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. 2017120092

DECISION

Theresa M. Brehl, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter in San Bernardino, California, on January 30, 2018, and March 27, 2018.

Jennifer Cummings, Program Manager, Fair Hearings & Legal Affairs, Inland Regional Center, represented Inland Regional Center (IRC).

Juanita Mantz, Deputy Public Defender, Law Offices of the Public Defender, County of Riverside, represented claimant.

The matter was submitted on March 27, 2018.

ISSUES

1. Is claimant eligible for regional center services under the Lanterman Developmental Disabilities Services Act (Lanterman Act) as a result of a diagnosis of Intellectual Disability that constitutes a substantial disability?

2. Should IRC perform additional intake and/or testing of claimant?[1]

FACTUAL FINDINGS

JURISDICTIONAL MATTERS

1. On October 31, 2017, IRC sent a Notice of Proposed Action to claimant, notifying him that IRC had determined he was not eligible for regional center services.

2. On November 21, 2017, claimant's attorney filed claimant's Fair Hearing Request, appealing IRC's determination. The Fair Hearing Request stated the following reason for seeking a fair hearing: "Defendant was found incompetent based on cognition and Dr. found arose before age of 18." The Fair Hearing Request described the following as needed to resolve claimant's complaint: "Acceptance in IRC & placement by same."

SUPERIOR COURT REFERRALS TO IRC FOR ASSESSMENT OF CLAIMANT'S REGIONAL CENTER ELIGIBILITY AND PATTON STATE HOSPITAL AND RIVERSIDE JAIL-BASED COMPETENCY TREATMENT PROGRAM FOR TREATMENT

3. Claimant was initially referred to IRC by the Riverside County Superior Court on November 14, 2014, related to criminal proceedings then pending against him. According to the court's November 14, 2014, minute order, the court declared "doubt" as to claimant's mental competence and referred claimant to IRC for "evaluation of 'competency and eligibility.'" The court ordered that a Spanish language interpreter be

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[1] At the commencement of the hearing, claimant moved for orders requiring IRC to conduct additional testing and delaying the hearing until additional testing was completed. Claimant's motions were denied, and the parties agreed to add whether IRC should conduct additional intake and/or testing as one of the issues to be decided in this proceeding.

present for the evaluation due to Spanish being claimant's preferred language. Claimant was evaluated by psychologist Michael McCormick, Psy.D., in January 2015, and based on that evaluation, IRC determined claimant was not eligible for regional center services.[2] Claimant did not appeal IRC's 2015 determination.

4. Claimant was admitted to Patton State Hospital (Patton) on June 23, 2015, under Penal Code section 1370 because the court found him not competent to stand trial. Patton's "Brief Admission Psychiatric Assessment" noted the following under the "General Observations" heading: "Attitude: cooperative but a poor and unreliable historian"; "Eye Contact: poor, avoidant, looking around his chair and the floor quite a bit"; "Speech: extremely garbled, mumbled, short yes or no responses mostly"; "Affect: confused, child-like, smiling at times"; "Thought Process: concrete, slow to process, slow to respond"; "Perception/Hallucinations: He endorsed auditory hallucinations but cannot describe other than they tell him to hurt self at times. He denied visual hallucinations, but was looking around the room and floor as if responding to internal stimuli"; and "Cognition: grossly intact." Claimant received treatment at Patton, including administration of medications, to stabilize his psychiatric symptoms and restore his competency to stand trial. On September 1, 2015, Patton staff reported to the court that claimant was then competent to stand trial. Upon his discharge from Patton on September 10, 2015, claimant was diagnosed with Unspecified Schizophrenia Spectrum and Other Psychotic Disorder; Cannabis Use Disorder, Moderate; and Methamphetamine Use, Moderate.

5. On September 21, 2017, in another criminal proceeding before the Riverside County Superior Court, the court minutes noted the court suspected

[2] Dr. McCormick's evaluation is discussed in more detail below under the "Psychological Evaluation" heading.

"defendant may fall under 1370.1 PC."[3] The court granted claimant's motion seeking a referral to IRC for assessment. The court's minutes stated:

> Court directs the Inland Regional Center to examine the defendant and provide a written report. In order to complete the report, the court orders that doctor(s) be admitted to the jail to personally interview defendant and review all medical and mental health records, including any classification notes. Court request [*sic*] defendant be evaluated for eligibility and placement recommendation. . . . Court [*sic*] the release of mental health/medical records from Patton State Hospital from 2015 to current be provided to Inland Regional Center by 10/03/2017. Court orders the release of mental health records [*sic*] Detention Mental Health Service to Inland Regional Center by 10/03/2017.

6. IRC did not conduct any additional examinations of claimant, and on October 26, 2017, IRC determined claimant was not eligible for regional center services based on "a full case review including, but not limited to," the previous 2015 psychological evaluation and medical records from Patton. IRC reported to the court on November 8, 2017, that:

[3] Under Penal Code section 1370.1, subdivision (a)(1)(B)(i), if a defendant "is found mentally incompetent and is developmentally disabled, the trial or judgment shall be suspended until the defendant becomes mentally competent. [¶] . . . [T]he court shall consider a recommendation for placement, which recommendation shall be made to the court by the director of a regional center or designee. . . ."

> The information contained in the records made available to IRC does not support a reasonable belief that the Defendant has a developmental disability as defined by the Lanterman Act that would trigger IRC's obligation to provide or procure a further assessment of the Defendant. (See Welf. & Inst. Code § 4642, subd. (a)(2).)
>
> The Defendant was previously evaluated by IRC on January 6, 2015 at the age of #24, and the Defendant was determined to be ineligible for regional center services. As provided in the enclosed psychological assessment, IRC found that the Defendant does not have a "developmental disability" as that term is defined by law . . . . Therefore, IRC is unable to provide services to the Defendant.

7. The Riverside County Superior Court's minute order, dated November 14, 2017, stated: "Court finds defendant does not qualify for service at Inland Regional Center. Referred to County Mental Health for recommendation re: placement, returnable 12/13/2017."

8. On January 15, 2018, claimant was admitted for evaluation and treatment at the Riverside Jail-Based Competency Treatment (JBCT) Program, where he received treatment to assist him to achieve competency to stand trial. Liberty Healthcare Forensic Psychologist Laaden Gharagozloo, Ph.D., issued a report, dated March 14, 2018, regarding claimant's evaluation and treatment at the JBCT Program.[4]

[4] The March 14, 2018, evaluation is discussed in further detail below, under the "Psychological Evaluation" heading.

