BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of the Eligibility of: CLAIMANT, and INLAND REGIONAL CENTER, Service Agency.	OAH No. 2017090102

DECISION

Mary Agnes Matyszewski, Administrative Law Judge, Office of Administrative Hearings, State of California (OAH), heard this matter in San Bernardino, California, on October 22, 23, and 24, 2018.

Jenny Chau, Attorney, Law Offices of Hirji & Chau, represented claimant who was not present.

Aaron Abramowitz, Attorney, Enright & Ocheltree represented Inland Regional Center (IRC).

The parties' request to submit written closing arguments was granted and a briefing schedule was set. The parties' closing briefs were received, considered and made part of this administrative record. The matter was submitted on December 4, 2018.

ISSUE

Is claimant eligible for regional center services under the Lanterman Developmental Disabilities Services Act (Lanterman Act) as a result of a diagnosis of Autism Spectrum Disorder, Intellectual Disability, or a condition closely related to an

Intellectual Disability or that requires treatment similar to that required for individuals with an Intellectual Disability (the "fifth category"), which constitutes a substantial disability?

FACTUAL FINDINGS

JURISDICTIONAL MATTERS

1. Claimant, currently a 54-year-old male, sought eligibility for regional center services on the basis of autism spectrum disorder, intellectual disability, or a condition closely related to an intellectual disability or that requires treatment similar to that required for individuals with an intellectual disability (the "fifth category").

2. On August [1]8, 2017, IRC notified claimant that he was not eligible for regional center services.

3. On August 30, 2017, claimant's representative filed a fair hearing request appealing that decision and, after several continuance requests were granted, this hearing ensued.

DIAGNOSTIC CRITERIA FOR AUTISM SPECTRUM DISORDER AND INTELLECTUAL DISABILITY

4. Official notice was taken of excerpts from the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-5*). The *DSM-5* provides the diagnostic criteria used by psychologists to make diagnoses of Autism Spectrum Disorder and/or Intellectual Disability, which an individual must have to qualify for regional center services based on Autism Spectrum Disorder and/or Intellectual Disability.

Autism spectrum disorder

5. The *DSM-5* criteria for the diagnosis of Autism Spectrum Disorder include persistent deficits in social communication and social interaction across multiple contexts; restricted, repetitive patterns of behavior, interests, or activities; symptoms that are present in the early developmental period; symptoms that cause clinically significant impairment in social, occupational, or other important areas of function; and disturbances that are not better explained by intellectual disability or global developmental delay. Nothing in the *DSM-5* requires formal testing, such as an Autism Diagnostic Observation Schedule (ADOS); rather, factors indicating a person has autism spectrum disorder may be obtained "currently or by history." As noted in the *DSM-5*:

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

The *DSM-5* outlines the severity levels for autism spectrum disorder. It identifies various levels of language impairment that may be present, as well as additional neurodevelopmental, mental or behavioral conditions that should be considered.

The *DSM-5* states:

> The stage at which functional impairment becomes obvious will vary according to characteristics of the individual and his or her environment. Core diagnostic features are

evident in the developmental period, but intervention, compensation, and current supports may mask difficulties in at least some contexts. Manifestations of the disorder also vary greatly depending on the severity of the autistic condition, developmental level, and chronological age; hence, the term *spectrum*. Autism Spectrum Disorder encompasses disorders previously referred to as early infantile autism, childhood autism, Kanner's autism, high-functioning autism, atypical autism, pervasive developmental disorder not otherwise specified, childhood disintegrative disorder, and Asperger's disorder.

The impairments in communication and social interaction … are pervasive and sustained. Diagnoses are most valid and reliable when based on multiple sources of information, including clinician's observations, caregiver history, and when possible, self-report. Verbal and nonverbal deficits in social communication have varying manifestations, depending on the individual's age, intellectual level, and language ability, as well as other factors such as treatment history and current support. … **Even when formal language skills (e.g., vocabulary, grammar) are intact, the use of language for reciprocal social communication is impaired in autism spectrum disorder.**

Deficits in social-emotional reciprocity (i.e., the ability to engage with others and share thoughts and feelings) are clearly evident in young children with the disorder, **who may**

show little or no initiation of social interaction and no sharing of emotions, along with reduced or absent imitation of others' behavior. What language exists is often one-sided, lacking in social reciprocity, and used to request or label rather than to comment, share feelings, or converse. **In adults without intellectual disabilities or language delays, deficits in social-emotional reciprocity may be most apparent in difficulties processing and responding to complex social cues** (e.g., when and how to join a conversation, what not to say). Adults who have developed compensation strategies for some social challenges still struggle in novel or unsupported situations and suffer from the effort and anxiety of consciously calculating what is socially intuitive for most individuals.

Deficits in nonverbal communicative behaviors used for social interaction are manifested by absent, reduced, or atypical use of eye contact (relative to cultural norms), gestures, facial expressions, body orientation, or speech intonation. An early feature of autism spectrum disorder is impaired joint attention as manifested by a lack of pointing, showing, or bringing objects to share interests with others, or failure to follow someone's pointing or eye gaze. Individuals may learn a few functional gestures, but their repertoire is smaller than that of others, and they often fail to use expressive gestures spontaneously in communication. … **Impairment may be**

relatively subtle within individual modes (e.g., someone may have relatively good eye contact when speaking) but noticeable in poor integration eye contact, gesture, body posture, prosody, and facial expression for social communication.

Deficits in developing, maintaining, and understanding relationships should be judged against norms for age, gender, and culture. **There may be absent, reduced, or atypical social interest, manifested by** rejection of others, **passivity**, or inappropriate approaches that seem aggressive or disruptive. **These difficulties are particularly evident in young children, in whom there is often a lack of shared social play and imagination** (e.g., age-appropriate flexible pretend play) and, later, insistence on playing by very fixed rules. Older individuals may struggle to understand what behavior is considered appropriate in one situation but not another (e.g., casual behavior during a job interview), or the different ways that language may be used to communicate (e.g. irony, white lies). **There may be an apparent preference for solitary activities or for interacting with much younger or older people.** Frequently, there is a desire to establish friendships without a complete or realistic idea of what friendship entails (e.g., one-sided friendships or friendships based solely on shared special interests). **Relationships with siblings, coworkers,**

and caregivers are also important to consider (in terms of reciprocity).

Autism spectrum disorder is also defined by restricted, repetitive patterns of behavior, interests or activities … which show a range of manifestations according to age and ability, intervention, and current supports. Stereotyped or repetitive behaviors include simple motor stereotypies (e.g., hand flapping, finger flicking), repetitive use of objects (e.g., spinning coins, lining up toys), and repetitive speech (e.g., echolalia, the delayed or immediate parroting of heard words; use of "you" when referring to self; stereotyped use of words, phrases, or prosodic patterns). Excessive adherence to routines and restricted patterns of behavior may be manifest in resistance to change (e.g., a toddler strongly attached to a pan; a child preoccupied with vacuum cleaners; an adult spending hours writing up timetables). Some fascinations and routines may relate to apparent hyper- or hyporeactivity to sensory input, manifested through extreme responses to specific sounds or textures, excessive smelling or touching of objects, fascination with lights or spinning objects, and sometimes apparent indifference to pain, heat, or cold. **Extreme restriction to or rituals involving taste, smell, texture, or appearance of food or excessive food restrictions are common and may be a presenting feature of autism spectrum disorder.**

> Many adults with autism spectrum disorder without intellectual or language disabilities learn to suppress repetitive behavior in public. Special interests may be a source of pleasure and motivation and provide avenues for education and employment later in life. **Diagnostic criteria may be met when restricted, repetitive patterns of behavior, interests, or activities were clearly present during childhood or sometime in the past, even if symptoms are no longer present.**
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> (Italics in original, bold emphases added.)

Under the section titled "Associated Features Supporting Diagnosis," the *DSM-5* states:

> Many individuals with autism spectrum disorder also have intellectual impairment and/or language impairment (e.g., slow to talk, language comprehension behind production). **Even those with average or high intelligence have an uneven profile of abilities.** The gap between intellectual and adaptive functional skills is often large. Motor deficits are often present, including odd gait, clumsiness, and other abnormal motor signs (e.g., walking on tip toes). Self-injury (e.g. head banging, biting the wrist) may occur, and disruptive/challenging behaviors are more common in children and adolescents with autism spectrum disorder than other disorders, including intellectual disability. Adolescents

and adults with autism spectrum disorder are prone to anxiety and depression. (Emphasis added.)

Under this section titled, "Development and Course," the *DSM-5* states:

> The age and pattern of onset also should be noted for autism spectrum disorder. Symptoms are typically recognized during the second year of life (12-24 months of age) but may be seen earlier than 12 months if developmental delays are severe, or noted later than 24 months if symptoms are more subtle. **The pattern of onset description might include information about early developmental delays** or any losses of social or language skills. In cases where skills have been lost, **parents or caregivers may give a history** of a gradual or relatively rapid deterioration in social behaviors or language skills. …
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> **The behavioral features of autism spectrum disorder first become evident in early childhood, with some cases presenting a lack of interest in social interaction in the first year of life.** Some children with autism spectrum disorder experience developmental plateaus or regression, with a gradual or relatively rapid deterioration in social behaviors or use of language, often during the first two years of life. **Such losses are rare in other disorders and may be a useful "red flag" for autism spectrum disorder**. …

First symptoms of autism spectrum disorder frequently involve delayed language development, often accompanied by a lack of social interest or unusual social interactions (e.g., pulling individuals by the hand without any attempt to look at them), odd play patterns (e.g. carrying toys around but never playing with them), and unusual communication patterns (e.g., knowing the alphabet but not responding to own name). **Deafness may be suspected but is typically ruled out.** During the second year, odd and repetitive behaviors and the absence of typical play become more apparent. Since many typically developing young children have strong preferences and enjoy repetition (e.g., eating the same foods, watching the same video multiple times), distinguishing restricted and repetitive behaviors that are diagnostic of autism spectrum disorder can be difficult in preschoolers. The clinical distinction is based on the type, frequency, and intensity of the behavior (e.g., a child daily lines up objects for hours and is very distressed if any item is moved).

Autism spectrum disorder is not a degenerative disorder, and it is typical for learning and compensation to continue throughout life. Symptoms are often most marked in early childhood and early school years, with developmental gains typical in later childhood in at least some areas (e.g., increased interest in social interaction). A small proportion of individuals deteriorate behaviorally

during adolescence, whereas most others improve. **Only a minority of individuals with autism spectrum disorder live and work independently in adulthood**, those who do tend to have superior language and intellectual abilities and are able to find a niche that matches their special interests and skills. In general, individuals with lower levels of impairment may be better able to function independently. However, even those individuals may remain socially naïve and vulnerable, have difficulties organizing practical demands without aid, and are prone to anxiety and depression. Many adults report using compensation strategies and coping mechanisms to mask their difficulties in public but suffer from the stress and effort of maintaining a socially acceptable facade. **Scarcely anything is known about old age in autism spectrum disorder.**

Some individuals come for first diagnosis in adulthood, perhaps prompted by the diagnosis of autism in a child in the family or a breakdown of relations at work or home. **Obtaining detailed developmental history in such cases may be difficult, and it is important to consider self-reported difficulties. Where clinical observations suggest criteria are currently met, autism spectrum disorder may be diagnosed**, provided there is no evidence of good social and communication skills in childhood. For example, the report (by parents or another relative) that the individual had ordinary and sustained reciprocal friendships

and good nonverbal communication skills throughout childhood would rule out a diagnosis of autism spectrum disorder; **however, the absence of developmental information in itself should not do so.**

Manifestations of the social and communication impairments and restricted/repetitive behaviors that define autism spectrum disorder are clear in the developmental period. **In later life, intervention or compensation, as well as current supports, may mask these difficulties in at least some contexts.** However, symptoms remain sufficient to cause current impairment in social, occupational, or other important areas of functioning.

(Emphases added.)

In the section titled, "Functional Consequences of Autism Spectrum Disorder," the *DSM-5* notes: "Many individuals with autism spectrum disorder, even without intellectual disability, have poor adult psychosocial functioning as indexed by measures such as independent living and gainful employment. Functional consequences in old age are unknown, but social isolation and communication problems (e.g., reduced help-seeking) are likely to have consequences for health in older adulthood."

Intellectual disability

6. The *DSM-5* provides three diagnostic criteria which must be met to support a diagnosis of Intellectual Disability: deficits in intellectual functions (such as reasoning, problem solving, abstract learning and thinking, judgment, and learning from experience) "confirmed by both clinical assessment and individualized standardized

intelligence testing"; deficits in adaptive functioning "that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility"; and the onset of these deficits during the developmental period. Intellectual functioning is typically measured using intelligence tests. The *DSM-5* states, "[i]ndividuals with intellectual disability have scores of approximately two standard deviations or more below the population mean, including a margin for measurement error (generally +5 points). On tests with a standard deviation of 15 and a mean of 100, this involves a score of 65-75 (70 ± 5). Clinical training and judgment are required to interpret test results and assess intellectual performance."

Under the heading, "Diagnostic Features," the *DSM-5* states:

> The essential features of intellectual disability (intellectual developmental disorder) are deficits in general mental abilities … and impairment in every day adaptive functioning, in comparison to an individual's age-, gender-, and socioculturally matched peers … onset is during the developmental period . … The diagnosis of intellectual disability is based on both clinical assessment and standardized testing of intellectual and adaptive functions.
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> [¶] … [¶]
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> Factors that may affect test scores include practice effects and the "Flynn effect" (i.e., overly high scores due to out-of-date test norms). **Invalid scores may result from the use of brief intelligence screening tests** or group tests; highly discrepant individual subtest scores may make an overall IQ score invalid. … Co-occurring disorders that affect

communication, language, and/or motor or sensory function may affect test scores. **Individual cognitive profiles based on neuropsychological testing are more useful for understanding intellectual abilities than a single IQ score.** Such testing may identify areas of relative strengths and weaknesses, and assessment important for academic and vocational planning.

IQ test scores are approximations of conceptual functioning but may be insufficient to assess reasoning in real-life situations and mastery of practical tasks. For example, **a person with an IQ score above 70 may have such severe adaptive behavior problems in social judgment, social understanding, and other areas of adaptive functioning that the person's actual functioning is comparable to that of individuals with a lower IQ score**. Thus, clinical judgment is needed in interpreting the results of IQ tests.

Deficits in adaptive functioning … refer to how well a person meets community standards of personal independence and social responsibility, in comparison to others of similar age and socio-cultural background. Adaptive functioning involves adaptive reasoning in three domains: conceptual, social, and practical. The *conceptual (academic) domain* involves competence in memory, language, reading, writing, math reasoning, acquisition of practical knowledge, problem solving, and judgment in novel

situations, among others. The *social domain* involves awareness of others' thoughts, feelings, and experiences; empathy; interpersonal communication skills; friendship abilities; and social judgment, among others. The *practical domain* involves learning and self-management across life settings, including personal care, job responsibilities, money management, recreation, self-management of behavior, and school and work task organization, among others. Intellectual capacity, education, motivation, socialization, personality features, vocational opportunity, culture experience, and coexisting general medical conditions or mental disorders influence adaptive functioning.

Adaptive functioning is assessed using both clinical evaluation and individualized, culturally appropriate, psychometrically sound measures. **Standardized measures are used with knowledgeable informants (e.g., parent or other family member; teachers; counselor; care provider)** and the individual to the extent possible. Additional sources of information include educational, developmental, medical, and mental health evaluations. Scores from standardized measures and interview sources must be interpreted using clinical judgment. When standardized testing is difficult or impossible, because of a variety of factors (e.g., sensory impairment, severe problem behavior), the individual may be diagnosed with unspecified intellectual disability. **Adaptive functioning may be difficult to assess in a controlled**

setting (e.g., prisons, detention centers); **if possible, corroborative information reflecting functioning outside those settings should be obtained.**

[Deficits in adaptive functioning criterion] are met when at least one domain of adaptive functioning - conceptual, social, or practical - is sufficiently impaired that ongoing support is needed in order for the person to perform adequately in one or more life settings at school, at work, at home, or in the community. … onset during the developmental period, refers to recognition that intellectual and adaptive deficits are present during childhood or adolescence.

(Emphases added.)

The *DSM-5* section titled, "Development and Course," states:

Onset of intellectual disability is in the developmental period. The age and characteristic features at onset depend on the etiology and severity of brain dysfunction. Delayed motor, language, and social milestones may be identifiable within the first 2 years of life among those with more severe intellectual disability, while mild levels may not be identifiable until school age when difficulty with academic learning becomes apparent. All criteria … must be fulfilled **by history or current presentation**. …

In acquired forms, the onset may be abrupt following an illness such as meningitis or encephalitis or head trauma occurring during the developmental period. When intellectual disability results from a loss of previously acquired cognitive skills, as in severe traumatic brain injury, the diagnosis of intellectual disability and of a neurocognitive disorder may both be assigned. …

After early childhood, the disorder is generally lifelong, although severity levels may change over time. The course may be influenced by underlying medical or genetic conditions and co-occurring conditions (e.g., hearing or visual impairments, epilepsy). **Early and ongoing interventions may improve adaptive functioning throughout childhood and adulthood**… For older children and adults, the extent of support provided may allow for full participation in all activities of daily living and improved adaptive function. **Diagnostic assessments must determine whether improved adaptive skills are the result of a stable, generalized new skill acquisition** (in which case the diagnosis of intellectual disability may no longer be appropriate) **or whether the improvement is contingent on the presence of supports and ongoing interventions** (in which case the diagnosis of intellectual disability may still be appropriate).

(Emphases added.)

In the "Differential Diagnosis" section, the *DSM-5* notes:

> Intellectual disability is common among individuals with autism spectrum disorder. Assessment of intellectual ability may be complicated by social-communication and behavior deficits inherent to autism spectrum disorder, which may interfere with understanding and complying with test procedures. **Appropriate assessment of intellectual functioning in autism spectrum disorder is essential**, with reassessment across the developmental period, because **IQ scores in autism spectrum disorder may be unstable**, particularly in early childhood. (Emphases added.)

The "Comorbidity" section in the *DSM-5* cautions that: "**Assessment procedures may require modifications because of** associated disorders, including communication disorders, **autism spectrum disorder**, and motor, sensory, or other disorders. **Knowledgeable informants are essential** for identifying symptoms such as irritability, mood dysregulation, aggression, eating problems, and sleep problems, and for assessing adaptive functioning in various community settings." Further, "[t]he most common co-occurring mental and neurodevelopmental disorders are … autism spectrum disorder … (Emphases added.)

FIFTH CATEGORY

7. Under the "fifth category" the Lanterman Act provides assistance to individuals with "disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability" but does not provide services for "other handicapping conditions that are

solely physical in nature."[1] Along with the other four qualifying conditions (cerebral palsy, epilepsy, autism spectrum disorder, and intellectual disability), a disability involving the fifth category must originate before an individual attains18 years of age, must continue or be expected to continue indefinitely, and must constitute a substantial disability.

The fifth category is not defined in the DSM-5. In *Mason v. Office of Administrative Hearings* (2001) 89 CalApp.4th 1119, 1129, the court held that the fifth category was not unconstitutionally vague and set down a general standard: "The fifth category condition must be very similar to mental retardation,[2] with many of the same, or close to the same, factors required in classifying a person as mentally retarded. Furthermore, the various additional factors required in designating an individual developmentally disabled and substantially handicapped must apply as well."

On March 16, 2002, in response to the *Mason* case, the Association of Regional Center Agencies (ARCA) approved the *Guidelines for Determining 5th Category Eligibility for the California Regional Centers* (ARCA Guidelines).[3] In those ARCA Guidelines, ARCA noted that eligibility for Regional Center services under the fifth

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[1] Welfare and Institutions Code section 4512, subdivision (a).

[2] The DSM-5 uses the term "intellectual disability," the condition previously referred to as "mental retardation." The Mason case was decided when the term mental retardation was in use and contains that term in its decision. For clarity, that term will be used when citing to that holding.

[3] The ARCA guidelines have not gone through the formal scrutiny required to become a regulation, were written before the DSM-5 was in effect, and are not given the same weight as regulations.

category required a "determination as to whether an individual functions in a manner that is similar to that of a person with mental retardation **OR** requires treatment similar to that required by individuals with mental retardation." (Emphasis in original.) The ARCA Guidelines stated that *Mason* clarified that the Legislative intent was to defer to the professionals of the Regional Center Eligibility Team to make the decision on eligibility after considering information obtained through the assessment process. The ARCA Guidelines listed the factors to be considered when determining eligibility under the fifth category.

Another appellate decision, *Samantha C. v. State Department of Developmental Services* (2010) 185 Cal.App.4th 1462, has suggested that when considering whether an individual is eligible for regional center services under the fifth category, that eligibility may be based largely on the established need for treatment similar to that provided for individuals with mental retardation, and notwithstanding an individual's relatively high level of intellectual functioning. In *Samantha C.*, the individual applying for regional center services did not meet the criteria for mental retardation. Her cognitive test results scored her above average in the areas of abstract reasoning and conceptual development and she had good scores in vocabulary and comprehension. She did perform poorly on subtests involving working memory and processing speed, but her scores were still higher than persons with mental retardation. The court noted that the ARCA Guidelines recommended consideration of the fifth category for those individuals whose "general intellectual functioning is in the low borderline range of intelligence (I.Q. scores ranging from 70-74)." (*Id.* at p. 1477.) However, the court confirmed that individuals may qualify for regional center services under the fifth category on either of two independent bases, with one basis requiring only that an individual require treatment similar to that required for individuals with mental retardation.

AUTISTIC SPECTRUM DISORDERS: BEST PRACTICE GUIDELINES

8. Claimant submitted the California Department of Developmental Services's (DDS), 2002 *Autism Spectrum Disorders: Best Practice Guidelines for Screening, Diagnosis and Assessment(Guidelines).* Claimant submitted these *Guidelines* to show that IRC failed to follow recognized best practices when evaluating claimant for regional center services. At the time these *Guidelines* were created, the *DSM-IV-TR* was the current version of the *DSM* in use. The Preface indicated that the goal of the *Guidelines* was to "provide a consistent and comprehensive base of information for screening, evaluation and assessment of persons with autism spectrum disorders (ASD)." These *Guidelines* noted that DDS had documented a steady increase in the number of individuals diagnosed with autism spectrum disorders since 1995. This continuing increase caused DDS to launch "an Autistic Spectrum Disorder Initiative" with the following goals: "to establish policy and best practice in assessment and intervention, and to establish public and private partnerships to address the needs of persons with ASD." The Preface further noted:

> The California State Legislature gave direction for developing evaluation guidelines in August 2001. Responding to the 1999 report from DDS and to concerns of parents and the professional community, the Legislature passed Assembly Bill 430, acknowledging the need for "the same diagnostic tools and Öthe same diagnostic methods … to ensure consistency and accuracy of diagnosis of autism disorder and other pervasive developmental disorders throughout California."
>
> Finally, several national consensus panels have published evidence-based guidelines for screening, diagnosis and

> assessment of ASD. These Guidelines are intended to provide professionals, policymakers, parents and other stakeholders with recommendations based on published research, clinical experience and judgment available about "best practice" for screening, evaluating and assessing persons suspected of having ASD. The DDS expects that the Guidelines will increase education and awareness of ASD among the public and policy-makers and provide a basis for training to achieve the high quality clinical screening and diagnostic skills anticipated.

