# BEFORE THE
# OFFICE OF ADMINISTRATIVE HEARINGS
# STATE OF CALIFORNIA

## In the Matter of:

## CLAIMANT

**vs.**

## GOLDEN GATE REGIONAL CENTER, Service Agency.

## OAH No. 2018080909

## DECISION

Administrative Law Judge Holly M. Baldwin, State of California, Office of Administrative Hearings, heard this matter on September 23-27, 2019 and January 16, 2020, in San Francisco, California.

Jay T. Jambeck, Attorney at Law, Leigh Law Group, P.C., represented claimant, who was not present at hearing. Claimant's parents were present at hearing.

Rufus L. Cole and Dirk van Ausdall, Attorneys at Law, Rufus L. Cole and Associates, represented Golden Gate Regional Center (GGRC), the service agency.

The record was held open for briefing. On February 18, 2020, claimant submitted a closing brief, which was marked for identification as Exhibit S. On March 24, 2020, GGRC submitted a closing brief in opposition, which was marked for identification as Exhibit 26. On April 8, 2020, claimant submitted a reply brief, which

was marked for identification as Exhibit T. GGRC was granted leave to file a sur-reply, which was submitted on April 15, 2020, and was marked for identification as Exhibit 27. The record closed and the matter was submitted for decision on April 15, 2020.

## ISSUE

Is claimant eligible for regional center services on the ground that he is substantially disabled by autism?

## FACTUAL FINDINGS

### Introduction and Procedural History

1. Claimant is 21 years old (he was 19 years old at the time he was assessed by the expert witnesses in this matter). Claimant lives with his mother and younger brother, and his father lives nearby. Claimant's parents are his co-conservators.

2. Claimant applied to GGRC for regional center services in April 2018. GGRC issued a finding that claimant was not eligible for regional center services on July 18, 2018. Claimant requested a hearing and this proceeding followed.

3. Claimant contends that he has comorbid conditions of autism spectrum disorder (ASD) and schizophrenia, and that his ASD is substantially disabling, rendering him eligible for regional center services. GGRC contends that claimant does not suffer from ASD, and that his presentation is best explained by a sole diagnosis of schizophrenia, a condition that does not confer eligibility for regional center services. GGRC concedes that claimant is substantially disabled, but contends that his adaptive functioning deficits are due to psychiatric illness and learning disorders, not ASD.

## DSM-5 Criteria for Autism Spectrum Disorder and Schizophrenia

4. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) was published by the American Psychiatric Association in 2013. It currently serves as the principal authority for diagnosis of mental disorders in the United States.

5. The diagnostic criteria for ASD set forth in the DSM-5 are:

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

1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.

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

3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts;

to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

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

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).

2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).

3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).

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

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

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

E. These disturbances are not better explained by intellectual disability (intellectual development disorder) or global development delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

(DSM-5 at pp. 50-51.) The diagnostic criteria for ASD also include a note stating: "Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder." (DSM-5 at p. 51.)

6. The key features of schizophrenia include: delusions (fixed beliefs not amenable to change in light of conflicting evidence); hallucinations (perception-like experiences occurring without external stimulus); disorganized speech (e.g., frequent derailment or incoherence); grossly disorganized or catatonic motor behavior; and negative symptoms (e.g., diminished emotional expression or avolition). (DSM-5 at pp. 87-88, 99). The diagnostic criteria for schizophrenia require two or more of the above

symptoms (at least one of which must be delusions, hallucinations, or disorganized speech), each of which is present for a significant portion of time during a one-month period. (DSM-5 at p. 99.) Prodromal symptoms often precede the active phase, and negative symptoms are common in the prodromal phase. (DSM-5 at p. 101.) The psychotic features of schizophrenia typically emerge between the late teens and the mid-30s, and childhood onset is rare. (DSM-5 at p. 102.) The essential features of schizophrenia are the same in childhood, but it is more difficult to make the diagnosis in children. (*Ibid.*)

7. The DSM-5 addresses differential diagnosis between ASD and schizophrenia. (DSM-5 at pp. 58, 105.) Schizophrenia with childhood onset usually develops after a period of normal or near-normal development (as opposed to ASD, which must have symptoms present in the early developmental period). Negative symptoms of schizophrenia in the prodromal state, such as social impairment or atypical interests and beliefs, could be confused with the social deficits seen in ASD. Deficits in social interaction with repetitive and restricted behaviors are a distinguishing feature of ASD. Hallucinations and delusions are distinguishing features of schizophrenia. A person with ASD must have symptoms that satisfy the diagnostic criteria for schizophrenia, with prominent hallucinations or delusions for at least one month, in order to be diagnosed with schizophrenia as a comorbid condition.

8. The DSM-5 also discusses comorbidity of ASD with other conditions, noting that many people with ASD have one or more other comorbid psychiatric conditions, and stating that when criteria for both ASD and another disorder are met, both diagnoses should be given. (DSM-5 at pp. 58-59.)

## Developmental, Social, and Educational History

9. Claimant was born in December 1998, in England. He grew up in England and Ireland, moving to the United States at age 17.

10. Claimant was a quiet and detached infant who showed few emotions. He was extremely attached to his mother, but related to his father as if to a stranger. When claimant's father spoke to his son, he received only minimal responses. Claimant's parents report that since infancy, claimant was "in his own bubble" or "a world of his own," and became very disoriented without external structure.

11. Claimant's first attempt at attending day care when he was nine or ten months old was unsuccessful due to his extreme distress being separated from his mother, and was abandoned after a week.

12. Since the age of one, claimant has had problems recognizing others' body language or reading emotions. This has persisted into adulthood, although his ability to recognize expressions on other people's faces has improved with effort.

13. As a toddler, claimant would physically push over other children when encountering them or hit them on the head to provoke a reaction, requiring his mother to always remain within arm's reach. This behavior continued until claimant was 10 years old, despite efforts to teach him to stop.

14. Claimant attended preschool, but could not tolerate being with his peers for long periods of time, requiring a shortened day and needing to sit apart from others by lunchtime. He did not engage in reciprocal play with peers as a preschooler, instead engaging in solitary or parallel play.

15. Toilet training was difficult, with claimant not achieving bladder control until age 5. When claimant attended preschool, his teacher noted he could not dress himself after using the toilet.

16. Claimant did not learn to tell time until he was 11 years old, and only learned to do so after intensive repetition and overlearning efforts by his parents. Once he learned to tell time and understand a daily meal schedule, claimant was helped by this sense of structure.

17. Throughout childhood, claimant's body language was static, and he did not engage in much voluntary body movement or the use of gestures. He also had a limited range of facial expressions. Claimant's eye contact with those outside his family was fleeting or inconsistent.

18. Since childhood, claimant has had difficulties engaging in reciprocal conversations, often speaking in a monologue without regard to his impact on the listener, or answering a question but then being unable to sustain the conversation. He also has reduced awareness of the impact of his statements on others, making socially inappropriate comments about others' finances, disabilities, or race.

19. Throughout claimant's life, his parents have had to explain social situations to him, and teach him social behaviors in a step-by-step manner, with extensive repetition and practice. At age 12, claimant's mother gave him daily social skills lessons. For example, she would knock on claimant's bedroom door and coach him to open the door and greet her, and then to ask her if she wanted to come in.

20. Since childhood, claimant has had problems developing friendships, generally only having one friend at a time. His mother has always been actively involved in facilitating play dates or interactions with peers. As an older child and

adolescent, claimant interacted with a few peers who had shared interests, but he struggled trying to interact with more than one peer at a time.

21. From early childhood, claimant has displayed differences in his use of language. He repeated words and phrases back to people, and repeated phrases over and over. At age five or six, his parents had to impose limits on the number of times he repeated a phrase. In childhood, claimant had problems understanding the use of pronouns, for example, thinking that when he was asked "do you want milk?", his name was "you." He also has used made-up words since childhood, even with those outside his family, coining words by adding a suffix or taking away part of a word (e.g., "welk" for "welcome," "mumlit" for his mother, or "goodmund" to express that he enjoys something). Claimant tends to speak in a monotone. He relies on rote phrases in conversation, beginning with a phrase such as "Did you know…?" or "Now what would you do if…?" He also is prone to using stilted or overly formal speech.

22. As an infant and toddler, claimant made repetitive circular motions with his arms while sitting in his high chair.

23. At age two, claimant arranged his toy cars in lines and patterns. Starting at age three or four, he collected car hubcaps. He arranged a collection of over 200 hubcaps in patterns in the back yard and would not allow interference with them.

