BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT

v.

INLAND REGIONAL CENTER

Service Agency

OAH No. 2021120092

DECISION

Kimberly J. Belvedere, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter remotely using the Microsoft Teams videoconference application, on May 9, 2022, June 14, 16 and 23, 2022, and July 7, 2022.

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

Monica Nguyen, Deputy Public Defender, Riverside County Public Defender's Office, represented claimant, who is incarcerated and could not be present.

Oral and documentary evidence was received. The record was closed and the matter submitted for decision on July 7, 2022. Following the closure of the record, it was decided that an additional portion of the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) on intellectual disability would be helpful because of the references made to that developmental disorder in connection with the fifth category. Both parties were notified, and IRC uploaded the exhibit. Claimant did not object. The record was reopened, the document was uploaded and placed at the end of Exhibit 31, which contains other excerpts from the DSM-5. The submission date remained July 7, 2022.

ISSUES TO BE DECIDED

1. Does claimant have autism spectrum disorder (autism), and if so, is he substantially disabled in three or more areas of a major life activity attributable to that diagnosis, thus rendering him eligible for regional center services under the Lanterman Developmental Disabilities Services Act (Lanterman Act)?

2. Does claimant have a disabling condition closely related to, or that requires treatment similar to, a person with an intellectual disability (fifth category), and if so, is he substantially disabled in three or more areas of a major life activity attributable to that disabling condition, thus rendering him eligible for regional center services under the Lanterman Act?

SUMMARY

A preponderance of the evidence did not establish that claimant meets the diagnostic criteria for autism, and even if he did, the evidence did not establish that

claimant has significant functional limitations in three or more areas of a major life activity as a result of autism. A preponderance of the evidence also did not establish that claimant suffers from a disabling condition closely related to, or that requires treatment similar to, a person with an intellectual disability. While claimant does have many mental health diagnoses that have been rendered over the years, the evidence did not show that any of the conditions are similar to an intellectual disability. Moreover, while claimant, like many individuals, may benefit from services provided by a regional center, that is not the standard under the fifth category. The standard is whether a person *requires* treatment similar to a person with an intellectual disability. The evidence did not establish claimant *requires* such treatment. Ultimately, even if claimant did meet the applicable criteria for autism or the fifth category, the evidence did not show he has significant functional limitations in three or more areas of a major life activity as a result as a result of cognitive impairment within the meaning of California Code of Regulations, title 17, section 54001. Accordingly, claimant is not eligible for regional center services.

FACTUAL FINDINGS

Procedural Background

1. Claimant is a male, currently approximately 28 years old, with an extensive criminal history, as detailed below. According to one of the psychological reports in evidence, claimant admitted being arrested approximately 50 to 60 times in his life, dating back to his juvenile years.

2. In May 2021, there were multiple criminal cases pending against claimant in the Superior Court of California, County of Riverside. Those cases included

RIF2101277 (felony robbery), RIF2003166 (felony assault with a deadly weapon, other than a firearm and misdemeanor petty theft), RIM2111696 (misdemeanor willful, unlawful, and malicious vandalism and battery), RIM2011793 (misdemeanor willful, unlawful, and malicious vandalism), and RIM2011532 (misdemeanor petty theft).

3. On May 27, 2021, the court ordered claimant to undergo a mental competency exam pursuant to Penal Code sections 1368 and 1370. On June 3, 2021, Gene N. Berg, Ph.D., evaluated claimant and found him competent to stand trial.

4. On June 19, 2021, criminal charges were filed against claimant in the Superior Court of California, County of Riverside, in Case Number BAF2100713, for a felony violation of Penal Code section 69, use of force or violence against a peace officer in the performance of his or her duties. On July 29, 2021, the superior court suspended criminal proceedings and ordered IRC to conduct an evaluation of claimant for eligibility and provide a written report regarding its conclusions. The superior court also ordered claimant to undergo another mental competency evaluation. The judge made further orders regarding the release of claimant's mental health records and provisions for prisoner access in order to permit psychologists to conduct interviews with claimant for psychiatric testing.