The *Guidelines* "provide recommendations, guidance and information about current 'best practice' in the field" and offer evidence-based recommendations. They were designed as a tool to help make informed decisions regarding identification, diagnosis and assessment of ASD. The *Guidelines* discussed the importance of early intervention and that accurate identification of individuals with ASD is entirely dependent on clinical competencies because there is no single biomedical marker, laboratory test or procedure for identifying individuals with ASD. The *Guidelines* specifically state: "Although identification of an ASD is usually made during childhood, **it is important to recognize that ASD is a lifelong disability** that compromises the individual's adaptive functioning from childhood through adulthood to variable extents, and requires different forms of intervention throughout the lifespan. (Page 5, emphasis added.) "**There should be collaboration between all interested parties and providers and interdisciplinary process. More importantly, the evaluation process must be family-centered and culturally sensitive."** (Page 6, emphasis added.) "Further, because of rapid developments in conceptualization, measurement and basic research on ASD, a commitment to periodic review of current best practices is required

and it is essential to stay current with new methods of evaluation and treatment, learn about and obtain the latest screening tools, and be aware of local and regional community resources." (Page 7.)

The *Guidelines* are divided into two sections, one for evaluating individuals from birth through age 5 and one for evaluating individuals age 6 and older. The *Guidelines* notes that diagnosing ASD in older individuals present unique challenges and there are many reasons for delays in diagnosis. "The older individuals suspected of ASD will require a more in-depth investigation and typically requires straightforward access to a specialist clinical team. Regional centers and other ASD evaluation clinics offer the clinical expertise needed to evaluate complex cases presented by older individuals." (Page 78.) "The complexity and variation in presentation of older individuals requires a coordinated team approach. It is important to investigate why the individual presented at a late age." (Page 79.) "**An accurate and detailed developmental and family history is crucial for older individuals, particularly those who were unlikely to have had prior evaluations.** As parents recall becomes weaker as children age, it is essential to include corroborating sources of information collated with current observations and other sources of information." (Pages 80-81, emphasis added.) "The collation and integration of multiple sources of information strengthens the reliability of the diagnosis." (Page 81.)

Evaluation and assessment procedures for older individuals "should begin to juxtapose the skills demonstrated with their ability to be useful in daily living and functional domains. **Children with ASD often may have considerable strengths in specific areas (i.e., rote memorization, labeling), but be unable to use these abilities in more functional and socially appropriate ways.**" (Page 83, emphasis added.) "Older individuals presenting for evaluation may have been overlooked and tend to be children who function toward the higher end of the spectrum." (Page 85.)

"Higher functioning individuals may also not have been identified and their poor cognitive functioning and social features only appear as they age." (Pages 85-86.) "Often the failure to develop friendships is a referring factor and should be carefully reviewed." (Page 86.) "There may be family considerations for why the individual was not identified or referred earlier." (Page 86.)

"Autism spectrum disorders are associated with a tremendous range in syndrome expression, meaning the symptoms change over the course of development and in relation to the degree of any associated mental handicap." (Page 90.) "Establishing an early developmental history is more challenging as the age of the individual increases. As a result, records and multiple sources of data become more important." (Page 90.) "**Interviews with family members and caregivers and collaboration with service providers, schools and other healthcare entities is a necessary component of the diagnostic process."** (Page 90, emphasis added.)

The *Guidelines* identified the primary components for the diagnostic evaluation of older individuals and provided that the primary best practice components for diagnostic evaluation of older individuals include: record review; medical evaluation; parent/caregiver interview; direct child evaluation - interview and observation; psychological evaluation - cognitive assessment, adaptive functioning assessment, and mental health assessment/site pediatric functioning; communication assessment; evaluation social competence and functioning; restricted behaviors, interests and activities; and family functioning. (Page 91.) "The focus of record review is more to examine past descriptions of behavior rather than diagnostic conclusions." (Page 92.) "The family medical/mental health history should be thoroughly explored as the presence of learning problems may indicate the possibility of undiagnosed conditions such as mild intellectual disability." (Page 93.) "A complete physical and neurological

exam should be completed which should include an expanded medical and neurological evaluation to rule out other medical conditions." (Page 93.)

"A comprehensive developmental history, generally in the form of a parent or caregiver interview, is the cornerstone of the diagnostic evaluation process. Adequate and reliable historical information facilitates the process of diagnostic evaluation and differential diagnosis. Traditionally, the parent/caregiver interview has served as the source for historical information. Securing the sequence of developmentally appropriate behaviors is also important. The parent interview should also include a careful review of medical and family history." (Page 94.) "These interviews pose challenges to the clinician because memories fade and the tremendous range of syndrome expression and symptoms of "higher functioning" individuals are further complicated by these fading memories." (Pages 94-95.) "Because of these issues, a method for increasing reliability is to also interview other caregivers such as a teacher or close family friend." (Page 95.) "Further, while parents typically have the utmost knowledge of the individual, they also often have the highest degree of adaptation to their child's condition. Compensation for subtle or more pronounced child deficits may not be apparent." (Page 95.) "Additional issues arise if parents reframe concerns in terms of their own experience or that of relatives or friends which is particularly likely if personal projections are less disturbing than an alternative conceptualization." (Page 95.)

"Individuals with ASD can vary widely in terms of cognitive functioning." (Page 99.) The *Guidelines* provide a list of recommended standardized tests and note that "the Wechsler tests are preferred for higher-functioning and older individuals with relatively good verbal language." (Pages 100-101.) Of note, the Kaufman Brief Intelligence Test administered by Paul Greenwald, Ph.D., a staff psychologist at IRC, is not on the list. "Examination of subtest scores may reveal relative strength in recalling rote information and significant deficits in sequencing social stimuli and demonstrating social judgment.

Findings of a normal IQ in light of extreme scatter among scores and regression to the mean should be interpreted with caution and may not be indicative of adequate skills for everyday situations." (Page 101.)

The section discussing adaptive functioning notes that "many higher functioning individuals with autism, all scoring in the normal range on IQ tests, are functionally impaired in that they are unable to generalize or demonstrate their abilities in daily situations." (Page 102.) "A diagnosis of mental retardation[4] requires deficits in adaptive functioning in addition to intellectual impairment." (Page 102.) "Higher-functioning individuals demonstrate wide discrepancies and often with ASD, social and communication domains are significantly below estimated cognitive potential which appears to be more marked in children of higher ability." (Page 102.) Suggested adaptive behavior scales to evaluate adaptive functioning were identified in the G*uidelines* and included the Vineland, as well as other tests; the SSSQ Dr. Greenwald administered was not on the list of suggested adaptive behavior scales. "In summary, a thorough evaluation of adaptive skills is necessary for purposes of diagnosis and intervention planning. Particularly with higher-functioning individuals, large discrepancies between cognitive performance and adaptive behavior indicate immediate targets for intervention and changes in instructional strategies." (Page 102.)

ARTICLE REGARDING THE MISUSE OF THE SSSQ DURING EVALUATIONS

9. Claimant also submitted an article written by George C. Denkowski, Ph.D., Clinical Psychologist, and Kathryn M. Denkowski, Ed.D., Psychologist, titled, "*Misuse of the Street Survival Skills Questionnaire (SSSQ) for Evaluating the Adult Adaptive Behavior of Criminal Defendants With Intellectual Disability Claims*," April 2008, published in the American Association on Intellectual and Developmental Disabilities,

[4] The Guidelines use the former term mental retardation.

volume 46, number 2, page 144-149, a peer-reviewed journal. In this article, the authors discussed the SSSQ, a measure Dr. Greenwald used during his IRC assessment of claimant. The authors noted that one of the instruments used for evaluating adaptive behavior has been the SSSQ and they wanted to "clarify why the SSSQ should not be used to establish the adult adaptive behavior of criminal offenders who have filed a claim of intellectual disability."

They stated that the SSSQ "was not designed for determining whether a person's adaptive behavior is adequate or deficient for the purpose of diagnosing intellectual disability." Instead, it "was specifically constructed for a developmentally disabled population" and created to be used "as part of … an approach for evaluating the functional strengths and weaknesses of 'the mentally disabled.'" As the authors noted:

> [The SSSQ] was formulated to assess nine 'components,' or skill areas: basic concepts, functional signs, tools, domestics, health and safety, public services, time, monetary, and measurements. It is clear from these descriptors that this instrument gauges a narrow slice of overall adaptive behavior because it does not address areas such as self-care, self-direction, use of leisure time, or social skills. Instead, because a critical purpose of [the SSSQ creators'] evaluation is discerning readiness of persons with intellectual disabilities for community-based employment, the SSSQ concentrates on measuring skills that constitute the practical dimension of the [American Association on Mental Retardation 2002] manual's … conception of adaptive behavior. On the basis of their SSSQ scores, clients are classified in terms of functional levels to permit more informed decisions about living and

> habilitation requirements in their readiness for the normalizing experience of community employment. As explained by [the SSSQ creators], the SSSQ to was intended for four applications: '(1) classification with respect to mental retardation [level], (2) vocational program placement, (3) residential program placement, and (4) training strategies.' (Page 144.)

The authors reviewed the "norming" of the SSSQ, noting that "this test was not normed on adults, and the cited reliability and validity data were derived from the scores of the standardization group of persons with developmental disabilities." Therefore, "because the SSSQ's 'normal/average adults' norms were not derived from either normal or average adults, much less on a sufficient and representative number of them, its use to establish any aspect of the adaptive behavior of adults who have not already been diagnosed as being developmentally disabled is contraindicated." (Page 145.) The SSSQ "manual presents neither reliability coefficients nor measurement error for the 'normal/average adults' group, and there appeared to exist no published data indicating that SSSQ scores are valid indexes of general adaptive behavior." (Page 145.) Because reliability scores produced by "normal/average adults" is unknown, the SSSQ scores of persons not diagnosed as being developmentally disabled are unreliable. (Page 146.)

The SSSQ manual shows only that the scores produced by persons who are developmentally disabled were useful for various habilitation purposes but "did not correlate significantly with their scores on the self-help, socialization, or even occupation scales of" broader adaptive behavior measures. Thus, examiners have "expressed concerns about the SSSQ's validity as a measure of overall adaptive behavior and advised they be used only in conjunction with more comprehensive instruments." (Page

146.) Furthermore, a 1994 study "found no significant" "relationship between the SSSQ and the Vineland Adaptive Behavior Scales'" "total scores in a group of youths with developmental disabilities. Since that time, **it has come to be generally accepted that the SSSQ is not a measure of overall adaptive behavior** and that it is best suited for its designed use, predicting 'entry or retention of competitive, gainful employment among people with mental retardation.'" (Page 146, emphasis added.)

The authors reviewed studies that tried to portray the SSSQ as an appropriate diagnostic tool. They noted that one study merely classified mentally disabled individuals and did not address whether "the SSSQ discerned adaptive behavior deficits as well as [other adaptive behavior scales] or whether the SSSQ can assess accurately the adaptive behavior of adults who are not disabled. Moreover, [the authors of that study] concluded that the SSSQ provides a 'measure of specific adaptive behavior,' not a comprehensive assessment." (Page 146.) The authors also reviewed claims that the SSSQ was comparable to the Vineland, noting that the studies "pointed out that 'none of the [SSSQ] questionnaire content covers social skills, moral understanding, or interpersonal relationships' and likewise advised against using the SSSQ as the sole assessment instrument, even with individuals who are intellectually disabled." (Page 146.)

The authors found that "there do not appear to be any published data that establish that the SSSQ validly measures any aspect of adaptive behavior of adults who are not intellectually disabled. Even with persons who are intellectually disabled, those who have researched [the SSSQ], including its developers, have found that it assesses a narrow group of behaviors of a select segment of the population, so that the test's total score is not a valid index of anyone's overall adaptive behavior." (Pages 146-147.) The authors further noted that because "the SSSQ was designed for persons who are severely to mildly mentally disabled, it is an 'easy' test that 'has little or nothing to do with adapting to real world environments or tasks.'" (Page 147.)

The authors further reviewed the reliability of the scores among the populations. They noted the "ceiling effect" that occurred because individuals who excelled on the SSSQ could not score higher as the test did not allow it. This effect, because the standard deviation was not significantly different between populations, causes persons with mild mental retardation to produce total SSSQ scores that are not meaningfully lower than those of normal/average adults. "As a result, the SSSQ is unlikely to discern significant deficits in adaptive behavior among" individuals "who are mentally retarded and will misclassify many or most as possessing adequate adaptive behavior." (Page 147.)

The authors concluded by noting that the American Psychological Association (APA) established guidelines for "competent and responsible" use of tests. The authors concluded that given those APA guidelines:

> Use of the SSSQ to establish adult adaptive behavior … disregards psychometric standards that the psychological testing community considers to be critical. **The SSSQ was designed to assess prevocational skills of persons who are developmentally disabled, not the adaptive behavior of those being evaluated for the possibility of developmental disabilities.** Norming with a representative adults [sic] who are not disabled was never conducted. Reliability of the SSSQ scores of persons who are not mentally disabled is unknown. A pronounced ceiling effect makes it virtually impossible to discriminate persons who function at the higher levels of developmental disability from those who are not disabled. Moreover, this instrument has not been shown to be a valid measure of overall adaptive

behavior, even for persons who are developmentally disabled. (Page 147, emphasis added.)

The authors further found that the SSSQ's shortcomings illustrate why others have warned that "no instrument can adequately serve all measurement purposes. The SSSQ was designed for persons with 'severe neurological disabilities.' To be applicable to that population, its difficulty had to be adjusted to an ability level that accommodates those with IQs in the 20s and 30s. As a result, the SSSQ was an easy test for anyone capable of the most basic kinds of work in the community, those with mild mental retardation." Using it for any other purpose "penalizes [individuals] with mental retardation for the adaptive behavior they have been able to acquire. **It is very important**, especially now that psychometrically sound instruments like [adaptive behavior assessments] provide a broad measurement coverage, **that the SSSQ not be used to diagnose developmental disabilities**. Representations of **SSSQ data as indexes of an [individual's] adaptive behavior must therefore be rebutted** vigorously **as a misuse of the instrument.**" (Pages 147-148, emphasis added.)

CLAIMANT'S SCHOOL RECORDS

10. Claimant's academic transcript identified his courses; almost all of which were special education classes. Claimant graduated in June 1983 and received grades ranging from A's to D's, with most grades being B's and C's. He earned a GPA of 2.71 in grades 9-12 and 2.94 in grades 10-12. Claimant graduated 317 in his class of 826. Claimant passed his required reading, writing, language, and math proficiency tests. There was no indication in the cover letter or the transcript of the basis for his special education placement. Even if the reason for his placement had been noted, a school providing services to a student under an autism or intellectual disability is insufficient, alone, to establish eligibility for regional center services. Schools are governed by

California Code of Regulations, Title 5 and regional centers are governed by California Code of Regulations, Title 17 and the criteria for determining eligibility are not the same.[5]

11. An August 28, 1995, letter from claimant's school district 's Special Education Secretary advised that "confidential records are retained for only five years following date of graduation." Due to claimant's 1983 graduation date, "the records you have requested are not available."

12. The February 26, 2015, cover letter from claimant's high school, enclosing his academic transcript, documented that claimant "received Special Education services and that a majority of the classes taken were Special Education classes." Pursuant to the district's policy, records are only kept "a total of five years from the date of graduation." As such, "all Special Education records for [claimant] have been purged." Further, "[t]here are no administrators or teachers remaining at [the high school] who have knowledge of [claimant]."

LETTERS FROM CLAIMANT'S FAMILY MEMBERS AND FRIENDS

13. Claimant's mother wrote a letter stating that when claimant was five years old he was "sent to a doctor appointed by [his school] for educational evaluation. At that time he was diagnosed with aphasia. He was assigned to 'special' education. He remained in 'special' education throughout his entire schooling …" Claimant also "participated in an educational study at UCLA for special needs children."

14. Claimant's paternal uncle wrote that claimant "since birth has suffered from some form of mental retardation. He received special education classes and training during his school years." Claimant's father tried to help claimant when he was a child. Claimant's father would become upset if people asked about seeking care for

[5] Dr. Greenwald merely stated that Title 5 and Title 17 are different.

claimant and told them it was not their business. When he further asked claimant's father about claimant's future care, the father replied that there were not any government agencies that would help. When the uncle tried to discuss claimant's future care, claimant's father would become very upset.

15. A letter from a family friend who has known claimant's family for "about 40 some odd years," wrote about watching claimant grow up. The family friend has a daughter with autism so he understood claimant's family's situation and reactions. He wrote that claimant's father loved his son and did not feel he needed any special care or treatment beyond what the father "would always be there to provide." Unfortunately, claimant's father did not realize that his own failing health would result in his demise and leave claimant with no one to care for him. The family friend discussed the tremendous supports and encouragement the father gave claimant, however, claimant is lacking in several areas. His social skills are lacking, his self-awareness and concept of himself are lacking resulting in him not realizing he needs to tend to his activities of daily living such as hygiene and grooming. Claimant's "concepts of how others view him are diminished."

16. Claimant's stepbrother has known claimant for over 30 years, meeting him when his mother married claimant's father. He wrote that "everybody understood" claimant to be autistic. Unfortunately, claimant's father was raised during a time when "developmental disabilities were poorly understood and often marginalized by both society at large and by the families dealing with these issues." Claimant's stepbrother referenced attempts to have claimant sign up for Selective Service when he turned 18 and how he was rejected for "reasons of mental defect." The stepbrother enclosed several letters, including one from claimant's school district indicating that "the majority of his classes were special needs classes" and one from their church deacon and longtime family friend attesting to the fact that claimant has always had "a condition."

Claimant's stepbrother contacted Regional Center of Orange County (RCOC) seeking services and was told by Amy Schiffer that the case had been closed because claimant moved out of the catchment area and that because claimant had graduated high school, he "can not [*sic*] possibly be autistic." Claimant's stepbrother asked if he could appeal and was told that RCOC "would not admit his case based on his high school transcripts." Claimant's stepbrother detailed the runaround he got from RCOC and IRC regarding transferring the case to IRC and the lack of faith his family has in the process due to how they were treated.

17. In a September 8, 2015, e-mail to Autism Society Inland Empire, claimant's stepbrother noted that the family has always been told that claimant is autistic and that "getting help from the Regional Center has been a lot like getting your teeth pulled." He referenced the poor job claimant's father did preparing for claimant's care after the father died and that they have been unable to find any documents among the father's personal effects attesting to claimant's condition. Claimant's stepbrother wrote that autism "is not something that strikes a person later in life" and that the fact claimant had the majority of his classes in special education indicated that he had been diagnosed with some condition at some point in his childhood.

18. A September 9, 2015, e-mail from Autism Society Inland Empire to claimant's stepbrother commended him for the job he and his family were doing to seek services and advised that the Society had been "**receiving a number of complaints the last few months about the regional center intake process.**" (Emphasis added.) The Society provided him with several resources he may wish to contact for assistance.

PHOTOGRAPHS

19. Claimant introduced numerous photographs depicting claimant's living conditions. His apartment contained no decorations and was sparsely furnished. The photographs showed his collections of trains and Star Wars memorabilia that were

neatly lined up, his filthy bathroom and bedsheets, his dirty counters and tables, and the few items of food in his refrigerator.

RCOC RECORDS

Intake Records

20. On August 19, 1985, claimant, who was 21 years old at the time, and his father came to an unknown regional center, but presumably RCOC, the intake document for that visit does not indicate which regional center, seeking "vocational training" services. Claimant had not seen his mother since September 1984, which had caused some emotional problems. Claimant's father reported that, as a child, claimant was diagnosed as autistic and aphasic and identified claimant's primary care physician. No records from that physician were introduced at this hearing. Claimant did not have seizures and was not on medication. Claimant was not in a day program or school but did work until November 1984 in a printing shop. He graduated from high school in 1983 from special education classes. He was a client of the Department of Rehabilitation (DOR). In the section marked "Level of Functioning," claimant was reported to be functioning at a 14-year-old level, he could do self-care skills for himself, and could follow a simple three-step command. He read at a third or fourth grade level, but could not write a simple sentence although he could write his name legibly.

21. An August 22, 1985, RCOC Interdisciplinary Note signed by Barbara Chappell, MSW, Unit Manager, Home Services Unit, stated: "Per Interdisciplinary Team this applicant does not appear to be eligible for special developmental services. Records will be collected so that we may obtain more information to determine whether that face-to-face contact and assessment process should be initiated." Given that no records had been collected, it was unclear what RCOC relied upon to determine that claimant was not eligible for services.

22. Ten years later, when claimant was 31 years old, a July 6, 1995, RCOC Referral for Service noted that claimant was referred to RCOC for services by DOR. The referral checked the box indicating claimant had been diagnosed with autism and "recently beat his stepmother." Claimant had difficulties with "reading and writing, not legible," "getting/keeping a job," and "living independently." In school he was "always in special ed." Claimant was seeking "adult program/job training" and "independent living services placement."

23. A July 20, 1995, RCOC Client Intake Information, documented that claimant was hospitalized in Orange County, but did not identify the date or reason. Claimant's father's occupation was identified as "cutting press man" and claimant's father had little or no information regarding claimant's mother. Claimant was currently not in school but had attended the Vern P. Call School for Auditory Handicapped, with his last date of contact being October 15, 1973. His other "past school" was high school with his last date of contact being June 18, 1983. Additional records could be obtained from UCI Medical Center and claimant's school district. The intake also identified claimant's family members.

24. A July 20, 1995, RCOC Health History contained claimant's birth history and documented that his parents did not take him home with them from the hospital. The reason for this was not listed. The "Developmental Milestones" section noted that claimant showed fear with strangers, his speech was "very delayed, other [illegible] were somewhat delayed, by age 2 noted difficulties, wouldn't eat, catch, [illegible] took a long time." Claimant had a history of measles, mumps and chickenpox. He had a "diagnosis of autism at age 5 or 6." The "Family History" section noted that claimant's father had speech problems as a kid, his speech was still hesitant, claimant's father's sister had scarlet fever at age three days, and she has "mental retardation because of it."

RCOC 1995 Social Assessment

25. A July 20, 1995, Social Assessment performed at RCOC documented that claimant's father contacted RCOC "requesting out- of-placement [*sic*], independent living skills training and job placement." Claimant and his father were seen at RCOC on July 20, 1995, for an initial assessment interview. Claimant was 31 years old and, according to his father, was "diagnosed as autistic and aphasic as a child." Claimant's parents were divorced and the whereabouts of his mother were unknown. Claimant resided with his father and stepmother who, because of medical issues, required special care in the home. Claimant had been taking care of her in the afternoons, but on one occasion, he "beat her to a point she required medical treatment." The treating physician reported the beating to Adult Protective Services which was now involved with the case. "Because of the beating incident, the family is seeking out-of-home placement for [claimant]." Claimant's father reported that claimant had "a speech problem as a child." He "also reported having a sister who had a high fever at 3 years of age resulting in mental retardation."

The "Birth/Developmental History" section noted: "By age 2, difficulties were noted in that, [claimant] was a poor eater and he was also showing developmental delays especially in speech. By age 5 or 6, the father reported that [claimant] was diagnosed as autistic. He always required special education classes." The "Medical" section documented that claimant had no psychiatric history.

In the "Current Functioning and Programming" section under the "Sensory Motor Domain" category, RCOC noted that claimant ambulated normally and could run, jump, alternate feet, and traverse stairs. He drove his own automobile and "passed his driver's license test after taking it 4 times and using the audiotapes as opposed to the regular test." Under "Fine motor skills," RCOC noted that he could button, buckle, snap, tie shoelaces and write cursively. The "Independent Living Domain" section noted claimant

has all his self-care skills, could prepare simple foods without cooking, could do household chores with supervision, and can manage purchases independently.

The "Social Domain" section noted that claimant reported he has no friends outside the family. He watches television for recreation. The "Emotional Domain" section noted that claimant presented himself in a friendly and cooperative manner throughout the assessment interview. Except for the recent physical assault incident, claimant presented no particular behavioral problems. Claimant's father reported that as a child, claimant would trash his room and destroy other property. Claimant's father also expressed his opinion that claimant may have been physically assaultive towards his stepmother on several occasions over the past months. The "Cognitive Domain" section documented that claimant reported graduating from high school in 1983 where he attended special education classes but: "Psychological and school records were not available at the time of the writing of this report."

The "Communication Domain" portion of the assessment stated: "[Claimant] is very hesitant in his speech, but does communicate his needs verbally and carries on simple conversation. His speech is somewhat difficult to understand. He can take and write a simple telephone message."