INFORMAL MEETING BETWEEN IRC AND CLAIMANT'S COUNSEL

9. During an informal meeting between claimant's counsel and IRC on December 18, 2017, the parties reviewed reports by Robert A. Leark, Ph.D., dated September 17, 2016, and July 16, 2017, related to his evaluations regarding whether claimant had cognitive or neuropsychological deficits that might impact his competency to stand trial. In a December 19, 2017, letter to claimant's counsel, IRC explained that after review of Dr. Leark's reports, IRC maintained that claimant was not eligible for regional center services. That letter noted:

> Dr. Leark summarized that [claimant] presents with neuropsychological deficits in memory, attention and language.
>
> Based upon a review of the records that are available, including a psychological assessment completed in 2015 for regional center eligibility consideration, Inland Regional Center (IRC) maintains that [claimant] is not eligible for regional center services. He has a severe mental health disorder and a longstanding history of substance abuse, which began around age 13. These factors have played a significant role in [claimant's] present level of functioning. There is no documented evidence of an intellectual disability prior to the age of 18. [Claimant's] family reported that he was never in Special Education. . . . While [claimant] exhibits some cognitive difficulties, [claimant's] intellectual and adaptive functioning is not indicative of an intellectual disability or a disabling condition closely related to intellectual disability (known as the "5th Category"). Mental

health and substance abuse treatment appear to be the most appropriate forms of treatment and/or services for [claimant].

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BACKGROUND PROVIDED BY CLAIMANT'S FAMILY MEMBERS DURING THE HEARING

10. Claimant is a 27-year-old male, and he has remained in custody after having been found incompetent to stand trial on pending criminal charges. Claimant has seven siblings, two of whom are regional center consumers. Claimant's mother and one of his sisters, who is two years older than claimant, testified about claimant's childhood and when his family began to notice his problems.

11. According to claimant's mother, claimant's weight was average at birth, but his height was "very small." Although the doctor mentioned that claimant might be premature because he was so small, he was delivered at nine months. No evidence was presented during the hearing regarding any problems with the pregnancy or delivery. When she was asked to describe claimant's development compared to his siblings, claimant's mother stated that he started walking "very quickly" when he was nine months old, and she did not remember anything unusual about his development.

12. Claimant did well during kindergarten and first grade, and his mother noticed claimant begin to have problems during second and third grade. She could not recall behavioral issues at school, although she stated he was reprimanded one time by a teacher because he was talking too much. The school did not ever suggest evaluating him for special education, as the school had done with one of his sisters. His grades in elementary school were not "that high and not that low." They were average. Beginning when he was 10-years-old, claimant was slow to learn. He used to get too distracted. No one talked to claimant's mother about whether he might have suffered from Attention Deficit Hyperactivity Disorder (ADHD). Claimant began having academic problems when

he was in high school. Claimant's mother had believed that claimant did not try at school, and she had thought it was because he was lazy.

13. According to claimant's sister, he began having problems when he was 14 years old, and he got worse when he was 17 or 18 years old. She described his development as "slow."[5] He wet his bed between the ages of five and 10. She did not remember claimant having any behavioral issues at school. When he was 14, "you would need to repeat things for him to get it." If you sent him to get groceries, everything needed to be written down. If he started to fill out an application, he could work on it for three hours, but he would not finish it. Claimant did not obtain a driver's license because he failed the written test. He began to have slurred speech, repetitive head movements, and problems walking when he was between 16 and 18 years old. Claimant's sister described his repetitive head movements as like a "tic" that included making faces with his mouth all day long. Claimant's sister also noted that he could not stay still. She described claimant as having problems cooking for himself, counting money, and getting lost, all of which started when he was 16 or 17 years old. He could not really work, and he was fired two times before he was 18 years old. Claimant's sister believed he had problems working because he would get lost and not pay attention to what he was doing. He lost a job at Jack-in-the Box after a couple months because he hurt his back. She noticed that claimant had trouble reading and retaining information before he was 18.

14. According to his sister, claimant also started having problems with anxiety, depression, schizophrenia, and bi-polar disorder before he turned 18. His sister

[5] Because she was only two years older than claimant, claimant's sister's testimony regarding his early childhood development seemed less reliable and was given less weight than his mother's testimony. Most of claimant's sister's testimony focused on when claimant was a teenager and older.

explained that starting when he was about 17 years old, claimant sometimes would sit on the couch and start talking when no one was there; he would argue with his mother for no reason; he would think someone was outside, when no one was there; and he would laugh for no reason. These issues seemed to impact his focus. His mother stated that when he was 17 years old, he started telling her that he heard voices; he had difficulty walking and walked on his tip toes; he had problems with his tongue and neck; and he told her that his right leg was loose and he had back pain. Claimant's mother also stated that claimant started talking to himself "in 2015," when he was "20 or 22 years old."[6]

15. According to claimant's mother, he began using alcohol when he was 16 or 17 years old, and he began having problems with drugs when he was 16 or 17 years old. Claimant's sister testified that she became aware of claimant's drug use when he was 18 years old. According to his sister, he "started doing it because of his anxiety," and his speech became "a little worse" and his way of moving became "way worse." Additionally, when he was using drugs, his focus "got even worse." Although claimant's sister did not observe him consuming drugs, she noticed that he seemed to be "on something." Claimant's sister was not aware claimant suffered any head injuries, but she knew he was in a car accident.[7] Since the accident, she described him as follows, "when you look at him, he seems lost."

[6] Because claimant is 27 years old now, he would have been 23 or 24 years old in 2015.

[7] Documentation in the record indicated the automobile accident occurred when claimant was 23 years old.

CLAIMANT'S SCHOOL RECORDS

16. Records from the Santa Ana Unified School District and the Alvord Unified School District were received in evidence.

17. Claimant attended school in the Santa Ana Unified School District from 1996 (when he was six years old) through April 2003 (when he was 12 years old). There was no indication in his Santa Ana Unified School District records that he ever received special education services or supports, and his mother and sister confirmed during the hearing that he was not ever assessed for, or placed in, any special education programs. Comments in his second grade progress report indicated he was "very bright," but lacked effort in core subjects. Notations in his third grade progress report stated that he was working hard, but he was "lacking essential skills." In fourth grade, he was achieving mostly C's (satisfactory) and his performance was rated as "BASIC" (defined in the school records as "approaching grade level standard.") Due to poor academic achievement, claimant was placed in a Structured English Emersion (SEI) program, and he repeated the sixth grade. His grades in sixth grade during both sixth grade school years were mostly Ds and Fs.

18. Claimant attended school in the Alvord Unified School District from September 2003 (when he was 13 years old) through March 2008 (when he was 17 years old), and the school district had no record of him being placed in special education programs during his attendance. He did not graduate from high school. According to his mother, he attended school through 10th grade.

DIAGNOSTIC CRITERIA FOR INTELLECTUAL DISABILITY

19. Official notice was taken of excerpts from the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-*

5), which IRC's expert, Ruth Stacy, Psy.D., referenced during her testimony.[8] As Dr. Stacy explained, the *DSM-5* provides the diagnostic criteria used by psychologists to make a diagnosis of Intellectual Disability, which diagnosis is necessary for an individual to qualify for regional center services based on Intellectual Disability.

20. The *DSM-5* provides that three diagnostic criteria 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 the deficits during the developmental period. Intellectual functioning is typically measured using intelligence tests. According to the *DSM-5*, "[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."

