic Children
- Professional Advisory Board, Ohio Society for Autistic Children
- Los Angeles Autism Society of America (ASLA)
- Norwalk-La Mirada Unified School District
- Canyon Hills School District
- Tacoma-Washington Unified School District
- World Vision Relief and Development, ROSES Program, Romania
- Autism Society of America, Tennessee State Chapter
- Autism Society of America, Washington State Chapter
- Autism Society of America, California chapters: Los Angeles, Long Beach, San Gabriel Valley, Ventura County
- Adults with Autism, California Autism Society of America
- Calif. Regional Centers: Westside, Harbor, Orange County, Inland Counties, So. Central Los Angeles
- Consultant, Pepperdine University, School Superintendents, April 2005
- Special Needs Network, Los Angeles CA (2014, 2015)
- South Los Angeles Autism Regional Taskforce (SLAART)
- Special Needs Network, Tools for Transformation Conference, Los Angeles CA (2017)

CONSULTING ACTIVITIES

1979-1985	KCOP "Save Autistic Children Telethon"
1981-Present	California Regional Centers
1984-Present	Utah Society for Autistic Children
1992	Clark County School District, Athens, Georgia

1991/1992	World Vision Relief and Development
1991/1992	Juneau Alaska School District
1990-1996	Department of Pediatrics, University of Timisoara, Romania
2000-2001	Alabama State Department of Education
2000-2003	Autism Partnership, Hong Kong China and Bangkok Thailand
2001-2003	San Luis Obispo County Office of Education/San Luis Obispo SELPA
2001-2003	Chattanooga Unified School District, Chattanooga TN
2002/2003	Westview School, Houston TX
2003	San Diego County SELPA, CA

School District Consultations (1991-1997)

- Pasadena Unified School District
- Canyon Hills School District, Chino CA
- Anaheim Unified School District, CA
- Saddleback Unified School District, CA
- ABC Unified School District, CA
- Ladera Heights Unified School District, CA
- California School Psychologists
- Marin County School District, CA
- Riverside County School District, CA
- Hurst-Eulis School District, Bedford, Dallas, TX
- Fulton County School District, Atlanta, Georgia
- Bellflower Unified School District, CA
- Houston Unified School District, Stewart County, FL
- Los Angeles Unified School District, CA
- Santa Barbara County Schools, CA
- ABC Unified School District, CA
- Bloomington, MI School District
- South Bay School for Autism, CA

(1998- 2002)

- San Marcos School District, CA
- Vista School District CA (2001/2002),
- Long Beach School District, CA
- Saddleback School District, CA
- San Luis Obispo School District CA (2001/2002),
- Greater Anaheim SELPA, CA
- Huntsville School District, Alabama
- Monroe County School District, Key West FL (2001/2002)
- Santa Clarita School District, CA
- Las Virgenes Unified School District, CA (1998-2006)
- Los Angeles Unified School District, CA
- North Consortium for Special Education, CA
- Vista Unified School District, Vista CA (2002/2003)

(2003-2006)

- Columbia County Unified School District, Columbia GA
- Hernando County Unified School District, Hernando FL
- Newhall Unified School District, CA
- Burbank Unified School District, CA (2004)
- Newport-Mesa Unified School District, Costa Mesa CA (2004)
- Saddleback Unified School District, CA
- Norwalk-La Mirada Unified School District, CA
- Los Alamitos Unified School District, CA
- Magnolia Unified School District, CA
- Montebello Unified School District, CA

- Monroe County School District, Key West FL
- Clinton School District, Clinton TN
- Fayette County Schools, Fayetteville GA (2002-2006)
- California Association of Suburban School Districts
- Palmdale School District, CA

(2007-2016)

- Los Alamitos Unified School District, CA
- Lucia Mar Unified School District, CA
- Anderson County School District, Clinton TN
- Broward County Schools, Ft. Lauderdale FL
- Gwinnett County Schools, Lawrenceville GA
- Monroe County School District, Key West FL
- Colorado Association of School Boards (CASB), Denver CO

Grand Rounds (1992-1994)

- Long Beach Memorial Hospital
- Kaiser Mental Hospital, Kaiser Pediatrics, Whittier
- Torrance Memorial Hospital
- University of Miami, Department of Pediatrics
- UCLA-Neuropsychiatric Institute

Media Interviews

- In House Radio Interview (KMPC) (1986)
- In-House Radio Interview (KBRT) (1988)
- Larry King Live, "Autism" (1990)
- Vital Signs, UCLA - Programs Help Autistic Children Succeed, April 2000
- Los Angeles Times, March 2001
- French Consulate, May 2001
- Discovery Channel, Fires of the Mind, 2001
- KCAL News, 2001
- Fox News, May 2002
- New York Times, May 2002
- PBS, May 2002
- CBS, with Special Needs Network, August 2015
- CBS, The Doctors, April 2018

Professional Advisory Boards

1987-	Ohio Society for Autism, Professional Advisory Board
1990-	Autism Society of America, Professional Advisory Board
	Professional Advisory Board, Main Street Children's Foundation
	Professional Advisory Board, Area Board 10 for Developmental Disabilities
1994-Present	California Department of Developmental Services Advisory Board on Autism
1994-	Lattice Foundation for Handicapped Children, ASA Foundation Research
1994-Present	Blue Ribbon Panel on Autism, California Department of Developmental Services
1994	Westview School, Houston Tx
1994	South Bay School for Autism
1994	Autism Treatment Services of Canada
1994	Frank Porter Graham Developmental Disabilities Program
2003	Autism Newsletter of Orange County
2004	TAP Board of Directors
2007-Present	Special Needs Network, Los Angeles CA
2013-Present	Autism Partnership Foundation, Los Angeles CA

Health Insurance/Managed Care Lectures (1998-2000)