The "Vocational Domain" section of the assessment noted that after graduating high school in 1983, claimant got his first job as a bookbinder where he worked for a few months. His second job was at a sporting goods store where he worked for one day. He then worked for a printing company for one day. He next worked part-time at the Mormon church for five and one half years, which was "a training program" that expired in 1992. Since then, claimant has been trying to find a job and was caring for his stepmother in the afternoon. At home, he could do laundry, dishes and vacuuming but not cooking. The "Financial Section" of the report noted that claimant was supported financially by his family.

The "Recommendation" was to determine eligibility, follow through with SSI and Medi-Cal benefits, "rule out diagnosis of autism," vocational training/job placement with the Department of Rehabilitation, and assist with out of home placement if claimant is eligible for regional center services. No records regarding whether eligibility was determined were offered at this hearing and it was unclear what RCOC did after this social assessment.

Other RCOC Records

26. A July 26, 1995, RCOC letter from an RCOC staff physician to claimant's high school documented that claimant applied for services and enclosed a Consent for Release of Information form. RCOC requested "all psychological evaluations, IEPs, health reports and all other assessments." RCOC identified the individual to whom all records should be mailed.

27. A January 29, 1997, letter to claimant from an RCOC Senior Service Coordinator, Intake and Assessment, stated:

> We have insufficient records to make a decision on your eligibility for regional center services. The Social Security [sic] did not forward a copy of your medical and psychological records.
>
> Since you are now residing outside of our jurisdictional area, your case is being inactivated at this time. When you move back to Orange County, you may contact us and we will be happy to complete the assessment process. You now reside in the jurisdictional area of Harbor Regional Center. Upon request we would forward your file to Harbor Regional Center whose staff can complete the intake process.

28. A January 29, 2015, RCOC "ID Note List by UCI –All" documented communications and work performed. One entry stated:

> The following is the text of the e-mail sent to consumer's step brother [sic] regarding the RCOC inquiry:
>
> Hector,
>
> I am writing to follow up with you regarding your inquiry as to an intake on behalf of your step brother [sic], [claimant], for services through the Regional Center of Orange County (RCOC). I would like to provide you with some additional information regarding eligibility for RCOC services, and also some additional resources and agencies that may be of help to you.

The text of the e-mail then described the eligibility criteria, advising that the "diagnosis must be present prior to the age of 18, be expected to continue indefinitely and constitute a substantial disability for that individual." The e-mail defined substantial disability and how the impairment must be found in at least three of the seven identified life functioning areas. The e-mail noted further:

> All available information regarding [claimant's] case was reviewed by [RCOC staff psychologist and intake area manager]. [Claimant's] prior intake was not completed due to his moving out of RCOC catchment area, and the case was never transferred or reactivated for intake and assessment. As a result, there is limited information available for review. Records available for review included high school transcripts

> which showed a GPA above 2.0 and showed that [claimant] graduated in the top one third of his class.[6] Partial initial intake meeting notes also showed that [claimant] was able to work, manage money, meet personal needs, and drive. Recommendations are that a reassessment is not indicated based on available information.
>
> Because the information provided for review is minimal and does not include any medical records, documentation or other assessments that would indicate an eligible condition or significant impairments in his ability to function, an intake and assessment does not appear appropriate at this time. In addition to the resources I have already provided for you during our telephone conversations, I would highly encourage you to look into the following organizations that may be of support to you, [claimant], and your family.

The e-mail next identified various mental health services and housing organizations that might provide assistance to claimant. Other ID Note entries documented a chart review and discussion with claimant's stepbrother which resulted in the e-mail sent to him. The final entry, dated February 4, 2015, documented a chart review with the Area Manager and RCOC psychologist and noted:

> The case was closed prior to completion of intake and assessment due to consumer moving out of the RCOC

[6] Since the transcript indicated claimant graduated 317 out of a class of 826, he was not in the top one third of his graduating class.

> catchment area. Records available for review included high school transcripts which showed a GPA above 2.0 and showed that the consumer graduated in the top one third of his class. Partial initial intake meeting notes also showed that the consumer was able to work, manage money, meet personal needs and drive. Recommendations are that a reassessment is not indicated based on available information.

29. An RCOC "Inter Regional Center Transmittal," dated August 17, 2015, transferred the case to IRC. The Case Status was "Closed" and the case "has been inactive as of 1/29/1997." An IRC Intake Eligibility Team Review dated August 26, 2015, documented the referral from RCOC and the "Team Recommendations" to obtain the signed intake application.

IRC SOCIAL ASSESSMENT

30. On September 17, 2015, claimant's stepbrother completed an IRC Applicant Intake Information, applying for services at IRC. IRC performed a social assessment on October 5, 2015, noting the initial request for services was received on August 27, 2015.[7] Claimant was 51 years old and living with his stepsister and her family. The section marked "Family History of Developmental Disabilities," noted that claimant has a sister and paternal grandmother with intellectual disabilities. His father had "some difficulties with anger, obsessions and would head-bang." A paternal aunt was suspected of having an intellectual disability. The "Developmental History" section noted that as an infant, the family was told not take claimant home.

[7] It was unclear where this date was derived.

No information regarding developmental milestones is available but claimant had speech therapy in school and was diagnosed with autism at five or six years old. His high school transcript showed that he was in special education classes. Claimant "has worked in a number of places for a matter of days" except for working on a part-time basis at his church for five and one half years. Claimant can make his own sandwiches and use the microwave but uses no other cooking devices. He has a driver's license and it took him four times to pass the DMV test. He is "overly cautious when he drives." Claimant does not manage funds and his clothes have to be thrown away because he does not clean them, wearing them until they are filthy.

The "Communication" section documented that claimant speaks in complete sentences, his speech is intelligible, and he speaks rapidly. During the assessment, claimant displayed animated body language. Claimant was reported to be emotionless over his father's passing. He does not show empathy towards others. He answers questions even if he does not know the answer. He is unable to distinguish between a girl who is a friend and a girlfriend. Claimant sometimes struggles to make sentences and his speech is pressured. He does not interact with others.

The "Challenging Behaviors" section documented claimant's obsession with the Anaheim Ducks hockey team and he reads and memorizes railroad magazines. He has a high energy level and cannot sit still. He likes things placed a certain way. He lines up and sorts things. He flaps his fingers and arms at random times. He paces. He has to have a certain order in his morning routine and lets people know if it is disrupted. He likes some foods a certain way.

The "Physical and Social Environment" section noted that claimant did not have any friends in school. He can read fairly well. He does not follow through on things. He was in an employment program but it was too much pressure for him. He worked one

job for a few months, another for one day, and another for 36 hours a week putting books on shelves. He also worked at the Mormon church part-time for five years.

LOMA LINDA UNIVERSITY BEHAVIORAL HEALTH INSTITUTE RECORDS

31. While claimant was seeking services from IRC, his family had him evaluated at Loma Linda University Behavioral Health Institute. On November 2, 17, and 30, 2015, claimant underwent a neuropsychological evaluation at Loma Linda. Steven Nitch, Ph.D., ABPP, the consulting neuropsychologist, authored a report dated December 7, 2015. Claimant was 51 years old at the time of the evaluation and was accompanied by his stepsister, who advised that claimant had a history of intellectual disability and possible autism and lived his entire life under the care of his family. Claimant's father had recently passed away in January 2015, his stepmother passed away in 2014, "necessitating a need for placement and services for" claimant. During the clinical interview, claimant "relayed that he experiences difficulty 'talking to people' and cannot clearly communicate his needs and preferences to others." Claimant's stepsister stated that claimant "is 'not used to engaging with others outside of his cocoon,'" which has become more evident recently since his parents passed away. The stepsister further added that claimant "has 'limited capacity to think outside of his self,' misconstrues or doesn't understand what others tell him, and has difficulty considering the broader implications of his actions."

Dr. Nitch administered the following tests: Advanced Clinical Solutions - Social Cognition; Barkley Deficits In Executive Functioning Scale (BDEFS); Barkley Functional Impairment Scale (BFIS); Dot Counting Test (DCT); Peabody Picture Vocabulary Test, Fourth Edition (PPVT-4), Form A; Texas Functional Living Scale (TFLS); Wechsler Adult Intelligence Scale, Fourth Edition (WAIS-IV); Wide Range Achievement Test, Fourth Edition (WRAT-4); and he conducted a phone interview with claimant's paternal uncle.

In the Medical & Developmental History section of his report, Dr. Nitch noted the claimant had not received regular medical or dental care over the past 25 years although a recent medical checkup, including laboratory work, found no abnormalities except for mildly elevated blood pressure. Claimant described himself as being in fair physical health with no chronic medical problems. He did not take any prescription medications on a regular basis. His history was negative for significant head trauma, strokes or other neurological problems, including headaches and he had not been hospitalized for medical treatment in the recent past. Per claimant's uncle, claimant was born after a normal pregnancy with no birth complications; he was delayed in speaking, "a quiet child," which caused some concern and prompted claimant's father to seek consultation, possibly at OCRC. The uncle reported that the feedback given was that claimant "was aphasic but not autistic." "Oh note, [claimant's] stepsister recalled that he developed rheumatic fever as an infant."

In the Mental Health History section of his report, Dr. Nitch wrote that except for special education services while in school, claimant did not receive any form of treatment or intervention during his childhood and adolescence. Although the family recently contacted local regional centers, it did not appear claimant received any services in the past. Claimant's stepsister explained that claimant's father "'denied there was a problem' and maintained that [claimant's] needs could be handled by the family without outside involvement." According to an e-mail from a family friend, claimant's father wanted his son treated like any other person, and "did not want any special treatment, considerations or handling" of his son. Accordingly, claimant had not previously been evaluated for a neurodevelopmental disability or other mental health condition. Claimant had not previously been hospitalized for psychiatric treatment nor had he taken psychotropic medication in the past. When asked about his recent mood,

claimant replied that "things were 'real great' and denied any problems with depression or other negative emotional states."

Dr. Nitch took an Educational and Occupational History, noting that claimant attended a "school for the handicapped" for several years in Orange County beginning when he was approximately five years old. For unspecified reasons, claimant's father then transferred his son to a public school for approximately three years. Claimant reported that he struggled in school from a young age for several reasons including behavioral issues (tantrums) and being unable to understand the lessons. At some point he received special education services that remained in place for the duration of his time in school. Two mainstream classes he took in middle school were home economics and wood/metal shop; the remainder of his courses were in separate special education classrooms. "By his account, [claimant] was able to make friends and did not experience any particular social problems."

In high school claimant again received special education services in a separate learning environment with a few mainstream classes, graphic arts and physical education. The high school was located near his home so he was able to take the bus on an independent basis. According to the high school transcript provided by the family, claimant took many self-directed learning classes and accumulated enough credits to graduate. He was also able to obtain passing marks in his proficiency tests for reading, language, math and writing. He graduated in 1983 and "stated that he obtained an outstanding achievement award for graphic arts." Claimant reported that after high school he obtained employment via an occupational training program at a graphic arts company. He left for unknown reasons and next worked at a printing house for several months but was let go when the company went out of business. Claimant also worked part-time from 1989 to 1993 for a network of thrift stores operated by the Mormon Church. His responsibilities at the stores included stocking merchandise, loading trucks

and cashier work. Claimant has not held any other formal employment for the past 20 years but reported that he assisted his father at the race track with various tasks.

In the Family History portion of his report, Dr. Nitch noted that claimant had been estranged from his mother and two siblings for several years, having lived exclusively with his father since age 15. When claimant was 24 years old, his father remarried and claimant then resided with his father, his stepmother and her four children. Claimant did not take the move well reportedly flying "into a rage" over relatively minor provocations. During these times, claimant's father had to physically hold claimant to calm him down and control his behavior. It was reported that although not diagnosed, claimant's father "had 'issues of his own'" including rage, social difficulties (poor communication and mistrust of others), and strong personality traits (very stubborn)." Claimant has never had any romantic relationships.

In the Substance Abuse section, Dr. Nitch reported that claimant denied any current or past history of alcohol abuse, smoking, using illicit drugs (claimant stated he was "clean as a whistle"). Claimant denied consuming coffee, tea, soda, or energy drinks.

The Lifestyle section documented that claimant's paternal uncle reported that claimant "'doesn't do well with people' and is not able to manage everyday activities of daily living." He presently resided in an apartment by himself, a "temporary situation," close to his stepsister's home and she checks on him daily. Claimant can perform some household chores including laundry, dishes, general cleaning but does not cook for himself. Claimant has a valid driver's license and can shop for basic items on his own at the grocery store.

In the Assessment Results section of his report Dr. Nitch reported his test findings as follows:

- Claimant arrived for testing with his stepsister who contributed to the interview but was not present during initial neuropsychological testing.

- Claimant was restless and fidgety, alert and oriented, but looked to his stepsister at times to provide relevant information regarding his personal background.
- Claimant spoke at a faster rate in a stilted and staccato fashion and at times appeared to become frustrated that he was unable to elaborate upon his responses.
- He was able to repeat information upon command and exhibited diminished speech prosody and mild word-finding problems.
- His comprehension for conversation and test instructions appeared to be adequate for the purposes of the evaluation.
- His thought processes, as reflected in the speech, were concrete and impoverished.
- He maintained blunted affect for the most part with limited range.
- He made fair eye contact and had a reserved manner when interacting with the examiner.
- Claimant had a serious yet polite demeanor and displayed little positive emotion.
- He demonstrated fair task persistence and did not become overly discouraged when he could not solve a problem.
- He appeared motivated to make a positive impression and provide his best effort during formal testing of his cognitive abilities.

Dr. Nitch wrote that in order to interpret claimant's full scale IQ, the size of the difference between his highest and lowest index scores must not exceed 1.5 standard deviations. In this case, the difference between claimant's highest index score (Processing Speed) and his lowest index (Working Memory) was 31 points, a value greater than 1.5 standard deviations making his full scale IQ not a reliable estimate of

his overall intellectual ability. There was also significant difference between his verbal and nonverbal comprehension which precluded interpretation of his General Ability Index score. As such, his intellectual abilities appeared to vary greatly depending upon the nature of the task at hand. The amount of discrepancy in his verbal and nonverbal scores indicated that his nonverbal abilities are more developed than his verbal skills. Claimant obtained a Borderline impaired score on the Working Memory Index, a relative weakness for him and an Average standard score on the Processing Speed Index, a personal strength for him.

To measure adaptive functioning, claimant was administered the Texas Functional Living Scale, a performance-based measure of functional competence for use with individuals suffering from a variety of neurodevelopmental and neurodegenerative disorders. The scale was designed to assess instrumental activities of daily living that are thought to be more susceptible to cognitive decline than basic activities of daily living. Claimant obtained a total score that was classified as "Low Average" and no areas of particular weakness were identified. Claimant required an oral prompt to remember the examiner's instructions. Dr. Nitch opined that claimant's "overall functional skills were somewhat above those reported in the test manual for individuals diagnosed with Autistic Disorder." On achievement testing claimant received variable scores ranging from a low of 55 on the spelling subtest, to a high of 82 on the reading subtest. Claimant's "Sentence Comprehension percentile rank of 3 means that 97% of the persons in his age range (45-55 years) in the standardization sample scored higher than him (5.5 grade equivalent). His score on the Reading Composite index was at the 4th percentile" according to age-based norms while his Math Computation score was at the 9th percentile.

Claimant performed better on social cognition testing when asked to understand and accurately interpret direct communication as opposed to indirect statements. As

compared to his measured intellectual abilities, claimant scored within the expected range on measures of social perception. On behavioral domain testing, claimant obtained a total score of 128, which was "well above the recommended threshold that has been found to best differentiate individuals diagnosed with autism spectrum diagnoses from healthy comparison controls. As such, his profile is more comparable to those with autism spectrum developmental disorders than the group without such a diagnosis."

Claimant's stepsister completed the BFIS, an empirically-based questionnaire designed to evaluate possible impairment in 15 major domains of psychosocial functioning in adults ages 18 to 89 years old. Claimant's stepsister rated claimant as being impaired in six of the seven domains that were relevant to his particular life activities which was indicative of an extreme level of impairment. Specifically, she viewed claimant as having difficulties within the domains of social interactions, money management, self-care, and health maintenance. Claimant's stepsister also completed the BDEFS, an inventory developed for the assessment of executive functioning deficits in daily life activities in adults. Claimant's stepsister's scores were indicative of a "mildly deficient" level of clinical significance, rating claimant as being "markedly deficient" in self-restraint and mildly deficient in self organization/problem solving. She rated him as somewhat deficient in the subdomains pertaining to self-motivation and self-regulation of emotions and as having minimal problems in the area of time management. She also provided ratings that placed him in the moderately elevated index associated with symptoms of attention deficit disorder.

Claimant's stepbrother also completed the BDEFS Other Report to provide input on claimant's everyday behavior from his perspective. Claimant's stepbrother generally rated claimant's level of executive functioning problems as more serious than did his

stepsister with particular areas of concern involving problem-solving and self-motivation.

In his conclusion part of his report, Dr. Nitch noted that claimant demonstrated low average verbal comprehension abilities and average nonverbal intellectual skills. This indicated that he generally performed better on tasks that require pattern analysis and creativity as compared to those that involve over-learned information (facts and figures). He performed within normal limits on measures of his processing speed but obtained a borderline impaired score in terms of his auditory working memory which indicated his learning potential may be constrained by the limited availability of working memory resources. Four of claimant's subtest scores were below the sixteenth percentile which "is not uncommon in people with his overall intellectual level" but the degree of variability amongst his subtest scores was high such that "a clear pattern of strengths and weaknesses was apparent, which is consistent with reports that [claimant] does well in some areas (e.g., knowledge of cars) but struggles greatly in others (e.g., communicating with others)."

Dr. Nitch added that, although claimant completed high school, he received Special Education services that consisted of placement in a separate classroom for most of the day. Given the results of the evaluation, "it is likely [claimant] would struggle to comprehend anything but basic written instructions or guidelines." Claimant would function best in work environments that provide ample supervision (job coach) and allow him to utilize his cognitive strengths, including pattern analysis, visualization, and hands-on learning; he struggled a great deal more in social situations and would be ill-equipped for a job that involves customer service. Claimant's lower working memory scores indicated his learning potential could be constrained by the limited availability of working memory resources. The cause of his reduced working memory may be related to poor learning strategies and limited information processing resources. A weakness in

working memory may make the processing of complex information more time-consuming thereby taxing his mental energies more quickly compared to others of the same age. While he had average nonverbal intellectual ability, claimant's low working memory put a limit on how much he was able to handle at any given moment. It was notable that claimant has led an impoverished social life as an adult as he primarily interacted only with his parents. He reportedly had always demonstrated a limited ability to initiate social interaction and had deficits developing and understanding social relationships, but did not seem to be perturbed by this limitation. Testing revealed that he had relative weaknesses in situations that called for the integration of different modalities of the motion (auditory and visual) in order to effectively interpret more complex emotional statements (sarcasm and humor). It appeared he can objectively assess affect and prosody but had difficulty applying this skill to his own life.

Dr. Nitch opined:

> Given his case history, it appears that autism spectrum disorder is a relevant diagnostic possibility for [him] as he continues to demonstrate deficient social skills as well as a restricted pattern of interests and behavior. It is likely that [claimant] falls on the upper end of the spectrum in terms of his level of functioning in comparison to other individuals diagnosed with autism.
>
> Nonetheless, these symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning. In light of the extreme impairment in social interactions he has had over the course of his lifetime, a diagnosis of autism seems to be applicable. Although he

> received Special Education services during the duration of his time in school, [claimant] has some clear intellectual strength and no apparent deficits in language skills. Nonetheless, his symptoms as a whole cause clinically significant impairment in social, occupational, or other important areas of current functioning and he best meets the DSM-V [sic] severity level designated as "requiring support."

Dr. Nitch's Diagnostic Impression was Autism Spectrum Disorder (Asperger's Disorder) without accompanying intellectual impairment, without accompanying language impairment. Claimant had a history of developmental delays (language); a history of special education; and a history of social isolation.

In terms of his level of functioning, Dr. Nitch noted that claimant exhibited delays in language development that caused his father to seek consultation from the local regional center. Claimant also required intensive special education services throughout his educational career. He lived with his parents for the majority of his life until his father died in January 2015. He had only been gainfully employed on a part-time basis at shelter worksites and had not held such a position in approximately 20 years. He did not maintain social relationships with anyone outside of his immediate family.

Dr. Nitch recommended ways to provide guidance to maximize claimant's potential for success in his future endeavors. He opined that claimant would function best in a semi-structured living environment, while he did not appear to need direct supervision with his daily activities, an aid or live in staff person would be helpful and claimant requires assistance with meal preparation, monetary assistance, communication, and self-care. He would benefit from life skills training and vocational training. Other goals can include working on communication skills with others and increasing his level of social awareness. Group therapy may be a good format for him as

well as activities that promote relaxation and wellness. In his opinion, claimant will learn best when the information is clearly presented with concrete and specific language content, when the limits of his abilities are not overly taxed, when the learning materials are not mixed with unnecessary or relevant information, and when the environments are quiet with limited stimulation.

IRC'S PSYCHOLOGICAL ASSESSMENT

32. On January 20, 2016, Dr. Greenwald, an IRC staff psychologist, performed a psychological assessment and authored a report. Dr. Greenwald noted that the reason for the assessment was to determine eligibility "under an Autism Spectrum Disorder (ASD) criterion, per his father's statement in a 7-20-95 [RCOC] Social Assessment (when [claimant] was 32 years old), had been assigned in childhood [*sic*]." Dr. Greenwald's report referenced the RCOC assessment determination, and the RCOC January 29, 1997, letter, but his report did not reference Dr. Nitch's report and it appeared Dr. Greenwald did not review Dr. Nitch's report prior to issuing his report.

In his "Developmental History" section Dr. Greenwald wrote: "[Claimant's] language (first words/phrases), motor, and other developmental milestones were not available for review in the current assessment." In his "Family History of Developmental Disabilities" section Dr. Greenwald noted that claimant's biological sister was diagnosed with intellectual disability as a result of a severe high childhood fever, and claimant's paternal grandmother and aunt were reported to also have been diagnosed with intellectual disabilities. Claimant's father reportedly suffered with depression and anger issues. Dr. Greenwald noted that following his father's death, claimant has lived with his stepsister.

In his "Previous Assessment" section Dr. Greenwald referenced the following pertinent findings from the 1995 RCOC Social Assessment: claimant reported he has no friends outside of his family; except for a recent serious incident of physically assaulting

his stepmother, he presents as no particular behavioral problems; as a child he would trash his room and destroy property and he was physically assaultive toward his stepmother on several occasions over the past months; he had no psychiatric history; he graduated in 1983 where he attended special education classes; psychological school records were not available to RCOC; claimant was very hesitant in his speech but did communicate his needs verbally and carried on simple conversation; his speech was somewhat difficult to understand; claimant had worked off and on a few months or a few days over the years at various odd jobs but nothing since 1992.

The "Assessment Procedures" Dr. Greenwald used were: clinical interview and mental status exam; Kaufman Brief Intelligence Test -2nd Edition (K-BIT2); Autism Diagnostic Observation Schedule – 2nd Edition (ADOS-2) Module 4; Childhood Autism Rating Scale-2nd Edition (CARS2-ST); Street Skills Survival Questionnaire (SSSQ); and he conducted a review of clinical records. However, the only record Dr. Greenwald's report stated he reviewed was the 1995 RCOC Social Assessment; no other records were identified in his report as having been reviewed.