21. Regarding the criterion that onset of deficits occur during the developmental period, the *DSM-5* states:

> 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

[8] Dr. Stacy's hearing testimony and opinions are discussed in more detail below, under the heading "Expert Witness Testimony."

> intellectual disability, while mild levels may not be identifiable until school age when difficulty with academic learning becomes apparent. All criteria (including Criterion C) must be fulfilled by history or current presentation. Some children under age 5 whose presentation will eventually meet criteria for intellectual disability have deficits that meet criteria for global developmental delay.

THE PSYCHOLOGICAL EVALUATIONS

Evaluation by Michael McCormick, Psy.D.[9]

22. Michael McCormick, Psy.D., holds a Bachelor of Science Degree in Psychology and a Bachelor of Arts Degree in Criminology from Ohio State University and a Doctorate Degree in Psychology from Argosy University. He started his California psychology practice working at Patton, originally working with patients who were not competent to stand trial. His recent work at Patton has involved conducting assessments

[9] Claimant's hearsay objection to the admission of Dr. McCormick's report was overruled. The appellate authority claimant supplied in support of that objection, *People v. Sanchez* (2016) 63 Cal.4th 665, 682 (regarding a criminal conviction); and *Scott S. v. Superior Court* (2012) 204 Cal.App.4th 326, 331 (regarding a guardian's authority to make medical decisions), did not concern fair hearings under the Lanterman Act. Pursuant to Welfare and Institutions Code section 4712, subdivision (i), fair hearings "need not be conducted according to the technical rules of evidence and those related to witnesses. Any relevant evidence shall be admitted. . . ." All the written psychological evaluations offered by the parties in this matter relied on hearsay, including the evaluations offered by claimant, and were received as evidence because they were relevant. (Welf. & Inst. Code, § 4712, subd. (i).)

and writing competency reports. He worked as a consultant for IRC from 2012 through 2017, which included providing training regarding competency and conducting eligibility and competency evaluations. Dr. McCormick has experience working with patients with dual diagnoses of mental health issues and developmental disabilities. He also has a private practice that he started approximately two years ago.

23. IRC referred claimant for an evaluation with Dr. McCormick in 2015. Dr. McCormick conducted his evaluation on January 6, 2015, when claimant was 24 years old, and he prepared a written Psychological Evaluation. Dr. McCormick's written evaluation was received as evidence, and he testified at the hearing.[10] He obtained background information from claimant and claimant's family, he observed claimant, and he administered psychological tests. A Spanish interpreter was used because claimant indicated that Spanish was his preferred language. During this hearing, Dr. McCormick explained that if a patient's preferred language is not used, it could impact the results if the patient struggled to understand the non-preferred language. Dr. McCormick's written Psychological Evaluation noted his behavioral observations of claimant:

> He appeared his stated age. He was oriented [*sic*] person and situation. He was unaware of the current date and where he was. His grooming was average. His tone of voice was monotone with some speech impediments. During the assessment, he appeared internally preoccupied (extended delays in responses and needing constant redirection), which may be a result of auditory hallucinations. He denied hearing voices, but his family expressed that he his [*sic*] does talk to

[10] Dr. McCormick's opinion testimony is discussed further below, under the "Expert Witness Testimony" heading.

himself at home. Frequently during the assessment, [claimant] exhibited some movement issues. He would spontaneously just stand up and had tics in his extremities. His thought process was organized but limited. At this point, he denied having thoughts of wanting to harm himself or others. He smelled of alcohol during the evaluation and he admitted to drinking that morning. During the interview, [claimant] was not forthcoming. His family had to provide this evaluator additional information.

24. Claimant's family told Dr. McCormick that there were no complications during claimant's delivery, and he was born full term, but small. He had been assaulted several times and was in a vehicle accident. Claimant did not graduate from high school, as he was dismissed from high school due to his drug use and "movement problems." His family also reported that he was never in special education and his grades decreased significantly after his substance abuse. Under the headings entitled "Mental Health History" and "Substance Use History," Dr. McCormick's report included the following information that was provided by claimant and his family:

Mental Health History

During the interview [claimant's] family informed the writer that all of his abnormal symptoms began after [*sic*] started using substances. They believe his problem with drugs began in 2007. His family expressed that he used marijuana, alcohol and "huffed" paint.

[Claimant] did admit to using drugs and stated that it started with drinking alcohol at the age of 13. As for symptoms, the

> family observed him talking to himself, having a speech impediment, delayed responses, and movement symptoms. His mother expressed that [claimant] has had suicidal ideation in the past, telling her that he wanted to hang himself. After his mother expressed this fact, he did admit to these thoughts and stated that they come from time to time. Currently, he does not have any thoughts of wanting to harm himself. He has never been hospitalized for substance or mental health treatment in the past.
>
> *Substance Use History*
>
> [Claimant] began using substances at the age of 13. Since then he has used marijuana and huffed paint products. His substance use has caused significant impairment in his functioning and has led to legal troubles.

25. Dr. McCormick administered the Test of Memory Malingering (TOMM), a standardized assessment instrument of recognition memory that measures the validity and accuracy of memory impairment; the Comprehensive Test of Nonverbal Intelligence, Second Edition (CTONI-2), which measures nonverbal cognitive ability; and the Adaptive Behavior: Street Survival Skills Questionnaire (SSSQ), which measures adaptive functioning skills. Although claimant smelled of alcohol and admitted he had consumed alcohol, Dr. McCormick testified during the instant hearing that he did not believe claimant was impaired, as his speech was not slurred and he was able to submit to testing. Dr. McCormick stated that if claimant was drunk, he might not have been a reliable source of historical information and his test scores would have been worse than if he was not impaired.

Based on two trials of the TOMM, with one score that fell below normal limits, and a second score that fell slightly below normal limits, Dr. McCormick's report concluded claimant "did not give his best efforts and may be feigning his memory deficits. As a result, the remaining results are likely not an accurate reflection of his true cognitive ability." However, during the instant hearing, both IRC's expert, Ruth Stacy, Psy.D., and claimant's expert, Robert A. Leark, Ph.D., testified that Dr. McCormick failed to follow the proper protocol when administering the TOMM because he did not administer it a third time. That cast doubt on the opinion in Dr. McCormick's report that claimant may not have given his best effort. During Dr. McCormick's testimony, he explained that as he interpreted the standards for administering the TOMM, it was only "optional" that he administer it a third time. Dr. McCormick also stated that, based on claimant's improved results on the second TOMM, it was a mistake to suggest that claimant may not have given his best efforts or malingered during the evaluation and testing on January 6, 2015.

On the CTONI-2, claimant received a Full Scale Score Intelligence Quotient (IQ) of 73, in the "poor range," suggesting he has "some mild cognitive deficits in nonverbal abilities"; 71 on the Pictorial Scale, within the "poor range," suggesting he has "mild deficits" in this area; and an 81 on the Geometric Scale, within the "below average range," suggesting he "may have some minor deficits" in this area.