- FHP
- Metra Health
- Blue Cross
- PacificCare
- Managed Health Network

LEGAL CASEWORK - TESTIMONY/CONSULTATION

DC vs Coffee County Schools, 1998
GP vs Collier County Public Schools, Collier County FL, 1999
AY vs Vista Unified School District, Vista CA, 1999
Deposition, Ashbury v Missouri Department of Education, January 2000
HP vs Inland County Regional Center, San Bernardino CA, January 2000
Lucia Mar Unified School District vs JT, San Luis Obispo County Office of Education., March 2002
KY vs East Los Angeles Regional Center, Los Angeles CA, February 2000
JW vs North Los Angeles Regional Center, Los Angeles CA, March 2000
J N vs Regional Center of Orange County, Orange CA, December 2000
R vs Long Beach Unified School District, Long Beach CA, June 2001
AD vs Inland County Regional Center, San Bernardino CA, August 2001
PF vs U.S. Dept. of Immigration, 2002
BR vs Harbor Regional Center, Los Angeles CA, March 2002
NB vs Lanterman Regional Center, Los Angeles CA, July 2002
JL vs Inland County Regional Center, San Bernardino CA, September 2002
JK vs Lanterman Regional Center, Los Angeles CA, December 2002
ZD vs Chattanooga Unified School District, Chattanooga TN, January 2003
CC vs Department of Developmental Services, Los Angeles CA, February 2003
GP & DP vs Palos Verdes Unified School District, Palos Verdes CA, March 2003
VK vs Harbor Regional Center, Los Angeles CA, May 2003
CH vs U.S. Immigration Office, Los Angeles CA, June 2003
Jones vs Department of Vocational Rehabilitation, Los Angeles CA, June 2003
ZD vs Chattanooga Unified School District, Chattanooga TN, July 2003
DT vs Fayette County, September 2003
Rae vs Los Angeles County Office of Education, Los Angeles CA February, 2004
CK vs Tri-Counties Regional Center, February 2004
Las Virgenes Unified School District vs B.B., January 2004
Las Virgenes Unified School District vs S.K., March 2004
JR vs Las Virgenes Unified School District, August 2004
Las Virgenes Unified School District vs H.B., September 2004
JM & EM vs Lanterman Regional Center, September 2004
AH vs Magnolia School District, October 2004
Las Virgenes Unified School District vs SK, June 2005
PL vs Regional Center of Orange County, 2005
JM vs LVUSD, March 2006
Davis, Levin, Livingston, Grande; Honolulu HI (2006-2008)
Watanabe Ing & Komeiji, B W-B, deposition (Sept 2007)
Law Offices of Angela Gilmartin, Los Angeles CA (June 2009-2010)
Bostwick & Associates, San Francisco CA (May-June 2008)
AA v Gwinnet County Schools; Thompson & Sweeney PC, Lawrenceville GA (May 2008)
CH v Gwinnet County Schools; Thompson & Sweeney PC, Lawrenceville GA (June 2008)
TM v Gwinnet County Schools; Thompson & Sweeney PC, Lawrenceville GA (Sept 2009)
EP, KP, DP v Broward County School Board; Broward County, Fla (May 2009)
Rosen vs. Solvay Pharmaceuticals, Reed Smith LLP, (Feb. 2010)
Consumer Watchdog (Strumwasser & Woocher) vs Dept of Managed Health Care (re ABA) (Oct 2010)

JCB v Collier County School District; Stanco Robinson & Pendley, LLP, Naples FL (Oct-Dec 2010)
MH & NH v Hawaii Dept. of Education; Robbins Meyer Rufo, Honolulu HI (June 2011)
Bostwick & Associates, San Francisco CA (March 2013)
NS v Madison City Schools; Lanier Ford Shafer & Payne, Huntsville AL (July 2013)
Claypool Law Firm, Pasadena CA (Jan 2017)
EM v San Mateo County; Law Office of John D. Forsyth, San Francisco CA (July 2017)
Rodriguez & Associates, LLC, Bakersfield CA (Sept 2017-Mar 2018)
Norton & Melnick, APC, Woodland Jills CA (Jan-Jun 2018)
Tiffany Law Group, PC, Torrance CA (May/July 2018)
Learning Rights Law Center, Los Angeles CA (April-July 2018)
Schmid & Voiles, Attorneys at Law, Orange CA (2017-2019)
Bostwick & Associates, San Francisco CA (Jan-Feb 2019)

LEGAL CASEWORK – CRIMINAL TESTIMONY/CONSULTATION

Kestenbaum, Eisner & Gorrin, LLP; Los Angeles CA (2008-2009)
DR v State of California, Law Offices of Robert Bacon (2010- 2015)
BF v SLO Dept of Corrections; Maguire & Ashbaugh, San Luis Obispo CA (Jan-Sep 2012)
EV v Los Angeles County Superior Court; J Marcus, L.A. County Public Defender's Office (Aug 2012)
GW v Clark County, NV; Public Defender's Office (2015-2017)
VH v Boulder County, CO; Public Defender's Office (2016)
People v JA, Orange County Public Defender's Office, Santa Ana CA (2017-2018)
People v JP, Los Angeles County Public Defender's Office, Los Angeles CA (2017)
People v LG, Los Angeles County, Alternate Public Defender's Office, Compton Juvenile Court, CA (2017)
SO v Clark County, NV; Public Defender's Office (July 2018)
JG v Clark County, NV; Public Defender's Office (Oct 2018)
SB v Clark County, NV; Public Defender's Office (Oct-Dec 2018)
JB v Clark County, NV; Public Defender's Office (April-May 2019)

(Update May 2019)

EXHIBIT C

Schakel
Clinical Psychology Service

Drs Hildegard Schakel
Consultant Clinical Psychologist
48 Fortyacre Drive, Bredbury
Stockport SK6 2EZ
Phone 07847352412
E-mail admin@schakel.co.uk
www.schakel.co.uk

29th October 2015
Our Ref: 2015.011

Mr Max Nesbitt
Irwin Mitchel Solicitors
2 Wellington Place,
Leeds
LS1 4BZ

re: **Sam Hughes**

Please find attached Drs Schakel's report for the above.

Yours sincerely

Hildegard Schakel
Consultant Clinical Psychologist

cc: Mrs Denise Williams, 35 Park Road, Little Lever, Bolton, BL3 1DP

Report of:	Drs Hildegard Schakel
Specialism:	Consultant Clinical Psychologist
On behalf of:	Samuel Trelawney Hughes

PSYCHOLOGICAL REPORT

FOR

Appeal NHS Pension Scheme

Report dated	29th October 2015
Specialist field	Clinical Psychology
On behalf of	Samuel Trelawney Hughes
On the instruction of	Irwin Mitchell LLP 2 Wellington Place Leeds LS1 4BZ Phone: 0870 1500 100

Report of: Drs Hildegard Schakel

Specialism: Consultant Clinical Psychologist

On behalf of: Samuel Trelawney Hughes

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APPENDICES

Report of: Drs Hildegard Schakel

Specialism: Consultant Clinical Psychologist

On behalf of: Samuel Trelawney Hughes

1. INTRODUCTION

1.1. Author

1.1.1. I am Drs Hildegard Schakel. My specialist field is Clinical Psychology and I am specialised in Autism Spectrum Disorder in Adults.

1.1.2. I followed my basic training in The Netherlands (University of Utrecht and Post-Graduate training by RINO Amsterdam) and worked in the Dutch Mental Health Services in various Learning Disability and Psychiatric settings from 1976-2000. I have worked as a Clinical Psychologist in the UK since 2001 and as a Consultant Clinical Psychologist since 2002. My Dutch education translated to a Statement of Equivalence in Clinical Psychology from the British Psychological Society in 2002. I have had substantial experience with Autism Spectrum Disorder in Adults since early 1990 and I have been diagnosing Autism Spectrum Disorder in Adults since 1994. I have delivered a diagnostic service to the NHS as well as done private assessments. I have assisted the Court on multiple occasions since 2002 and have attended courses in Expert Witness skills. A more extensive Curriculum Vitae can be seen in Appendix 1.

1.2. Background Case

1.2.1. Sam Hughes has been diagnosed at the age of 6 with High Functioning Autism at the Lorna Wing Centre for Social and Communication Disorders and received a diagnosis from Lorna Wing (consultant child psychiatrist) and Judith Gould (consultant clinical psychologist).

1.2.2. His father Geraint Hughes was a pensioner of the NHS Pension Scheme until he passed away in November 2013. The NHSPS rules provide for a dependent's pension for a child who is incapable of earning a living due to permanent physical or mental infirmity.