In the "Assessment Results" portion of his report, Dr. Greenwald noted the following: the K-BIT2 results were a verbal standard score of 84 - low average range, a nonverbal standard score of 90 - average range, and an IQ Composite standard score of 86 - low average range. Dr. Greenwald noted the following for ADOS-2 Module 4 Diagnostic Algorithm: "Communication =1 (Autism cutoff = 3; autism spectrum cutoff = 2); Reciprocal Social Interaction = 5 (Autism cutoff = 6; autism spectrum cutoff = 4); Stereotyped Behavior/Restricted Interests = 0; and Communication + Reciprocal Social Interaction Total = 6 (Autism cutoff = 10; autism spectrum cutoff = 7)."[8]

[8] As noted more fully below, Dr. Cronin testified that the algorithms used by Dr. Greenwald were outdated, having been modified two years before his assessment, and

Dr. Greenwald documented ratings on the CARS 2-ST between 1 and 2.5 in the various categories, for a total score of 20 which demonstrated Minimal autism spectrum symptoms with the Minimum to Mild-Moderate cutoff being 27.5.) Claimant's SSSQ raw score was 199, his standard score was 99 and the classification was average. His scaled score for average adult norms for the health and safety category was significantly below average adult norms. The Vineland-II Adaptive Behavior Scales[9] contained Communication scores in the Severe Deficit Adaptive Level; Daily Living Skills were in the Moderate Deficit Adaptive Level; Socialization Skills were in the Profound Deficit Adaptive Level; and the Adaptive Behavior Composite was in the Profound Deficit Adaptive Level.

In the "Mental Status & Behavioral Observations" section of his report, Dr. Greenwald noted that claimant's grooming was mildly disheveled, but his hygiene appeared more than adequate. Claimant and his brother were sitting in the IRC reception area and claimant immediately acknowledge Dr. Greenwald's calling his name, turned his head to reciprocate gaze (eye contact), verbal greeting, and social smile. Claimant readily transitioned to the assessment room and evidenced no vulnerability to sensory distractibility or repetitive stereotyped behaviors at any time during the assessment. Claimant used conventional phrase speech to respond to Dr. Greenwald's questions/conversational bids, providing relevant responses. Claimant's "grammatical/syntactic (sentence structure) and semantic (word meanings) usage also sounded conventional. Echolalic, scripted (over-rehearsed) and/or neologistic (made-up

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that if an evaluator uses the algorithms currently in use, claimant received scores in the autism and autism spectrum ranges on his IRC assessment.

[9] Dr. Greenwald did not include this assessment in his list of Assessment Procedures.

or artificial) words typically heard among persons on the autism spectrum were not heard. For example, when asked the reason for the current assessment he replied, 'I need job training and job placement.' Prosody characteristics of speech included strong voice with expressive tonality." Claimant was mildly anxious and reported feeling nervous although Dr. Greenwald did not observe any psychomotor agitation. Claimant maintained a cooperative demeanor throughout the assessment and proved to be alert, demonstrating satisfactory personal, temporal, and spatial awareness, with fully intact recent and remote memories. Claimant's attention, concentration, and comprehension proved satisfactory for the purpose of valid testing.

Under the "Cognitive Assessment" heading Dr. Greenwald noted that claimant's KBIT-2 scores showed current global cognitive levels measuring non-significantly below the mean for the general population, classified Low Average. Claimant's verbal scores were also classified Low Average.

Under "Autism Assessment," Dr. Greenwald reported that claimant's ADOS-2 Diagnostic Algorithm Social Affect and Restricted and Repetitive Behavior Total Score (6) did not meet cutoff criterion (10) consistent with autism spectrum this order. His result approaches, but did not meet cutoff (7) indicative of behaviors on the autism spectrum. He did not meet full criteria for that disorder. In the areas of communication, claimant's emphatic expressive tonal prosody and conventional syntax and semantic structure proved free of stereotyped/idiosyncratic use of words or phrases. Claimant spontaneously displayed emphatic or emotional gestures during conversation and used descriptive, conventional, instrumental or informational gestures to illustrate his words throughout the assessment. While claimant's responses to Dr. Greenwald's bids to conversation proved satisfactory for providing relevant answers to questions, claimant "asked few follow-up questions, especially about non preferred topics and [claimant] proved more productive discussing preferred (Ducks, drag racing, and steam

locomotives) topics." Dr. Greenwald wrote, "More prominent were [claimant's] limitations and anomalies identified in the area of Reciprocal Social Interaction" and "[s]pecifically moderate deficits were identified in two areas addressing personal *Responsibility*… *Comments on Others' Emotions/Empathy* and *Communication of Own Affect*. (Italicized in original.)

Dr. Greenwald wrote: Milder limitations also applied to two other ADOS-2 categories addressing reciprocal social interaction. *Quality of Social Overtures* were skewed in favor of personal interests though not exclusively so. Contrasting this, there also were no anomalies or deficiencies at initiating, modulating and reciprocating gaze to suggest *Unusual Eye Contact*." (Italicized in original.) During his interview with Dr. Greenwald, claimant displayed unrestricted and situationally congruent facial expressions directed to Dr. Greenwald and proved quite productive in the amount of reciprocal social communication giving extensive verbal and nonverbal communication exchanges with Dr. Greenwald. In addition, claimant evidenced shared enjoyment in interaction, a form of joint referencing typically absent among persons with autism spectrum disorder, pausing to look and smile at Dr. Greenwald and his stepbrother when shown an amusing video. Claimant demonstrated an example of stereotyped behaviors and restricted interests when he referenced steam locomotives and the Anaheim Ducks hockey team, but he did not engage in repetitive behaviors, unusual sensory interests, or hand and finger mannerisms during Dr. Greenwald's assessment.

In the "Adaptive Functions" section, Dr. Greenwald noted the SSSQ results. He wrote that the "SSSQ measures functional knowledge and skills that are relevant and critical to community life and independent living. It tests nine adaptive areas: basic concepts, functional signs, tools, domestics, health and safety, public services, time, monetary and measurements." Dr. Greenwald wrote that the total SSSQ "provides standard score benchmarks allowing for comparisons of a subject's independent living

skills with norms for both neurologically impaired and non-impaired 15-55 year old adults." Claimant's score of 99 "is classified fully average functional range and commensurate adult norms [*sic*]." "Eight of the nine skills categories[10] measured within norms established for average non-neurologically impaired 18-55 year old adults. These outcomes exceeded norms established for neurologically impaired adults."

In his report "Summary," Dr. Greenwald noted the claimant was assessed to determine eligibility under autism criteria and that an "initial 8-22-85 RCOC assessment when claimant was age 21 concluded at that timey [*sic*] that he did not appear eligible for services."[11] Claimant used conventional phrase speech to respond to Dr. Greenwald's questions/conversational bids, providing relevant responses. Claimant's IQ scores were in the low average and average ranges. His ADOS-2 Diagnostic Algorithm Total Score did not meet cutoff criterion consistent with autism spectrum disorder. The result approached, but failed to meet criteria and indicating behaviors on the autism spectrum and the CARS2-ST total score failed to approach cutoff consistent with autism spectrum disorder. Assessing claimant's adaptive functions, his 99 SSSQ standard score was classified fully average range and stood in "stark contrast" to the ratings supplied by his

[10] The health and safety category did not measure within norms.

[11] This finding was confusing because the only RCOC assessment referenced in Dr. Greenwald's report was the July 28, 1995, RCOC Social Assessment and the only RCOC records introduced by IRC were dated 1995, 1997 and 2015. No evidence of an assessment performed in 1985 when claimant was age 21 was referenced anywhere else in Dr. Greenwald's report. The 1985 referral record offered by claimant at this hearing was dated 8-19-85, not 8-22-85. Moreover, the RCOC records established that RCOC never completed its assessment.

stepbrother on the Vineland-II which had suggested the presence of profound adaptive deficits.

Dr. Greenwald's diagnostic impressions were: "Rule Out Avoidant Personality Disorder" and "Rule Out Schizoid Personality Disorder." He opined that claimant was not eligible for regional center services under autism spectrum disorder or intellectual disability and recommended he undergo comprehensive behavioral health assessment/consultation to address the rule out diagnoses.

IRC Actions Following Its Evaluation

33. In a notice of proposed action dated January 20, 2016, IRC notified claimant that he was not eligible for regional center services.

UCLA Neuropsychiatric Evaluation

34. In response to IRC's denial, claimant underwent a neuropsychiatric evaluation on July 18, 19, and 22, 2016, at the Semel Institute for Neuroscience and Human Behavior, Stewart and Lynda Resnick Neuropsychiatric Hospital at UCLA. The Institute issued a 22-page report on October 3, 2016, that was signed by C. Enjey Lin, Ph.D., BCBA-D, psychologist and assistant clinical professor; Karen Guan, M.A., psychology external practicum trainee; and Kyle Cassidy, M.S.W., psychometrist. The report also identified seven members from the Multidisciplinary Team, which consisted of two clinical psychologists, a speech language pathologist, a neurologist, and three psychiatrists, who "contributed to the diagnostic impressions and recommendations based on a review of all aspects of the assessment including the developmental history, behavioral observations and testing."

The measures Dr. Lin/UCLA administered were: Achenbach Adult Behavior Checklist (ABCL); Aberrant Behavior Checklist (ABC-C); Autism Diagnostic Interview - Revised (ADI-R); Autism Diagnostic Observation Schedule, Second Edition (ADOS-2)

Module 4; MINI International Neuropsychiatric Interview (M.I.N.I.); Social Responsiveness Scale (SRS) (Self Report); and Vineland Adaptive Behavior Scales - Second Edition (VABS-II); Wechsler Adult Intelligence Scale (WAIS-IV). The reason for the referral was "to obtain an accurate diagnosis."

Claimant currently lived alone in an apartment with regular support from his stepsister.[12] The Developmental History noted that claimant demonstrated delays in his language as a child and was diagnosed with autism at approximately age five. The Medical History noted that claimant received poor medical care while living with his father. There was a family history of substance abuse (mother-alcohol), attention and emotion regulation difficulties, language delay, and intellectual disability (paternal aunt and suspected in his biological siblings). Claimant primarily lived with his father at age 15 when his biological parents divorced. He has had intermittent contact with two older biological siblings who are largely uninvolved in his life. Claimant's father remarried when claimant was 24 years old and he has four adult younger stepsiblings from that marriage. His mother resides out-of-state and he has not seen her for the past 30 years.

The Intervention/School/Work History noted that claimant is currently unemployed. He received special education services throughout his schooling but did not receive any other interventions. He has had a series of short-lasting jobs in the past. Dr. Lin reviewed records of the 2015 Loma Linda evaluation, 2015 IRC assessment, 1995 RCOC social assessment and an August 1985 RCOC record noting claimant was ineligible for services based on an interdisciplinary team discussion.

The Behavior Observations section noted claimant presented as well-groomed and casually dressed. His affect was euthymic; he was friendly and appeared to warm up

[12] Dr. Lin testified that the references in her report to "half-sister" and "half-brother" were typos.

quickly to the evaluator. He had atypical prosody of speaking at a slower rate at times, odd intonation, and it had a monotone quality. He often referred to specific dates and events during conversations and he always referred to people by using their first, middle and last names. At one point he burst into exaggerated laughter over a joke the evaluator made. During social chitchat he answered questions about himself by talking for several minutes uninterrupted, often with great detail. His recounting of experiences tended to focus on details rather than building a comprehensive picture of the event, such that it was difficult at times to comprehend a sequence of events as they occurred. He demonstrated interest in the evaluator's comments and conversational bids by remarking "Oh, wow," but did not continue the conversation by making comments or asking questions.

His tone of voice was quiet and he frequently mumbled quickly making it difficult at times to understand his articulation. His speech was choppy such that at times he mixed up his words in ways that were difficult to comprehend. He made eye contact when speaking or spoken to, although at times his gaze was fixated for longer than was appropriate. Throughout the evaluation he demonstrated some fidgeting behaviors such as spreading his hands in front of him on the table and rubbing his chin. He was highly compliant with instructions and appeared attentive and motivated to do well on tasks, apologizing when he did not know the answer. Given his consistent level of effort and attention, the results were believed to be an accurate representation of claimant's current functioning.

ADI-R Findings

The ADI-R was completed with information gathered from claimant's stepbrother and paternal uncle to assess for developmental concerns associated with autism spectrum disorder. The following is a summary of the findings from this assessment: Claimant's scores met cutoff levels for autism indicating his developmental history is

indicative of delays and atypical features consistent with autism spectrum disorder. Claimant also presented with current ongoing features that are consistent with autism spectrum disorder. Claimant has a history of demonstrating restricted and repetitive quality in his interests and behaviors that have been present for a significant duration of his life. Claimant has a history of engaging in unusual interests that include focusing on dates of events. Claimant has shown a restricted interest in trains and the Anaheim Ducks hockey team since age 12, knows specific facts and details and "talks incessantly and repetitively about these topics." He also has an interest in Star Wars, collecting empty cereal boxes, and a history of engaging in idiosyncratic rituals and compulsions by positioning items and completing activities in specific ways. He has difficulties with changes to his schedule and routines. He insists on following set schedules and having items placed in specific places. He insists on following or keeping things in place but does not get overly upset when things or schedules are changed.

Claimant has a history of engaging in repetitive hand and body movements, including hand flapping, wiggling his fingers, and moving his hands. He engages in repetitive pacing behaviors, especially at night, and does so while talking to himself by repeating conversations or things that he heard from earlier in the day which seemed to be a type of delayed echolalia. Claimant is always engaged in these behaviors. He also shows some sensory seeking behaviors including visually examining the motors of cars and looking at pictures and touching new objects that he sees. Claimant has a history of atypical features in his communication development. He shows delays in his language development, as he did not speak in phrases until about four to seven years of age. He spoke using stereotyped phrases and delayed echolalia from television commercials before age four. He began to demonstrate more functional and spontaneous language after age four. As a young child (between the ages of four to five years), he did not

comprehend spoken language, he understood words and labels for items but could not follow instructions.

Currently he speaks using phrases that are spontaneous and functional. In the past, up to age four, his use of stereotyped language was frequent (repeating lines from cartoons and commercials). He continues to occasionally use stereotyped language by using movie lines verbatim. His social verbalizations are limited as he communicates primarily to indicate his needs or to tell someone about his restricted interests. He is not able to engage in reciprocal conversations, does not build on the conversation of others, tends to be one-sided in sharing his interests, or listens but does not ask questions to keep the conversation going or make relevant comments to build on what was said. He sometimes makes inappropriate comments due to a lack of social understanding and appropriateness (making a remark about an actress's breasts in front of others). His voice prosody is atypical - his pitch (high) and rate of speech (fast) are strikingly different from that of other people. At this time, his initiation of joint attention is limited in quality as he does not coordinate his eye gaze with his spoken language when he points at something afar that captures his interest. On the other hand, he has an appropriate use of nonverbal gestures.

Many of the expected communication development milestones were absent when he was younger, even up to the age of four to five years old. He did not attend to the voices of others when they entered the room as he usually did not look up in a socially directed manner. He also did not spontaneously initiate the actions of others or engage in imaginary play by himself with peers. He did not play with toys but sat passively on the floor or on the lap of adults. His social and play development in starting, responding to, and maintaining social interaction were also atypical from a young age (present even between the ages of four to five years old) to the present. He has a history of making infrequent initiations to start social interactions and a limited

range when doing so. When he was younger, claimant did not try to show items or direct other's attention to his interests as he often was passive. Currently he is limited in that he typically only tries to get the attention of the people when it is related to his restricted interests. He has a history of not engaging in spontaneously offering or sharing his belongings with others in a social manner (food, items, a blanket). Sharing his enjoyment with others in a socially related manner was absent when he was younger (smiling and looking toward someone when something exciting occurs or when engaged in a playful interchange) but is present in a limited range now related to his particular interests (telling someone the Star Wars movie is coming out soon).

Claimant has a history of limited responsiveness in social situations. He did not spontaneously notice or offer comfort to others in the past, but will now do so in a learned manner (patting someone's back at the funeral while saying, "It's for the better."). He has exhibited a limited range of facial expressions. When younger his facial expressions did not vary; he was flat and did not even demonstrate excitement. He currently is overly exaggerated and animated with his facial expressions such that it is almost cartoon-like. He has a history of engaging in inappropriate facial expressions - laughing to himself for no apparent reason. As a child he did not engage in reciprocal social smile, did not laugh or respond with a smile, which **caused concern in his family that he may have a hearing impairment**. (Emphasis added.) He currently has a limited social smile he will use with familiar people. When younger he did not show interest when adults tried to interact with him. Presently, he shows interest by looking but the quality is limited as he does not smile or sustain the interaction with others (he provides short answers).

Claimant's play development was atypical as a young child. He often passively laid down or sat near adults, rather than engaging in play, exploration, or playful interactions with others. Currently he engages in a limited range of activities that include

mostly activities related to his restricted interests. He did not engage in imitative reciprocal social play (patty cake, peekaboo) when younger. He has never had meaningful friendships with same-aged peers in or outside of school. He does not currently have any friends. He was not observed to play with peers or even his siblings when he was younger.

ADOS-2 Findings

The following is a summary of the findings of the ADOS-2 assessment: Claimant showed many positive aspects in his interactions but also exhibited substantial atypical qualities in his social interactions and use of communication for social purposes. His scores met research cutoff levels of concern for autism spectrum disorder based on the current algorithm (2014). Claimant's symptom severity level was in the high range, strongly indicating that his social interactions and behaviors are consistent with someone with a diagnosis of autism spectrum disorder. Claimant showed several positive qualities in his social interactions, integration of nonverbal communication and use of communication for social purposes. He readily offered information in response to topics and materials that were presented to him, used a range of nonverbal gestures that included descriptive gestures to accompany his verbal language and spontaneously noticed and made comments about other people's emotions during conversations and activities.

On the other hand, he also displayed notable atypical qualities, inconsistencies, and a limited nature to his social behaviors and use of communication across social situations. His prosody was atypical - his rate of speech was jerky, his voice was monotone, his intonation was exaggerated and overall he had difficulty modulating these aspects of his voice. Claimant used frequently stereotyped phrases with the same intonation, such as "goodness gracious me" and "holy mackerel." He was unable to describe personal events that he experienced in a comprehensible, sequential manner

but reported routine events clearly. He tended to be overly general when describing his personal experiences, being unable to provide details.

The quality of his nonverbal communication was limited and inconsistently integrated. His eye gaze was not well integrated across situations. When requesting blocks to complete a puzzle, he asked for them verbally but did not look toward the evaluator and sometimes he looked too long without appropriately averting his eye gaze. Although he used a range of nonverbal gestures, he did not integrate a range of facial expressions to further convey his affect as he demonstrated a narrow range of facial expressions overall but showed some appropriate expressions. His emphatic or emotional gestures were of atypical quality as he tended to be jerky with his hand movements, which were quick and awkward at times.

Claimant demonstrated difficulty initiating and maintaining reciprocal conversations. Although there were occasions when he responded to social bids by making brief comments ("oh, wow"), there were numerous occasions when he did not respond at all, but merely smiled or nodded his head in response. When he did respond, he often brought the conversation back to his specific interests. His responses were odd in quality because at times he was long-winded, especially with details about his restricted interests. He did not inquire about the evaluator's thoughts, experiences, or feelings making it difficult to be an equal social partner with claimant and sustain conversations with him.

There was an unusual quality to his spoken language. While talking about his own specific interests, he was very verbose, pedantic, and detailed, using stereotyped language about these topics at times as if he were reading from a manual or pamphlet. During those times, he tended to give a monologue about details that were one-sided. When talking about other topics unrelated to his interests, he struggled to talk at length, provide details, or answer in an on topic manner. He gave the impression that he

did not understand or comprehend some of the more abstract questions that were expected for someone of his age. His communication functioning was limited in range. There was a limited quality to his understanding of social relationships; it was basic and lacked the depth and maturity of someone his age. He did have a limited sense of his responsibility in social situations (he reported that he annoyed people by messing up his words). He referenced personal friendships, but it was unclear if those were simply acquaintances (the racecar drivers he met through his father) and he exhibited a limited sense of responsibility for his own actions and daily living expectations. He advised that his family assisted him with managing his personal finances.

It was "very striking" how often claimant talked about his restricted interests, which came up frequently and with great detail. He also showed a tendency for a need for sameness and following idiosyncratic routines, straightening the picture cards each time one was presented to him during an activity and needing the puzzle piece colors to be in a particular pattern.

WAIS-IV Results

The following is a summary of the results of this assessment: Claimant demonstrated significant variability in his functioning with and across domains. As such, his verbal comprehension index and full scale IQ scores are inaccurate and must be interpreted with caution as they are not a valid representation of his broader cognitive functioning. Instead, the individual scores are a better indicator of his functioning across areas. Claimant showed marked challenges with verbal abstract reasoning and working memory that was substantially below expected levels. Claimant demonstrated the most delays and significant variability in his verbal reasoning and comprehension skills. His understanding and application of common information about the world was within the limitations in his fund of acquired vocabulary in that he had difficulty giving precise definitions of words. His skills in abstract verbal reasoning are impaired. He frequently

became absorbed in concrete details and differences between items. The results demonstrated that while he is able to express basic facts using his verbal skills, he has difficulty understanding conceptual relationships and expressing verbal concepts.

Claimant's nonverbal reasoning skills were a source of significant strength. However, his working memory skills are significantly impaired. He had difficulty retaining and solving problems suggesting that he is likely to have difficulty keeping auditory information in his mind making it challenging to engage in mental manipulation of this information. Claimant demonstrated intact visual processing speed abilities.

M.I.N.I. Results

The M.I.N.I. results showed the following: The M.I.N.I. was conducted with claimant and his stepbrother to assess for a broad range of psychiatric conditions. Claimant did not meet diagnostic criteria for any psychiatric conditions. Claimant and his stepbrother both denied any past or current symptoms of major depressive disorder, persistent depressive disorder, suicidality, bipolar disorder, panic disorder, agoraphobia, social anxiety disorder, obsessive-compulsive disorder, posttraumatic stress disorder, alcohol or substance use disorder, psychotic disorders, and generalized anxiety disorder.

Vineland Results

The Vineland was administered to claimant's stepbrother and stepsister to assess claimant's current adaptive functioning across three domains: communication, daily living skills, and socialization. Compared to same-aged peers, claimant's adaptive functioning is considerably below age expectations across all areas. Due to significant variability in the scores, the domains are not an accurate overall summary of his functioning. Instead, the individual area should be considered as valid estimates of his current adaptive functioning. The Vineland assessment results are as follows:

Claimant demonstrated significant challenges in his adaptive communications, exhibiting the most weakness in his expressive and receptive adaptive communication. He does not consistently follow single step or multi step instructions. Although he speaks using fluent language, he demonstrates limitations using his language across expected situations in a meaningful manner in his daily life. He has trouble relating experiences or information in a cohesive manner. His written language abilities are also limited. His reading and writing functioning are markedly limited. His reading comprehension is reported to be at a sixth-grade level with rudimentary ability to compile short sentences with prompting and support.

Claimant's daily living skills are below developmental expectations. Although he lives independently, he is provided with ongoing support to maintain this home living arrangement. He is markedly below expected levels with his domestic skills functioning. He does not do many household chores unless prompted/reminded. His meal preparation is limited to cereal, sandwich making, and heating a frozen dinner in the microwave. He does not use the stove top or oven. His personal care functioning is markedly impaired. He needs reminders to attend to his personal hygiene. He requires full support to manage his medical health. His community-based functioning is below age expectations. His ability to apply basic community concepts is limited but he does drive independently short distances to familiar locations.

Claimant's social functioning was markedly impaired. The details of his social challenges and behaviors were captured in the ADOS-2 and ADI-R. He does not verbally articulate his own emotions, seek out companionship, spend time with or seek out friends. He has a limited range of leisure activities, does not use or notice expected social conventions or nonverbal cues in social situations and does not appropriately start and maintain social conversations.