Claimant's total adaptive functioning score on the SSSQ was 78, placing him in "borderline" range. Dr. McCormick's report explained that "[t]his score would suggest that [claimant] has minor difficulties with completing his activities for daily living. On the other hand, there was significant discrepancy within his scaled scores, which suggests that his SSSQ is not an accurate reflection of his adaptive functioning." During the instant hearing, Dr. McCormick explained that he likes the SSSQ because it requires the patient to do the items being tested. A composite score of "10" is average, a score of "1"

means there is significant impairment, and a "5" is in the borderline range. Claimant's composite scores varied, and were as follows:

Basic Concepts	8
Functioning Signs	11
Tools	5
Domestics	5
Health & Safety	4
Public Services	4
Time	9
Monetary	9
Measurements	1

26. Dr. McCormick's written evaluation stated that his diagnostic impressions were that claimant suffered from "Substance-Induced Psychotic Disorder, Other Substance"; "Cannabis Use Disorder, Severe"; and "Alcohol Use Disorder, Severe." The written evaluation stated Dr. McCormick's opinion that claimant did not have a developmental disability that would qualify him for regional center services, and it also concluded that claimant was not competent to stand trial "due to his symptoms related to use [*sic*] extensive substance abuse." In the portion of Dr. McCormick's report titled "Integrated Assessment," he explained his conclusions as follows:

> [Claimant] has been referred for possible eligibility for services from Inland Regional Center. . . . His overall cognitive and adaptive scores fell slightly above the level, which would qualify him for a developmental disability. Additionally, any deficits that he did display could also be a result of his extensive substance use, which started when he was 13 years

> old. As a result, a developmental disability could not be diagnosed at this time.
>
> In regards to competency, it does not appear that [claimant] has sufficient knowledge of the court process and his symptoms related to his substance use (hallucinations, depression, and movement issues) may prevent him from working with his attorney effectively as well.

Evaluations by Robert A. Leark, Ph.D.

27. Robert A. Leark, Ph.D., obtained a Bachelor of Science Degree in Psychology from Pacific Christian College in 1975; a Master's Degree in Psychology from Pepperdine University in 1976; and a Doctorate Degree in Psychology from United States International University in 1981. Dr. Leark specializes in clinical psychology and neuropsychology, with a subspecialty in test construction. He has assisted in developing, and he has given, many IQ tests. Dr. Leark has conducted forensic evaluations of competency in capital cases, including looking at intellectual abilities in connection with competency.

28. Dr. Leark was retained to evaluate claimant's competency to stand trial in criminal cases against him, and he spent over 12 hours with claimant. Dr. Leark wrote two reports, one dated September 17, 2016, and the other dated July 19, 2017, explaining his evaluations and opinions. In both reports, Dr. Leark described the purpose of his evaluations as follows: "The evaluation was to determine if there were cognitive and/or neuropsychological deficits that may impact [claimant's] ability to understand, reason, rationally assist his counsel, as well as process information in the court room."

Dr. Leark's reports were received as evidence, and he testified during the instant hearing.[11]

DR. LEARK'S SEPTEMBER 17, 2016, EVALUATION

29. When Dr. Leark conducted his 2016 evaluation, he reviewed medical records; school records; competency evaluations conducted by other professionals, including Dr. McCormick; and a family interview summary supplied by the office of the public defender. He also interviewed claimant and administered psychological tests.

30. The following information from the family interview summary was described in Dr. Leark's September 17, 2016, evaluation:

> [A]s per the family, [claimant's] early development was normal in kindergarten or the 1st grade. . . . [Claimant] seemed to lose his concentration and did not have a good memory during childhood. When [claimant] was in approximately the 4th grade the family relocated to the Riverside, California area. The family member also disclosed that while in middle school one of [claimant's] teachers contacted the family complaining that "[claimant] would often laugh a lot in class." While the teacher thought that [claimant] was on drugs, [claimant] denied being on drugs and frankly stated that "He could hear persons talking to him." In 2009 the family noticed that the [claimant] was having serious symptoms of mental illness. He stopped

[11] Dr. Leark's opinion testimony is discussed further below, under the "Expert Witness Testimony" heading.

> taking showers. He stayed indoors, isolated himself, and she could not get him to go out of the house. In addition, the [claimant] continued to talk to himself. The family described his symptoms as severe with him becoming very paranoid. The [claimant] would tell his family that "A neighbor's cat sometimes came to the front door and stared at him and that the cat had evil eyes." [Claimant] slept on the floor although he had a bed to sleep in.
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> Another family member interviewed indicated that the [claimant] did isolate himself from family and appeared unusual quite often. The family did indicate that the youngest sister has been placed in a special education center for 1st grade and continued to receive special education throughout high school. The family members recalled that the youngest sister does have a developmental disorder of unknown nature.

31. Dr. Leark's report noted that claimant reported the following under the heading "Substance Abuse":

> The [claimant] reported that he has a history of paint sniffing and pain [*sic*] inhalation. He would spray paint into a brown paper bag and inhale it. He does notice that after he did this his "speech slowed down" and he "think(s) it hurt my memory." He also admits to using methamphetamines, marijuana, and alcohol.

32. Dr. Leark administered the Reynolds Intellectual Assessment Scales-Second Edition (RIAS-2), to measure claimant's intellectual functioning. The RIAS-2 results include a Verbal Intelligence Index (VIX) and a Non-verbal Intelligence Index (NIX). Those two indices are combined to form the overall Composite Intelligence Index (CIX). Claimant's CIX score was 63, which was significantly below average; his VIX score was 53, within the significantly low average range of verbal intelligence skills; and his NIX score was 82, within the below average range of non-verbal intelligence skills. The RIAS-2 also contains subtests to assess verbal and non-verbal memory, which form a composite memory index (CMX) to assess working memory. Claimant's CMX score was 46, within the significantly below average range for working memory skills. Dr. Leark's report noted:

> While the CIX is a good estimate of [claimant's] overall general intelligence, a statistically significant discrepancy exists between his non-verbal intelligence of 82 and his verbal intelligence of 53 demonstrating better developed non-verbal intelligence or spatial abilities. A difference of this size is relatively uncommon and occurs in less than 5% of the cases in the general population. In comparison of his overall level of general intelligence, his overall level of general memory is significantly below that of his generalized intelligence. This indicates that he is able to engage in some intellectual problem solving and general reason task [*sic*] at a level that exceeds his ability to immediately recall and working memory functions. While this difference is notable, the magnitude of the difference observed is relatively common occurring in more than 20% of any population.

> Therefore, this difference may or may not be indicative of a psychopathological condition, but it does impact his overall abilities.

33. Dr. Leark also administered the CTONI-2, a standardized measure of generalized intelligence which Dr. McCormick had also administered in 2015. When Dr. Leark administered the CTONI-2, claimant's Full Scale Index score was 76; his Pictorial Scale Index score was 84; and his Geometric Scale Composite score was 74. Dr. Leark noted in his report that claimant's "performance on the CTONI-2 are [*sic*] consistent with his non-verbal intelligence scores on the RIAS-2." (Dr. Leark's report also noted that claimant's "IQ score of 73" on the CTONI-2 when administered by Dr. McCormick was "from 1 to 2 standard deviations below age expected peers.")