24. Claimant has longstanding fixed interests. Since age two or three, he has been intensely interested in cars, recognizing symbols for every make of car; collecting and organizing sets of back-issue car magazines; collecting hubcaps; writing lists of all neighborhood vehicles by make, model, and year; and memorizing extensive sets of classic car facts. Claimant has also been interested in ducks since early childhood,

amassing a large collection of ornamental ducks that he organizes in boxes and arranges in rows on shelves. These interests have continued into adulthood.

25. Since early childhood, claimant has had atypical reactions to certain sensory input. By age three, his parents noticed claimant could not tolerate loud noises such as a lawnmower or vacuum. Throughout his childhood and schooling, claimant was overstimulated and disoriented by noisy environments. Since age three or four, claimant was hyper-sensitive to the feel of seams and labels in his clothing, and would wear his clothing inside-out. When claimant first started eating solid food as an infant, he enjoyed foods with powerful tastes, but did not know when to stop eating, gorging until he vomited. Later in childhood and continuing, claimant did not like foods with runny or viscous textures. Ever since he started eating more than one type of food at a time, claimant has not allowed different foods to touch on a plate, and he eats the different foods sequentially.

26. Throughout childhood, claimant became very upset with any changes to his routines. For example, he found it difficult to cope with periodic short days at school, transitions at the end or beginning of school terms, or substitute teachers. His parents needed to notify claimant well in advance of any planned activity, and tell him about all the steps required to get ready for that activity.

27. At age five, claimant attended a local primary school. He did not join in playing with his peers, and his teachers could not make a connection with him. Claimant needed intense overlearning to acquire new information.

28. At age six, claimant's family moved to Belfast, Northern Ireland, for his father's work. Claimant attended a Rudolf Steiner (Waldorf style) school from ages six to nine. He was bullied by his peers and did not perform well at this school. Claimant

had displayed signs of dyslexia since his preschool years, and he was formally diagnosed with severe dyslexia by the Northern Ireland Dyslexia Service. He received three years of individual reading lessons, making very slow progress.

29. In 2008 and 2009, when claimant was nine and ten years old, his family moved to Inishmaan, a very small island off the coast of Ireland, to live in the family's vacation cottage and focus on claimant's needs. Claimant received individual tutoring by a dyslexia specialist two days a week. Claimant's mother homeschooled him three days a week, focusing especially on teaching him concepts of time and spatial orientation. Claimant had a daily routine of walking to the shop, with a shopping list, to buy three items. He could do this successfully, but not without the list or if there were more than three items.

30. Claimant's family moved back to England in 2009.

31. From 2009 to 2012, when claimant was 10 to 13 years old, he attended Stanbridge Earls School, a private school focused on teaching students with ASD and learning disorders. Classes were very structured and claimant received individual teaching, as well as advisory help from teachers and counselors on how to be in a group class. He also received speech and language therapy and occupational therapy. Claimant did well in this environment.

32. As discussed in more detail below (Factual Finding 45), in January 2011, at age 12, claimant was evaluated by a child and adolescent psychiatrist and was diagnosed with Asperger's Syndrome. Claimant was also evaluated by other professionals during the same time period (Factual Findings 46-48), in connection with an appeal regarding his special education needs, in which his parents sought to keep claimant in a specialized school, rather than a mainstream secondary school.

33. Claimant's speech and language therapist, Clara Groome, wrote a report on November 11, 2011, finding that claimant had expressive and receptive language and social communication difficulties in line with a diagnosis of Asperger's Syndrome. She stated that claimant can become fixated on one topic (especially motorbikes and cars), and will talk about it with limited awareness of the listener's understanding or interest. Groome also discussed claimant's ongoing difficulties with using and interpreting non-verbal communication, inflexibility to changes in plans, doing the same activity over and over again, use of context (taking language literally), social relations, and problems with abstract language.

The following year's report from Groome, dated October 5, 2012, noted improvements in claimant's assessment scores, but found that claimant continued to have problems with social communication, using and understanding words associated with feelings, and interpreting language literally. Claimant had "his own agenda" when expressing himself. He benefited from participating in a social communication group.

34. In claimant's annual review from Stanbridge Earls School in January 2012 (Year 8), his teachers noted improvements in a number of areas. His teachers' notes of claimant's weaknesses included social communication, sensory integration, motor skills, communication in team sports, and understanding nonverbal communication. Claimant's teachers reported that he could become fixated on certain topics (cars and motorbikes), and that he was prone to literal interpretation of what he hears.

In the next year's review in November 2012 (Year 9), claimant's teachers noted that he was doing well at the school in the last year, and that his anxiety level was reduced, after taking two years for him to settle in. Claimant's teachers found that he continued to struggle to manage friendships, and he needed support with how to have conversations and express emotions. He struggled going into shops and found it

very difficult to be in unfamiliar places. The school planned to change the focus of services from occupational therapy to personal and social development.

35. Stanbridge Earls School closed, and claimant attended a public school from ages 14 to 16. He did not perform well in this environment, despite being in a small unit for children with learning disabilities. Claimant did not have any friendships with peers, and was uncomfortable interacting with people outside his family.

36. In 2014, when claimant was 15 years old, his mother had a subarachnoid brain hemorrhage and nearly died. Claimant's mother spent three months in the hospital and her period of recovery and rehabilitation took two or three years.

37. Claimant's parents separated in 2015. Their divorce was finalized in Spring 2018.

38. Claimant finished the end of his mandatory schooling period at age 16, in July 2015. An upcoming change in the law meant that the mandatory schooling period was being extended to age 18 in England, but not in Ireland. Claimant and his parents felt that he could not endure two more years in school. His parents also wanted to test to what extent claimant could live semi-independently.

39. Claimant planned to spend a "gap year" living by himself in the family cottage on Inishmaan island from 2015 to 2016, at age 16 to 17. Claimant lived on the island during this time, but not for a full year. He lived in the island cottage alone for a total of about four months, in periods of three to six weeks, spread over a timespan of about nine months. Claimant's time alone on the island was punctuated by visits from his mother and by his return home to England for four months from November 2015 to March 2016.

As discussed above, the island was a small and familiar environment for claimant. He enjoyed the peace and quiet there, and activities such as walking, kayaking, reading, and watching television. His mother ordered weekly deliveries of groceries for claimant. His parents spoke with him daily by telephone or Skype videoconference. Claimant's parents also told all the neighbors to keep an eye on him, and received reports from the neighbors about his activities. Despite these supports, claimant was not successful in independently maintaining his activities of daily living and self-care. He did not know which foods to refrigerate and freeze, leading to food spoilage and rat infestation. He did not know what items could not be microwaved, or not to put a hot pan on the table. He broke the washing machine, and after it was repaired, broke it again. He was unkempt in his personal hygiene.

40. Claimant returned home to England in late spring or early summer 2016.

41. In August 2016, at age 17, claimant moved to California with his father and brother. Claimant's father had been visiting California for consulting work for many years.

42. In mid-to-late 2017, at ages 18 and 19, claimant began to exhibit symptoms of psychosis, which gradually increased. These symptoms are discussed below in Factual Findings 49 through 56.

43. Claimant's mother moved to California in February 2018 to live with claimant and his brother, and claimant's father moved to a separate home nearby.

44. Claimant applied to GGRC for regional center services in April 2018. Claimant's parents also began seeking a conservatorship, which was granted in 2019.

## Diagnosis of Asperger's Syndrome

45. Dr. Richard Soppitt, a child and adolescent psychiatrist, evaluated claimant and wrote a psychiatric report dated January 12, 2011. Claimant was 12 years old at the time of evaluation. His parents sought a psychiatric assessment in connection with their efforts to maintain claimant in an appropriate educational setting, and to gain a broader picture of claimant's mental condition.

Dr. Soppitt specializes in diagnosis and management of neurodevelopmental disorders such as ASD and ADHD (attention-deficit/hyperactivity disorder), as well as emotional disorders such as depression and obsessive compulsive disorders. He has lectured on autism and has published articles on a variety of topics, including Asperger's Syndrome, autism, ADHD, and schizophrenia.

Dr. Soppitt reviewed claimant's school records from 2007 forward, and conducted a two and one-half hour assessment of claimant, with claimant's parents.

Dr. Soppitt diagnosed claimant with Asperger Syndrome, citing Gillberg's criteria[1] and the ICD 10 (International Classification of Diseases, 10th revision). He wrote:

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[1] Gillberg's diagnostic criteria for Asperger Syndrome include six areas:

(1) *social impairment* (extreme egocentricity), including (at least two) difficulties interacting with peers, indifference to peer contacts, difficulties interpreting social cues, and/or socially and emotionally inappropriate behavior;

> Comparing the Gillberg Criteria for Asperger Syndrome (AS 1995), [claimant] meets all five criteria including severe reciprocal social interaction difficulties, narrow interests, routines and imposition of routines on others, speech and language issues and non-verbal communication problems.