Caregiver ratings

Claimant and his stepbrother completed measures to examine claimant's social, emotional, and behavioral functioning in his home and community settings. Claimant endorsed experiencing clinically elevated levels of social challenges and restricted, repetitive behaviors of interest. Claimant experiences marked difficulties with understanding and engaging in problem-solving in social situations, meeting social expectations, and using his communication to effectively start and maintain reciprocal social interactions. Claimant also endorsed a high level of repetitive thinking and inflexible ways of doing things and talked about the same things repeatedly. Claimant is perceived to have challenges with using stereotyped language, hyperactivity, and atypical communication. When compared to other individuals with neurodevelopmental conditions, claimant's challenges seem to be at levels even greater than expected.

The UCLA Team's Summary

The UCLA team summarized the results of the assessments it administered to claimant as follows: Claimant is a pleasant mannered and friendly man with a keen interest in the vast knowledge of certain topics. He has definite areas of strength in his social functioning by sharing his interests readily with others, using a wide variety of gestures to accompany his verbal language, engaging in shared enjoyment when he experiences a pleasant interaction with someone, and on some occasions he can engage in brief reciprocal social conversations. His nonverbal reasoning and visual processing speed are intact and that the levels of other adults his age. However, the UCLA team concluded that claimant meets the diagnostic criteria per the *DSM-5* for autism spectrum disorder; the team noted he has a history of atypical features in his social and communication development, and a history of engaging in restricted repetitive interests and behaviors. This condition seems to have been present since he was a young child

and the symptoms continued to be present today at high levels negatively impacting his adaptive functioning.

Claimant is markedly below the expected ranges in his ability to meet daily expectations for someone his age. He struggles with appropriately modulating and integrating his verbal and nonverbal communication, uses stereotyped language, has difficulties starting and maintaining social interactions, has no meaningful friendships or relationships outside of his family, and has shown an excessive interest in specific topics and difficulties with changes to routines and schedules. His impairments were more pronounced when he was young child but continue to markedly impact him as an adult.

The UCLA team also concluded that claimant meets the diagnostic criteria per the *DSM-5* for intellectual disability-mild. His cognitive reasoning is highly scattered making his overall score invalid. Despite his adequate nonverbal reasoning and processing speed, he shows marked struggles with abstract verbal reasoning and immediate working memory. He also has more to difficulties in his adaptive functioning, requiring significant supports from caregivers. Despite his ability to learn and retain rote information and engage in some basic academic and daily life skills, he struggles with higher levels of thinking, abstract reasoning, judgment, critical thinking, and executive functioning that pose an obstacle to his independent functioning. His extensive knowledge about his restricted interests can be deceiving as he may come across as using more complex language and vocabulary but these seem to be related to stereotyped language that he has learned from materials and memorization of facts. When talking about topics unrelated to his restricted interests, his fund of language and complexity of speech diminishes as he tends to speak in shorter phrases, having difficulty understanding and answering abstract questions, and giving brief, general responses. The combination of his symptoms of autism spectrum disorder and his intellectual limitations negatively impact his current adaptive functioning.

Although claimant has a friendly nature, shows a desire to do well and please others, and has intact nonverbal problem solving skills, he needs significant support and access to programs to improve his adaptive functioning, social relationships, and engage in meaningful work so that he can live as independently as possible and have a meaningful and good quality of life. The report contained several recommendations, which Dr. Lin described in her testimony, including treatments for intellectual disability and autism spectrum disorder.

35. During his direct examination, IRC's attorney asked Dr. Greenwald to comment on the number of signatures on the report. Dr. Greenwald testified that so many signatures made it difficult to determine who performed what testing. However, given the Interdisciplinary Team Approach used by IRC, as well as other regional centers, as part of the intake/eligibility determination process, Dr. Greenwald's testimony was difficult to understand. Moreover, rather than detract from the report, the fact that 10 licensed professionals participated in the UCLA assessment lent greater weight to its findings. Dr. Greenwald was also dismissive of the role of the "psychometrist" in his testimony when asked to define the term "psychometrist," answering the question in a condescending and demeaning manner making it seem that a psychometrist was some type of "made up" profession. Again, his testimony was difficult to understand. A psychometrist is one who is highly trained in administering and scoring various tests and instruments that assess an individual's neuropsychological functioning. Psychometrists work under the supervision of a licensed neuropsychologist. The signature on the UCLA report demonstrated that the psychometrist was also an M.S.W., meaning he had earned his Master of Social Work degree. Having an M.S.W. psychometrist involved in the UCLA evaluation bolstered the reliability of that assessment. Moreover, the report was replete with examples to support its findings, lending further credence to it.

CLAIMANT'S AND IRC'S ACTIONS AFTER UCLA TEAM EVALUATION

36. On October 31, 2016, claimant submitted a letter prepared by his stepbrother requesting his case be reopened. He gave a brief summary of his case and referenced the Loma Linda and UCLA evaluations, as well as other records, noting Loma Linda and UCLA both found claimant had autism spectrum disorder and UCLA determined he also had intellectual disability. Claimant attached documents to his letter.

37. On November 1, 2016, Evelyn De La Torre, IRC Intake Coordinator, Riverside County, wrote on a document entitled "Reactivation Notes," that claimant requested "we review new documents. Case was closed not D.D. [developmentally disabled] on 10-12-16 by IBI.[13] All information is the same." How Ms. De La Torre could write that all information was the same when claimant was submitting new documents was not explained at this hearing.

38. An IRC Intake and Assessment Flowsheet noted that on November 1, 2016, the UCLA report was requested from claimant's "brother" and another note that same date indicated "sent for review." On November 22, 2016, the matter went "to case central." The note on November 30, 2016, read: "C.C. [case central] to close."

39. An IRC Eligibility Determination/Team Review, dated November 21, 2016, and signed by an IRC psychologist, an IRC physician and program director, who were not identified in the document at this hearing, but the signature that appeared on the psychologist signature line did not appear to be Dr. Greenwald's signature. The boxes indicating that claimant was not eligible on the basis of cerebral palsy or epilepsy were checked but the boxes for intellectual disability, autism spectrum disorder and fifth category were not checked. No explanation for this was offered at this hearing.

[13] No evidence regarding what that acronym meant was offered at this hearing.

40. On November 22, 2016, IRC notified claimant that he was not eligible for services. On December 14, 2016, IRC again notified claimant that he was not eligible for services after claimant's stepbrother advised that he never received a response and IRC verified that it had used an incorrect zip code. On January 13, 2017, claimant's stepbrother, on claimant's behalf filed a request for fair hearing.

LETTER FROM NANCY PERRY, PH.D.

41. On January 26, 2017, Nancy Perry, Ph.D., a licensed California psychologist, wrote a letter to claimant's stepbrother and stepsister commending them for their efforts to find services for claimant, summarizing claimant's history, and offering her opinions. Claimant's family explained at this hearing that in their quest to find prior records, they recalled that a "Dr. Perry" had treated claimant in the past. Internet research located Nancy Perry, Ph.D., an autism expert whom they thought might be claimant's prior treater. Although they learned she was not after contacting her, Dr. Perry was interested in this case and asked to review claimant's records. Following her review, she authored her letter.

Dr. Perry understood that claimant "has received no services or supports except for special education" and that "sadly, [his] situation is not uncommon for disabled people his age. Parents of children with disabilities back in the 1950s and '60s often believed they had to soldier on alone. Many families felt it was their 'cross to bear.'" After speaking with the family members, Dr. Perry believed that claimant's family's "humility" "precluded" them from telling IRC all it "needed to know to make the correct decision about [claimant's] eligibility."

Dr. Perry noted that claimant's mother was an active alcoholic, mentally unstable, and left the family when claimant was very young and claimant had not seen her since that time. As the family now views it, claimant's father "had behaviors consistent with autism spectrum presentation himself, but functioned well enough, and had personality

features that did not allow for anyone to challenge him. He had grown up with a sister who is profoundly disabled and cared for at home with no outside assistance, so that was his model for the care of a disabled child. [¶] [Claimant's father] would not allow any discussion of [claimant's] condition, or any attempt to seek help. Despite that, [claimant] was diagnosed with autism at age 5 . …"

Dr. Perry wrote that although unclear, claimant's family believed that claimant's father lied to RCOC telling them that claimant had moved from the RCOC catchment area "solely to end the application process." In fact, claimant "never lived away from his father." Dr. Perry noted the profound stroke that claimant's stepmother suffered, which left her an invalid the last 25 years of her life. Claimant's stepbrother returned home to care for his mother and was able to observe the relationship between claimant and his father, noting that the father had "compulsive behaviors," did not care for his wife's hygiene or nutrition, nor would he take her to visit her sister who lived around the block because it "'didn't fit into his routine.'"

Claimant's stepbrother observed that claimant's father taught claimant useful skills through repetition. Claimant's father used claimant as his aide and, because driving was important to the father, claimant learned to drive. Claimant was able to get a driver's license although he required test-taking modifications and four attempts to get his license. Dental care, nutritious eating, and other aspects of self-care were not important to claimant's father so he did not teach those habits to claimant. Claimant had no social activities beyond participating in his father's interests. Claimant's pleasant personality can lead a casual observer to think claimant is higher functioning than he actually is.

After the death of both claimant's father and stepmother, the family house was sold and claimant had to move. Claimant currently lives independently in an apartment, which Dr. Perry believes was the fact IRC used to determine that claimant was not

impaired enough to need services. However, claimant is living in "supported independence" as all his finances, medical appointments, and self-care needs are being taken care of by his family members. Dr. Perry observed that Dr. Lin's/UCLA report documented the substantial disability that was required for regional center eligibility because claimant was impaired in multiple areas.

Dr. Perry wrote:

> In my experience reading records of hundreds of clients on the spectrum and testifying before many Administrative Law Judges, **[claimant's UCLA] evaluation report would be seen as one of the most comprehensive, thorough, and convincing documents, from a prestigious clinic devoted to neurodevelopmental conditions, settling beyond doubt that [claimant] has a developmental disability, that it is Autism Spectrum Disorder, and that the severity of the disorder warrant eligibility for Regional Center services.** In my experience, an administrative law judge would be mystified and perhaps angry to see this case come before her/him. (Emphasis in original.)

Dr. Perry recommended that claimant's family should report to DDS or an IRC quality assurance person "some things [that] have been done in this case" to the quality assurance personnel at IRC. She then wrote:

> One was the manner of questioning [claimant] that you describe, in which he was led by repeated step-wise questioning, to provide answers that sounded more competent than he could provide by himself. The "good"

answers were then reported as if [claimant] had produced them without the manipulation. When you questioned this practice, [Dr. Greenwald] said you should have to agree to disagree. As a licensed psychologist, I know this technique is ethical only when the entire exchange is reported, thus showing that assistance was required to attain a better answer.

Another wrong tactic was a statement [made] to you that no one who graduated from high school could possibly qualify for Regional Center eligibility, which is patently untrue. These are unethical tactics that should be reported whenever they occur. I know that family members are loath to appear adversarial while they are still in the process of applying for services, then they become reluctant to appear ungrateful if they win the fight. Nevertheless, these violations of public trust should be exposed when they occur.

I am profoundly moved by your story, and I am discouraged by how many similar ones I have heard. I have no doubt [claimant] will eventually receive eligibility because it is the right and correct decision.

PSYCHOLOGICAL EVALUATION PERFORMED BY PAGEEN CRONIN, PH.D.

42. Pageen Cronin, Ph.D., of Cronin Assessments, provides assessments of individuals with autism spectrum disorders. Dr. Cronin evaluated claimant on May 8, 2017, when claimant was almost 53 years old, and authored a 30-page, extremely detailed report dated July 28, 2017.

Dr. Cronin's curriculum vitae noted she received a Bachelor of Arts in Psychology from University California, Berkeley, in 1987; a Master of Science in Clinical Psychology from Palo Alto University (formerly Pacific Graduate School of Psychology), in 1992; and a Doctor of Philosophy Degree in Clinical Psychology from Palo Alto University (formerly Pacific Graduate School of Psychology), in 1995. From 1997 until 2004 she was the Assistant Director, Autism Evaluation Clinic, Department of Child Psychiatry, UCLA Semel Institute for Neuroscience and Human Behavior; from 2004 to 2012 she was the Clinical Director, Autism Evaluation Clinic, Department of Child Psychiatry, UCLA Semel Institute for Neuroscience and Human Behavior; since 2013 she has been a clinical psychologist in private practice. She also worked at the UCLA Center for Autism Research and Treatment (CART) from 2003 to 2012 as an Understanding Autism, Principal Investigator. She was a Primary Investigator Diagnostic Core for multi-site studies: Studies To Advance Autism Research and Treatment, from 2005 2008; Autism Center for Excellence 2007 to 2011; Simons Simplex Collection 2007 to 2011; and Autism Center for Excellence - Supplement 2011 to 2012.

Dr. Cronin's professional activities included being a research assessor, and performing multiple consultations with school districts, news outlets, public defender's offices, disability rights organizations, UCLA Center for Autism Research and Treatment Annual Symposium, California Department of Corrections and Rehabilitation, and county Department of Social Services. Her community service included working with numerous autism and behavioral health organizations and the Westside Regional Center. She has been a guest reviewer for several authoritative journals, is a member of several professional associations and has given numerous lectures and presentations, the majority of which were on autism related issues. She has provided ADOS trainings to several California regional centers, medical schools, colleges, school districts and

counties. She has authored numerous articles and research papers in peer-reviewed journals and book chapters.

As part of her evaluation of claimant, Dr. Cronin administered the following measures: ADOS-2; Social Language Development Test-Adolescent (selected subtests); and the Vineland - third edition, completed by claimant's stepbrother. In addition, Dr. Cronin interviewed claimant's mother, claimant's older sister, claimant's paternal uncle, claimant's DOR caseworker, claimant's older brother, claimant's stepsister, and claimant and her report provided extensive details of the information she obtained from these collateral sources of information. Dr. Cronin noted the reason for referral as:

> [Claimant] is a 52-year-old man referred for evaluation as part of an appeal for his eligibility to [IRC]. The current evaluation concurs with [claimant's] two prior diagnostic evaluations that are consistent to The Best Practices Guidelines for Screening, Diagnosis and Assessment of Autism Spectrum Disorder as set forth by the California Department of Developmental Services (DDS, 2002) and more recently (again) by the American Academy of Child and Adolescent Psychiatry as these guidelines thoroughly assess and evaluate developmental milestones and behavioral abnormalities that may be associated with any type of developmental delay. **The reader is referred to either or both of these reports that systematically document [claimant's] developmental history, cognitive abilities, social communication, and adaptive deficits that indicate the diagnoses of Autism Spectrum Disorder and Intellectual Disability-Mild, that cause his substantial**

> **disabilities** [and she referenced the Loma Linda and UCLA reports]. (Emphasis in original.)
>
> While neither of claimant's biological parents were present for these evaluations ([claimant's] father is deceased), not only were collateral sources of information availed who provided detailed information about [claimant's] developmental history and adaptation, [claimant's] father wrote and reported for Regional Center applications (1985, 1995) that his son had been diagnosed with autism by the time he was 5-6 years old and had been a special education student through all of his educational career and needed independent living skills.

Dr. Cronin summarized her interviews with claimant's collateral sources. She wrote the following regarding those interviews:

> Claimant's Mother

Claimant's mother reported that claimant did not cry but was fussy which worried her. He had a different way of "handling his body" and had a "tic" when he needed a diaper change but otherwise made no requests or fussed when hungry. She had to monitor his food intake so he would eat. He was a picky eater and she had to use physical prompting to get him to open his mouth. Claimant "never really spoke as a baby but could recite advertisements verbatim." When he did speak, he did so quickly and was difficult to understand. He was a special education student in school, would repeat information verbatim from shows, and his "memory was amazing." Claimant "attended a UCLA program for children with cognitive delays; his father took him every morning for a semester." Claimant also participated in Special Olympics and was among

the group identified as the "most severely retarded." Claimant "did not have 'a lot of eye contact,'" and was delayed in feeding, dressing, and toileting.

Claimant did not play baby games. He preferred to play with a car and a play/hammer "for hours because he liked the noise." He did not ask for help but might point and say a short sentence. If things did not work the way he wanted, he would throw a loud fit. He could do something if he was interested, if not, he would walk away. He appeared never to care. He did not imitate but preferred activities to sort small parts into buckets. He collected small cars and trains and would sit in his room and play by himself.

As he got older, he enjoyed working on cars with his father but was "not always quick" and he wanted to be by himself. He watched PBS for hours and they had to stop him from explaining information he learned. He was not interested in kids his age, but rather older children. He did not have friends, played by himself, invented things, or would find older children to play with but he was mostly alone all the time and he only paid attention if the other person was three to 10 years older. He loved trains and knew a great deal of information about them. Claimant's mother did not see claimant much after he began middle school.

Claimant's Sister

Claimant's sister recalled that their mother had to force feed claimant until he was 10 years old as he would not chew and they never knew when he was hungry. They always made blended drinks for him and one day he said he was hungry. The sister recalled they were on the interstate and stopped at a restaurant where their father bought a painting to celebrate the fact that claimant said he was hungry. It took claimant an hour to eat his burger because he would not chew. She recalled claimant looking at things so closely he would "put his nose in." He would stare more than appropriate when interested and required prompting not to stare.

He did not talk much, but when he did he asked odd questions for hours. He loved model trains and would go to the train yard and watch them all day long. He also liked classic and antique cars and knew all of their details. Claimant "had to know 'what is right or not going to happen,' as gray areas for him do not exist." If he was "given simple, understandable things to do, and shown how a couple times, he could do it. If not, he would be upset." He thought in black and white, not gray. If changes in time or routine were explained to him slowly, it was okay. If it was a rule or routine, such as showering and dressing, he did it. With regard to friends, in 1970 through 1975, teens and adults played basketball and claimant would have fun. If claimant liked someone, he would follow along and do the same things.

Claimant's Older Brother

Claimant's brother recalled that claimant was diagnosed early on with aphasia and self-reported that he had it, too. He also recalled that claimant would not eat and his parents had to purée all his foods, adding chocolate sauce to get him to eat. This lasted until claimant was 12 years old. He recalled that as a young child claimant was "similar to a 'savant.'" If he was "intrigued with something, one or two areas, he would try to find out everything about it he would tune out everyone else, not respond to anyone, and could not be pulled away from his interest." Claimant was interested in trains and cars and would repeatedly read his train and car magazines.

Claimant attended special schools. Claimant was always in a remedial education program. There had to be a structure that he could understand with the same daily routine. With any school changes, their mother had to alert any new instructors that claimant required specific structure and routine, taking two to three months to adjust any transition. Claimant needed to be told repeatedly why there would be any deviation in a routine. If anyone tried to get his attention, he "'would go ballistic," hitting the walls,

punching, a blind rage so everyone would carefully speak to him so he "'wouldn't blow up.'"

Claimant "did not have a single friend at home." Claimant did not know how to engage with other people. In social circumstances, if claimant did not know anyone he would not get involved, but if he knew something pertinent, he would correct others and not back down when he thought he was right. Claimant would become unglued and upset and was fired from a place where the employer/employees "'pushed him'" so he would become very angry. Their paternal grandparents cared for their disabled daughter and claimant understood that their aunt was different and when he observed her happy about something he "'got a grin out of it.'" He did not want to visit his grandparents after his aunt died.

Claimant's paternal uncle

Claimant's paternal uncle also participated in the UCLA evaluation. He again reported that claimant "doesn't do well with people and is not able to manage everyday activities of daily living and finances." Claimant did not speak until he was six or seven years old and was late with potty training. At family gatherings claimant played with a cousin who was six years younger than him. Claimant always required coaxing to eat. He did not have conversations, but was interested in trains and cars. Other than saying his father "is in a better place," claimant does not elaborate on his father's death. Dr. Cronin noted that claimant's uncle provided a letter that noted claimant's father's difficulties in recognizing his son's delays that prevented him from seeking services when claimant was young but that letter was not offered at hearing.

Claimant's Stepsister

Claimant's stepsister is four years younger than claimant and met him when her mother married claimant's father. At that time, claimant's stepsister was 19 years old and

away at college. When her mother and claimant's father married and claimant first moved into that home, claimant was prone to fits of rage and she observed that claimant "had not been socialized." Claimant's stepmother provided a lot of support and nurturing to claimant; it took her months to get him on a routine. After she became an invalid due to her stroke, claimant had to be "forced" to do things around the house and the family had difficulties getting home healthcare because of the unkempt house.

Claimant spontaneously talks about trains, the hockey team and car racing. He is now preoccupied with Star Wars and Carrie Fisher. He never asks about his stepsister's interests. He is in his "own little bubble" and spontaneously says odd things. Claimant lived with her and her family in 2016 and had to be socialized for activities of daily living, prompted to perform self-care, monitored so as not to wear the same unwashed clothing for months and he did not initiate helping out around the house. He was encouraged to go out but said that he did not want to leave the house. He was like a child but did not demonstrate comprehension for social rules. He needed to be taught manners, did not understand family-style sharing of food, and had to be coached about proper eating habits. He followed strict routines regarding his food intake and sleep. Claimant demonstrated repetitive motor mannerisms, pacing and fidgeting with his hands, and his reactions to watching TV and to other social events are "not normal."

Claimant's stepsister reported that claimant is not capable of taking care of his life. He lacks the capacity to get a checking account or use an ATM card. He "does not handle anything independently." Claimant asked no questions when his father and stepmother died regarding his living arrangements. Claimant "**cannot see outside of himself or see the future.**" (Bold in original.) Claimant is unable to handle his bills, unable to understand the difference between important and unimportant mail, and does not understand privacy issues. He often misconstrues things. He is unable to schedule

medical appointments and must be reminded to perform self-care. "There are many things that [claimant] does not pick up on his own or retain."

Claimant's Department of Rehabilitation (DOR) Case Manager

Claimant is a DOR consumer and his case manager was interviewed by Dr. Cronin. Despite a lot of direct instruction regarding communicating with prospective employers, claimant's deficits "almost cost him the opportunity for a job." Claimant is a "yes" man and even if he is asked to repeat back what he is told, he will still not demonstrate a working knowledge. He does not mind his safety, moves too quickly, and has repeatedly been instructed to slow down. He requires this as an ongoing support. His self-direction and problem-solving difficulties cost him his job, but his employer hired him back and he is being provided with an on-site job coach.

Although employed, independent living supports are needed. Claimant is able to perform tasks "if the road is straight" but any deviations are very difficult for him. DOR is a short-term support agency and claimant requires IRC services for the extended supports that are needed for him to maintain his job. Although claimant has a good work ethic, when he was recently hurt, because claimant only sees things "in black and white," rather than seek help from his job coach, he stayed home, did not call his employer to report his injury, and lost his job. That incident made it more evident to DOR that claimant requires additional supports. In the area of communication, claimant requires direct instructions and sometimes mispronunciation makes it difficult to understand him. Claimant "is good at black and white, but has difficulties with gray areas."

Dr. Cronin's Observations and Results Documented In Her Report

In the "Behavioral Observations" section, Dr. Cronin noted that claimant presented as older than his stated age of 52 with mannerisms that are often more

typical of an older individual. "Of note [claimant's] speech was typically fragmented. He also demonstrated repetitive utterances before beginning to speak. This presentation was similar to an extremely young child who is learning to talk. Claimant's responses to questions were also often tangential or 'off the mark.'" However, claimant "presented as an affable man who is eager to report his own interests; specifically his interest in locomotives and trains were [*sic*]frequently reported in great detail, and it was only at these junctures that his speech pronunciation was clear." Dr. Cronin noted that claimant "demonstrated poor gaze aversion albeit he incorporated nonverbal communicative gestures. He was also not a good historian for his own circumstances." She noted that he could not detail his finances such as his income and paying his bills. When asked about his autism diagnosis he responded, "needed to overcome barriers," and "repeated this concrete response of 'barriers' without providing any specific information about 'barriers' or comprehension for other aspects of his experience of autism."

In the "Social Communication/Behavior Assessment" portion of her report, Dr. Cronin documented her administration of the ADOS-2. She noted that the ADOS-2 manual "instructs examiners to avoid including scores and reports because the specific scores may not be interpreted as intended and are therefore not helpful to the individual being evaluated (ADOS-2 2012, p. 213). Dr. Cronin noted this was the third time claimant had been administered this measure in the past two years; IRC administered it in January 2016 and UCLA administered it in July 2016.