34. In the summary portion of his report, Dr. Leark stated that claimant "clearly has cognitive impairments, congenital in nature." Other than mentioning to claimant's academic performance as reported in claimant's school records, Dr. Leark's report did not point to any information to explain his conclusion that claimant's condition was "congenital in nature." Dr. Leark's report also noted, "Clearly the [claimant] has a cognitive impairment that is fixed, and the cognitive impairment is consistent with an intellectual disability, if not a developmental disability. In addition to the fixed intellectual disability, the defendant presents with verbal memory deficits as well. His verbal memory scores are greater than two standard deviations below age match peers."

35. Dr. Leark's September 17, 2016, report provided the following conclusions under the "Opinion" heading:

> The [claimant's] intellectual disability and cognitive deficits are chronic and debilitating. These deficits make it extremely difficult, if not impossible, for the [claimant] to assist council [*sic*] in the conduct of the defense and to do so in any

rational manner. While the [claimant] is clearly able to be taught to parrot terminology and courtroom schemes, his understanding is not matched with his ability to parrot. He is not able to attend to, nor understand, information provided in a highly verbally loaded environment, such as the courtroom. His ability to assist council [*sic*], and to do so in any reasonable and rational manner, is impaired. Further, his mental defect impairs his ability to formulate a rational understanding of the proceedings against him. This impairment is not likely to improve over the course of the defendant's lifetime. The California Department of Corrections also found the [claimant] to have a disability that required their action. This disability was noted while the [claimant] was serving time for prior convictions.

The [claimant's] behavior is that of immaturity and is likely linked to his cognitive and intellectual deficits. . . .

The [claimant's] cognitive and intellectual disabilities are further impacted by his mental illness and substance abuse. He has been diagnosed as having Schizophrenia with psychotic features and is taking antipsychotic medications, and an antidepressant medication, to treat his illness. Further, the [claimant] has a history of paint sniffing/huffing, which further impacted a prior impaired cognitive skill set. This trifecta of intellectual disability, mental illness and additional brain impairment has severely impacted the

> [claimant's] cognitive and mental health, as well as his ability to exercise due caution with regards to his behavior.

36. Despite his repeated use of the words "intellectual disability" in his report, Dr. Leark did not state in his report, or during his hearing testimony, that claimant met the *DSM-5* criteria for an Intellectually Disability diagnosis.

DR. LEARK'S JULY 19, 2017, EVALUATION

37. Dr. Leark conducted a second evaluation regarding claimant's competency to stand trial and issued a report dated July 19, 2017. This evaluation and report responded to competency evaluations by Jennifer A. Bosch, Psy.D., dated March 22, 2016, and October 11, 2016, and Renee Wilkinson, Ph.D., dated October 19, 2016, opining that claimant was competent to aid in his own defense.

38. In July 2017, Dr. Leark administered the Repeatable Battery for the Assessment of Neuropsychological Status (RBANS), a test measuring five domains of psychological functioning: "attention, language, visuospatial/constructional abilities, and immediate and delayed memories." His scores were 49 on the Immediate Memory Index, significantly below average; 102 for Visuospatial/Constructional Index, in the average range; 74 for the Language Index, significantly below average; 49 for his Attention Index, significantly below average; and 48 for his Delayed Memory Index, significantly below average. His combined Total Index was 55, significantly below average. This test did not, however, measure cognition or intelligence.

39. Under the heading, "Forensic Opinion," Dr. Leark wrote:

> [Claimant] has a mental disease (schizophrenia) and a mental defect (cognitive disorder, not otherwise specified) each chronic in nature, and fixed. While he is taking medication to decrease his psychosis, his cognitive deficits remain

permanent. His attentional abilities will wax and wane as impacted by his mental disease and medication but will always be problematic. It will be problematic in several aspects: impact his ability to sustain focus to the task at hand, and may be a problem in keeping him compliant to taking his medication.

The use of antipsychotic medication has helped [claimant] function socially. The medication has been helpful in reducing the hallucinations and delusions, symptoms of schizophrenia. The reduction in delusional thinking coupled with the decrease in hallucinations has helped him be more rational in thought than when he is not taking his medications.

His cognitive deficits are permanent. As stated prior, his attentional abilities may improve slightly while taking his antipsychotic medications, his attentional abilities are still well below average compared to individuals is [*sic*] own age. His ability to cognitively process information is impaired, as he has a basic skill set functionally well below average. His ability to process information from very basic to complex, and his speed to process information are both significantly below average.

Report of Progress Toward Recovery of Mental Competence By Laaden Gharagozloo, Ph.D**.**

40. On March 14, 2018, Liberty Healthcare Forensic Psychologist Laaden Gharagozloo, Ph.D., issued a report regarding claimant's evaluation and treatment at the Riverside JBCT Program, in which he was admitted on January 15, 2018. Dr. Gharagozloo did not testify at this hearing. Dr. Gharagozloo's report concluded that claimant had not achieved trial competence, there was a "substantial likelihood" he would achieve trial competence, and he needed further treatment. The report also concluded that claimant was not "suitable for treatment in the JBCT program," and recommended that he be transferred to a state hospital because he needed longer term treatment than what was provided by the JBCT program.

41. According to the report, claimant's attorney told Dr. Gharagozloo that:

> [Claimant] has 'pretty severe' intellectual disabilities, with an IQ in the 60s.[12] She indicated he could not 'assist or understand,' because the information does not sink in." She also said he has Schizophrenia, including delusional thinking, but that it was controlled. She noted he had a "severe" speech impediment, as well as "processing and language issues." She indicated he "doesn't understand very much of anything" and needs help with his "cognition."

[12] Claimant's counsel's representation regarding claimant's IQ scores was not consistent with the evidence presented in this case, which included Full Scale Index scores on the CTONI-2 (which Dr. Leark referred to as IQ scores) in the 70s (73 when tested by Dr. McCormick and 76 when tested by Dr. Leark), not in the 60s. Although Dr. Leark's report referred to an "overall intellectual functioning score of 63," that was not claimant's "IQ score," as according to Dr. Leark's report, claimant's "Full Scale IQ score was 76."

42. Dr. Gharagozloo reviewed prior records and evaluations, including records from claimant's treatment at Patton during 2015 and the evaluation reports written by Dr. McCormick and Dr. Leark.

43. Dr. Gharagozloo's March 14, 2018, report mentioned that summaries in the Patton records "indicated family members reported a 'drastic change in his level of functioning' beginning in 2009, 'correlating with extensive use of substances and alcohol.' Elsewhere in the records, it said he had been using substances since 2007, and that family members noted 'drastic change in his functioning, speech and movement since he used inhalants extensively.'" Dr. Gharagozloo's report also noted that during his psychological admission assessment at Patton, claimant reported a frontal lobe head injury in 2013 due to an automobile accident and he "noted difficulties with thinking clearly and speech after the accident." Additionally, the results of a July 2, 2015, Montreal Cognitive Assessment, conducted while claimant was at Patton, indicated "cognitive impairment in the areas of attention, language, abstraction, and delayed recall." When he was discharged from Patton in September 2015, claimant was diagnosed with Unspecified Schizophrenia Spectrum and Other Psychotic Disorders; Cannabis Use Disorder, Moderate; and Methamphetamine Use, Moderate.