Regarding Area 1 (social impairment), Dr. Soppitt noted: claimant's low self-esteem and vulnerability to misreading social cues and sarcasm, with claimant liking to joke around but not understanding the impact on others; claimant wanted friends and was socially motivated; he missed body language cues; his behavior was often quirky and eccentric; his jokes lacked finesse; and he demonstrated a blurred distinction between

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(2) *narrow interest*, including (at least one) exclusion of other activities, repetitive adherence, and/or more rote than meaning;

(3) *compulsive need for introducing routines and interests*, which (at least one) affects the individual's every aspect of everyday life, and/or affects others;

(4) *speech and language peculiarities*, including (at least three) delayed speech development, superficially perfect expressive language, formal pedantic language, odd prosody and peculiar voice characteristics, and/or impaired comprehension including misinterpretations of literal/implied meanings;

(5) *non-verbal communication problems*, including (at least one) limited use of gestures, clumsy/gauche body language, limited facial expression, inappropriate facial expression, and/or peculiar stiff gaze; and

(6) *motor clumsiness*, poor performance on neurodevelopmental examination.

reality and fantasy. Regarding Area 2 (narrow interests), Dr. Soppitt noted claimant's fixation with classic cars and related facts, and his need for routine around him. Regarding Area 3 (routines), Dr. Soppitt found that claimant needed routine and disliked changes, having difficulties with ends of school terms and substitute teachers. Regarding Area 4 (speech and language peculiarities), Dr. Soppitt found claimant has pronoun reversal, lacked prosody, and was literal with sarcasm and humor but able to understand idioms. Regarding Area 5 (non-verbal communication), Dr. Soppitt noted that claimant lacked use of gesture, had reasonable facial expression, and had poor eye contact.

Dr. Soppitt did not specifically address Area 6 of the Gillberg criteria (motor clumsiness). He did, however, write the following regarding the physical examination: "[Claimant] demonstrated very poor eye tracking with no convergence at all. This is linked with very poor visuomotor integration and copying and writing difficulties. . . . His balance and catching were fair. His Fog's test was abnormal on medial inversion."[2]

As part of Dr. Soppitt's evaluation, claimant's parents completed the Asperger Syndrome Screening Questionnaire (ASSQ), yielding a score of 32, above the threshold of 17 for ASD.

In addition to Asperger Syndrome, which he put under the heading of "communication and interaction," Dr. Soppitt noted other issues for claimant, which he grouped into several categories. Regarding "cognition and learning," Dr. Soppitt found claimant had significant specific learning difficulties (SpLD), very poor short-term

[2] As explained in the testimony of GGRC's staff psychologist, Dr. Telford Moore, Fog's test is a neuromotor test involving walking on the outside edges of the feet.

auditory memory, and a very marked disparity between his literacy and verbal language skills. Dr. Soppitt also noted that claimant "is easily distracted by auditory overload or his interests and lacks awareness of road related danger." Regarding "personal, emotional and social difficulties," Dr. Soppitt found claimant had very low self-esteem and awareness of being different from his peers, a previous diagnosis of depressive adjustment disorder, and high levels of anxiety especially around academics and novel activities.[3] Regarding "motor and sensory," Dr. Soppitt noted claimant's poor eye teaming skills which affect visuomotor integration, poor handwriting skills, and immature neurodevelopment including an abnormal Fog's test.

Given the complexity of all the above needs, Dr. Soppitt concluded that claimant required a specialist school and teaching approach with small class sizes, and specialist teaching (rather than a teaching assistant within a non-specialist setting).

## Special Education Assessments

46. Denise Thornton, a chartered psychologist and registered educational psychologist, wrote an educational psychology report on February 20, 2011. She reviewed claimant's school records and educational reports, observed claimant in class, talked with teaching staff, conducted an individual assessment of claimant, and interviewed his mother. Thornton administered the Wechsler Intelligence Scale for Children – Fourth Edition, United Kingdom edition (WISC-IV), as well as tests of reading, objective language skills, written expression, numerical operations, and a developmental and neuropsychological assessment. She determined that claimant's

[3] Dr. Soppitt administered the SCARED self-reporting tool to claimant, which resulted in a score of 19, below the cut-off of 25 for diagnosis of anxiety disorder.

cognitive ability fell within the average range, except for his processing speed index, which was very low.

Thornton's analysis of claimant's special educational needs included findings of: "Social communication and social interaction difficulties consistent with his diagnosis of Asperger's Syndrome"; severe specific learning difficulties (dyslexia); high levels of anxiety; social and emotional immaturity; sensory processing and modulation difficulties; and slow visual processing speed.

Thornton concluded that claimant needed a small class setting with a highly structured, low arousal environment, where his significant anxiety, ASD-based difficulties, literacy, numeracy, motor and sensory difficulties could be supported through a highly differentiated curriculum. She noted that even in the specialized setting of Stanbridge Earls School, claimant was struggling to cope with social and emotional demands.

47. Nikki Wilkins, a pediatric occupational therapist, wrote an occupational therapy report on April 4, 2011. She reviewed claimant's special education files and school records, psychological reports, Dr. Soppitt's report, and occupational therapy records. Wilkins assessed claimant for two to three hours, and interviewed claimant's father. She administered tests of motor proficiency and visual perception, a sensory profile, an assessment of independence skills, and a handwriting assessment.

Wilkins observed that claimant did not make much initial eye contact, but it improved over the assessment. He did not initiate any conversation but responded to specific questions. Wilkins noted claimant's very slow speed at processing information.

Claimant was only able to manage basic self-care routines on his own, and needed prompting to get dressed. He frequently lost his possessions. Claimant was able to tell time, but could not plan or organize his time independently.

Claimant's sensory profile showed he was very self-contained, with a tendency to avoid sensory experiences. He was unusually still and quiet, and was rigid when his father hugged him. Claimant reported that he found it hard to listen and concentrate when there are lots of words, noise, or people moving about. He disliked strong smells, flavors, moving about, bright colors, bright lights, and noisy or crowded environments. He disliked having his hair cut, his back rubbed, or going barefoot. He disliked the feel of seams or labels in his clothing; thus he wore his socks inside out.

Wilkins found that claimant had below average manual dexterity, but average scores on other motor skills. She found that claimant cannot multi-task, which "makes it extremely challenging for [claimant] to apply the motor skills he has to more complex situations where he has to integrate a lot of information at the same time." Wilkins' testing of claimant's visual perception similarly revealed very low scores in visual motor searching and visual motor speed, with average or superior scores on other sub-tests. Wilkins determined that this showed claimant's difficulties occur when he had to process and integrate visual information quickly.

Wilkins concluded claimant required a specialized educational setting offering a modified sensory environment, small classes, and consistent routines. She also concluded claimant needed teaching staff who are trained in the needs of children with Asperger's Syndrome, specific difficulties with sensory processing and sensory integration, and dyslexia. She recommended continuing occupational therapy and speech and language therapy.

48. Samantha Peacock (D.Clin.Psychol.), a chartered clinical psychologist, wrote a clinical psychology report on April 15, 2011. Her experience included work with children with neurodevelopmental disorders, particularly ASD and related conditions. Dr. Peacock reviewed claimant's 2010 educational psychology report, Thornton's report, Dr. Soppitt's report, and a recent speech and language therapy report. Dr. Peacock assessed claimant at home and interviewed his parents.

Dr. Peacock noted that claimant was clearly anxious at her presence and the disruption to his routine. When she arrived, claimant was eating breakfast while wearing only a shirt and underpants, because his favorite pants were in the dryer and he would not wear other pants. He displayed no insight into the inappropriateness of this attire in Dr. Peacock's presence.

Claimant had difficulty responding to Dr. Peacock's questions about his feelings and labeling or processing emotions. He replied with phrases such as "kind of," "sort of," and "I just feel weird." He repeatedly said he was "bored" or that school activities were "boring," but it was apparent that this described a range of emotions for him. He became more visibly anxious and withdrew to his bedroom during the assessment, but later returned to watch a television show about cars in the next room.

Claimant's mother reported claimant's ongoing difficulties with transitions between home and school, and changes to his routine. Dr. Peacock noted that this is a common difficulty in children with Asperger's Syndrome.

Dr. Peacock concluded that claimant "is a child with severe and complex needs arising from his severe specific learning difficulties, his Asperger's syndrome and his significant levels of anxiety." She agreed that claimant required specialist teaching, rather than placement in a mainstream secondary school.