1.2.3. Sam Hughes made an application for a dependent's pension but was rejected by the NHDPS in the basis that he with time and appropriate treatment would be able to recover sufficiently to resume study and undertake suitable employment.

The NHSPS decision focused on Sam Hughes's depression as the cause for his inability to work rather than his permanent and underlying Autism.

1.2.4. To support an appeal of the original decision a report from a medical expert with expertise in Autism Spectrum Conditions is required.

1.3. Technical Terms and Explanations

1.3.1. The new edition of the *Diagnostic Statistic Manual of Mental Disorders, edition number V* (DSM-V, American Psychiatric Association, 2013) has recently changed the criteria used for diagnosing mental health conditions. All previous diagnoses under the category Pervasive Developmental Disorders such Autism, High Functioning Autism, Asperger Syndrome, Rett's Disorder, Childhood Disintegrative Disorder and Pervasive Developmental Disorders NOS (not otherwise specified) are now called Autism Spectrum Disorder, which by clinicians usually is referred to as Autism Spectrum Condition.

1.3.2. A diagnosis of Autism Spectrum Disorder/Condition has two key features:

- Persistent deficits in social communication and social interaction across multiple contexts such as deficits in social-emotional reciprocity, deficits in non-verbal communicative behaviours for social interaction, and deficits in developing, maintaining and understanding relationships.

- Restricted, repetitive patterns of behaviour, interests or activities such as stereotyped repetitive motor movements, use of objects or speech, insistence in sameness, inflexible adherence to routines or ritualised patterns, highly restricted fixated interests that are abnormal in intensity or focus, and hyper- or hypo reactivity to sensory input or unusual interests in sensory aspect of the environments.

1.3.3. Symptoms must be present in childhood, although may not become fully manifested until social demands exceed limited capacities, or may be masked by learned strategies in later life.

1.3.4. Symptoms cause clinically significant impairment in social, occupational or other important areas of current functioning.

1.3.5. These disturbances are not better explained by intellectual disabilities or global developmental delay.

1.3.6. A diagnosis of Autism Spectrum Disorder/Condition is no indication of an ability to acquire independent living skills or of an ability to live independently. Some people with such a diagnosis are able to live independently, have significant relationships and can even have 'high-flyer' jobs, other people need 24/7 care and support. In the new edition of the DSM V when given a diagnosis of Autism Spectrum Disorder the severity levels also need to be indicated ranging from level 3 'requiring very substantial support' to level 1 'requiring support'.

1.3.7. Autism Spectrum Disorders/ Conditions are considered to be a Neuro-Psychiatric condition and a Disability.

1.3.8. Although several screening tools can be used to assess the likelihood of an Autism Spectrum Condition, it is seen as good practice under Mental Health professionals (usually clinical psychologists or psychiatrists) to use in a diagnostic assessment either the Diagnostic Interview for Social and Communication Disorders (DISCO) or a combination of the Autism Diagnostic Observation Schedule (ADOS) and a thorough developmental interview, e.g. Autism Diagnostic Interview-Revised (ADI-R). Educational Psychologists assess Autism Spectrum Disorder in schools and might use other tools, e.g. Gilliam's Asperger Disorder scale.

1.3.9. In the diagnostic process it is regarded as essential to use an informer, usually someone who knows the person well preferably from childhood, to put the information given by the person assessed in a wider perspective. If this is not possible medical or other professional records can be used as collaborative source of information.

Report of:	Drs Hildegard Schakel
Specialism:	Consultant Clinical Psychologist
On behalf of:	Samuel Trelawney Hughes

2. ISSUES

2.1. Statement of Instructions

2.1.1. I am instructed to prepare a psychological report that addresses the following issues:

2.1.1.1. What is the nature of Sam Hughes' medical condition? Please comment on the permanence and how the condition manifests itself specifically with regard to our client.

2.1.1.2. What effect has Sam Hughes' condition on his ability to carry out day-to-day activities?

2.1.1.3. What effect has Sam Hughes' condition on his ability to maintain a job? Please comment on the practical difficulties our client may have in obtaining and retaining a job.

2.1.1.4. Do you anticipate there will or could be detrimental effect on Sam Hughes' health of him obtaining a job?

2.1.1.5. Our client suffers from repeated episodes of depression. Please consider the impact of depression on Sam Hughes' condition taking into account the duration and frequency of the episodes.

2.1.1.6. Do you anticipate any long term improvements in Sam Hughes' condition?

2.1.1.7. In your opinion is Sam Hughes incapable of earning a living because of his condition?

Report of: Drs Hildegard Schakel

Specialism: Consultant Clinical Psychologist

On behalf of: Samuel Trelawney Hughes

3. PSYCHOLOGICAL ASSESSMENT

3.1. Assessment Procedure

3.1.1. I interviewed Sam Hughes in two separate interviews on 3rd August and 7th September 2015. He was accompanied by his aunt Denise Williams who I also interviewed. The interviews lasted in total around 5 hours.

3.1.2. For assessing Autism Spectrum Condition I used an adapted version of the Autism Diagnostic Observation Scale (ADOS) and an adapted version of the Autism Diagnostic Interview–Revised (ADI-R).

3.1.3. As seen as good practice Autism Spectrum assessments are conducted with an informer to put information provided in context and to get a developmental history. Sam Hughes's Aunt Denise Williams acted as such an informer.

3.1.4. For the report I consulted the information provided to me by the solicitor. I also consulted his medical records from 2006 onwards. Unfortunately there is no access to records prior to this date as the records could not be traced. For a list of the consulted documents see Appendix 2.

3.2. Relevant Developmental and Social Background Information

3.2.1. Sam Hughes was born on and he is the younger of two brothers; his brother Mark is 3½ years older than him. Both parents were GPs as were both grandparents and many of the siblings from both parents.

3.2.2. Sam Hughes's older brother Mark is married to Jemma. Both are medics by profession. Together they have a baby who was born in 2014.

3.2.3. The family lived in Cornwall where both parents worked at separate GP surgeries. Mother is retired on grounds of ill health. She suffered from severe depression since her son was diagnosed with Autism Spectrum Condition when he was 6. She became psychotic in the latter years. She had a stroke in 2011 and had heart problems. At the time of his death, father was retired as well, but still did some work as a GP.

3.2.4. Sam Hughes' father died in November 2013 at the hand of his mother who subsequently was convicted of manslaughter and admitted to a medium secure unit at St Andrews, Birmingham under the Mental Health Act.

3.2.5. Sam Hughes showed difficult behaviours from when he was little and was seen as a naughty boy. Unfortunately not many details are available about his developmental history. However, in 1995 age 6 he was assessed at the Lorna Wing Centre for Social and Communication Disorders and received a diagnosis from Lorna Wing (consultant child psychiatrist) and was further assessed by Judith Gould (consultant clinical psychologist). Wing and Gould were and still are seen as the leading experts on Autism Spectrum Conditions. Judith Gould thought at the time Sam Hughes had an IQ of 86, which puts him in the bracket of low average. However, a note of caution needs to be put in as it is currently assumed that IQ tests for Autism are inaccurate with some difficulties and IQ total scores often do not reflect the intellectual capacities of the person.