44. Dr. Gharagozloo's report also stated that on January 18, 2018, JBCT program Dr. Azar's diagnostic impression of claimant was noted as Unspecified Schizophrenia Spectrum Disorder, and "she recommended ruling out Unspecified Neurocognitive Disorder."

45. The March 14, 2018, report described claimant's behavior during a March 8, 2018, interview that Dr. Gharagozloo conducted as follows:

> He displayed significant deficits in attention and concentration; he was very distracted. There were numerous instances in which I would ask a question, and [claimant]

would not respond, appearing "zoned out." On some occasions, he would ask me to repeat my question, indicating he knew I had asked him something but did not know what I had asked. There were also occasions in which he did not seem to notice I had asked a question, and I had to repeat myself in order to get a response from him. He was able to answer when I repeated myself. [Claimant] appeared to have an easier time responding to questions during the background interview, which occurred after the competency interview, so his distractibility cannot be explained away by fatigue. Rather, it is likely he had more difficulty focusing on the competency interview because the information was more complex. He was slow to process information and had difficulty responding to abstract and open-ended questions. However, when I broke the material down for him or reasoned through the information with him step by step, his ability to demonstrate an understanding of the material improved. . . . [Claimant] also displayed deficits in his ability to learn and/or recall information I taught him. . . .

[¶] . . . [¶]

[Claimant] said it had been "a long time" since he last experienced auditory hallucinations, stating it was prior to his Liberty admission. He said he last experienced visual hallucinations of "shadows" about a month ago. Despite denying hallucinations, [claimant] appeared distracted and as though he was responding to internal stimuli, as he would

> suddenly jump across the attorney booth as though something has started him. Or, he would look startled as though something was crawling on him and make motions to brush it off him, even though there was nothing there. He would also randomly crouch down as though he was picking something up off the floor. I asked him why he was doing that if he was not hallucinating, and he said, "I just do that." He said he had been doing that for "a couple of months." When I asked if it had ever happened before, he said it had, but he could not recall when it started. He stood for the majority of the interview and told me his back hurts if he sits down. He made occasional abnormal movements, such as twisting his neck or moving his lips oddly.
>
> [Claimant's] speech was mumbled, and I occasionally had to ask him to repeat himself, which he did. However, his speech impediment was not so severe as to make it impossible for me to understand. His speech was linear and goal-oriented. He did not evidence delusional thinking. . . .

46. Claimant provided Dr. Gharagozloo with the following background information: He was not aware of his mother having any pregnancy complications, nor did he believe she used drugs or alcohol while she was pregnant. He believed he was born full term. He was slow in school, held back in ninth grade, and expelled in tenth grade for smoking marijuana on campus. He did not obtain a GED. He worked for the 99 Cents Store for about six months in 2008, and he was fired for being late twice. He worked for Jack-in-the-Box for three or four months in 2009, and he was laid off due to back pain. Since then, he did landscaping work, and he last worked in 2016. He always

lived with his mother. He did not have a driver's license because he failed the exam twice. He occasionally took the bus and could follow the bus routes or would ask the bus driver. He occasionally shopped for groceries and cooked food without recipes. When he worked, he had his own bank account, managed his own account, and never overdrew his account.

47. Dr. Gharagozloo's report also included the following information obtained from claimant under the heading, "Substance Use History":

> [Claimant] said he began smoking marijuana to manage the "panic" he started experiencing after his head injury. He said the panic onset about a week after the accident and ended three weeks after the accident. [Claimant] said, however, that he first used marijuana around age 15 or 16 and used daily until he was incarcerated at age 23 or 24. He said he has not used since then. He believed he was addicted to marijuana because he "couldn't stop smoking." He said he huffed "air dust" about six times in his life, beginning at age 16. He said he began using methamphetamine at age 19 until age 24. He said he used it occasionally and never daily. He responded "not really" when asked if he felt addicted to methamphetamine. He reported using cocaine twice in his life, with the first time being at age 16. He said he first tried alcohol when he was 13 but began drinking more consistently at age 16. He thought he was an alcoholic when he was 19 years old, drinking more than three times a week. He said he last drank alcohol when he was 25 or 26. He said he wanted to attend rehab "to stop the addiction" to

marijuana, but that he could not afford it. He denied any other drug or alcohol treatment.

48. When Dr. Gharagozloo asked claimant when he started hearing voices, claimant could not estimate an age. He started seeing shadows when he was 25, and he did not experience hallucinations until after he started using drugs. Dr. Gharagozloo's report noted that "[claimant] described himself as 'more normal' before he started using drugs, and explaining, 'I used to talk more.' He did not know if his memory, concentration, or comprehension had changed since he began using drugs."

49. Dr. Gharagozloo administered an RBANS Update, which measures attention, language, visuospatial/constructional abilities, and immediate delayed memory.[13] However, Dr. Gharagozloo's report noted that the RBANS Update "purposely excluded certain individuals from its standardization sample, including individuals with current major psychiatric illness, individuals taking antipsychotic medications, individuals with current or historical diagnoses of drug or alcohol dependence, and individuals currently taking antidepressant medication." Therefore, Dr. Gharagozloo's report stated the "interpretations are made with caution, as the normative data may not generalize to [claimant]," who was a member of the excluded categories. Dr. Gharagozloo compared the scores claimant achieved on the RBANS Update in 2018 to Dr. Leark's 2017 administration of the RBANS. The following lists the scores in July 2017 as compared March 2018:

Index/Subtest	July 2017 Score	March 2018 Score
Immediate Memory	49	61
Language	74	74
Delayed Memory	48	74

[13] Dr. Leark had previously administered the RBANS in 2017.

Visuospatial/Constructional	102	78
Attention	49	56

Claimant's Total Scale Score in March 2018 was 60, which according to Dr. Gharagozloo's report, indicated "his general cognitive functioning is in the Extremely Low range." However, Dr. Gharagozloo noted the variability in claimant's scores, and stated:

> Overall [claimant's] current level of performance on the Immediate Memory and Delayed Memory Indexes [*sic*] appears to have improved considerably from his performance at the time of Dr. Leark's testing, and his performance on the Attention Index was also improved, though not as dramatically. His performance on the Visuospatial/Constructional Index was far lower at the time of my testing. Dr. Leark did not include the subtest scaled scores in his report, so I cannot make a determination as to the specific areas in which [claimant's] performance changed.