The results of Dr. Cronin's administration were consistent with the results of Dr. Lin/UCLA's administration of the ADOS-2. She noted that both she and UCLA used "the most current scoring algorithm" which "indicates two classifications, autism spectrum disorder and no classification, rather than the original ADOS algorithms that indicated three classifications: autism, autism spectrum, and no classification." Dr. Cronin wrote:

> Dr. Greenwald reported using the most current algorithm for the ADOS-2, but his report of results indicated that he used the former version. In addition consistent with standard practice [claimant] was administered this measure on a one-to-one basis rather than with his stepbrother in the room that occurred when Dr. Greenwald administered the ADOS-2; "The ADOS-2 is intended to be administered by one person as its primary focus is on interactive social behavior between the examiner and the examinee" (ADOS-2 2012, p. 15).
>
> Similar to prior reports, [claimant] demonstrated poor gaze aversion and was eager to speak about his restricted range of interests. Alternatively his speech was often peppered with grammatical errors, primarily single word or short phrase sentences, and utterances as he began to speak and while he was reciting. His speech was also notable for some repetitive utterances and was compulsive in completing lists of information. Further at times his responses to questions were tangential rather than related to the question. As indicated in prior reports [claimant] tends to provide a great deal of detail with regard to any fund of knowledge.

Dr. Cronin cited specific examples of claimant's responses to questions posed to him and her observations of him during the administration of the ADOS-2. Most of his responses were incomplete phrases; not complete sentences, and did not correlate to the question posed. Dr. Cronin noted that claimant did not seem to understand the

questions at times as his answers were not responsive. Although he claimed to have friends, he could not identify any by name. Dr. Cronin wrote:

> [Claimant] demonstrated notable difficulties with social overtures that are restricted to his interests and detailed descriptions. Similarly his social responses were poor and notable for tangents, non sequiturs, his lack of comprehension, and his overfocus on his restricted interests. He also peppered his speech with a variety of idiosyncratic words and phrases did not demonstrate abilities for reciprocal conversational exchanges. His language was compulsive in nature including lists and recitation of all the detailed aspects of his interests. Thus results from this measure are consistent with prior results of the classification of autism spectrum disorder.

Dr. Cronin documented the results of the Social Language Development Test-Adolescent, a diagnostic measure of social language skills for adolescents ages 12 to 17 that "also provides information to better understand claimant's social perception in language-based interactions and age equivalencies." She noted that the "[t]asks focus on taking the perspective of others, making correct inferences, solving problems with peers, interpreting social language, and understanding idioms, irony and sarcasm." Dr. Cronin administered the first two subtests and part of the third subtests. In spite of claimant's "social comprehension his performance was extremely poor." Claimant did not answer any items correctly on the first subtest, answered only three items correctly on the second subtest and "**demonstrated extremely poor social perception and**

social comprehension necessitating the discontinuation of the measure." (Bold in original.)

Dr. Cronin noted that making inferences was "a significant area of weakness for [claimant] as he does not perceive and process visual social cues." She documented his responses on the subtests and wrote: "**As reported and observed he does not coordinate gaze and eye contact across settings and therefore is likely missing, literally not seeing, and has not learned a variety of visual social cues.** Thus he tended to misinterpret what was communicated across items." (Bold in original.) On the interpreting social language subtest claimant "struggled and did not know the purpose of a compliment or three reasons to listen carefully in a conversation." She provided examples of his incorrect responses and noted that his "speech often included overlearned phrases." On the problem solving subtest, claimant's "responses never indicated recognition of how to negotiate, compromise, or problem solve with a friend." Dr. Cronin provided examples of claimant's responses supporting her conclusion.

When reporting the independent functioning assessment, Dr. Cronin noted that the instructions with the Vineland state that individuals thought to have close knowledge of the examinee's adaptive skills are asked about them to prevent significant and lengthy intrusion into the examinee's life that would happen if there was direct observation. Asking these individuals these questions is thought to be a valid measurement that cannot be adequately measured through direct administration of tasks. Dr. Cronin noted that this best practice was followed during the Loma Linda and UCLA evaluations. She noted that Dr. Greenwald's report provided results from the Vineland II but did not indicate whether he used the interview measure with claimant's stepbrother while not in claimant's presence or whether claimant's stepbrother completed the Vineland parent/caregiver checklist. However, Dr. Greenwald's results on

the Vineland II were consistent with the Loma Linda and UCLA results, as well as Dr. Cronin's Vineland 3 results.

Dr. Cronin noted that the Vineland 3 is a measure of current functioning, not capabilities, and she detailed claimant's Vineland 3 results. Among them, she noted that claimant struggles to follow instructions, especially as the steps increase; struggles to answer "why?" questions; does not consistently understand sarcasm; only talks about his own interests; is not understandable when retelling stories; cannot give simple instructions; struggles in the areas of reading and writing and does not write e-mails or letters; requires a great deal of direct instruction repetition for activities of daily living; uses utensils and recognizes that some foods are unhealthy; knows the value of money but does not manage any monetary exchanges for himself; does not tend to understand the mail he receives; does not have a best friend or group of friends; does not engage at family events; does not ask others about their interests or activities; has not demonstrated social imitation or play skills especially when he was young; requires a great deal of monitoring from family members; does not think through consequences of his actions; does not recognize he may be taken advantage of by others; and becomes extremely fixated on specific topics to an annoying degree.

In her record review section, Dr. Cronin documented the numerous documents she reviewed. She reported that the August 19, 1985, RCOC referral for service application, when claimant was 21 years old, noted that his father reported claimant had been diagnosed as autistic with aphasia, attended special education, and functioned like a 14-year-old. Claimant's stepsister reported that claimant did not complete bathing skills unless part of the routine or heavily prompted by his stepmother and required repetitive prompting to bathe. Claimant read at a third or fourth grade level and could not write a simple sentence. Despite those reports, three days later the RCOC interdisciplinary team wrote that claimant "does not appear to be eligible for special

development services. Records will be collected so that we may obtain more information to determine whether the face-to-face contact and assessment process should be initiated." Dr. Cronin wrote: "As a decision was predetermined *before* evaluation, it is not clear that any evaluation proceeded."

Dr. Cronin reported that the RCOC 1995 records noted a "family history for intellectual disabilities for [claimant's father's] sister." The RCOC July 20, 1995, Client Development Evaluation Report (CDER) indicated that while claimant graduated from high school, "he attended special education and received a modified high school diploma." Claimant's father "again indicated [claimant's] early diagnosis of autism and aphasia." She also wrote that the information regarding claimant's ability to perform certain activities of daily living were not accurate as claimant's stepsister visited claimant regularly and "none of these things were observed" and claimant required prompting for self-care and did not initiate chores. Although claimant drove, he only drove to familiar places "after practice and direction from his siblings and drives very slowly." Also, claimant has poor memory unless it pertains to his restricted interests and his speech was hesitant and difficult to understand. Dr. Cronin wrote that RCOC's February 4, 2015, ID note failed to reference that claimant attended special education classes or the "immense amount of scaffolding he required to function and therefore was not independent."

Dr. Cronin also reported on her review of IRC's records, most of which were not offered by IRC at this hearing. An October 5, 2015, IRC social assessment reported that claimant's sister and paternal grandmother presented with intellectual disabilities. Additional information regarding claimant's developmental history "was that as an infant 'his family was told not to take him home.' Yet again, 20 years later, it was reported that claimant was diagnosed with autism between five and six years of age." The IRC evaluator reported that claimant was substantially disabled across all areas of

independent living skills and that claimant "answers questions even if he does not know the answer" and was unable to explain different relationships. The IRC evaluator observed that sometimes claimant "struggles to make sentences and his speech is pressured. He does not engage in interactions with others." Claimant's restricted areas of interest were memorizing railroad magazines and being obsessed with the Anaheim Ducks hockey team. Claimant's restricted routines were noted, as well the fact that he had no friends and "doesn't follow through on things."

Dr. Cronin noted that concurrently while claimant was undergoing IRC evaluations, he and his family "participated in a best practices evaluation" with Loma Linda.

Dr. Cronin reviewed the IRC January 20, 2016, Client Development Evaluation Report (CDER) that indicated claimant "performs personal-care activities independently without reminders" despite the fact that "collateral sources have repeatedly said he does not do this, and he had to be taught and reminded." Claimant had no friends and "of note" his family structures his social opportunities. Dr. Cronin opined that the IRC letter of determination and Dr. Greenwald's psychological evaluation were both dated January 20, 2016, "so it is not clear that this evaluation followed best practice guidelines as it appeared to bring a limited amount of information together at one time, inconsistent with best practice guidelines, and then [claimant] was found ineligible for services."

43. Dr. Cronin reviewed Dr. Greenwald's assessment noting: "Dr. Greenwald's report falls short of a best practices evaluation, specifically with his [not] seeking collateral sources of information for [claimant's] developmental history for diagnosis of autism spectrum disorder. Of note the diagnosis requires a comprehensive developmental history and the best practice guidelines indicate the importance of using *Autism Diagnostic Interview-Revised* as occurred in the" UCLA evaluation.

Dr. Cronin referenced the measures Dr. Greenwald administered and offered her opinions regarding each one as follows:

Dr. Cronin noted that the KBIT-2 is a brief intelligence measure and indicated that claimant's "cognitive abilities measured in the low average to average ranges but this measure is over 10 years old (publication 2004) and thus overestimates [claimant's] abilities with standard scores measuring 3 to 4 points higher than his actual skills. Therefore, results would measure lower as would the confidence interval. Thus while his scores do not significantly change they are lowered into the borderline range."

Although Dr. Greenwald noted that the ADOS-2 Module 4 has "updated protocols, revised algorithms, and a new comparison severity score," Dr. Greenwald did not utilize these in his scoring. Dr. Cronin wrote: "Of note repeat administration of this measure by providers using the current algorithms have yielded results that indicated the classification of autism spectrum disorder . ..." Dr. Cronin also found it "problematic with Dr. Greenwald's administration that he allowed claimant's stepbrother to be present for the entire assessment. The ADOS-2 is to be administered solely with the adult undergoing evaluation. Additional people are only in the room if it is problematic for an individual such as young child [*sic*] to be left alone with an unfamiliar adult. In this case [claimant] does not present significant behavioral issues including those that would require his stepbrother in the room, and thus again would skew the results of the ADOS-2 as it is not standardized on additional family members or others in the room beside the examiner and the person undergoing evaluation."

Dr. Cronin wrote that the SSSQ "measure is also outdated at this juncture (published 1986) and is primarily to evaluate the daily functioning and independent living skills in individuals with intellectual disabilities. Thus at this juncture it overestimated [claimant's] abilities and is not generalizable to date with the standards of daily functional skills but rather [claimant's stepbrother's] reports on the [Vineland-II],

(also the older edition as there is now a [Vineland-3]) continues to demonstrate, consistent with prior reports including those consistent with best practice guidelines, that [claimant] demonstrate substantial disability across areas of adaptive functioning. For an individual who 'verbalizes' rules of safety, but seldom follows them, adaptive behavior would be considered inadequate . …"

Dr. Cronin noted that the CARS-2 "is a self-report measure by the provider, specifically Dr. Greenwald. In light of the limited exposure and appreciation of collateral sources of information [Dr. Greenwald's] results would be interpreted with caution."

In her conclusions regarding Dr. Greenwald's assessment, Dr. Cronin noted that Dr. Greenwald acknowledged that claimant demonstrated "moderate deficits" regarding his individual responsibilities such as future goals and expectations and in his comments about others' emotions and communicating his own affect. Claimant's ability to make social overtures was "skewed to favor personal interest though not exclusively so." Dr. Cronin referred readers of her report to the two evaluations "consistent with best practice guidelines that include comprehensive review" of claimant's developmental history, cognitive functioning, and most importantly his adaptive functioning that measures substantially lower than his low cognitive abilities. Further collateral sources of information, even his father's report in prior records, indicated that from an early age [claimant] was diagnosed with autism and demonstrated substantial disabilities."

Dr. Cronin next reviewed Dr. Nitch/Loma Linda's report noting it was "consistent with best practice guidelines as it includes a comprehensive developmental history, measures of cognitive and adaptive functioning, and collateral sources of information that included" claimant's stepsister and paternal uncle. Dr. Cronin noted that the results of the Wechsler Adult Intelligence Scale - Fourth Edition (WAIS-IV) "yielded significant differences between [claimant's] strengths and weaknesses." "In light of the significant differences between scores a Full Scale IQ would not be considered valid to represent

[claimant's] overall abilities. It is recommended that these results are given more weight than those obtained on the older brief intelligence measure, the KBIT-2, administered by Dr. Greenwald."

Dr. Cronin noted that the TFLS measure identified claimant's impressions of his abilities, measured in the low average range and was "similar to individuals on the autism spectrum in that [claimant] is not perceptive of his skills and abilities that are repeatedly recognized as substantially disabling by collateral sources of information." Dr. Cronin noted that the WRAT-4 scores were consistent with claimant's attendance in special education as his academic abilities measured at the elementary level. His scores on the Advanced Clinical Solutions Social Cognition indicated that he was better able to understand and accurately interpret direct communication as opposed indirect statements. Claimant's RAADS-R results "indicated scores that tend to differentiate individuals diagnosed with autism spectrum disorder 'from healthy comparison controls.'"

Claimant's stepsister completed the BFIS and the results indicated that in six of seven domains claimant presented as substantially impaired especially in the areas of social interaction, money management, self-care, and health maintenance.

Dr. Cronin concluded that in the Loma Linda evaluation claimant presented with a "clear pattern of strengths and weaknesses" which were consistent with his current areas of strength and his struggles. His struggles in social situations made him ill-equipped for customer service jobs and his learning potential could be constrained by the limited availability of his working memory resources. Claimant had led "an impoverished social life," primarily interacting only with his father and stepmother. He had always demonstrated a limited ability to initiate social interactions and had deficits in developing and understanding social relationships, but did not seem upset by this limitation. Loma Linda found that given his extreme impairment in social interactions

during his lifetime, an autism diagnosis was appropriate. Although Loma Linda noted that the results indicated "Autism Spectrum Disorder (Asperger's disorder) without accompanying intellectual impairment and without accompanying language impairment," there is no diagnostic difference between Autism Spectrum Disorder and the qualifier of Asperger's disorder and it is not indicated by the *DSM-5*. Further, Dr. Cronin noted that claimant clearly demonstrated significant differences between his intellectual abilities as reported in the Loma Linda report, which would indicate the qualifier "intellectual impairment" be used with his autism diagnosis Further, based on how claimant speaks, specifically his inconsistent fluency, and the language processing and comprehension difficulties reported, an accompanying "language impairment" qualifier would be indicated. The Loma Linda report also referenced the functional impact of claimant's deficits and recommendations for needed services in light of his substantial disability, again supporting an intellectual disability diagnosis.

Dr. Cronin discussed Dr. Lin/UCLA's evaluation. She noted the evaluation was consistent with best practices guidelines as it included a comprehensive developmental history, measures of cognitive and adaptive functioning, collateral sources of information, and records review. The UCLA report included measures consistent with best practices guidelines that were administered for the purposes of differential diagnoses, specifically to screen for other psychiatric diagnoses, none which were found. Dr. Cronin referenced the *DSM-5* autism spectrum disorder diagnostic criteria contained in the UCLA report, noting the findings were consistent with other reports, and supported the diagnoses of autism spectrum disorder with accompanying intellectual impairment and language impairment and mild intellectual disability. The UCLA report documented that claimant was substantially disabled not as the result of the learning disability or psychiatric disorder, and he requires significant supports to maintain his

independence as well as prompting for activities of daily living. Dr. Cronin opined that UCLA correctly determined that claimant be found eligible for regional center services.

In her summary, Dr. Cronin noted that her evaluation was intended to complement the prior reports consistent with best practice guidelines. She concurred with the Loma Linda and UCLA evaluations that diagnosed claimant with autism spectrum disorder, as well as with the UCLA evaluation that also indicated he had an intellectual disability diagnosis. As a result of these diagnoses, Dr. Cronin opined that claimant is substantially disabled and his significant deficits in adaptive functioning have been reported from the time he was young. Claimant does not demonstrate insight or knowledge about his diagnosis. Dr. Cronin outlined the specific evaluations performed that supported these diagnoses, noting that the results obtained on testing were consistent with reports from collateral sources and his issues were reported across all collateral sources of information. Consistent with the records and collateral sources, from an early age claimant demonstrated significant social communication delays and deficits, and his repetitive behaviors. His adaptation was always poor and there has not been a change or decline in his adaptive functioning from an early age. Further, with changes in support, he did not maintain skills or routines for activities such as self-care and the delays were consistent over time and noted in adaptive functioning measures.

Dr. Cronin noted that claimant's social skills measures are significantly lower and demonstrate a **profound social disability** characteristic of his *DSM-5* diagnosis of autism spectrum disorder. (Emphasis in original.) Across measures of adaptive functioning, claimant's abilities consistently measured significantly below both age expectations and his cognitive abilities. His DOR caseworker reported claimant's social perception difficulties that require support. Dr. Cronin identified the difficulties in evaluating and predicting future social functioning for individuals with autism. She noted claimant, consistent with a diagnosis of autism, did not demonstrate motivation

and initiation for age-appropriate adaptation and demonstrated poor organization, planning and coping skills for activities that are not part of his routine or restricted interests. He had a lack of social adaptation and difficulties reported since he was young. Repeat measures of independent adaptive functioning indicated that claimant demonstrated substantial social impairment. As Dr. Cronin wrote, "**Therefore, he clearly requires targeted intervention and supervision and the delay in receiving autism-specific support has increased the severity and frequency of his social behavior deficits."** (Emphasis in original.) In addition, Dr. Cronin cautioned any changes to claimant's supports should be strictly monitored because he has not done well with changes in supports in the past.

Dr. Cronin next evaluated claimant's substantial disabilities under the Title 17 categories. She specifically addressed the learning, communication, independent self-care, self-direction and economic self-sufficiency areas, noting specific examples supporting her opinion. She concluded that claimant meets the *DSM-5* diagnoses for Autism Spectrum Disorder associated with requiring substantial support for social communication and social interaction, restricted repetitive behaviors; with accompanying intellectual impairment; with language impairment; and without any accompanying co-occurring psychiatric condition. Claimant also meets the criteria for a diagnosis of Mild Intellectual Disability (Intellectual Development Disorder). Dr. Cronin reported specific examples of how claimant met the *DSM-5* criteria and provided several pages of her recommendations for his care.

IRC'S EXPERT'S TESTIMONY

44. Paul Greenwald, Ph.D., is a staff psychologist at IRC who conducts assessments to determine eligibility. Dr. Greenwald received his Bachelor of Arts in Psychology from the University of Miami and his Ph.D. in 1987 from the California School of Professional Psychology in San Diego. He worked in Florida from 1988 to 1990

as a research associate at University of Miami School of Medicine; from 1990 to 1992 as a postdoctoral resident at a family psychology center; from 1992 to 1995 as a precertification psychologist performing psychodiagnostic assessment/hospital authorizations for Florida Medicaid prescribers; from 1995 to 2001 as a Clinical Programs Director for a senior program providing group counseling; from 2003 to 2004 as a Clinical Coordinator for a children's psychiatric center; and from 2001 to 2006 as a Psychologist working in multiple venues. In California, Dr. Greenwald was an independent psychology vendor for Harbor Regional Center from 2006 to 2008 and has been an IRC staff psychologist since 2008.

Dr. Greenwald reviewed records, performed an assessment, and authored a report in which he determined claimant was not eligible for regional center services. Claimant submitted a voluminous set of exhibits at this hearing, including the three psychological assessments claimant underwent after receiving IRC's denial. Dr. Greenwald repeatedly testified that he reviewed those exhibits "over the weekend" before this hearing to prepare for his testimony at Monday's hearing. It was not established that he had reviewed them at any other time. Dr. Greenwald's demeanor while testifying was quite dismissive of claimant's voluminous exhibits and he did not appear to have seriously considered any of those documents. Further, Dr. Greenwald did not contact any of the authors of the assessments or the percipient witnesses who contributed to them.

When asked about Dr. Nitch's Loma Linda report, Dr. Greenwald replied that claimant was 51 years old the time and deficits must be shown by age 18. Dr. Greenwald was "familiar with some but not all" of the tests Loma Linda administered. He noted that claimant's self-report of being able to make friends and not experiencing any particular social problems was inconsistent with a diagnosis of autism and showed a self-awareness of the need to have friends and report that fact. Claimant also graduated

from high school and was able to demonstrate skills and interest in his vocational efforts, specifically a job as a cashier. Claimant's report that he was "clean as a whistle" when asked about drug use showed that he was proud of it. His ability to reside in an apartment by himself and perform some household chores, and have a driver's license, shows a "level of adaptability."

When IRC counsel asked Dr. Greenwald about claimant's activities of daily living, Dr. Greenwald testified about his wife who is a nurse who assesses patients' activities of daily living, explaining how she evaluates her patients' ability to do their activities of daily living. Dr. Greenwald's testimony in this regard was extremely odd. As an IRC psychologist making eligibility evaluations, Dr. Greenwald should be knowledgeable regarding Lanterman Act substantial handicapping conditions and activities of daily living and evaluate them during his assessments using the Lanterman Act criteria. Dr. Greenwald's testimony referred to his wife's occupation, the patients she serves, and her evaluations of her patients' activities was completely irrelevant and raised concerns regarding his knowledge and ability to assess consumers.

Dr. Greenwald reviewed his assessment noting that claimant was able to recall personal information, which would cut against diagnoses of intellectual disability or autism. He explained that he gave the ADOS, an objective assessment where the evaluator observes an individual's responses. He also gave the CARS, a non-objective test where the information is derived from other sources. Dr. Greenwald gave the SSSQ because it measures adaptive behavior using presses and challenges asking questions involving real world choices in areas relative to independent living. He described it as an "objective test" and said the source of the information was claimant's "cousin." That testimony was unclear as no "cousin" participated in the IRC evaluation, the family members participating were claimant's stepbrother and stepsister.

Dr. Greenwald found it important that claimant acknowledged his name, turned his head, and made eye contact when Dr. Greenwald greeted him at IRC. Dr. Greenwald opined that this showed claimant recognized the need to reply and was able to use three forms of social communication. Dr. Greenwald did not observe claimant have any difficulty transitioning from the waiting room to the assessment room. He did not observe any vulnerability to sensory distractibility or repetitive stereotyped behaviors. Claimant's prosody (the tonality of his speech) was expressive, meaning it was emotional. Dr. Greenwald explained that his diagnoses were "Rule Outs" because he was assessing claimant for qualifying developmental disabilities only. He was not making non-qualifying diagnoses so he was not sure if claimant had those disorders and believed claimant should be examined by another mental health professional for those conditions.

When IRC's counsel asked Dr. Greenwald how to treat someone with an intellectual disability, a relatively straightforward question aimed at obtaining opinions regarding the fifth category, Dr. Greenwald replied "it is not my specialty." Dr. Greenwald then proceeded to give lengthy anecdotal testimony regarding his experiences in Boca Raton, Florida. He testified that the facility where he worked in Boca Raton shared space with the facility next door; the mistakes he had made calling that facility a "rehabilitation facility" when it was actually a "habilitation facility," and the individuals with intellectual disabilities who received care at that Boca Raton facility. Dr. Greenwald described the nursery where those patients worked and the graphics used to give them instructions and how they were taught using supervision, repetition and graphics.

Given that Dr. Greenwald's curriculum vitae demonstrated that he last worked in Boca Raton in 2004, and last worked in Florida in 2006, his observations about how another facility in Florida worked with its intellectual disability patients back then was irrelevant and did not establish he had any knowledge regarding the treatment

individuals with intellectual disabilities receive in 2018. Dr. Greenwald's testimony seemed oddly out of place, raised doubts regarding his knowledge of the treatment individuals with intellectual disabilities receive, and established that he was not qualified to render fifth category opinions. Given that eligibility under the fifth category was one of the issues in this matter, and Dr. Greenwald was IRC's only expert who testified, Dr. Greenwald's responses to the fifth category questions were greatly troubling.