3.2.6. According to his aunt Denise the family, with the exception of his mother, did not accept the diagnosis and blamed Sam Hughes' behaviour on his mother.

3.2.7. Sam Hughes received support throughout his education and had a Teaching Assistant to help him through school. He managed to get 8 GCSEs and went to College of FE in Truro, Cornwall where he did a Higher National Diploma in IT. He obtained several distinctions. He then moved to Plymouth to study multi-media computing studies and got a degree. He lately has been following an Open University course in science, astrophysics and physics, but struggles with exams as he can't understand the questions which according to him are too open. As he currently is under a considerable amount of stress he has stopped his Open University work.

3.2.8. Sam Hughes did not have any friends when younger. His current friends he has met online when gaming and mainly is in contact with them via the internet.

3.2.9. When Sam Hughes was in his early twenties he got a job at an IT company in Crawley, West-Sussex. He left home to live in shared accommodation. When the job fell through after a couple of months in 2012 his father did not allow him back

home. This was the only job he had, apart from a temporary job at a petrol station during College, from which he was discharged quickly as he was not able to fulfil the requirements. He reported that in the jobs has done so far it became clear he struggles following instructions; when the instructions were too open he did not understand what to do; and he did not deliver within a reasonable time frame.

3.2.10. A while after the death of Sam Hughes' father his Aunt Denise got in touch with him, and became highly concerned about the state he was in. She brought him to the Manchester area to live near her. He currently lives in a purpose-build bed-sit and is supported by his aunt.

3.2.11. Sam Hughes is currently receiving Employment Support Allowance, and is seen as having limited capability for work-related activity. He has been placed into the Employment Support Allowance Support Group.

3.2.12. Sam Hughes has a passion for the USA and loves everything American. He likes visiting the USA. He recently went on a trip by himself and was supported by his aunt via daily long telephone conversations. He reported he has planned to run the New York marathon in aid of Autism and after this he will travel around in the USA together with his aunt. He has a strong belief that everything American is good, that 'there are no bad people there' and he feels accepted without any prejudice by any of the Americans.

3.2.13. Sam Hughes has joined Aspiration, a social club for people with Autism, is a keen cyclist and has joined a cycling club and is a member of the astronomical society in Bolton. He is also a keen box-game player and likes to play games such as Call of Duty or racing games.

3.2.14. Sam Hughes' independent living skills are unevenly spread. He is able to drive a car, travel to the USA and hold a talk on astronomy, but he struggles with using common sense and executing mundane tasks such as making telephone calls or sometimes even managing his self-care.

3.2.15. Sam Hughes has been accused by his uncle Derek of sending malicious emails and is involved in a court case for this. It is not sure as yet if the case will be taken to trial.

3.3. Medical and Psychiatric history

3.3.1. Sam Hughes has a long history of depression and self-harm. In his medical records the following entries with reference to suicidal ideation and self-harm are found:

3.3.1.1. Prior to 2006 he was seen by Ken Sampson, Community Psychiatric Nurse of the Child & Family Care Centre in Treliske until November 2005 for attempts to self-harm as a result of bullying. Sam Hughes reported he has been under the care of the Cornwall Child and Family Services for a period of time due to his low mood and suicidal ideation.

3.3.1.2. In December 2004 age 15 he was picked up at a bridge contemplating if he would jump or not; no further actions were required.

3.3.1.3. In February 2006 age 17 he was detained under the Section 136 of the Mental Health Act due to risk of self-harm and suspected possession of a knife and a gun and taken into Newquay Custody Suite where no offensive weapons were found on him; no further action was taken.

3.3.1.4. From November 2007 until May 2008 he was seen by the Community Mental Health Team for depression and was treated with medication. In November 2009 on referral of the Student Counselling Service when attending Plymouth University he was seen urgently by the Mental Health team due to concerns about suicidal ideation; he received some anger management training.

3.3.1.5. In March 2011 there is a referral that he was seen by the CMHT, but no further information is found in his medical records.

3.3.1.6. In Feb 2015 he was picked up by an ambulance with a stab wound in his thigh and was seen by the Mental Health liaison team; there were concerns about safeguarding; he was referred to a well-being practitioner but did not attend.

3.3.1.7. July 2015 seen at A&E after superficial self-harm cuts and referred on to Mental Health liaison team who referred to well-being practitioner, which he did not attend.

3.3.2. Sam Hughes recently has been depressed when being accused of sending malicious emails to his uncle Derek, after which he cut his wrists and ended up in hospital. According to his aunt the depressions are coming on very quickly without much warning.

3.3.3. At the time of the assessment Sam Hughes was prescribed Citalopram 20mg/daily; Mebeverine 200mg 1capsule 2x daily; and Omeprazole 20mg 2x daily.

3.4. Assessment Autism Spectrum Condition

3.4.1. For assessing Autism Spectrum Condition I used an adapted version of the Autism Diagnostic Observation Scale (ADOS) and an adapted version of the Autism Diagnostic Interview–Revised (ADI-R). I have only reported the features relevant for this court case.

3.4.2. *Reciprocal Social Interaction*

3.4.2.1. Sam Hughes' ability to regulate social interaction with eye contact, facial expressions and descriptive and expressive gestures is somewhat limited. He is able to hold eye contact, but his eye contact is somewhat intense and has a staring quality. He has little expression on his face and does not use gestures to illustrate the expressive communication nor does he use gestures when listening to others. Difficulty with regulating social interaction with expressive non-verbal communication is consistent with an Autism Spectrum Condition.

3.4.2.2. Sam Hughes has significant difficulty with reading non-verbal communication such as facial expression, body language, tone of voice and gestures. Difficulty with reading non-verbal communication is a common feature in Autism Spectrum Condition. As more than 90% of our communication is non-verbal he misses out a significant amount of communication and is prone to misinterpretations and

misunderstandings. This makes communication unpredictable and scary for him and he tries to avoid communication with others as much as possible.

3.4.2.3. Sam Hughes has significant difficulty understanding the social world. A consequence of the difficulty in understanding the non-verbal communication is that Sam Hughes struggles to pick up social cues and social rules in social situations as most of these cues and rules are expressed non-verbally. He therefore has significant difficulties understanding social situations and understanding which behaviour is expected of him. This is consistent with Autism Spectrum Condition and is seen as a key symptom in the condition.

3.4.2.4. Sam Hughes struggles to understand where other people are coming from. He has little understanding of the moods of others and he has little concept of other people's feelings. He struggles to understand emotions in others and he is unable to make sense of them; he does not understand what triggers the emotions and how they build up. This difficulty is a key feature in Autism Spectrum Condition and is related to difficulty with Theory of Mind, the ability to recognise that other people have thoughts, feelings and intentions that are different to one's own and an ability to intuitively guess what these might be.

3.4.2.1. As a consequence of the lack of Theory of Mind Sam Hughes is unable to show empathy as this concept requires an intuitive understanding of what others feel. This is consistent with Autism Spectrum Condition. He is indifferent to other people's distress and he is unable to see how his behaviour can hurt others; but when he himself is hurt by others he can lash out without thinking what it does to others or if his lashing out is in proportion to the hurt done to him.

3.4.2.2. Sam Hughes did not have friends in childhood and has only internet based friends now. He does not know how to make and maintain friendships and does not seem to understand the concept of friendships or relationships. This is consistent with Autism Spectrum Condition.