50. Dr. Gharagozloo's report listed the seven "most appropriate *DSM-5* diagnoses" of claimant's condition, which did not include Intellectual Disability. The report explained the complexity and challenges when diagnosing claimant, and noted that Dr. Gharagozloo could not diagnose him with Intellectual Disability due to the absence of sufficient information about claimant's presentation during the developmental stage, as follows:

> [Claimant] has displayed deficits in attention, concentration, comprehension, and memory over time and across numerous tests. He clearly has deficits in his cognitive

functioning. Records suggest the deficits have been present since [claimant] was a child, but his substance use and mental illness have undoubtedly worsened his pre-existing cognitive deficits. Although [claimant] does have characteristics indicative of a neurodevelopmental disorder, it is not possible to diagnose a specific neurodevelopmental disorder (e.g., Intellectual Disability) absent more information regarding his presentation during the developmental period. As such, a diagnosis of Unspecified Neurodevelopmental Disorder seems appropriate. Relatedly, a neurocognitive disorder diagnosis would require the establishment of acquired cognitive deficits which represent a moderate or significant decline from a previous level of performance, and the observed deficits cannot be better-explained by another mental disorder. Because [claimant] has a schizophrenia spectrum disorder and a neurodevelopmental disorder, it would be nearly impossible to discern whether his current level of cognitive deficits is the result of his nondevelopment disorder, schizophrenia spectrum disorder, substance use history, head injury, or some combination of these. However, because records suggest a significant decline in his functioning coinciding with inhalant use, [claimant] likely does have a neurocognitive disorder. Given the unclear etiology of his current cognitive deficits, a diagnosis of Unspecified Neurocognitive Disorder seems most appropriate.

EXPERT WITNESS TESTIMONY

Dr. Stacy's Testimony

51. Ruth Stacy, Psy.D, received her Doctorate Degree in Psychology from Trinity College of Graduate Studies in 2008. She obtained her Bachelor of Arts Degree in Psychology and Sociology from California Baptist College in 1978; Master of Arts Degree in Sociology from California State University, Chico, in 1980; and Master of Arts Degree in Counseling Psychology from Trinity College of Graduate Studies in 2004. Dr. Stacy has served as a staff psychologist at IRC since October 2015, having previously worked for IRC as a Senior Counselor/Intake from October 2000 until October 2015, Senior Consumer Services Coordinator from October 1991 until July 2000, and Customer Services Coordinator from July 1991 until September 1991. Dr. Stacy also has experience working as a marriage and family therapist and qualified mental retardation professional before working as an IRC staff psychologist. In Dr. Stacy's current position, she is responsible for performing and interpreting psychological assessments to evaluate the eligibility of claimants seeking regional center services.

52. Dr. Stacy did not meet or examine claimant. Her opinions were based on her review of all the documents provided to IRC, including school records; medical records, including Patton records; and the evaluations by Dr. McCormick and Dr. Leark.[14] Dr. Stacy explained that to be eligible for regional center services, claimant must be diagnosed with a qualifying condition, his condition must be substantially handicapping, and his condition must have occurred before he was 18 years old. Dr. Stacy described Intellectual Disability as a "significant impairment in cognitive and adaptive functioning that occurs during the developmental stage."

[14] Dr. Gharagozloo's March 18, 2018, report was not issued until after Dr. Stacy testified on January 30, 2018.

Dr. Stacy pointed out that claimant's scores on tests administered by Dr. McCormick were in the borderline range, above what she would be looking for to diagnose Intellectual Disability. She noted that at the time of Dr. McCormick's evaluation, there was an indication that claimant may not have given his best effort, he was not feeling well, he may have been under the influence of alcohol, and he had mental health issues. If claimant was impaired by a substance during Dr. McCormick's evaluation, Dr. Stacy would expect his scores to be lower as a result of that impairment. Nevertheless, his scores were above the levels expected to diagnose him with Intellectual Disability. She also noted that there was a high discrepancy in the SSSQ scores, such that those scores were not a good indicator of claimant's adaptive functioning. Dr. Stacy saw no records to indicate claimant was in special education, and she noted that claimant's second grade school records indicated that he was "very bright."

Dr. Stacy explained that a "cognitive disability" is not the same as an "intellectual disability." Cognitive disability can occur after age 18 and can be caused by other things. A cognitive decline may be due to substance abuse or an illness. She also testified that a "neurological disorder" may be diagnosed when there is a cognitive decline, as opposed to being present at birth. Additionally, poor academic performance can be due to things other than an intellectual disability, such as a learning disability, lack of self-esteem, or a lack of coping skills.

According to Dr. Stacy, Dr. Leark's reports did not support a diagnosis of Intellectual Disability. In particular, Dr. Stacy pointed to the large split between the verbal and non-verbal scores on the RIAS-2 administered by Dr. Leark. Dr. Stacy stated that if claimant suffered from Intellectual Disability, she would expect all his scores to be very similar. Claimant's low verbal scores could have resulted from claimant's head injury and his substance abuse. Based on the evaluations already performed, Dr. Stacy did not believe a further evaluation was necessary.

Dr. Leark's Testimony[15]

53. Dr. Leark's testimony was consistent with the opinions he provided in his two written evaluations. He stated that he had testified in criminal court that claimant was incompetent to stand trial due to a disability with reasoning and understanding. Dr. Leark noted that based on his review of claimant's school records, claimant was impaired in grade school. Dr. Leark explained that all persons with Intellectual Disability have a cognitive disability, but all cognitive disabilities do not lead to a diagnosis of Intellectual Disability. He acknowledged that several of the tests he administered were "not per se intelligence tests," and he did not perform any adaptive functioning tests because it was not necessary for the evaluations he was asked to perform. He also explained that "severe substance abuse can affect cognitive function over time."

Dr. Leark opined that claimant suffered from a "cognitive intellectual disability" of "unknown origin" prior to age 18, and "there are some big questions that need to be answered." Dr. Leark did not testify, nor did either of his reports state, that claimant met the *DSM-5* diagnostic criteria for an Intellectual Disability diagnosis. Additionally, although claimant's counsel asked Dr. Leark if fetal alcohol syndrome could cause problems with cognitive functioning, Dr. Leark testified that he did not see any evidence that claimant's condition resulted from fetal alcohol syndrome.[16]

[15] Dr. Leark did not comment on Dr. Gharagozloo's March 18, 2018, report, which was not issued until after Dr. Leark testified on January 30, 2018.

[16] Claimant's counsel also asked IRC's expert witness, Dr. Stacy whether "anoxia," a lack of oxygen, may cause brain damage and whether Dr. Stacy specialized in genetic disorders. There was no evidence in the record to suggest that claimant suffered from a

Dr. McCormick's Testimony

54. Dr. McCormick was present during claimant's mother's and sister's testimony, and he stated that their testimony did not change his opinion that claimant is not eligible for regional center services. Dr. McCormick also read Dr. Leark's reports, which he stated did not change his opinions either.