## Emergence of Psychotic Symptoms and Schizophrenia Diagnosis

49. As noted above, claimant moved to California in August 2016 at age 17.

50. In mid-to-late 2017, at age 18, claimant began to exhibit signs of psychosis, which gradually worsened in 2018 and 2019. As his father described it, claimant became "more and more lost," and would wander off to meet with homeless people at a local encampment; those people gave claimant drugs including marijuana and LSD. Claimant began to engage in odd behavior such as lying down in the street and walking around partially dressed in the rain.

Claimant returned to England to visit his mother for Christmas 2017, and remained there with her until he accompanied her move to California in February 2018. She became increasingly concerned about claimant's behavior, but was not sure at that time whether claimant's odd behavior was due to his use of drugs or to psychosis. Claimant dressed oddly. He had a diminished ability to engage in conversation and a focus on bizarre topics. Claimant also began to have difficulty sleeping, and would leave the house and stay out all night without telling his mother. Claimant's mother took him to visit family in England in the summer of 2018, but had to cut the trip short due to claimant's behavior. He did not cope well with visiting his aunt and cousins. One of his cousins was pregnant, and claimant touched her belly and talked about the magical properties of baby blood and how people would want her baby's blood.

Over time, claimant expressed a number of delusions, such as beliefs that his father is the true Prince of Wales, that the British royal family wants to harm claimant, that the current Prince of Wales is a Nazi, and that claimant's mother is not his true mother and his real mother is a black woman with red hair (claimant's mother is white). Claimant became preoccupied with the Bible, drawing a family tree showing himself as

a direct descendent of biblical figures. Claimant also had paranoid thoughts about items with non-organic properties damaging his health, manifested by only eating breakfast foods from specific organic stores, and expressing a desire to go to Ethiopia to live off fresh fruits. On one occasion, claimant made superficial cuts in his forehead in order to "open his third eye," believing an old chicken pox scar to be his "third eye."

In August 2018, claimant built a shrine with his childhood photographs at a local elementary school; staff at the school were alarmed and called the police. Claimant had other encounters with the police on dates not established by the record, including a citation for riding a bicycle through a stop sign, and shoplifting a trinket from a store. In January or February 2019, claimant broke into the car of one of his friends, took a jacket, and replaced it with claimant's own childhood belongings.

51. In May 2018, claimant began psychotherapy with Steven A. Frankel, M.D., a psychiatrist. Claimant's father brought him to see Dr. Frankel initially for evaluation and claimant subsequently began weekly psychotherapy sessions. The observations and opinions of Dr. Frankel are discussed in more detail below (Factual Findings 109-113).

52. In June 2018, claimant began seeing psychiatrist Arthur James Ashe, M.D., for initial evaluation and subsequent medication management. On a date not established by the record, Dr. Ashe diagnosed claimant with schizophrenia and prescribed medications.

In a letter dated August 15, 2019, Dr. Ashe discussed the DSM-5 diagnostic criteria for schizophrenia, and claimant's symptoms. Dr. Ashe found that claimant's condition is consistent with the diagnosis of Paranoid Schizophrenia (ICD 10 code F20.0), also listed as Schizophrenia Disorder (DSM-5 295.90 (F20.9)). He found that

claimant clearly met the criteria for delusions and negative symptoms, and that elements of hallucinations and grossly disorganized behavior had been present, but to a lesser degree. Dr. Ashe described claimant's odd behavior, delusions, and paranoid beliefs from Fall 2017 to August 2018. He also discussed negative symptoms in claimant's presentation, including flat or blunted affect, lack of interest in the world, internal preoccupation, focus on a perseverative narrow set of ideas, and difficulty feeling pleasure. Dr. Ashe also noted a number of symptoms that he listed as "associated features" contributing to a diagnosis of schizophrenia, including: inappropriate affect (laughing in absence of stimuli); disturbed sleep patterns (staying awake for two days then sleeping for 15 hours); dysphoric mood; anxiety; depersonalization; derealization; cognitive deficits impacting language, processing, executive function, and/or memory; lack of insight into his disorder; social cognition deficits; and increased hostility and aggression (if challenged, using insults that the other person is evil or has one eye).

In discussing differential diagnosis, Dr. Ashe wrote the following:

> There is a history of autism spectrum disorder or a communication disorder (childhood onset), but the diagnosis of schizophrenia is made here because the prominent delusions or hallucinations, along with other symptoms, are present for at least one month. [Claimant's] behavior is consistent with the diagnosis of Autism Spectrum Disorder without significant intellectual or language impairment 299.00 (F84.0). It is also true that he meets the criteria that prominent delusions and other symptoms have been present for greater than one month.

53. Despite being prescribed medications by Dr. Ashe, claimant was resistant and non-compliant with taking his medications in 2018 and early 2019.

54. On February 13, 2019, claimant was taken by the police to Marin General Hospital for an evaluation under Welfare and Institutions Code section 5150, but he was not detained in the hospital on such a hold. Notes from a therapist with the county mental health mobile crisis response team reflect that there had been several welfare-check calls from the family as claimant's decompensation worsened.

55. Claimant was subsequently hospitalized for six weeks at a secure unit for psychiatric patients in Santa Rosa, due to his hallucinations and delusions. After he was released from the hospital, claimant spent five to seven weeks at a halfway house, Casa Rene in Kentfield.

56. As of the time of hearing in September 2019, claimant's psychotic symptoms had been stabilized with medication. He was continuing psychotherapy with Dr. Frankel. Claimant was also receiving group therapy for people with psychosis at Marin Behavioral Services.

## Adaptive Functioning

57. As discussed above (Factual Findings 18, 21, 33-34), claimant has had significant deficits in his use of receptive and expressive language since childhood.

58. Claimant was very poor at learning daily living skills, even prior to the emergence of his psychosis. He needs consistent help and daily reminders regarding self-care, such as bathing and changing his clothing. When claimant's psychosis emerged, he became less amenable to help with self-care.

59. Claimant's ability to navigate his community independently is poor. This was the case prior to the emergence of his psychosis. Claimant gets distracted and lost on his way to the store. Claimant does not have a driver's license. He took a class on car restoration at the College of Marin, but had problems taking the bus. Even though the bus route went directly to the college, and his father escorted him a couple of times, claimant got lost on subsequent trips and his father had to drive him to and from the class. Claimant has recently been taking a rehabilitative services training program in gardening, and a bus picks him up and drops him off. When he was dropped off a few hundred yards behind the usual spot, claimant walked two miles in the wrong direction.

60. Claimant has always had problems planning and organizing, even prior to the emergence of his psychosis. He requires help from a parent to plan and execute activities. As an example, claimant's mother described claimant's trips to the gym at age 17 (between the time he returned from the island and his move to California). Claimant's mother would tell claimant that she was going to take him to the gym, and that he should be ready at a specific time, and that he needed to bring his gym bag, clothing, money for the locker, and his gym card. Claimant would appear prepared, sitting by the door with his gym bag, but then he would have to go back multiple times for the various other items he needed to bring.

61. Claimant is not able to independently purchase groceries or ingredients to make a meal, finding it too confusing. Claimant has lost his passport multiple times. He had a bank account but kept losing his debit card. At age 16 or 17, claimant was the victim of an online romance scam on a pornography website, and sent $400 to someone in Eastern Europe. It took his parents several months to convince claimant

that this woman was not his girlfriend. Since that incident, claimant's father was added to his son's bank account in order to monitor it.

## GGRC Evaluation

62. On April 6, 2018, claimant and his mother completed a telephone intake with GGRC. Claimant's mother completed an application for regional center services on May 1, 2018. Claimant was evaluated by an interdisciplinary team of GGRC staff, including licensed clinical social worker Katie Schloesser, L.C.S.W.; pediatrician John D. Michael, M.D.; and licensed psychologist Telford I. Moore, Ph.D.

### SCHLOESSER

63. On May 2, 2018, Schloesser interviewed claimant and his mother at their home for two hours. Schloesser had a follow-up interview with claimant's mother at her home for one or two hours on May 10, 2018. Claimant was supposed to be present at that meeting, but had left home the night before and had not yet returned. After gathering information at these meetings, Schloesser wrote a social assessment report, including her observations of claimant, and information regarding claimant's physical and mental health, developmental history, current level of functioning, educational history, and other social information. Schloesser testified at hearing.

64. When Schloesser met claimant, he was appropriately dressed, gave fleeting eye contact, and answered questions in full sentences. Schloesser noted that claimant had a delay, longer than is normal, in responding to her questions. She also noted that claimant's parents were in the process of seeking a conservatorship.