3.4.2.3. As Sam Hughes lacks Theory of Mind and is unable to put himself in the position of another, he is unable to see other people's perspective and can only contemplate his own perspectives. This is consistent with an Autism Spectrum

Condition. He is unable to make comparisons between self and others or differentiate between self and others except for clear observable objective facts. He also expects others to know about his thoughts or feelings without explanation.

3.4.2.4. Sam Hughes can work out to some extent a sequence of events on a logical level but he struggles making a sequence of social and emotional events and putting these events in a wider context. This is indicative of a difficulty with Central Coherence, the ability to bring together various details from the perception to make a meaningful whole. Difficulty with Central Coherence is a key feature of Autism Spectrum Condition. When asked about his reasoning e.g. about subjects he feels strongly about, he tends to take into account only limited factors he himself has observed, usually factors in his favour, but is unable to contemplate the bigger picture.

3.4.2.5. As a consequence of the difficulties with Central Coherence Sam experiences delayed processing of events. As he may not have been able to take in all of the information discussed or the details may become confused and mixed up, a simple activity can cause a fluctuation in ability and can leave him feeling confused and anxious. As a consequence the full effect of an event may not appear until several hours or days later at which point his anxieties are prone to rise and he is likely to become confused and highly anxious. Such experiences can result in days whereby he struggles with executing the most ordinary daily livings tasks. This is a common feature in Autism Spectrum Conditions.

3.4.2.6. Sam Hughes has difficulty with anticipating the consequences of his behaviour. This is a common feature in Autism Spectrum Condition and relates to his difficulty with Central Coherence. He has a strong external locus of control; others are misinterpreting him or others are doing things wrong and he is unable to see his role in wrong doings. He minimises the effect of his behaviour on others. This is not only linked to his lack of Central Coherence, in which he can't make sense of social and emotional events, but also to his lack of Theory of Mind, in which he can't understand where others are coming from.

3.4.2.7. Due to his difficulty in Central Coherence Sam Hughes lacks common sense and has little ability to problem-solve adequately, either in practical or in social situations. He is unable to understand the different elements and layers of a problem and therefore cannot unravel the problems to find solutions. This is a common feature in Autism Spectrum Condition.

3.4.2.8. Sam Hughes has a very limited understanding of his own emotions and has a limited ability to express his emotions adequately. He has no immediate and natural understanding of what he feels or of the build-up of his emotions and he is only able to recognise his emotions to a limited extent by what he does and not by what he feels. He lacks the ability to see the cause and effect of his emotions and has difficulty managing and containing his emotions. This is a common feature of Autism Spectrum Condition. Others struggle to pick up his emotions due to his lack of verbal and nonverbal communication about his emotions.

3.4.3. *Language and Social Communication*

3.4.3.1. Sam Hughes has a monotonous voice and uses little inflection when speaking. This is a common feature in Autism Spectrum Condition

3.4.3.2. Sam Hughes has a reasonably expressive use of language, and he gives the impression that he understands the language and the words used in the communication. However, when tested it became clear that his understanding of the meaning of the communication is limited. He tends to interpret words more literally then intended and struggles to understand metaphorical and/or more abstract language. He often uses words slightly out of sync, e.g. when talking about his mother's understanding of Autism he commented it made him feel bored. He often does not realise he has a different interpretation of the communication than others intended. He also struggles to pick up the meaning of words from the context in which they are used, causing difficulty as the same words often have different meanings when used in a different context. Difficulty with receptive language is a common feature in Autism Spectrum Condition. The combination of difficulty understanding non-verbal communication and verbal information result in Sam Hughes' understanding of language and

communication being severely hampered. These difficulties in language and communication will not be immediately obvious to others and will be causing many miscommunications and misinterpretations in daily communication. Only by explicitly asking about his understanding of specific words and concepts will one be able to detect the misunderstandings. He seems to be better when in a one-to-one situation, but struggles when he needs to communicate in a group. He also reported he struggles to talk on the phone, probably as the little non-verbal information he gets when talking face-to-face has disappeared and he has to rely on tone of voice mainly to understand the communication.

3.4.3.3. Sam Hughes struggles with answering open questions, e.g. 'what happened', or 'how do you feel today' as he would struggle knowing what answer is required. He reported he struggles with open questions for his Open University exams and will not know how to answer these questions. This is a common feature in Autism Spectrum Condition and is linked to the difficulty with Central Coherence.

3.4.3.4. Having a reciprocal conversation with Sam Hughes is difficult. He does not engage in chitchat which is used to oil the communication. When engaged in a conversation he prefers to talk about his own subjects and can be obsessive in talking about these subjects. This is a common feature in an Autism Spectrum Condition.

3.4.3.5. Sam Hughes does volunteer information, but the information lacks consistency and he needs specific questions for the listener to understand fully his account of events; he struggles giving an accurate overview of factual information and easily misses out important details. This is consistent with an Autism Spectrum Condition and is in line with his difficulty with understanding language and communication as mentioned above as well as his difficulty with Central Coherence.

3.4.3.6. Sam Hughes struggles to make sense of dos and don'ts, especially when based on emotional requests or socially acceptable behaviours. This is a common feature in an Autism Spectrum Condition. Due to his lack of Theory of Mind he struggles understanding the need for certain dos and don'ts based on emotional

requests and socially acceptable behaviours. He can only understand dos and don'ts he feels have a clear rationale behind them, which unfortunately is based only on his own interpretation, not on generally accepted rules.

3.4.3.7. Sam Hughes is often blunt in his opinions and he can give socially inappropriate or hurtful answers or comments. He does not seem to have an understanding of the extent to which words he has used can hurt others. This is a common feature in Autism Spectrum Condition. He reported he likes to speak his mind on Facebook and feels he has a right to do so, regardless of social appropriateness or other people's feelings.

3.4.4. *Lack of Social Imagination and Lack of Flexibility*

3.4.4.1. Sam Hughes is rule-based, but this applies only to his own rules. When others or society are imposing rules on him he gets upset and struggles to cope. This is a common feature in an Autism Spectrum Condition.

3.4.4.2. Sam Hughes struggles significantly with unpredictability and sudden changes he has not instigated. He gets very anxious and upset when unpredictable things are happening. This is a common feature in an Autism Spectrum Condition.

3.4.4.3. Sam is a keen cyclist with an interest in astronomy. Since early childhood Sam Hughes has shown a tendency of obsessional hobbies and behaviours. Since he was a child he has had a strong interest in astronomy. He is also is quite obsessional about anything American. Obsessional behaviours are common in Autism Spectrum Conditions.

3.4.4.4. Sam Hughes tends to think in black and white and does not have the ability to entertain nuances and grey areas. This is a common feature in Autism Spectrum Condition. He tends to overgeneralise his dislikes, e.g. he reported he hates the British and the British accents and everything American is wonderful. He is extremely rigid in his interpretations and once he has made up his mind it is difficult to get it changed.