Dr. McCormick explained that Dr. Leark found that claimant suffered from a neurological cognitive disorder, which is not a developmental disability. According to Dr. McCormick, unlike a developmental disability, neurological cognitive disorders are acquired, such as through a brain injury. Further, although Dr. Leark had administered some tests Dr. McCormick was not familiar with, Dr. McCormick pointed out that the results showed significant gaps between verbal and non-verbal abilities, suggesting a language barrier or possibly a memory problem due to an attention issue. Dr. McCormick stated that typically the scores of a person with Intellectual Disability will be consistent with each other as opposed to there being a large discrepancy. Dr. McCormick also did not agree that claimant's problems were congenital in nature because claimant's mother said his functioning was average until second grade. If his problems started at birth, Dr. McCormick would expect to see problems before he was two years of age.

Dr. McCormick opined that claimant does not suffer from intellectual disability because his full scale cognitive score of 73 on the CTONI-2 Dr. McCormick administered was above 70, and although claimant exhibited significant deficits, it was hard to flesh out what caused his cognitive decline. The records did not support a diagnosis of Intellectual Disability because there was no evidence of problems in the developmental

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genetic disorder, oxygen loss/anoxia, or fetal alcohol syndrome, and it was not clear why claimant's counsel chose to raise them as possibilities without any supporting evidence.

stage. Dr. McCormick did not see anything to suggest claimant suffered from a developmental disability before he was 18 years old. When Dr. McCormick reviewed a recent report by Liberty Healthcare, he noted that it did not find that claimant suffered from an Intellectual Disability and instead focused on claimant's mental health and substance abuse problems. Dr. McCormick pointed out that testing performed by Liberty Healthcare, which he referred to as a "mini cognitive screening," showed a decline in cognitive testing over six months, which would not be consistent with a developmental disability.

LEGAL CONCLUSIONS

BURDEN OF PROOF

1. In a proceeding to determine regional center eligibility, the burden of proof is on the claimant to establish he or she meets the proper criteria. The standard is a preponderance of the evidence. (Evid. Code, §§ 115 and 500.)

2. "'Preponderance of the evidence means evidence that has more convincing force than that opposed to it.' [Citations.]" (*Glage v. Hawes Firearms Company* (1990) 226 Cal.App.3d 314, 324-325.) "The sole focus of the legal definition of 'preponderance' in the phrase 'preponderance of the evidence' is on the *quality* of the evidence. The *quantity* of the evidence presented by each side is irrelevant." (*Ibid.*, italics in original.) "If the evidence is so evenly balanced that you are unable to say that the evidence on either side of an issue preponderates, your finding on that issue must be against the party who had the burden of proving it [citation]." (*People v. Mabini* (2001) 92 Cal.App.4th 654, 663.)

STATUTORY AUTHORITY

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

4. 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. . . .

5. 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.

6. California Code of Regulations, title 17, section 54000[17], 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.

[17] The regulation still uses the former term "mental retardation" instead of "intellectual disability."

(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 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.

7. 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.

8. Welfare and Institutions Code section 4642, subdivision (a), requires a regional center to perform initial intake and assessment services for "any person believed to have a developmental disability." Welfare and Institutions Code section 4643, subdivisions (a) and (b), provide the following regarding assessment services:

(a) If assessment is needed, the assessment shall be performed within 120 days following initial intake. Assessment shall be performed as soon as possible and in no event more than 60 days following initial intake where any delay would expose the client to unnecessary risk to his or her health and safety or to significant further delay in mental or physical development, or the client would be at imminent risk of placement in a more restrictive environment. Assessment may include collection and review of available historical diagnostic data, provision or procurement of necessary tests and evaluations, and summarization of developmental levels and service needs and is conditional

upon receipt of the release of information specified in subdivision (b).

(b) In determining if an individual meets the definition of developmental disability contained in subdivision (a) of Section 4512, the regional center may consider evaluations and tests, including, but not limited to, intelligence tests, adaptive functioning tests, neurological and neuropsychological tests, diagnostic tests performed by a physician, psychiatric tests, and other tests or evaluations that have been performed by, and are available from, other sources.

AUTHORITY REGARDING EXPERT OPINION TESTIMONY

9. California courts have repeatedly underscored that an expert's opinion is only as good as the facts and reasons upon which that opinion is based. (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 924.) "Like a house built on sand, the expert's opinion is no better than the facts on which it is based. . . . [W]here the facts underlying the expert's opinion are proved to be false or nonexistent, not only is the expert's opinion destroyed but the falsity permeates his entire testimony." (*Ibid.*)

10. An expert witness "does not possess a carte blanche to express any opinion within the area of expertise. [Citation.]" *Jennings v. Palomar Pomerado Health Systems, Inc.* (2003) 114 Cal.App.4th 1108, 1117.) "Where an expert bases his conclusion upon assumptions which are not supported by the record, upon matters which are not reasonably relied upon [by] other experts, or upon factors which are speculative, remote or conjectural, then his conclusion has no evidentiary value. [Citations.]" (*Pacific Gas & Electric Co. v. Zuckerman* (1987) 189 Cal.App.3d 1113, 1135-36.)

EVALUATION

11. There was no dispute that claimant suffers from significant cognitive deficits. However, the Lanterman Act and the applicable regulations set forth criteria that a claimant must meet to qualify for regional center services. Claimant failed to prove by a preponderance of the evidence that he meets the *DSM-5* diagnostic criteria for Intellectual Disability. None of the evaluators, including Dr. Leark, diagnosed claimant with Intellectual Disability. Cognitive testing placed claimant in the borderline range, above the level expected when diagnosing Intellectual Disability, and the evidence did not support a finding that claimant's cognitive deficits existed during the developmental stage. Based on his school records and his mother's testimony, claimant was performing in the average and/or normal range in kindergarten and the early part of his elementary school education.

Despite claimant's counsel's arguments and questions implying that some sort of congenital defect might have caused claimant's cognitive deficits, there was no medical or other evidence to support the argument that claimant suffered any congenital defect. Additionally, Dr. Leark's use of the word "congenital" was speculative because it was not supported by any evidence.

Given the testing performed by several psychologists and the lack of evidence that claimant suffered deficits during the developmental stage, additional evaluation of claimant was not necessary. It was appropriate for IRC to rely on the 2015 evaluation by Dr. McCormick, school records, Patton medical records, and the other evaluations by Dr. Leark that were presented to IRC during 2017 to determine whether claimant was eligible for regional center services. (Welf. & Inst. Code, § 4643, subds. (a) and (b).) The March 14, 2018, evaluation by Dr. Gharagozloo was not inconsistent with the other evaluations and did not support a diagnosis of Intellectual Disability.

The evidence was insufficient to meet claimant's burden of proving claimant suffers from an Intellectual Disability. Additionally, the evidence did not support a

finding that further testing is warranted under the circumstance of this matter. Thus, claimant's request that additional testing be ordered and his appeal from IRC's determination that he is ineligible to receive regional center services are both denied. Claimant is not eligible for regional center services.

ORDER

1. Claimant's request that Inland Regional Center perform additional intake and/or testing of claimant is denied.

2. Claimant's appeal from Inland Regional Center's determination that he is not eligible for regional center services and supports is denied. Claimant is ineligible for regional center services and supports under the Lanterman Developmental Disabilities Services Act.

DATED: April 3, 2018

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THERESA M. BREHL

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.