65. When claimant was absent on May 10th, his mother told Schloesser that it was typical behavior for claimant to go "camping" with his "friends" and be gone a

night or two without telling her. Claimant's mother explained that claimant had two older "friends" in the local area (ages 35 and 42); these are the homeless people that claimants' parents were concerned about him interacting with. Claimant's mother suspected these people had taken advantage of claimant financially and sexually, and claimant reported he had been in physical fights with these people. One had been to claimant's home and stolen property; claimant's parents obtained a restraining order. In her testimony, when Schloesser was asked if she considered claimant's interactions with these people to be socially appropriate relationships, she noted that claimant shares interests with them and he considered them "friends," and that it was not her role as a social worker to judge claimant's choices.

66. Schloesser reported that claimant's mother discussed claimant's anxiety and his dyslexia, but did not mention schizophrenia or psychotic symptoms during the two interviews.

### DR. MICHAEL

67. Dr. Michael is a board-certified pediatrician and staff physician at GGRC. He also is a professor of pediatrics at the University of California, San Francisco (UCSF) School of Medicine. As a physician in the GGRC clinical services unit, Dr. Michael has performed developmental disability assessments for 30 years. As a professor at UCSF, he teaches residents and staff, and helps evaluate children with developmental disabilities. He has given presentations at educational conferences on topics including autism and developmental disabilities.

68. Dr. Michael met with claimant on July 18, 2018, for one and one-half hours, wrote a medical review for eligibility report, and testified at hearing. When he met with claimant, Dr. Michael observed that claimant's facial expressions were

appropriate, although he did not always make direct eye contact. Dr. Michael noted that it was hard to get details from claimant, and that he was tangential in conversation, which Dr. Michael found suggestive of mental illness. Claimant told a joke, although his explanation of it did not really make sense (he asked if they knew what Native Americans called a large duck, and then said, "a peacock!"). Claimant also discussed his interests, including visiting his "friends." Dr. Michael found claimant's interest in spending time with friends to be non-indicative of ASD. Dr. Michael also found it significant that claimant had spent a year living alone on the island, without injuring himself, and that claimant felt safe and in control there. At the end of their conversation, claimant made an odd, surprising reference to "MK Ultra," a CIA mind control project from the 1950s. Dr. Michael also found this suggestive of mental illness.

69. Dr. Michael concluded that claimant did not have ASD or another qualifying developmental disability. Dr. Michael found claimant's behavioral history to be "possible symptoms similar to a psychosis." He noted that claimant had been prescribed an antipsychotic medication, Abilify, which he had not been taking. Dr. Michael also concluded that claimant had social anxiety. Dr. Michael wrote: "History of being diagnosed with Asperger disorder in London at about 10 years of age according to his mother. There is no documentation or further explanation. His presentation today does not support that diagnosis." At hearing, Dr. Michael conceded there was documentation of the Asperger's diagnosis, and stated he read Dr. Soppitt's report. Regardless, Dr. Michael did not find claimant's presentation at age 19 to be consistent with ASD or a prior Asperger's diagnosis.

## DR. MOORE

70. Dr. Moore has been a staff psychologist at GGRC for 21 years. He is board-certified in clinical psychology, behavioral psychology, and neuropsychology. Dr. Moore also has been a consulting psychologist for Social Security evaluations for 28 years, in which role he has seen a wide variety of psychiatric disorders. Prior to working at the regional center, Dr. Moore's experience included work as a hearing officer for Welfare and Institutions Code section 5250 evaluations.

71. Dr. Moore met with claimant and his mother on June 27, 2018, and administered a variety of cognitive and neuropsychological tests. Dr. Moore met again with claimant and his mother on July 18, 2018. He wrote a psychological review for eligibility report. Dr. Moore reviewed the evaluations and reports submitted by claimant, including Dr. Soppitt's report, and the report of claimant's experts from the UCSF STAR Center (discussed below in Factual Findings 91 through 108). Dr. Moore testified at hearing regarding his observations and opinions from evaluating claimant, and his opinions about the evaluation conducted by the UCSF STAR Center.

72. In meeting with claimant, Dr. Moore found him to be polite and appropriately interactive, calling him a "delightful young man." Dr. Moore noted claimant's very slow responses to questions and slow thinking, as well as the often peculiar notions expressed by claimant.

73. Dr. Moore administered these tests: Ability-Focused Neuropsychological Battery (AFNB); Controlled Oral Word Association Test (COWAT); Dot Counting Test (DCT); Grooved Pegboard Test (GPT); Trail Making Test (TMT); Wechsler Adult Intelligence Scale Fourth Edition (WAIS-IV); Wechsler Memory Scale Fourth Edition (WMS-IV); and the WMS-IV Brief Cognitive Status Exam (BCSE).

74. Dr. Moore's testing of claimant showed slow processing speed, a learning disability, problems with working memory, and symptoms that he found consistent with a thought disorder (alogia or poverty of speech, and impairment in cognitive flexibility). On the WAIS-IV cognitive test, Dr. Moore calculated a full scale intelligence quotient for claimant of 84 (in the low-average range), and a general ability index of 100 (in the average range). The difference between these scores was due to impaired working memory and processing speed. Dr. Moore found this significant, as suggesting a learning disability, and found that claimant's slow processing plays an important role in his overall functioning. The BCSE cognitive status test yielded a score in the borderline range, and showed claimant had problems with orientation, mental control time, and inhibition time. Dr. Moore found that claimant's scores on the AFNB battery were consistent with disordered thinking.

75. In observing claimant's speech and language, Dr. Moore noted flat linguistic prosody, reduced phrase length (consistent with poverty of speech and content), and odd or peculiar references (such as "ferrying a rock" and the MK Ultra mind-control program). Regarding claimant's affect, Dr. Moore noted blunted or flat affect, but not inappropriate affect.

76. Dr. Moore's report discussed the DSM-5 diagnostic criteria for ASD, and opined that claimant met only one of the criteria:[4]

[4] Some of Dr. Moore's findings regarding the DSM-5 criteria appear to be based solely on current observations of claimant, and not also on historical information regarding claimant's developmental period and childhood. At hearing, Dr. Moore testified that he did consider such historical information.

(a) Dr. Moore did not find deficits in social-emotional reciprocity. He wrote: "[Claimant] demonstrated slow but fairly normal social-emotional reciprocity, fairly normal social approach with fairly normal back-and-forth conversation; but reduced sharing of interests, emotions, and affect. This presentation is more indicative of deficits in thinking processes than deficits in social-emotional reciprocity."

(b) Dr. Moore did not find deficits in nonverbal communication used for social interaction. He wrote: "[Claimant] responded slowly but fairly well to nonverbal communicative behaviors, displayed excellent and direct eye content [*sic*] at all times, and showed no atypical body language or gestures. Notably, [claimant's] facial affect was fairly blunted/flat, but he did smile appropriately."

(c) Dr. Moore did find deficits in developing, maintaining, and understanding relationships. He wrote: "[Claimant] demonstrated, and has reportedly always demonstrated, deficits in developing, maintaining, and understanding relationships including inability to tolerate peers at school and current problems with adult 'friends' who are allegedly actively exploiting him. These relationship problems are examples of the frequently observed negative symptoms seen in individuals with Schizophrenia Spectrum Disorders." At hearing, Dr. Moore elaborated, stating that claimant's ability to make these adult "friends" and his knowledge that he does not fit in socially both argue against a finding of autism.

(d) Dr. Moore did not find stereotyped or repetitive motor movements, use of objects, or speech. He wrote: "[Claimant] did not demonstrate or have reported problematic stereotyped or repetitive motor movements sufficient to score this deficit. [Claimant's] mother did report that he engages in spontaneous incoherent verbal phrases that he sometimes repeats. Incoherent verbal phrases that

are sometimes repeated can be examples of symptoms seen in individuals with Schizophrenia Spectrum Disorders."

(e) Dr. Moore did not find insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior. He wrote: "[Claimant] did not demonstrate or have reported elements of problematic insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior."

(f) Dr. Moore did not find highly restricted, fixated interests that are abnormal in intensity or focus. He wrote: "[Claimant] did demonstrate interest in unusual/odd/eccentric/peculiar ideas/issues, but they were not highly restricted, fixated interests that are abnormal in intensity or focus."

(g) Dr. Moore did not find hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment. He wrote: "[Claimant] did not demonstrate or have reported problematic hyperreactivity or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment."