3.4.4.5. Sam Hughes has difficulty with Executive Functioning. Executive functions consist of several mental skills that help the brain organise and act on information. These skills enable people to plan, organise, remember things, prioritise, pay attention and get started on tasks and help to use information and experiences from the past to solve current problems. Problems with Executive Functioning are a common feature in an Autism Spectrum Condition. Sam Hughes' skills are quite skewed. He can do some things well, e.g. driving a car, travelling through the USA (although he needs daily phone calls from his aunt to manage this well) and holding a talk for the astronomy society, but other skills cost him significant effort. It can take a long time to plan, prepare and initiate any task within his day to day life. He will often plan to undertake a number of tasks throughout the day and not be able to undertake them all as he has overestimated not only the time available to complete these activities but also the effects these things will have on him. When overwhelmed by other day-to-day occurrences his ability to self-care becomes minimal and sometimes non-existent. Tasks involving the outside world, such as making phone calls, or filling in forms, are very difficult for him and he needs support in this. He struggles with using common sense and his problem solving skills are minimal.

3.4.4.6. Social imagination allows us to understand and predict other people's behaviour, make sense of abstract ideas and imagine social situations outside our immediate daily routine. Lack of social imagination is a key feature of Autism Spectrum Condition. Sam Hughes struggles predicting other people's behaviour, he finds it difficult to predict consequences and is unable to imagine situations he has not encountered before. He can't get his head around the future and what will be expected of him. He consequently struggles understanding new things and new behaviours as he lacks the ability to understand what it entails; interestingly and as common in Autism Spectrum Condition unless it is his interest. When new things or behaviours are required he needs to have it spelled out in detail. E.g. his aunt reported that when he was looking at a house he might want to buy he could only think of the house with that particular furniture in and struggled imagining him living in that house with different furniture.

3.4.4.7. Sam Hughes experiences a multitude of sensory sensitivities which can have a debilitating effect on his level of functioning. His hypersensitivity can cause severe difficulty in even basic tasks such as grocery shopping. When sensory overstimulated he can become overwhelmed to the degree he can no longer function and finds the need to use his own soothing techniques such as making cat noises.

3.4.5. *Conclusions of the Autism Spectrum Condition assessment*

3.4.5.1. Sam Hughes has significant difficulty with reciprocal social interaction and with language and social communication; he has a lack of social imagination and flexibility; and he has difficulties with Executive Functioning which are indicative for an Autism Spectrum Condition. These difficulties were present from early childhood onwards and were previously called High Functioning Autism.

3.4.5.2. Autism Spectrum Condition is considered a neurological condition and is seen as a disability; one can learn to manage, but one cannot cure the condition.

3.4.5.3. Although Sam Hughes does not need support on an hourly basis, his condition affects him in such a way that he needs access to support 24 hours a day. Within DSM V classification he would score on level 1 'requiring support'. This is for situations where he is distressed and/or unable to solve a problem as it is highly unlikely that he would feel able to seek assistance or communicate his increasing anxiety, emotions or feelings.

3.4.6. *Assessment of recurrent depression*

3.4.6.1. Sam Hughes suffers from recurrent depression and self-harm. This is not uncommon in Autism Spectrum Conditions.

3.4.6.2. Sam Hughes also suffers with an almost constant high level of anxiety due to his difficulties he experiences in coping with day-to-day life and the demands of social interactions placed on him. This is quite common in Autism Spectrum Conditions.

3.4.6.3. In the medical records entries regarding Sam Hughes' depression and self-harm the underlying problem is seen as social isolation, lack of friends and no girlfriend. This is common theme in Autism Spectrum Conditions.

3.4.6.4. In all entries the suicidal ideation and self-harm was seen as insignificant and Sam Hughes was not diagnosed with a serious mental illness. This level of suicidal ideation and self-harm is usually seen as a cry for help.

3.4.6.5. Sam Hughes received counselling on many occasions, but found this only partly helpful. It appears that since adulthood up till recently he has not received any specific support for his Autism Spectrum Condition and he has not received the access to support 24 hours a day.

3.4.6.6. I consider it most likely that his recurrent suicidal ideation and self-harm behaviours should therefore be seen as a cry for help for an inability to solve whatever problem he is encountering at that time, resulting in significant levels of anxiety.

3.4.6.7. I consider it most likely that his recurrent depression stems from his Autism Spectrum Condition difficulties in meeting the demands of day-to-day life and his inability to make friends and have a girlfriend/partner.

3.5. NHS Pension Scheme Test

3.5.1. The test for a dependent's pension comes within the Regulation H1 (6) of the NHS Pension Scheme 1995 Section and is stated to be:

'a child who is incapable of earning a living because of permanent physical or mental infirmity from which he was suffering at the time the member died or from which he started to suffer whilst qualifying as a dependent child will be treated as a dependent child for so long as he remains incapable of earning a living'

4. MY OPINION

4.1. What is the nature of Sam Hughes' medical condition?

4.1.1. *Please comment on the permanence and how the condition manifests itself specifically with regard to our client.*

4.1.2. Sam Hughes has been diagnosed with Autism Spectrum Condition (High Functioning Autism) at the age of 6. From my assessment I have come to the same conclusion and therefore can confirm this diagnosis is correct.

4.1.3. Autism Spectrum Condition is considered a neurological condition and a disability; one can learn to manage, but one cannot cure the condition. It is therefore considered a life-long condition.

4.1.4. Autism Spectrum Condition is often referred to as 'the hidden handicap' as most of the features of the condition are not directly visible to the outside world. However, the condition has significant impact on understanding the social world and often leads to continuous high levels of anxiety and to depression.

4.1.5. Sam Hughes is significantly affected by this condition and has debilitating difficulties with Theory of Mind, Central Coherence, Social Imagination and Flexibility and with Executive Functioning to a level where he requires access to support 24 hours a day.

4.1.6. An Autism Spectrum Condition has a wide range of consequences and I refer to chapter 3 for the details of how this condition is affecting Sam Hughes.

4.2. What effect has his condition on his ability to carry out day-to-day activities?

4.2.1. Due to the key features of the condition, such as lack of Theory of Mind, weak Central Coherence and difficulty with Social Imagination and Flexibility Autism Spectrum Condition has a wide range of consequences in daily life ranging from lack of understanding the social world, to difficulty in understanding the communication, to difficulty managing own emotions, to difficulty in executing

daily living tasks. As the effects of the condition are so diverse, I only highlight the more obvious ones.

4.2.2. As common in Autism Spectrum Condition Sam Hughes has difficulty with Executive Functioning. It can take Sam Hughes a long time to plan, prepare and initiate any task within his day to day life. He will often plan to undertake a number of tasks throughout the day and not be able to undertake them all as he has overestimated not only the time available to complete these activities but also the effects these things will have on him. When overwhelmed by other day-to-day occurrences his ability to self-care becomes minimal and sometimes non-existent. Tasks involving the outside world, such as making phone calls, or filling in forms, are very difficult for him and he needs support in this. He struggles with using common sense and his problem solving skills are minimal.

4.2.3. As common in Autism Spectrum Condition Sam Hughes has a limited capacity to imagine situations he has not encountered before. He consequently struggles getting his head around new things and new behaviours as he lacks the ability to understand what it entails. When new things or behaviours are required he needs to have it spelled out in detail.