Dr. Greenwald testified about the IQ test Dr. Nitch administered, noting there was a disparity between the norms. Dr. Greenwald criticized a psychiatrist giving this test, which he testified is "specifically within the purview of the psychological examiner." Dr. Greenwald noted that the scores were above the cut off for intellectual disability, were splintered, and testified that typically one with an intellectual disability has low and flat scores. Dr. Greenwald was critical of the "Autism Spectrum Disorder (Asperger's Disorder)" diagnosis Dr. Nitch gave noting that it is a "retired diagnosis entity under the current *DSM-5*." However, that criticism was without basis because Dr. Nitch not only put that part of his diagnosis in parentheses, but specifically referred to the *DSM-5* in his report and also used the qualifiers, "without accompanying intellectual impairment," and "without accompanying language impairment" that the *DSM-5* requires, demonstrating he was aware of the *DSM-5*. Further, Dr. Greenwald provided no support for his testimony that a psychiatrist is not qualified to administer psychiatric testing.

Dr. Greenwald was also critical of the autism diagnosis, testifying that none of the tests Loma Linda administered were autistic-specific tests. However, that testimony was also not persuasive because Dr. Nitch's report specifically explained the autism test administered, the Ritvo Autism Asperger Diagnostic Scale-Revised, as well as other tests administered to evaluate claimant's impairments and executive functioning deficits. Dr. Greenwald did not know whether the RAADS-R administered at Loma Linda was a valid measure to diagnose autism

Dr. Greenwald was critical of the UCLA report because there were no citations to the sources of the history obtained and he claimed there were "no formal tests." This testimony was not persuasive in light of the *DSM-5* references to obtaining facts "by history." Moreover, UCLA administered the ADOS, which Dr. Greenwald previously testified is the "gold standard" for assessing autism. Dr. Greenwald also thought the UCLA report was "rather vague" and noted the difficulty UCLA had obtaining documents from claimant's past. These criticisms were unsupported and further demonstrated that Dr. Greenwald was acting as an advocate and not as a non-interested expert. Dr. Greenwald also disagreed with several of the UCLA report findings. He noted that claimant could describe the exact routes and highways he travelled, which would require "a level of alertness and 3-D space," and require him to be able to translate those experiences into words, which is a fairly sophisticated process that would cut against an intellectual disability. Claimant also exhibited a desire to please which would rule against a diagnosis of autism. Dr. Greenwald opined that the ADI-R findings were not solely indicative of autism and the repeated notation that claimant "has a history" of behaviors was "questionable" and Dr. Greenwald did not observe any during his assessment.

Dr. Greenwald also noted that the Vineland administered by UCLA is a non-objective test and the scores received on the Wechsler Adult Intelligence Scale were above intellectual disability scores. Dr. Greenwald opined that there was a lot of consistency in the scores between UCLA and Loma Linda. He disagreed with Dr. Cronin's criticism of how he administered the ADOS (with claimant's stepbrother in the room), testifying that the ADOS manual refers to the presence of participants, not observers. However, that testimony was not persuasive given the language from the ADOS manual that Dr. Cronin cited and did not address Dr. Cronin's concerns. Further, Dr. Greenwald offered no supporting documentation for his position. More importantly, Dr. Greenwald did not address Dr. Cronin's criticism that he used the outdated version of the ADOS

algorithm when he scored claimant's results, resulting in erroneous findings. Dr. Greenwald did not address Dr. Cronin's opinion that had Dr. Greenwald used the current algorithm, the scores would have been in the autistic ranges.

During his cross-examination, Dr. Greenwald admitted that his assessment took place in one day, lasting approximately three hours. Dr. Greenwald acknowledged that he did not put in his report that it took claimant four attempts to get his driver's license. He was not sure whether the IRC social assessment noting that claimant "speaks rapidly" would provide any diagnostic information. Dr. Greenwald admitted that claimant was documented as answering questions even when he did not know the answers to them. He acknowledged he does not ask for additional records unless he has knowledge of the sources and he "was not privy to" the letters authored by claimant's family members and friends. His testimony regarding "the sources" made no sense because Dr. Greenwald is the one interviewing IRC applicants and can presumably ask questions that would illicit information about other treaters/sources of information. Moreover, these letters were referenced and discussed in the reports of claimant's other evaluators and it was unclear why Dr. Greenwald had not obtained or reviewed them.

Dr. Greenwald could not recall if he knew claimant was living with his stepsister at the time of the IRC evaluation. Dr. Greenwald did not interview anyone other than claimant's stepbrother who was present during the assessment. Dr. Greenwald acknowledged he has the Best Practices book, which is "a guideline" for IRC. He admitted that the tests he administered required claimant to have language comprehension even though claimant does have deficient language functions, including a prior diagnosis of aphasia. Dr. Greenwald further admitted that the Vineland scores reported by UCLA, Dr. Cronin and Dr. Greenwald were all below the first percentile.

When asked about the article criticizing the SSSQ, Dr. Greenwald explained that the SSSQ is not adequate to determine intellectual disability and should be used with

other diagnostic tools which was why he also used the Vineland. However, that testimony did not fully address the concerns expressed in the article criticizing the use of the SSSQ and Dr. Greenwald made no such representations in his report about the SSSQ's limitations.

On re-direct examination, Dr. Greenwald explained claimant receiving special education services was not controlling because eligibility for special education is not the same as eligibility for regional center services. He noted that the 1985 regional center Referral for Service indicated claimant could "do all for himself," which further supported IRC's determination. Dr. Greenwald believed that the IRC's evaluation complied with Best Practices. He opined that it was appropriate to use the SSSQ as part of the assessment, that the scores were close to those received on other Vineland tests administered, that all tests have flaws, and that a comprehensive approach is best. Dr. Greenwald concluded his testimony by noting that he was "intrigued" by the close correspondence between the content of the Texas adaptive test given at Loma Linda and his own "in terms of the content of the questions and presses administered to claimant which were very isomorphic with the SSSQ."

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CLAIMANT'S EXPERTS' TESTIMONY

Pageen Cronin, Ph.D.

45. Pageen Cronin, Ph.D., has a clinical psychology private practice and performs diagnostic evaluations, with an expertise in developmental disabilities. She testified consistent with her curriculum vitae and report. Dr. Cronin described her education, training, and experiences identified in her curriculum vitae. She discussed her extensive training and development of autism programs at UCLA, her consultations and trainings regarding best practices, her ADOS training and research, and her work with

other regional centers. Dr. Cronin has been hired by the Department of Developmental Services (DDS) to provide training to regional centers regarding Best Practices for administering the ADOS. Dr. Cronin testified about her extensive 15 years of ADOS training, explaining that she was hired by its authors to train others how to use it to ensure that it was being administered and scored correctly. Her testimony demonstrated she was eminently qualified to provide opinions regarding the administration of the ADOS. She also authored a book chapter on adaptive functioning.

Dr. Cronin explained the bases for her opinions, going through the specifics of her findings and the facts on which he relied. She described in great detail her assessment process. Her testimony demonstrated that she was extremely thorough and obtained extensive background facts and sought multiple sources for supporting information. She described her interaction with claimant, noting that he was only eager to speak about areas of his interest, he had fragmented and unintelligible language unless it was in an area of interest, and a hesitancy in speaking similar to that of young children. Claimant was not a good historian of his own circumstances and would give "concrete responses" that did not really answer the questions posed to him. He used catch phrases that were not on point to what was being asked. Dr. Cronin opined that her evaluation followed Best Practices, including an extensive record review.

Dr. Cronin was critical of Dr. Greenwald's "Rule Out" diagnoses, testifying that "Rule out" is not a diagnosis. She also disagreed with his two rule outs. She explained that "avoidant personality disorder" is a diagnosis for individuals who are very interested in social engagement but have an increased sense of rejection and avoid social interaction due to that fear. Dr. Cronin did not find claimant to be avoidant at all. He was interested in things, for example he would go to the Anaheim Ducks' games where he has always been around lots of people and never exhibited being fearful of their rejecting him. Dr. Cronin also criticized Dr. Greenwald's opinion that claimant may have

"schizoid personality disorder," noting that diagnosis is for individuals who have no emotions and do not demonstrate facial expressions. Despite claimant's lack of appropriate facial expressions, he can be animated regarding his areas of interest. Dr. Cronin believed that IRC missed the autism and intellectual disability diagnoses because it did not gather enough information and did not follow Best Practices.

Dr. Cronin explained that "unfortunately claimant came to this system before the Individuals with Disabilities Education Act (IDEA), so special education courses were not mandated." At the time claimant was in school, California did provide special education services but only served the most delayed students. The fact that claimant received services during this time demonstrated how extremely delayed he was as a child. Moreover, claimant's participation in the UCLA program in the 1970s is an extremely important fact. Claimant participated in the center-based program at UCLA for children with delays, which was a precursor to the UCLA program where Dr. Cronin previously worked.

That UCLA program only took the most severe cases of autism and intellectual disability, again demonstrating that claimant was someone recognized as "a child with severe enough developmental disabilities" that he was able to participate in that UCLA program. Claimant was in a group of children "considered to be the most mentally retarded," as shown by his participation in that UCLA program. Moreover, during this timeframe, the autism diagnosis was just emerging and at the time evaluators were looking for individuals who had highly repetitive behavior, highly repetitive speech, delays in speaking, pronounced deficits, compulsions, restricted interests, and lack of interpersonal relationships. At that time, only four or five out of 10,000 children were identified as being autistic, and claimant was one of them. Moreover, to be considered autistic in the 1970s, one also had to have intellectual delays. Claimant being recognized

during the 1970s as qualifying for the UCLA program is clear evidence that he had both intellectual disability and autism as a child.

46. Dr. Cronin also pointed out that there is much historical information indicating claimant had his conditions before age 18. There are records that the family was told not to take claimant home after birth. He had delayed speech diagnoses. He had an aphasia diagnosis. His father on several occasions referenced claimant's autism diagnosis at age five or six. Again, Dr. Cronin opined that claimant getting this diagnosis at that time demonstrates how severe claimant's developmental delays were perceived to be. Records also documented that claimant cannot tell the difference between a girlfriend and a girl friend. Additionally, claimant was the third of his mother's children so for her to state he had developmental delays is persuasive because she would have recognized the difference between him and his two older siblings.

47. Dr. Cronin was critical that IRC fell short of the Best Practices when it evaluated claimant. She opined that IRC did not give weight to claimant's developmental history. IRC did not review collateral sources of information, which would be especially important when evaluating an adult for developmental disability. IRC overlooked "lots of collateral" for information regarding claimant's early history.

Dr. Cronin was critical that Dr. Greenwald used the Kaufman Brief Intelligence test when Best Practices discusses the need for a comprehensive cognitive evaluation of older individuals. Dr. Cronin opined that the Wechsler IQ test given by Loma Linda and UCLA should be given more weight than the Kaufman test because they are comprehensive measures of functioning, something which is especially important to measure when evaluating older individuals. It is necessary to tease apart an older individual's strengths and weaknesses, something which will help better understand certain behaviors. For example, claimant's results explain why telling him something slowly a number of times will help him eventually "get it." In spite of that criticism, she

noted that the Kaufman brief IQ test did show how impaired claimant's working memory skills are and captured claimant's cognitive deficits, especially when considered with the UCLA and Loma Linda assessments.

48. Dr. Cronin was also critical that Dr. Greenwald had used the outdated ADOS algorithms. The new algorithms were published in 2014 and Dr. Greenwald performed his evaluation 2016, almost two years later, so it is unclear why he used the outdated algorithms. If Dr. Greenwald had used the current algorithms, claimant's ADOS scores would have been in the autism qualifying ranges and met the criteria for an autism diagnosis. Dr. Cronin was also critical that Dr. Greenwald reported the ADOS scores in his report as the ADOS authors advise against doing so because the scores can be misused.

49. Dr. Cronin criticized Dr. Greenwald's use of the SSSQ, as it is not a valid measure for evaluating adaptive functioning. The article criticizing the SSSQ was published in 2008 in a peer-reviewed journal. Dr. Cronin explained the purpose of the SSSQ, its use as a vocational tool, and its limitations because it fails to have a "robust, evidence-based, strong normative sample or consistency over time," making it an invalid tool to measure adaptive functioning. Moreover, she was not surprised claimant did well on the SSSQ as he is functioning in a sheltered work environment with a job coach, performing structured tasks. However, if claimant loses that job, he has no other plans in place for employment. Dr. Cronin also explained that cognitive functioning is not symbolic of adaptive functioning. An individual with an IQ above the intellectual disability cut off can still be cognitively impaired. Here, claimant reads at a third or fourth grade level, and he cannot write sentences. The *DSM-5* discusses cognitive abilities and adaptive functioning and their impact on intellectual disability and autism consistent with what advocates have been advocating for the past 25 years.

50. Dr. Cronin disagreed with the Loma Linda determination that claimant did not have intellectual disability primarily because that report and test results captured an intellectual disability. She believed the two conditions may have been linked in the Loma Linda report. She explained that some evaluators think autism includes intellectual disability and in the past it was assumed that if one had autism that meant he or she also had intellectual disability. However, the two should be parsed. Dr. Cronin agreed with the UCLA findings, noting they used "gold standard measures" to determine that claimant had autism and intellectual disability. Dr. Cronin explained that claimant's autism and intellectual disability are what cause his issues. If he just had intellectual disability, he could perform skills after generalization, but because of his autism, he needs scaffolding and support. If he just had autism, he would be able to continue with routines once learned, but here, when his stepmother died, he stopped his routines and his sister had to retrain him. Accordingly, Dr. Cronin opined that claimant has both conditions. Dr. Cronin acknowledged that claimant does have strengths, but he does not maintain his skills over time and he does not demonstrate them consistently across the board.

Christie Lin, Ph.D.

51. Christie Lin, Ph.D., authored the UCLA report of claimant's psychological assessment performed at UCLA. Dr. Lin received her Bachelor of Arts Degree in Developmental Psychology from the University of California, Berkeley in 2001. She received her Master's in Counseling Psychology in 2007, and her Ph.D. in Clinical Psychology in 2010, both from the University of California, Santa Barbara. From 2009 to 2010 she was a clinical psychology intern at Lucille Packard children's hospital at Stamford/children's health Council. She was a Clinical Psychology Fellow from 2010 to 2012 at the University of California, Los Angeles, Division of Psychological Studies in Education, and a Clinical Psychology Fellow from 2011 to 2012 at the University of

California, Los Angeles, Division of Child and Adolescent Psychiatry. Dr. Lin is a licensed psychologist and a board certified behavior analyst, doctorate level.

Dr. Lin is currently an Assistant Clinical Professor and Clinical Psychologist at the University of California, San Francisco. Prior to that, she was an Assistant Clinical Professor, Clinical Psychology, from 2012 to 2017 at UCLA David Geffen School of Medicine and a Staff Psychologist II, Clinical Psychology, UCLA Department of Psychiatry. Her professional activities include being an Attending Psychologist at UCSF School of Medicine, STAR Center. Dr. Lin was an Attending Psychologist at UCLA David Geffen School of Medicine in the Child and Adult Neurodevelopmental Clinic, and has been a course instructor, primary clinical supervisor, clinical supervisor, clinical psychologist, and advanced practicum clinician at UCLA. She also had a private therapy practice in Los Angeles. She has been a therapist, assessment clinician, training clinician, program supervisor, and practicum clinical supervisor at the University of California, Santa Barbara,

Dr. Lin is an ad hoc reviewer for several peer-reviewed scientific journals, has given numerous international and national presentations, and serves on university committees and teaches postgraduate and other courses. She has published in numerous peer-reviewed journals and authored several book chapters. She was awarded a research grant to study parent interventions for repetitive and restricted behaviors and interests in children with autism spectrum disorders. Dr. Lin also attended *DSM-5* conferences specific to autism, learned how the diagnostic criteria were developed, and read the supporting research.

Dr. Lin has received several honors and special awards including receiving two awards from the International Society for Autism Research and an Autism Center Fellowship at the University California, Santa Barbara which she took to further her advancement and training in autism spectrum disorders, with a particular emphasis on

interventions and assessments. To receive the award, she had to submit her work to an autism spectrum disorder research conference. She developed a curriculum to make trainees more competent to diagnose autism spectrum disorder so as to assist community providers to be more aware of the diagnosis. Her doctoral program only accepted advanced trainees and provided advanced training for assessing patients with autism spectrum disorder. The training was for more advanced doctoral candidates who applied nationwide for the internship in their final year of training and wanted to specialize in the autism area. The students would watch ADOS videos in their entirety, code them, and teach others how to administer the ADOS. The purpose was to ensure the reliability through research of the ADOS standards. For five years at UCLA, she performed two to three autism assessments per week; at UCSF she performs one to one and one-half per week.

Dr. Lin testified about claimant's UCLA evaluation, and remembered "being particularly struck by how supportive" claimant's family was of him. She described the team approach used at UCLA. The psychometrist has a Bachelor of Arts degree and assists the psychologist with administering and collecting data from the evaluation. At UCLA all evaluations are presented to the broader case conference, consisting of UCLA faculty: psychiatrists, psychologists, neurologists and other professionals. All cases are reviewed with this team, including a review of all test results, as well as the videotape of the ADOS administered. Dr. Lin explained that the ADOS is videotaped to ensure that the information the team gets is all the information so that they can review it as a team and make an accurate diagnosis and get recommendations from all the disciplines involved.

After the evaluation, Dr. Lin diagnosed claimant with autism spectrum disorder and intellectual disability. Claimant also requires treatment similar to one with an intellectual disability, but Dr. Lin never actually opined that claimant qualifies under the

fifth category. Dr. Lin explained that autism is a neurodevelopmental condition that starts in utero. It starts at a very early age and, for whatever reason, the brain of the autistic individual "is just wired differently." Autism is a pervasive disorder that is present early on and persists throughout an individual's lifetime. Individuals can also have intellectual disability with autism spectrum disorder. The symptoms vary between individuals which is why individuals with autism spectrum disorder can have both high functioning and low functioning abilities. Individuals do not "grow out of autism," they retain the condition throughout their lifetime.

Dr. Lin testified about the symptomatology of autism spectrum disorder, noting that the main ones seen are problems with social development and communication development, nonverbal communication, a lack of understanding of social relationships and restricted repetitive behaviors and interests that may also have sensory components. The *DSM-5* changed the autism continuum, now requiring three deficits: impairment in conceptual abilities, impairment in adaptive functioning, and presentation of symptoms at an early age.

Dr. Lin described the UCLA evaluation, the work performed by UCLA team members, her administration or supervision of the testing performed, and her interactions with claimant. She and her team routinely gather information about an individual's developmental history from family members. It is "very typical to ask family members for information, that is generally the way developmental history is obtained." Dr. Lin specifically sought information from claimant's uncle because he could provide information about when claimant was younger. The striking information she gained from those interviews were the uncle's statements regarding how claimant just sat there often and was held, he did not engage, to the point that his family became concerned he had a hearing problem. The family members, especially claimant's uncle, relayed lots

of delays and atypical behaviors, and there were concerns about claimant from a very young age. Dr. Lin also administered testing that ruled out psychiatric conditions.

Dr. Lin described claimant's odd intonation, explaining that he sounded like a cartoon character. He demonstrated immaturity in emotional regulation and displays of emotion. Claimant had restricted interests and ritualistic types of behaviors: he was more focused on dates and not the social aspects of events. Claimant had "a lot of difficulty engaging in social chitchat." It was hard to have a back-and-forth interaction with him; Dr. Lin said claimant talked at her, not with her. It was very hard to have a conversation with claimant. He just gave facts or narrated an event, even if Dr. Lin tried to add information, he did not build on it. Claimant did not ask questions or show interest in Dr. Lin's experiences and it was "very striking" that he did make some attempts to show he was listening by making comments like "Oh, wow," but he never went any further. When asking about non-routine experiences, he could only provide vague answers but no details. However, when discussing areas of interest, he used full sentences and a varied vocabulary, but as Dr. Lin listened, she realized he was merely repeating what he had read or seen. When asked about topics unrelated to his interests, his language became very impoverished. Claimant's actual language levels are quite low and delayed. This is why he gives the impression of being brighter than he is; but he does struggle with language delays.

In addition to the language delays, claimant also has limited socialization. He is able to speak in sentences and can combine sentences but struggles using language for social interactions to start and maintain conversations with others. His nonverbal problems include eye gaze; his use of gestures where his motions are jerky and he holds his hands in a slightly odd way when speaking; his flat, more subdued type of facial expressions; and his lack of variation in his expressions. Claimant did have areas of strengths, consistent with individuals with autism spectrum disorder. Autism spectrum

disorder is very heterogeneous which is why it requires well-trained, skilled clinicians to diagnose the condition. Individuals with the disorder can have certain qualities but still be lacking in others and variety and heterogeneity among individuals with autism is commonly observed.

Claimant had moments of normal eye gaze but no modulating of his eye gaze and no consistently integrated eye gaze. He did not consistently pair his eye gaze with the social situation. He lacked modulation of eye gaze by social situations and he did not modulate his eye gaze appropriately.

Dr. Lin testified that to "really use the full scale IQ," there needs to be consistency within the subtests. "If there is too much variability in a domain, the scale score for that domain is significant because there is too much scatter." If there is more than one standard deviation, conservatively 1.5 standard deviation, "you start to question whether the score is valid." Individuals with autism spectrum disorder often show a lot of scatter which is why it is important to look at the whole cognitive score and how the individual functions in society.

Claimant's IQ scores "varied quite a lot." He did well on tests of his crystallized knowledge, as he had memorized facts, but his vocabulary and abstract reasoning were very low. Claimant does not understand what words mean and even more striking was his difficulty understanding conceptual nuances between words, a skill requiring reasoning that claimant lacks. Claimant has trouble understanding and explaining concepts very much below expected levels. He had trouble understanding how two words were related and had trouble defining and explaining their relationship. Claimant had trouble discerning how information was linked and trouble drawing inferences. Dr. Lin explained that all individuals "have a tray of information we hold in our mind," and claimant's "tray" is significantly challenged, making it hard for him to hold information

especially when it is given to him quickly. If he is given information, he is not likely to remember it unless it is meaningful for him.

Claimant's activities of daily living were very much below expectations. He requires prompts and reminders. He cannot manage his needs, including medical appointments or finances. His scores were three standard deviations below where one would expect him to be given his age. His leisure activities are all solitary. He has no friends. It is important to get information in this regard from the caregivers to learn how claimant functions in the world and his community. Dr. Lin stated that the "hallmark of autism spectrum disorder" is a really significant impairment of social interaction. Here, claimant has no friendships, although he thought he had "many friends," but further questioning revealed he merely had acquaintances and does not really understand friendships, or what they entail. It was clear that claimant would like some social interaction but does not know how to proceed and that is a hallmark of autism spectrum disorder; it is not that one with this disorder cannot have social interaction, it is that they do not know how to do so.

Claimant has "a lot of stereotyped language." He repeats what he has heard and in the tones he has heard it. He can monologue and sound intelligent, but he has merely memorized information. At age four or five he could repeat commercials and was using languages he created. He had stereotyped body mannerisms: flapping his hands, posturing his hands. During the ADOS Dr. Lin administered, claimant needed things presented in a very particular way. She observed his need to create specific sequences and it was "very, very apparent" he had limited interests, for example trains. Restricted interests are not required to be present in early development, they can show up later in life and can change over time. However, claimant has had restricted interests for a long time: a hockey team, cars, vehicles, trains. Restricted interests are more of a distinction for someone with autism spectrum disorder as opposed intellectual disability. However,

Dr. Lin was struck by claimant's restrictions because they "really interfered" with his ability to have social interactions and varied interests.