77. Dr. Moore concluded that "[claimant], at age nineteen years, did not present to the Interdisciplinary Team as meeting DSM-5 criteria for Autistic Spectrum Disorder, but did present as showing many diagnostic criteria for Schizophrenia Spectrum Disorders, which include Schizotypal Personality Disorder and Schizoid Personality Disorder." He noted that distinguishing between the symptoms of ASD and early-adult onset of Schizophrenia Spectrum Disorder is difficult, in part because the symptoms are overlapping, difficult to tease apart, or described with similar terms. Dr. Moore emphasized that ASD is primarily an impairment of relationships, while schizophrenia is primarily an impairment of thinking. Dr. Moore found two items

particularly significant in this differential diagnosis. First, he referred to claimant's time spent living alone on the island, stating: "The mother's descriptions of that year are textbook examples of the negative symptomology seen in Schizophrenia Spectrum Disorders." Second, he referred to the "demonstration of odd/eccentric/peculiar thinking expressed by [claimant]." He found that these two groups of symptoms, with the absence of most ASD symptoms, argued strongly for Schizophrenia Spectrum Disorder as the primary disorder.

78. At hearing, Dr. Moore opined that claimant is substantially disabled, but that this is due only to schizophrenia, and not ASD.

79. Dr. Moore acknowledged the report of Dr. Soppitt, who had diagnosed claimant with Asperger's Syndrome, but disputed its validity. Dr. Moore discussed Dr. Soppitt's use of the Gillberg's criteria for Asperger's Syndrome, and opined that the diagnosis was flawed because Dr. Soppitt only found five of the six criteria, without a finding regarding motor impairment.[5]

Dr. Moore noted that the DSM-IV in effect at the time of Dr. Soppitt's report precluded diagnosing co-occurring Asperger's and schizophrenia (this is a difference between the DSM-IV and DSM-5). Dr. Moore opined that, because it is now known

[5] However, a 2002 publication by Christopher Gillberg, "A Guide to Asperger Syndrome," states: "When these criteria are used in research, all six have to be fulfilled for a definitive diagnosis to be made (and a total of 9 out of the 20 specified symptoms have to be met). In clinical practice, a diagnosis of Asperger syndrome is made if the social interaction dysfunction criterion is met along with at least four of the other five criteria."

that claimant has schizophrenia, the prior Asperger's diagnosis must be invalid. He believes strongly that many symptoms now seen by the profession as indicia of ASD are really symptoms of schizophrenia. Dr. Moore also emphasized a notation in a progress note from the UCSF psychiatrist, which stated that at the time claimant's parents took him out of school to be homeschooled (ages 9-10), they were concerned about his thinking. Claimant's parents reported that at that time claimant was suspicious of others and worried that others were following him. Dr. Moore finds this to be an indication of early-onset schizophrenia symptoms.

Dr. Moore also opined that Dr. Soppitt's Asperger's diagnosis is not "well-established" pursuant to the DSM-5, because it was made when claimant was already 12 years old, rather than earlier in the developmental period. He was skeptical of information provided by claimant's parents regarding claimant's early years, stating that parents are not objective sources.

80. When asked whether a comorbid diagnosis of ASD and schizophrenia was possible, Dr. Moore did not directly answer the question, stating that claimant's schizophrenia is severe and that he is unlikely to also have ASD, and noting that the younger an individual is, the more the symptoms overlap.

81. Dr. Moore disputed the validity of the UCSF STAR Center evaluation, which found that claimant has comorbid ASD and schizophrenia. At the time of the UCSF assessments in September and November 2018, claimant was displaying some psychotic symptoms while refusing his schizophrenia medication. Dr. Moore contends that testing claimant while he was in a psychotic state rendered the evaluation invalid. Dr. Moore did not discuss whether this same critique could be applied to his own evaluation in June and July 2018, a time period in which claimant was also displaying psychotic symptoms while non-compliant with medication.

82. Dr. Moore also compared the testing instruments administered by GGRC and UCSF evaluators. The UCSF psychologists administered the Autism Diagnostic Observation Schedule (ADOS)-2 Module 4 test, a standardized autism assessment instrument for adolescents and adults who speak in complete and complex sentences. Dr. Moore did not administer the ADOS, and has many criticisms of it, finding it to be over-inclusive. Dr. Moore conceded that GGRC does use the ADOS for some eligibility assessments, but stated that he did not administer the ADOS to claimant because he did not think claimant has ASD. When asked how GGRC replicates the content of the ADOS assessment tool, Dr. Moore stated that the ABAS and Vineland adaptive behavior assessments are used. However, Dr. Moore did not administer either of these adaptive behavior assessments in evaluating claimant. Dr. Moore also did not administer the ADI-R, a parent-reported autism assessment tool, to claimant's parents, finding it unnecessary.

83. On July 18, 2018, the GGRC assessment team issued a finding that claimant did not have a qualifying developmental disability, and was not eligible for regional center services. Claimant filed a fair hearing request on August 16, 2018.

### DR. MAK

84. On August 30, 2018, claimant's mother participated in an informal appeal meeting with GGRC social worker Dominique Gallagher, L.C.S.W., and staff psychologist Elsie Mak, Ph.D. On February 14, 2019, Gallagher and Dr. Mak signed a report regarding the informal appeal meeting, documenting their conclusion. They concurred with the GGRC assessment team that claimant is ineligible for regional center services. Dr. Mak reviewed the GGRC evaluation, the reports of Thornton and Dr. Soppitt, Dr. Frankel's letter, and the UCSF STAR Center report. Dr. Mak did not meet with claimant.

85. Dr. Mak testified at hearing. Dr. Mak is a licensed clinical psychologist. She has been a staff psychologist at GGRC since 2017, and was previously a staff psychologist for several months at the San Andreas Regional Center. In addition to her work at GGRC, Dr. Mak also has a private practice as a neuropsychologist. Her prior experience includes two years of working at a Kaiser Permanente ASD clinic.

86. Claimant was scheduled to come in for additional testing with Dr. Mak on October 11, 2018, but claimant's mother canceled the appointment because claimant was experiencing active psychotic symptoms. Dr. Mak believes that testing during an altered mental state would render the results invalid.

87. Based on her review of the reports, Dr. Mak did not see a clinical picture of ASD in claimant's presentation. She found no evidence he met ASD criteria prior to age three. She also agrees with Dr. Moore's criticisms of Dr. Soppitt's diagnosis of Asperger's Syndrome.

88. Dr. Mak focused particularly on the overlapping symptoms of ASD and schizophrenia discussed in the DSM-IV and DSM-5. She believes that claimant's autism-like behaviors reported from childhood are all prodromal and negative symptoms of schizophrenia.

89. Dr. Mak has never diagnosed comorbid ASD and schizophrenia, or treated a person with such a dual diagnosis. She conceded that onset of schizophrenia prior to age 13 is uncommon; she has seen it two or three times in her career.

90. Dr. Mak disputes the validity of the UCSF STAR Center evaluation, believing the clinical observations of those evaluators are suspect due to claimant's psychotic symptoms.

## Claimant's Experts

### UCSF STAR CENTER EVALUATION AND DR. PARK

91. Claimant was evaluated by an interdisciplinary team at the University of California, San Francisco (UCSF) STAR Center[6] for ASD and NDDs (neurodevelopmental disorders). The UCSF team included licensed clinical social worker Katy Ankenman, L.C.S.W.; psychiatrist Bennett L. Leventhal, M.D.; licensed clinical psychologist Mi Na Park, Ph.D.; and post-doctoral fellow Emma Salzman, Psy.D.

92. Claimant's family contacted the UCSF STAR Center on May 2, 2018, and was placed on an intake waitlist. Claimant was evaluated by the UCSF STAR Center in September and November 2018, resulting in a Multidisciplinary Evaluation Report dated February 8, 2019.

93. The UCSF evaluation team reviewed claimant's prior records, including the reports of Dr. Soppitt, Thornton, and Dr. Peacock; the evaluation by GGRC; and a letter from Dr. Frankel.

94. The following testing instruments were administered by the UCSF team: Autism Diagnostic Interview-Revised (ADI-R); Vineland Adaptive Behavior Scales, Third Edition, Comprehensive Parent/Caregiver Form (Vineland-3); Adult Behavior Checklist (ABCL/18-59); Stanford Binet Intelligence Scales, Fifth Edition (SB-5); Autism Diagnostic Observation Schedule, Second Edition (ADOS-2) Module 4; ADOS – Adapted Module 1; Beck Depression Inventory, Second Edition (BDI-II); Beck Anxiety Inventory (BAI); and the Adult Self-Report (ASR/18-59).

[6] STAR stands for Service, Training, Advocacy and Research.

95. On September 19, 2018, Ankenman interviewed claimant and his parents, together and separately, for about 70 minutes.

96. On November 5, 2018, Dr. Park interviewed claimant's parents and administered the ADI-R, a standardized parent interview designed to gather information in the areas associated with a diagnosis of ASD; the Vineland-3, an assessment tool to measure an adult's everyday adaptive skills in the home; and the ABCL/18-59, a parent-report measure of emotional, behavioral, and social functioning in adults aged 18 to 59 years.