4.2.4. As common in Autism Spectrum Condition Sam Hughes has significant difficulties in communicating with others. Although on the surface he has a reasonably expressive use of language, and he gives the impression that he understands the language and the words used in the communication, his understanding of the meaning of the communication is limited. This is linked to his significant difficulties with interpreting the non-verbal communication resulting in his understanding of language and communication being severely hampered. These difficulties in language and communication will not be immediately obvious to others and will be causing many miscommunications and misinterpretations in daily communication. Consequently interacting with the outside world is difficult for Sam Hughes and makes him highly anxious. He needs 24 hour access to support to help him unravel the communication to avoid him getting confused, anxious and angry.

4.2.5. As common in Autism Spectrum Condition Sam Hughes experiences delayed processing of events. As he may not have been able to take in all of the information discussed or the details may become confused and mixed up, a simple activity can cause a fluctuation in ability and can leave him feeling confused and anxious. As a consequence the full effect of an event may not appear until several hours or days later at which point his anxieties are prone to rise and he is likely to become confused and highly anxious. Such experiences can result in days whereby he struggles with executing the most ordinary daily livings tasks.

4.2.6. As common in Autism Spectrum Condition Sam Hughes is often blunt in his opinions and he can give socially inappropriate or hurtful answers or comments. Due to his lack of Theory of Mind he does not have an understanding of the extent of how words he has used can hurt others. There are several examples through his life where this outspokenness gets him into trouble with the law.

4.2.7. As common in Autism Spectrum Condition Sam Hughes has a very limited understanding of his own emotions and has a limited ability to express his emotions adequately. He has no immediate and natural understanding of what he feels or of the build-up of his emotions and he is only able to recognise his emotions to a limited extent by what he does and not by what he feels. He lacks the ability to see the cause and effect of his emotions and has difficulty managing and containing his emotions. He therefore needs help in unravelling and containing his emotions, especially as he often is highly anxious.

4.2.8. As common in Autism Spectrum Condition Sam Hughes has difficulty with anticipating the consequences of his behaviour. And he needs help in realising the consequences of his behaviours and the effects they have on others.

4.3. What effect has his condition on his ability to maintain a job?

4.3.1. *Please comment on the practical difficulties our client may have in obtaining and retaining a job.*

4.3.2. Sam Hughes reported that in the jobs has done so far it became clear he struggles following instructions; when the instructions were too open he did not understand what to do; and he did not deliver within a reasonable time frame. These are limitations ae related to the Autism Spectrum Condition.

4.3.3. Sam Hughes is receiving Employment Support Allowance, and is seen as having limited to none capability for work-related activity.

4.3.4. Given his difficulties stemming from an Autism Spectrum Condition such as his limited ability to understand the social world, his difficulty in understanding the communication, his difficulty in understanding instructions, his lack of ability to problem solve, his lack of ability to understand procedures and follow them, his high levels of anxiety etc. I am of the opinion that Sam Hughes will struggle and will continue to struggle significantly in obtaining and retaining a job.

4.4. Will or could there be detrimental effect on his health when obtaining a job?

4.4.1. Sam Hughes has a long history of depression and self-harm. Analysing his medical records combined with the Autism Spectrum Condition assessment I am of the opinion that his suicidal ideation and self-harm behaviours must be interpreted as a cry for help as he is unable to manage the wide range of difficulties stemming from the Autism Spectrum Condition. He gets highly anxious when he doesn't understand something or needs to do something outside his abilities. Subsequently he gets depressed as he is unable to meet the demands of life and he is unable to form relationships.

4.4.2. Given the sheer amount of his difficulties and the level of support he needs in managing the daily demands of a job as pointed out under 4.3 having a job will cause him significant levels of distress and anxiety and consequently will make him depressed.

4.4.3. I am therefore of the opinion that when Sam Hughes has a job this will be detrimental to his mental health.

4.5. What is the impact of recurrent depression on his condition?

4.5.1. *Please consider the impact of depression on Sam Hughes' condition taking into account the duration and frequency of the episodes.*

4.5.2. Sam Hughes has a long history of depression and self-harm. Analysing his medical records combined with the Autism Spectrum Condition assessment I am of the opinion that his suicidal ideation and self-harm behaviours must be interpreted as a cry for help as he is unable to manage the wide range of difficulties stemming from the Autism Spectrum Condition. He gets highly anxious when he doesn't understand something or needs to do something outside his abilities. Subsequently he gets depressed as he is unable to meet the demands of life and he is unable to form relationships.

4.5.3. It is my opinion that the main cause of Sam Hughes' depression is the debilitating effects of the Autism Spectrum Condition. Therefore the depression should be seen as a consequence of the debilitating effects of the condition. When given the right support in the right frequency it might be his depression will be alleviated somewhat and will occur less frequent.

4.6. Are there any long term improvements anticipated in his condition?

4.6.1. An Autism Spectrum Condition is a life- long condition and seen as a disability. Although one can learn to manage, one cannot cure the condition.

4.6.2. Improvements can be seen once the right support for the Autism Spectrum Condition is in place with the right frequency. However, in my experience improvements will be in quality of life rather than an improvement in abilities and skills.

4.6.3. It is therefore my opinion that there will not be any significant long-term improvement in Sam Hughes' condition.

Report of:	Drs Hildegard Schakel
Specialism:	Consultant Clinical Psychologist
On behalf of:	Samuel Trelawney Hughes

4.7. Is he incapable of earning a living because of his condition?

4.7.1. Given Sam Hughes' difficulties stemming from an Autism Spectrum Condition such as his limited ability to understand the social world, his difficulty in understanding the communication, his difficulty in understanding instructions, his lack of ability to problem solve, his lack of ability to understand procedures and follow them, his high levels of anxiety etc. and given the fact that this condition is a life-long condition and a disability from which not much improvement in abilities and skills can be expected I am of the opinion that Sam Hughes will struggle and will continue to struggle significantly to obtain and retain a job.

4.7.2. It is therefore my opinion that Sam Hughes is incapable of earning a living because of his Autism Spectrum Condition.

5. SUMMARY OF CONCLUSIONS

5.1.1. Sam Hughes has been diagnosed with Autism Spectrum Condition (High Functioning Autism) at the age of 6. From my assessment I have come to the same conclusion and therefore can confirm this diagnosis is correct.

5.1.2. Sam Hughes is significantly affected by this condition and has debilitating difficulties with Theory of Mind, Central Coherence, Social Imagination and Flexibility and with Executive Functioning to a level where he requires access to support 24 hours a day. Due to the key features of the condition, such as lack of Theory of Mind, weak Central Coherence and difficulty with Social Imagination and Flexibility Autism Spectrum Condition has a wide range of consequences in daily life ranging from lack of understanding the social world, to difficulty in understanding the communication, to difficulty managing own emotions, to difficulty in executing daily living tasks. As the effects of the condition are so diverse, I have only highlighted the more obvious ones under 4.2.

5.1.3. Given his difficulties stemming from an Autism Spectrum Condition such as his limited ability to understand the social world, his difficulty in understanding the communication, his difficulty in understanding instructions, his lack of ability to problem solve, his lack of ability to understand procedures and follow them, his

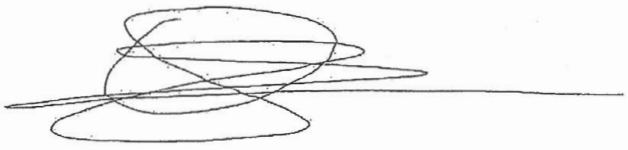
high levels of anxiety etc. I am of the opinion that Sam Hughes will struggle and will continue to struggle significantly in obtaining and retaining a job.