Dr. Lin is familiar with the Kaufman brief IQ test Dr. Greenwald administered. She does not use it because she does not like to choose brief tests especially for first-time evaluations, as they tend not to provide complete information. In fact, the *DSM-5* cautions against using very abbreviated measures because they only provide limited information. Dr. Lin was critical that Dr. Greenwald had claimant's stepbrother in the room when he administered the ADOS. No one but the examiner was in the room when it was given at UCLA. Having someone else in the room with an older individual can impact the scoring and make the examinee uncomfortable. Further, the directions provided with the ADOS modules recommend not having someone else in the room except with young children or individuals with behavioral issues, neither of which applied here.

Additionally, Dr. Greenwald used the outdated ADOS algorithms; the current algorithms are available to evaluators, they are even available on Google. If an evaluator is administering the ADOS, the evaluator should be aware of the need to use the current algorithms. Had Dr. Greenwald used the correct algorithms, claimant would have had scores in the autism ranges. Dr. Greenwald also listed the ADOS scores in his report and evaluators who give training or who are trained using ADOS are instructed not to disclose the codes in reports because they can be misconstrued, misinterpreted and misused.

Dr. Lin opined that evaluators should not base a diagnosis on the ADIR or the ADOS. These are simply tools among many that evaluators should use to assess individuals. Information from multiple sources should be gathered and integrated, the diagnosis should not be made based on the results of one test. Further, the "cutoff levels" are derived from certain questions that research has shown help distinguish

autism spectrum disorder from other disorders. The ADIR is designed specifically to distinguish autism spectrum disorder from other disorders; it seeks to determine if an individual has shown or ever shown those behaviors, especially if the individual is over three years old.

On cross-examination Dr. Lin noted that her record review indicated that claimant had been diagnosed with aphasia at a young age, but admitted she did not reference this diagnosis in her report. The records also reference his autism diagnosis. Dr. Lin was aware of what was required in 1969 or 1970 for those diagnoses. An aphasia diagnosis meant an individual does not have language or has language delays. Claimant receiving that diagnosis shows that claimant had a very significant language delay when he was younger. Social functioning impairment was the core diagnostic feature of autism spectrum disorder at that time.

When questioned regarding the information obtained by "history," she explained that it was obtained from claimant's family members as allowed by the *DSM-5* which permits information to be obtained "by history." The scores given on behavior tests complied with the questions posed which allows scoring if the behavior was "ever present." Moreover, the research shows that repetitive behaviors or restricted interests may not manifest early but may manifest later in life. Further, the *DSM-5* does not require any specific age for the behaviors to manifest. Autism spectrum disorder is a pervasive lifelong disorder, so behaviors may manifest at different times. Although specific behaviors might be present at different times, claimant had behaviors, motor mannerisms and restricted and stereotyped behaviors, as a child. Thus, Dr. Lin testified it is likely claimant had autism spectrum disorder his entire life given that it is a pervasive condition. Also, the *DSM-5* discusses the condition being present during the early developmental period, which can be any time in childhood. The *DSM-5* was left broad

for a reason, because research is showing that clinicians were not aware of what to look for to make the diagnosis.

EVALUATION OF THE EXPERT TESTIMONY

52. The opinions and testimony of Dr. Cronin and Dr. Lin are given greater weight than that of Dr. Greenwald. Dr. Cronin and Dr. Lin performed extensive thorough, assessments of claimant, complied with Best Practices, used correct tests and scoring methods, and obtained pertinent historical information. Their opinions were well supported by the evidence. They were imminently qualified to render the opinions they gave; in fact, have given trainings on the very matters that were at issue in this hearing. Their testimony was delivered objectively and they did not appear to be advocates. Contrary to the arguments IRC raised in its closing briefs, claimant's experts did not appear biased and their opinions were supported by the evidence.

In contrast, Dr. Greenwald dismissed the vast historical information because there were no documents, despite the *DSM-5's* clear reference to obtaining information "by history." He did not obtain information from necessary collateral sources. He discounted overwhelming evidence that demonstrated claimant had developmental disabilities and relied on incomplete behaviors exhibited in his brief testing. He did not follow Best practices, used an incorrect algorithm, made unsupported conclusions, and, as noted below, lead claimant to the answers but did not reveal that fact in his report. Most concerning was his anecdotal testimony which demonstrated a lack of understanding of the relevant issues. He appeared very much an advocate for IRC who refused to consider the overwhelming evidence that showed that claimant had autism and intellectual disability.

PERCIPIENT WITNESS TESTIMONY

53. Hector Miranda, claimant's stepbrother, met claimant in 1988 when his mother married claimant's father. After leaving for college, Mr. Miranda returned home on weekends after his mother had a stroke as all the children helped. After claimant's father died in 2015, Mr. Miranda has seen claimant three or four times a week as they cleaned out the house and sold it. He also spent lots of time with claimant during the eligibility process. Mr. Miranda explained that when the parents first married, his mother pulled them aside and told them that claimant was "retarded." She said they needed to be aware of that fact, be patient with claimant, and after Mr. Miranda met claimant, his mother's statements appeared to be true. Claimant's father was less blunt in his speech. He told them claimant was different, for the children to be patient with him, that claimant can get really upset, that they could "take him in a fight" but to please not do that, and to not let claimant's behaviors upset or affect them. Claimant's father told them claimant had been diagnosed with aphasia and autism and was in a UCLA study of autistic children in the late 1960s, although Mr. Miranda is not aware of the specifics of that program.

When they lived together they had to always remind claimant to brush his teeth, bathe, use soap and wash his clothes. Claimant was socially awkward; you could not have a regular back-and-forth conversation with him. Claimant never asked others what their interests were or how their day was, but he would "hit you with a barrage of information" regarding his interests. Claimant would also make socially inappropriate comments, for example after the families merged he talked about "making whoopee" with his new stepsister. Claimant also had a "bad habit" of leaning in too close when he got excited and inadvertently spitting on people as he spoke. They had to tell him to stay at "arms distance" and "say it don't spray it." These things were just a "reality we had to deal with."

Claimant never shopped, cooked, or made meals. Claimant does not make his own medical appointments, buy clothing, or pay his bills. Claimant does not buy groceries, pay rent, do laundry or clean. Mr. Miranda said you can sometimes get him to pitch in to help clean, but he does not initiate and you have to give him repeated instructions. For the past 30 years, he eats a bowl of Cheerios for breakfast, eats a mustard, ham and cheese sandwich for lunch, and eats whatever dinner is made for him. Claimant had a daily routine he followed with his father, he did what his father told him to do, and "did his own thing." Claimant always did, and still does, become upset if someone disrupts his routine and they will have to talk claimant down from it. Although he will go to bed at eight o'clock, you will hear claimant pacing back and forth in his bedroom and muttering to himself.

Claimant does not understand sarcasm. He does not understand social boundaries. He cannot tell someone is taking advantage of him. He has no friends. Claimant does not initiate. Claimant will "hang around the perimeter of conversation" and will possibly get excited wanting to be happy with you. He goes through his books and can quote details and facts from them, including his books of trains. Claimant has limited interests including trains, Star Wars, and the Anaheim Ducks. Claimant does not do what he is asked to do, or finish tasks, and it is difficult to get him to perform tasks. Claimant's family have "learned to keep it simple," use a "one bullet point task" and still they have to check to see that claimant completed the task.

Claimant lived with his father his entire life until his father died. Claimant did not react to that death; he was completely unemotional about it. Claimant's father was in the hospital at the end of his life and the other children were there but not claimant. When they asked claimant why he did not come to visit his father at the hospital, claimant replied that there was an Anaheim Ducks game. When claimant's father was

sent home for hospice care, claimant was uninvolved and very "robotic" in his attempts to console his siblings after his father died.

Claimant had no idea where he was going to live after his father died and just assumed he would remain at the house where he lived, but gave it no real thought. At the time, claimant had no money and was not employed. Claimant has not really worked and Mr. Miranda explained that claimant's job at the Mormon church was done as a favor to claimant's father, a longtime church member. Eventually the church told the family in 1990 that they could no longer continue to create work for claimant. From 1990 until very recently, claimant was not employed. He is now employed at an automotive distribution center where he takes inventory requests written on a slip of paper, finds the item, and puts it on a pallet. He got this job through DOR and has a job coach who provides supports for him at work. Claimant has never gotten a job on his own. He actually lost the automotive job when he injured his back at home and did not report to work or call in sick. DOR was able to work with the employer to get claimant's job back. Claimant earns some money from recycling, but Mr. Miranda does not know what instructions are given to assist him with that task.

Mr. Miranda assisted with the IRC applications. He tried to locate past records but could only locate the ones he produced. He reached out to various autism societies trying to get assistance and provided additional information after IRC initially rejected claimant's application for eligibility. Mr. Miranda completed all the IRC paperwork; claimant is not capable of filling it out on his own. Claimant does not take care of any of that type of work, either Mr. Miranda or his sister handle all of his affairs. Although claimant drives, he was recently in an accident that he did not tell his family about; Mr. Miranda and his sister only learned of it when contacted by the insurance company and even then claimant could not give them details of the accident.

Mr. Miranda described his experience at IRC. During the social assessment, he advised the IRC intake person that claimant would bang his head on the wall as a child but the IRC intake person told him that information was not relevant. During the assessment with Dr. Greenwald, Mr. Miranda was present the entire time. Mr. Miranda explained the reasons he gave the scores that he did on the Vineland, which were based on claimant's behaviors and actions.

Mr. Miranda observed that a couple of times during Dr. Greenwald's assessment, claimant would not answer the questions asked, he shut down, and Dr. Greenwald would repeat the question or come back to it later. However, Dr. Greenwald did not document anywhere in his report that claimant did not answer the question. As an egregious example of Dr. Greenwald's repeated efforts to have claimant answer a question Mr. Miranda stated he observed Dr. Greenwald hold up a newspaper which had an article about a drug lord's mansion in Miami being seized and asking claimant if he knew what "infamous" meant, asking the question two times. Claimant did not respond, and Dr. Greenwald moved on with his questions. Dr. Greenwald later came back to that question and claimant again shut down. Dr. Greenwald asked it a number of times, and eventually claimant said he was "famous for being bad." Mr. Miranda questioned this form of inquiry. Additionally, there were a number of words that had nuances to them that claimant did not know and Dr. Greenwald "sort of pulled the answer out of [claimant]" which Mr. Miranda also thought was egregious.

Following IRC's denial, claimant's sister initiated having him evaluated at Loma Linda as they were seeking objective second party opinions. Mr. Miranda filled out the test forms given, explaining the reasons for his answers. They also had claimant evaluated at UCLA, a process that lasted three days between three and four hours per day. During that testing, only the examiner and claimant were present. Following those evaluations, which both determined claimant had a developmental disability, they

resubmitted their request to IRC that claimant be found eligible for services. Mr. Miranda explained that Dr. Perry became involved because claimant's stepsister thought she may have been involved in claimant's care as a child at UCLA, and forwarded information to her. They later learned that she was not the same Dr. Perry, but she was interested in the case and provided additional information that they gave to IRC. Dr. Perry did not meet with claimant but reviewed all the records. Dr. Cronin became involved because UCLA recommended her.

54. Patricia Miranda-Wagner, claimant's stepsister, described claimant's activities of daily living and her observations/knowledge of claimant, whom she met in 1988 when her mother married claimant's father. When she met claimant, he spoke very few sentences, he was very different, he was "not normal" compared to people his own age. She did not know what to make of claimant, he gave strange looks and she thought he was mentally retarded.

Claimant was diagnosed as autistic and aphasic at a very young age. He was diagnosed early in grade school. He had "rocking behavior," he would bang his head, and he would fly into rages. They could not get him to eat, cooperate, or interact with other children. He stayed on his own. Claimant was like a small child. He required prompting for all activities of daily living such as hygiene.

In fact, the family had trouble finding caregivers for their mother after her stroke because of claimant's body odor. After her stepfather died, claimant came to live with her and her family. Ms. Miranda has been his primary caretaker for the past four years. She described her family as very close, with lots of contact. They tried locating medical records for claimant but were unsuccessful. They located a high school transcript and an old report card, but that was all. Claimant still has poor hygiene. He will wear his clothing until it is worn out. He does not realize he has bad body odor. When claimant first lived with her family, he was not working. He would stay all day at home, watch TV,

and not contribute to the household. He followed the same daily routine. He ate the same breakfast and same lunch, and stayed in his room with his trains or watching TV.

She is aware of past attempts to seek regional center services for claimant, especially after claimant hit their mother. She suggested many times that they get help for claimant, but claimant's father would not. After her stepfather's death, claimant was alone at the house and had nowhere to stay. When he was asked, he would mention buying a condo near where the Anaheim Ducks played, but had no plan. His biological family wanted nothing to do with him so after the house was sold he came to live with Ms. Miranda and her family. Ms. Miranda described the numerous supports she gave claimant: buying his bedding, toiletries, clothing, and food. She tried to integrate him into the family and give him prompts; it was a hard situation especially as claimant has no boundaries regarding privacy. Over time this living arrangement did not work out because of claimant's significant needs, Ms. Miranda's own family's needs, and the size of her house which made it non-conducive for them all to live together.

They located a small apartment in a gated community approximately 10 minutes from her home. Claimant did nothing to help find the apartment. He shows no interest, concern or worry about "adult type things." She sees claimant on a regular basis. She must monitor his medical and health needs, as he is unable to do so. He can pour cereal, make a sandwich, and heat food in the microwave, but he uses no other cooking devices. She described his many medical issues she has addressed. Claimant cannot make his own medical appointments and does not perform any house cleaning without prompting but even then fails to follow through. Ms. Miranda often has to throw away and replace his bedding, towels, and clothes because he does not clean them. She does not know why he stacks his few clothes on top of his dresser and does not put them in the drawers. Claimant can follow instructions if they are not involved and if they are tasks he has performed before. He does not ask for help. If he becomes stressed, he

does not want to talk about it and he begins to stammer. He could not provide any information regarding his recent motor vehicle accident.

Claimant has a bank account with an ATM card he can access that he uses at the same grocery store. Claimant does not pay his rent or bills. He has no concept of balancing his account and brings his receipts to Ms. Miranda to do so. He does not maintain a budget or have any concept of his living expenses. Claimant brings his mail and bills to her to review and pay. He cannot do any kind of math. Recently she had to assist him with open enrollment because he had no idea about health insurance or how to apply. Claimant has no friends, nor has he expressed a desire to have any. His only "social outings" are visits to her house. Claimant is standoffish. If he wants, he will come talk to you about what he wants to talk about, but it is not a reciprocal conversation. She has tried teaching him social boundaries to no avail. She is concerned because he has been taken advantage of by both his father who borrowed money and never paid him back and his sister of whom he is afraid.

Ms. Miranda was not involved in the IRC evaluation. She was not contacted by IRC at any time. The Loma Linda evaluation took place over three days, each session lasting from one to more than two hours.

55. Francine Lau-Knalson, a Department of Rehabilitation (DOR) Qualified Rehabilitation Professional Counselor, testified about DOR's efforts securing employment for claimant. Ms. Lau-Knalson has a Bachelor's degree in Child Development and a Master's degree in Rehabilitation Counselling. Ms. Lau-Knalson has worked in the rehabilitation field for 33 years, 23 of which have been at DOR. Ms. Lau-Knalson explained that to be eligible for DOR services, an individual must have a disability that is an impediment to employment. DOR relied on the Loma Linda report diagnosing claimant with autism as the basis for finding he had a qualifying disability that impeded his ability to work.

Ms. Lau-Knalson opined that claimant's impediments were his need for self-direction, difficulties with problem-solving and poor interpersonal skills. After meeting with claimant and his family, Ms. Lau-Knalson retained DOR's vendor Exceed to help claimant seek and obtain employment. She described the difficulty Exceed had when it first contacted claimant because he refused to provide his social security number to them, having been previously instructed by his family not to give out that information to strangers.

Ms. Lau-Knalson's testimony established the tremendous supports claimant requires in the workplace in order to remain employed.

PARTIES' ARGUMENTS

56. Claimant asserted he was eligible for regional center services under diagnoses of autism spectrum disorder and intellectual disability which are substantially handicapping conditions for him. Claimant asserted he had these conditions before age 18 as shown by his diagnosis of autism and aphasia as a child, his inclusion in a UCLA program in the 1970's, and his special education classes throughout his entire schooling. He asserted the extensive evaluations at Loma Linda, UCLA, with Dr. Cronin, as well as his IRC testing, and the opinions of his witnesses established his eligibility for regional center services.

57. IRC asserted that there is no evidence claimant was diagnosed with autism spectrum disorder or intellectual disability before age 18. IRC asserted that claimant's mother who gave historical information had not seen claimant in decades so her statements should be discounted. However, that argument missed the mark because she was being asked about claimant's early developmental period, when she was involved in his life, making her statements relevant. IRC also argued that claimant's mother was the "sole source" of information from this early period; an assertion that was factually incorrect. Further, IRC's position that there are no documents was not

persuasive in light of the DSM-5's reference to gathering information "by history." IRC further asserted that claimant's IQ scores are well above the 70 cutoff required for an intellectual disability diagnosis. That argument failed to take into account the extensive evidence regarding claimant's poor adaptive functioning skills and their relationship to IQ testing. IRC also asserted claimant was not eligible under "fifth category" but given Dr. Greenwald's odd testimony about Boca Raton, IRC's argument had no support. Here because claimant is eligible under a diagnosis of intellectual disability, it is not necessary to find him eligible under the "fifth category."

LEGAL CONCLUSIONS

BURDEN AND STANDARD OF PROOF

1. In a proceeding to determine eligibility, the burden of proof is on the claimant to establish he or she meets the proper criteria. The standard of proof is a preponderance of the evidence. (Evid. Code, § 115.)

STATUTORY AUTHORITY

2. The Lanterman Act is set forth at Welfare and Institutions Code section 4500 et seq.

3. Welfare and Institutions Code section 4501 states:

> The State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge. Affecting hundreds of thousands of children and adults directly, and having an important impact on the lives of their families, neighbors and whole communities, developmental disabilities present

social, medical, economic, and legal problems of extreme importance . ...

An array of services and supports should be established which is sufficiently complete to meet the needs and choices of each person with developmental disabilities, regardless of age or degree of disability, and at each stage of life and to support their integration into the mainstream life of the community. To the maximum extent feasible, services and supports should be available throughout the state to prevent the dislocation of persons with developmental disabilities from their home communities.

4. Welfare and Institutions Code section 4512, subdivision (a), defines "developmental disability" as follows:

"Developmental disability" means a disability that originates before an individual attains 18 years of age; continues, or can be expected to continue, indefinitely; and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include intellectual disability, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability, but shall not include

other handicapping conditions that are solely physical in nature.

5. California Code of Regulations, title 17, section 54000,[14] provides:

(a) "Developmental Disability" means a disability that is attributable to mental retardation, cerebral palsy, epilepsy, autism, or disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation.

(b) The Developmental Disability shall:

(1) Originate before age eighteen;

(2) Be likely to continue indefinitely;

(3) Constitute a substantial disability for the individual as defined in the article.

(c) Developmental Disability shall not include handicapping conditions that are:

(1) Solely psychiatric disorders where there is impaired intellectual or social functioning which originated as a result of the psychiatric disorder or treatment given for such a disorder. Such psychiatric disorders include psycho-social

[14] The regulations still use the term "mental retardation," instead of the term "Intellectual Disability."

deprivation and/or psychosis, severe neurosis or personality disorders even where social and intellectual functioning have become seriously impaired as an integral manifestation of the disorder.

(2) Solely learning disabilities. A learning disability is a condition which manifests as a significant discrepancy between estimated cognitive potential and actual level of educational performance and which is not a result of generalized mental retardation, educational or psycho-social deprivation, psychiatric disorder, or sensory loss.

(3) Solely physical in nature. These conditions include congenital anomalies or conditions acquired through disease, accident, or faulty development which are not associated with a neurological impairment that results in a need for treatment similar to that required for mental retardation.

6. California Code of Regulations, title 17, section 54001, provides:

(a) "Substantial disability" means:

(1) A condition which results in major impairment of cognitive and/or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential; and

(2) The existence of significant functional limitations, as determined by the regional center, in three or more of the following areas of major life activity, as appropriate to the person's age:

(A) Receptive and expressive language;

(B) Learning;

(C) Self-care;

(D) Mobility;

(E) Self-direction;

(F) Capacity for independent living;

(G) Economic self-sufficiency.

(b) The assessment of substantial disability shall be made by a group of Regional Center professionals of differing disciplines and shall include consideration of similar qualification appraisals performed by other interdisciplinary bodies of the Department serving the potential client. The group shall include as a minimum a program coordinator, a physician, and a psychologist.

(c) The Regional Center professional group shall consult the potential client, parents, guardians/conservators, educators, advocates, and other client representatives to the extent that they are willing and available to participate in its

deliberations and to the extent that the appropriate consent is obtained.

(d) Any reassessment of substantial disability for purposes of continuing eligibility shall utilize the same criteria under which the individual was originally made eligible.

EVALUATION

7. The Lanterman Act and the applicable regulations set forth criteria that a claimant must meet in order to qualify for regional center services. Claimant presented clear, concise, and convincing evidence establishing that he had autism spectrum disorder and intellectual disability. As claimant demonstrated he has an intellectual disability, it is not necessary to consider if he would qualify under the fifth category."

In determining the weight to be given to an expert's testimony, the expert's qualifications, credibility and basis for his or her opinions was considered. Each expert's opinion was only as good as the facts and reasons on which it was based. "Like a house built on sand, an expert's opinion is no better than the facts on which it is based." (*People v. Gardeley* (1996) 14 Cal.4th 605, 618; *Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 924.)

Claimant was evaluated by three extremely competent experts, Dr. Nitch, Dr. Lin and Dr. Cronin, whose opinions were supported by reliable evidence; whereas Dr. Greenwald's opinions were not. Further, Dr. Lin's and Dr. Cronin's opinions and testimony regarding claimant having intellectual disability were more persuasive than Dr. Nitch's report concluding he did not. As they further explained, Dr. Nitch's evaluation had findings that would qualify claimant as having an intellectual disability. The evidence Dr. Greenwald based his opinions on was shown to be unreliable. Dr.

Greenwald's assessment did not comport with best practices, did not comply with ADOS instructions, used an outdated ADOS algorithm, used an improper test (SSSQ), and failed to obtain important sources of collateral information. As such, claimant established he had both autism spectrum disorder and intellectual disability. In light of the overwhelming evidence that claimant produced, it was inexplicable why IRC did not find him eligible.

IRC's argument that because claimant was unable to produce any documentary evidence from before the age of 18 demonstrating he had a qualifying condition, he did not meet his burden, has no support in the law. While the Lanterman Act requires the developmental disability to occur prior to age 18, it does not require individuals to produce documentary evidence of its existence before that age. Absolutely nothing in either the Welfare and Institutions Code or Title 17 regulations require an individual seeking eligibility to produce documents. Further, the *DSM-5* provides that the information upon which a diagnosis is reached can be obtained by "history." As such, IRC's argument is rejected.

While the standard of proof in these cases is a preponderance of the evidence, claimant's evidence greatly exceeded that standard and left no doubt that claimant is autistic and has an intellectual disability and that those conditions are substantially handicapping conditions. As such, claimant established that he has a qualifying developmental disability, and is eligible to receive regional center services. His appeal is granted.

ORDER

Claimant's appeal from Inland Regional Center's determination that he is not eligible for regional center services and supports is granted. Claimant is eligible for regional center services and supports under the Lanterman Developmental Disabilities Services Act under the intellectual disability and autism spectrum disorder categories.

DATED: December 17, 2018

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MARY AGNES MATYSZEWSKI

Administrative Law Judge

Office of Administrative Hearings

NOTICE

This is the final administrative decision. Both parties are bound by this decision. Either party may appeal this decision to a court of competent jurisdiction within ninety days.