97. On November 6, 2018, Dr. Leventhal met with claimant and his parents for about 90 minutes, and conducted a psychiatric interview.

98. Also on November 6, 2018, Dr. Park and Dr. Salzman met with claimant, accompanied by his father, for three to four hours. Dr. Park and Dr. Salzman made behavioral observations of claimant and tested claimant. They began the WAIS-IV cognitive test, but claimant recognized the questions, so it was discontinued. They also began the Stanford-Binet cognitive test, but did not have time to complete it. Dr. Park and Dr. Salzman administered the ADOS-2 Module 4, a semi-structured standardized assessment instrument designed to obtain information about social, communication, and play behaviors, which is intended for adolescents and adults who speak in complete and complex sentences. They also administered self-report inventories to claimant to measure anxiety (BAI) and depression (BDI-II), and the Adult Self-Report (ASR/18-59), which is a self-report measure of emotional, behavioral, and social functioning for adults aged 18 to 59.

99. On November 14, 2018, Dr. Park interviewed claimant's mother. Claimant was also supposed to be present at this meeting, to complete the cognitive testing,

but he left the house the night before and had not returned. Dr. Park and claimant's mother exchanged follow-up emails on November 16, 2018, and claimant's mother stated that claimant had returned home and told her he had gotten distracted.

100. On November 14, 2018, Dr. Salzman spoke with Dr. Frankel by telephone.

101. After collecting all of the above information, the UCSF evaluation team diagnosed claimant with comorbid ASD and schizophrenia. The diagnostic summary section of the February 8, 2019 UCSF report states:

> [Claimant] is a 19-year-old male with a long history of developmental delays and developmental deviations. From an early age, he exhibited significant anxiety, learning challenges, and executive [*sic*]. In addition, he was slow to understand and learn fundamental skills and concepts related to successful adaptive functioning. [Claimant's] parents are seeking a comprehensive diagnostic evaluation to clarify recent confusion regarding his development and to identify and access appropriate treatment recommendations. Though his records show that he was previously diagnosed with Asperger's Syndrome, there is now discussion and confusion about whether his development and current presentation represents autism spectrum disorder (ASD), schizophrenia, or both.
>
> [¶] Based on review of records, his developmental history, parent interviews, and direct testing and examination of [claimant], his development and current presentation are

> consistent with co-occurring diagnoses of autism spectrum disorder (ASD) and schizophrenia. Though there is some overlap in developmental variances across ASD and schizophrenia that complicates the differential diagnostic formulation, there is a clear history of impairments across social, communication, and behavior domains that meet diagnostic criteria for ASD. These diagnoses are not mutually exclusive and should be considered holistically in understanding and developing an individualized, comprehensive treatment plan for [claimant].
>
> [¶] At this time, he is actively psychotic and in need of immediate treatment associated with his psychosis. Once his symptoms of psychosis are better managed, he will need additional support and skill building more closely associated with his ASD-related impairments to optimize his independence and quality of living. It will be essential to work closely with and support his family in achieving these ends. Capacity for emotion regulation and management of anxiety is another important area to strengthen as part of treatment. Moreover, [claimant] has expressed his own ambitions. It will be important to provide him with the necessary therapies and supports in order to accomplish these life goals to the fullest extent possible.

The UCSF team's report concluded by making DSM-5 diagnoses of: schizophrenia; autism spectrum disorder; specific learning disorder, with impairment in reading (per

history); specific learning disorder, with impairment in written expression (per history); and specific learning disorder, with impairment in mathematics (per history).

The UCSF team recommended that claimant receive: multi-disciplinary comprehensive care including: (1) medication management, individual and/or group therapy (cognitive behavioral therapy for psychosis), social work or case management support, and vocational/educational support; (2) conservatorship; (3) a social skills treatment group such as the PEERS program for young adults with ASD; and (4) a follow-up evaluation in one year and ongoing monitoring of claimant's functioning.

102. Dr. Park testified at hearing regarding her observations and evaluation of claimant, and the UCSF STAR Center team's overall evaluation process. Dr. Park is a licensed clinical psychologist, and is a board-certified behavior analyst-doctoral (B.C.B.A.-D.) for the treatment of autism and developmental disabilities. She is certified as "research reliable," the highest level of training, in the administration of the ADOS and ADI-R autism assessment tools. Dr. Park has been an assistant clinical professor and attending psychologist in the UCSF School of Medicine, Department of Psychiatry, in child and adolescent psychiatry, since 2017. Prior to that time, Dr. Park was an assistant clinical professor and clinical instructor at the University of California, Los Angeles (UCLA), and was an attending psychologist in the UCLA child and adult neurodevelopmental clinic. Dr. Park has presented nationally and internationally on topics related to autism, and has published on autism spectrum disorder.

103. Dr. Park explained that the UCSF STAR Center is a multidisciplinary clinic focused on assessment and treatment of autism and neurodevelopmental disorders, as well as connecting people with these conditions to community services, and providing community education. Dr. Park sees one to two families a week for assessment. The

UCSF STAR Center emphasizes the differential diagnosis of ASD and NDDs with other conditions.

104. Dr. Park did not find that there were any problems conducting a reliable evaluation of claimant, despite his psychosis. She observed some psychotic symptoms in claimant (such as occasionally appearing to respond to internal stimuli), but they were present for a minority of the time, rather than being consistent throughout the evaluation. Claimant displayed odd thinking at times, but otherwise seemed coherent.

105. Dr. Park discussed the UCSF findings in detail, including the behaviors and symptoms corresponding to the DSM-5 diagnostic criteria for ASD, which were both observed by the evaluators and reported by claimant and his parents. The ADI-R tool administered to the parents yielded a score exceeding the diagnostic cut-off for ASD, across all domains. This scoring included clinician impressions in addition to parent reports. The ADOS-2 Module 4 tool administered to claimant included the clinicians doing activities with claimant, asking him questions, and observing his behaviors. Claimant's score on the ADOS-2 exceeded the diagnostic cut-off for ASD on both the original and revised scoring algorithms (the revised algorithm is more sensitive). Although claimant's father was in the room at claimant's request during this assessment, only the interactions between the examiner and claimant were scored.

The Vineland adaptive behavior assessment revealed a disconnect between claimant's cognitive abilities and his adaptive functioning, with the most impacted areas being skills related to understanding of language (Communication: Receptive), home care skills (Daily Living Skills: Domestic), and demonstration of socially conventional behavior and capacity to flexibly adapt to social situations (Socialization: Coping Skills). In completing the assessment, claimant's mother noted that while

claimant has always depended on his parents and others to meet his daily needs, his adaptive functioning had worsened in the past few months with his psychosis.

106. Dr. Park explained that no one instrument determined the diagnosis of ASD for claimant, which was based on all the information the team gathered as a whole. The UCSF evaluation team's diagnostic formulation included consideration of other psychiatric conditions instead of, or in addition to, ASD. The analysis and conclusions of the evaluation team were presented to and discussed with the entire clinical staff. Dr. Park and the other members of the UCSF evaluation team all concurred that claimant met the diagnostic criteria for both ASD and schizophrenia.

107. Dr. Park discussed claimant's anxiety, and found that while anxiety was present, claimant's symptoms did not rise to the level of meeting diagnostic criteria for an anxiety disorder. She also noted claimant's dyslexia, but found that neither anxiety nor dyslexia explained claimant's past and present challenges, or undermined the ASD diagnosis.

108. Dr. Park's testimony included discussion of a progress note from psychiatrist Dr. Leventhal, in which Dr. Leventhal stated he did not believe that claimant met the DSM-5 criteria for ASD, but identified ASD as a differential diagnosis. During the UCSF team's analysis, Dr. Park discussed this with Dr. Leventhal. At the time Dr. Leventhal wrote that progress note, he was not aware of the information collected by Dr. Park about claimant's repetitive and stereotyped behaviors and interests, and about the quality of his social relationships. Dr. Park observed repetitive and stereotyped behaviors of claimant that did not fall into the category of delusional thinking, such as the stereotyped use of language. She also observed claimant's poor understanding of the nature of friendships, his circumscribed interests, and compulsive behaviors such as counting all the objects on a page during testing. The UCSF team

discussed the overlapping symptoms of ASD and schizophrenia, and Dr. Leventhal and the rest of the team ultimately agreed on the final comorbid diagnoses.

### TREATING PSYCHIATRIST DR. FRANKEL

109. As noted above, Dr. Frankel has treated claimant since May 2018. Dr. Frankel is a psychiatrist, and is board-certified in general psychiatry and child psychiatry. He also is a certified psychoanalyst. Dr. Frankel is in private practice in general and child/adolescent psychiatry, with a focus on clinically complex patients who have both medical and psychiatric issues. Dr. Frankel also is an associate clinical professor at UCSF, and a faculty member of the San Francisco Psychoanalytic Institute.