5.1.4. Given his sheer amount of difficulties and the level of support he needs in managing the daily demands of a job as pointed out under 4.3 having a job will cause him significant levels of distress and anxiety and consequently will make him depressed. I am therefore of the opinion that when Sam Hughes has a job this will be detrimental to his mental health.

5.1.5. It is my opinion that the main cause of Sam Hughes' depression is the debilitating effects of the Autism Spectrum Condition. Therefore the depression should be seen as a consequence of the debilitating effects of the condition. When given the right support in the right frequency it might be his depression will be alleviated somewhat and will occur less frequent.

5.1.6. An Autism Spectrum Condition is a life- long condition and seen as a disability. Although one can learn to manage, one cannot cure the condition. Improvements can be seen once the right support for the Autism Spectrum Condition is in place with the right frequency. However, in my experience improvements will be in quality of life rather than an improvement in abilities and skills. It is therefore my opinion that there will not be any significant long-term improvement in Sam Hughes' condition.

5.1.7. It is therefore my opinion that Sam Hughes is incapable of earning a living because of his Autism Spectrum Condition.

Signature 

Date: 29th October 2015

Report of: Drs Hildegard Schakel

Specialism: Consultant Clinical Psychologist

On behalf of: Samuel Trelawney Hughes

Appendices

Appendix 1 - My experience and qualifications

I am Hildegard Schakel, chartered Consultant Clinical Psychologist and accredited Cognitive Behavioural Therapist.

I received my basic training in the Netherlands (University of Utrecht and Post Graduate training RINO Noord-Holland) and worked in the Dutch Mental Health Services in various Learning Disability and Psychiatric settings from 1976-2000.

I have worked as a Clinical Psychologist in the UK since 2001 and as a Consultant Clinical Psychologist since 2002. My Dutch education translated to a Statement of Equivalence in Clinical Psychology from the British Psychological Society in 2002. I have had substantial experience with Autism Spectrum Condition in Adults since early 1990 and have been diagnosing Autism Spectrum Condition in Adults since 1994. I have undertaken assessments at the request of the NHS as well as on a private basis. I have assisted the Court on multiple occasions since 2002 and have attended courses in Expert Witness skills.

I moved to the United Kingdom in 2000 and received a Statement of Equivalence by the British Psychological Society in 2002. I am accredited by the British Association for Behavioural and Cognitive Psychotherapy since 2002 and before that an accredited member of the Dutch sister organisation (VGCT) since 1998. I am registered with the Health Professional Council.

From 2001 until 2007 I have worked in the United Kingdom for a short period as a Clinical Psychologist and since 2002 as a Consultant Clinical Psychologist, mainly in adult psychiatry. Since 2007 I run my own Clinical Psychology practice in Clinical Psychology and work mainly with Autism Spectrum Conditions.

I am specialised in severe mental illness and Autism Spectrum Condition in adults. I have assessed and treated adult clients with severe mental illness since 1985 and clients with Autism Spectrum Condition since the early nineties. My 25+ years of experience in adult Mental Health and Autism Spectrum Condition has given me a breadth of expertise and knowledge about Mental Health issues and Autism issues.

I have worked for the Court on numerous occasions since 2002 and followed training in Expert Witness skills organised by Bond Solon.

From 2006-2009 I chaired the Division of Clinical Psychology (a division of the British Psychological Society and my professional body) Conference Committee, in charge of organising the annual Clinical Psychology conference which aims at presenting the current state of the art in clinical psychology.

Until 2011 I have been the Chair of the British Association of Behavioural and Cognitive Therapy (the professional organisation for Cognitive Behavioural Therapists) Lancashire branch, which aims at delivering skill-based Cognitive Behavioural Therapy workshops in the North West region.

Report of: Drs Hildegard Schakel

Specialism: Consultant Clinical Psychologist

On behalf of: Samuel Trelawney Hughes

Appendix 2 - List of documents used

1. Instructions from Solicitor

03/08/2015	Letter (forwarded by email) to Hildegard Schakel from Max Nesbitt - Irwin Mitchell solicitors (2 pages)

2. **Medical Records** (provided by the GP surgery)

2006 onwards	Medical records

3. Miscellaneous

02/09/2004	Letter from Ken Sampson, Child Mental Health Nurse, Cornwall Child & Family Services
12/04/2015	Report from Sara Crookdake, The National Autistic Society, Development Team - North

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Attorneys for Plaintiff
UNITED STATES OF AMERICA

UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, Plaintiff, v. SAMUEL TRELAWNEY HUGHES, Defendant.	No. CR 20-332-DSF GOVERNMENT'S SENTENCING POSITION FOR DEFENDANT SAMUEL TRELAWNEY HUGHES; DECLARATION OF SABRINA FERGUSON; EXHIBITS Hearing Date: November 15, 2021 Hearing Time: 8:30 a.m. Location: Courtroom of the Hon. Dale S. Fischer

Plaintiff United States of America, by and through its counsel of record, the Acting United States Attorney for the Central District of California and Assistant United States Attorney Lauren Restrepo, hereby files its Sentencing Position for defendant Samuel Trelawney Hughes in the above-captioned case.

The Government's Sentencing Position is based upon the attached memorandum of points and authorities, the declaration of FBI Special Agent Sabrina Ferguson and accompanying exhibits, the files and

No._____

IN THE SUPREME COURT OF THE UNITED STATES

SAMUEL TRELAWNEY HUGHES,

Petitioner,

v.

UNITED STATES OF AMERICA,

Respondent.

On Petition for A Writ of *Certiorari* to The United States Court of Appeals for the Ninth Circuit

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PROOF OF SERVICE

I, David A. Schlesinger, declare that on July 24, 2023, as required by Supreme Court Rule 29, I served Petitioner Samuel Trelawney Hughes's MOTION FOR LEAVE TO PROCEED *IN FORMA PAUPERIS* and PETITION FOR A WRIT OF CERTIORARI on counsel for Respondent by depositing an envelope containing the motion and the petition in the United States mail (Priority, first-class), properly addressed to her, and with first-class postage prepaid.

The name and address of counsel for Respondent is as follows:

The Honorable Elizabeth B. Prelogar, Esq.
Solicitor General of the United States
United States Department of Justice
950 Pennsylvania Ave., N.W., Room 5614
Washington, DC 20530-0001
Counsel for Respondent

Additionally, I mailed a copy of the motion and the petition to my client, Petitioner Samuel Trelawney Hughes, by depositing an envelope containing the documents in the U.S. mail (for overseas delivery), postage prepaid, and sending it to the following address:

Samuel Trelawney Hughes
3 Pen An Vre, Treliever RD
Mabe Burnthouse
Penryn
Cornwall England
TR109DF
United Kingdom

I declare under penalty of perjury that the foregoing is true and correct.

Executed on July 24, 2023

DAVID A. SCHLESINGER
Declarant