110. Dr. Frankel's treatment of claimant has been psychotherapy, not psychoanalysis or medication management. Dr. Frankel wrote letters dated June 8, 2018 and August 15, 2019, and testified at hearing.

111. Dr. Frankel finds that claimant's behavior is consistent with a diagnosis of ASD, without significant intellectual or language impairment. He has observed that claimant has problems with social communication, having poor social skills and not understanding other people. Dr. Frankel found claimant has severe problems with relationships. He is unable to be involved in most usual activities, with most of his activities being repetitive and rote. Dr. Frankel found that claimant has restricted and repetitive interests, such as cars, the recording artist Snoop Dogg, and English royalty. He found these interests to be separate from claimant's delusions and psychosis, and found them consistent with autism.

112. Dr. Frankel concurs with the UCSF STAR Center evaluation and its diagnosis of claimant, and he has treated claimant with the understanding that he has both ASD and schizophrenia, which Dr. Frankel finds to be separate but interactive

conditions for claimant. Dr. Frankel found that claimant's symptoms and limitations were consistent with ASD since the beginning of treatment, and then his psychotic symptoms became more prominent after a few months of treatment. To Dr. Frankel, claimant's psychotic symptoms, such as paranoid ideation and delusions, seemed superimposed on a preexisting developmental disability.

113. Dr. Frankel reported that claimant was not cooperative with medication treatment by Dr. Ashe, and that claimant currently sees a different psychiatrist for medication management, a Dr. Kennedy. Dr. Frankel reports that medications are helping claimant, and that he now has decreased psychotic symptoms.

## Claimant's Additional Evidence

114. Terrence Owens, Ph.D., testified at hearing and wrote a letter dated April 20, 2019, based on his observations of claimant. Dr. Owens is a clinical psychologist and psychoanalyst in private practice. He has experience in treating children and adolescents, and has treated people with autism and people with schizophrenia. Dr. Owens has known claimant for seven years, as a friend of claimant's family, and has observed him in social settings. Dr. Owens has not treated claimant professionally or reviewed his medical records.

115. Dr. Owens believes that claimant is best described as having an autistic condition. He has observed that claimant has poor eye contact (initially making eye contact and then diverting). Claimant is uncomfortable in social situations, and does not initiate social contact. He does not maintain reciprocal conversation, but will instead monologue without having awareness of his impact or seeking any response. Claimant does not welcome physical contact beyond a brief handshake, and Dr. Owens has learned not to try to hug him. Dr. Owens has also observed that claimant has a

blunted affect with limited emotional range, that does not change very much based on context. Claimant displays an intense interest in a limited number of things (e.g., cars), with a remarkable memory for statistics. Claimant also engages in repetitive behavior, such as eating one type of burrito exclusively, and repetitive walking routes.

## Ultimate Factual Findings

116. Claimant presents a complex set of symptoms, including longstanding developmental problems and more recently occurring psychosis. As the DSM-5 notes, it can be difficult to differentiate symptoms of autism and schizophrenia, which may overlap. Both parties agree that claimant suffers from schizophrenia. GGRC contends that this diagnosis solely accounts for claimant's presentation, and that claimant does not meet the diagnostic criteria for ASD. Claimant contends that he has co-morbid ASD and schizophrenia. All of the parties' expert witnesses are qualified and credible. However, the analysis of claimant's experts was ultimately the most persuasive.

Dr. Moore focused his analysis retrospectively, finding that claimant's current schizophrenia diagnosis necessarily undermines the prior diagnosis of Asperger's syndrome. This was not a persuasive approach. Dr. Moore did not administer either the ADOS or ADI-R, two well-known instruments for assessing autism, and admitted he did not administer the ADOS because he did not believe claimant has autism. Dr. Moore's findings regarding the diagnostic criteria are also not fully supported by the evidence of claimant's developmental history.

Neither Dr. Moore nor Dr. Mak was persuasive in their contentions that claimant's history of problems with social relationships and communication, restricted interests, and repetitive behaviors and speech are wholly explained by prodromal or negative symptoms of schizophrenia.

Dr. Mak never met claimant, and thus her opinion is accorded less weight.

The opinions of Dr. Park and the UCSF STAR Center were more persuasive. The UCSF evaluation was comprehensive, and was focused on a differential diagnosis of autism and other mental disorders. The conclusions of Dr. Park and the UCSF evaluation team that claimant has co-occurring ASD and schizophrenia are consistent with the observations of claimant's treating psychiatrists. The diagnosis of ASD is also consistent with the observations of Dr. Owens.

The UCSF team's diagnosis of ASD is also consistent with claimant's prior diagnosis of Asperger's Syndrome. The DSM-5 states that a person with a well-established DSM-IV diagnosis of Asperger's disorder should be given the diagnosis of autism spectrum disorder. GGRC contends that Dr. Soppitt's diagnosis of claimant with Asperger's is not "well-established" because it was made at age 12, discussed only five of the six Gillberg's criteria, and conflicts with the DSM-IV's prohibition on concurrent diagnosis of Asperger's and schizophrenia. As discussed above, the current schizophrenia diagnosis does not retroactively invalidate the prior diagnosis of Asperger's syndrome. In addition, a publication by Gillberg states that only five of the six criteria are needed for a clinical diagnosis. Moreover, even if Dr. Soppitt's diagnosis of Asperger's disorder were not considered "well-established," that would not preclude a diagnosis of ASD.

The recent and comprehensive evaluation by the UCSF STAR Center, which concluded that claimant has co-occurring ASD and schizophrenia, is both well-supported and persuasive. It was established by a preponderance of the evidence that claimant has co-occurring ASD and schizophrenia.

117. It was established by a preponderance of the evidence that claimant is substantially disabled, having significant functional limitations in the areas of receptive and expressive language, learning, self-care, mobility, self-direction, capacity for independent living, and economic self-sufficiency. (Factual Findings 57-61.) GGRC concedes that claimant is substantially disabled, but contends that this is due solely to schizophrenia, and not to autism. That contention is not supported by the evidence, which established that claimant was substantially disabled by his ASD prior to the emergence of psychotic symptoms.

## LEGAL CONCLUSIONS

1. In a proceeding to determine whether an individual is eligible for regional center services, the burden of proof is on the claimant to establish that he or she has a qualifying developmental disability. The standard of proof required is a preponderance of the evidence. (Evid. Code, §§ 115, 500.)

2. The State of California accepts responsibility for people with developmental disabilities under the Lanterman Developmental Disabilities Services Act (Lanterman Act). (Welf. & Inst. Code, § 4500, et seq.)[7] The purpose of the Lanterman Act is to rectify the problem of inadequate treatment and services, and to enable people with developmental disabilities to lead independent and productive lives in the least restrictive setting possible. (§§ 4501, 4502; *Association for Retarded Citizens v. Department of Developmental Services* (1985) 38 Cal.3d 384.) The

[7] Statutory references are to the Welfare and Institutions Code.

Lanterman Act is a remedial statute; as such it must be interpreted broadly. (*California State Restaurant Association v. Whitlow* (1976) 58 Cal.App.3d 340, 347.)

3. A developmental disability is a disability that originates before an individual reaches age 18; continues, or can be expected to continue, indefinitely; and constitutes a substantial disability for that individual. (§ 4512, subd. (a); Cal. Code Regs., tit. 17, § 54000, subd. (b).) The term "developmental disability" includes intellectual disability, cerebral palsy, epilepsy, autism, and disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability. (§ 4512, subd. (a); Cal. Code Regs., tit. 17, § 54000, subd. (a).) Under the Lanterman Act, conditions that are solely psychiatric in nature, or solely learning or physical disabilities, are not considered developmental disabilities. (Cal. Code Regs., tit. 17, § 54000, subd. (c).)

4. "Substantial disability" means major impairment of cognitive and/or social functioning, and the existence of significant functional limitations, as appropriate to the person's age, in three or more of the following areas of major life activity: receptive and expressive language, learning, self-care, mobility, self-direction, capacity for independent living, and economic self-sufficiency. (§ 4512, subd. (l)(1); Cal. Code Regs., tit. 17, § 54001, subd. (a).)

5. Claimant met his burden of establishing that he is substantially disabled by autism, a developmental disability as that term is defined in the Act. (Factual Findings 116-117.) His disability originated before the age of 18 and is expected to continue indefinitely.

6. Claimant is eligible for regional center services.

## ORDER

The appeal of claimant from the service agency's denial of regional center eligibility is granted. Claimant is eligible for regional center services.

DATE:

HOLLY M. BALDWIN
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 90 days.