5. On July 20, 2021, Elsie Cheng, Ph.D., evaluated claimant for competency. Dr. Cheng struggled in her evaluation of claimant because of, as she described it, his "presentation," and determined that, at the time of her July 27, 2021, report, it was "impossible for [claimant] to be able to work with his counsel in his legal case."[1]

[1] Dr. Cheng's report listed the following criminal matters that were pending against claimant at the time, some of which were repetitive of those listed in Dr. Berg's

6. On October 30, 2021, C. Sherin Singleton, Psy.D., pursuant to the superior court order, conducted a psychological evaluation of claimant to determine eligibility for regional center services. Dr. Singleton concluded claimant "does not have a developmental disability" and was therefore not eligible for regional center services.

7. Following Dr. Singleton's assessment and a review of various prior records, a multidisciplinary team at regional center comprised of Linh Tieu, D.O., Holly Miller-Sabouhi, Psy.D., and Yvonne Guajardo, Forensic Specialist, made a determination that claimant was not eligible for regional center services under any qualifying category.

8. After IRC's determination that claimant was not eligible for regional center services, IRC issued a Notice of Proposed Action indicating that claimant does not have a "substantial disability" as a result of a qualifying condition and notifying claimant of his appeal rights.

9. On November 30, 2021, claimant's attorney filed a fair hearing request on claimant's behalf requesting a hearing regarding the ineligibility determination. The fair hearing request stated: "Inland Regional Center erroneously denied services to [claimant]. [Claimant] was diagnosed with Autism Spectrum Disorder as a young child,

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report: BAF2100713 (felony use of force or violence against a peace officer in the performance of his or her duties), RIF2003166 (felony assault with a deadly weapon, other than a firearm and misdemeanor petty theft), RIM2011532 (misdemeanor petty theft), RIM2011696 (misdemeanor willful, unlawful, and malicious vandalism and battery), and RIM 2011793 (misdemeanor willful, unlawful, and malicious vandalism).

but Inland Regional Center did not diagnose him with Autism Spectrum Disorder." The fair hearing request desired claimant be found eligible for regional center services.

10. On December 14, 2021, an informal meeting was held concerning claimant's fair hearing request. Following the informal meeting, IRC adhered to its determination that, based on Dr. Singleton's evaluation finding claimant did not have a developmental disability and other records from claimant's developmental and adult years, claimant was not substantially disabled as a result of autism. In a letter dated December 14, 2021, memorializing the meeting and explaining why IRC was adhering to its determination of ineligibility, IRC wrote:

> The records on file with Inland Regional Center (IRC) indicate a reported history of Asperger's Disorder, a diagnosis that is no longer utilized. . . . [N]one of the records on file with IRC include an assessment and diagnosis of Asperger's Disorder, Autism, or PDD-NOS.
>
> [Claimant] has a well-documented psychiatric history with multiple mental health diagnoses and behavioral problems dating back to his childhood.
>
> In July 2008, Tammy Terrell, Licensed Professional Counselor recommended a full psychological evaluation to rule out developmental disorders.
>
> In July 2008, Dr. Ladd, psychologist, administered the Childhood Autism Rating Scale (CARS), which was completed by [claimant's] mother. The CARS rating fell in the non-autistic range. Overall the measures did not

> indicate [claimant] falls in the Autism range. However, based on the prior diagnosis of Asperger's, the continued symptoms reported by [claimant's mother], and the examiner's observation of his poor eye contact and awkward social skills, [claimant] was assigned a rule out for Pervasive Development Disorder (PDD) Not Otherwise Specified (NOS).
>
> In November 2021, Dr. Singleton, IRC consulting psychologist, conducted a psychological evaluation. [Claimant's] overall intellectual functioning fell in the low average range (FISQ = 87). Adaptive functioning fell within the High/Independent range. Dr. Singleton noted: "Although [claimant] reported being previously diagnosed with Asperger's, Tourette's, and OCD, he did not describe, throughout the course of the evaluation any present symptoms that would meet the diagnostic criteria for any of the aforementioned disorders. There were no records provided that substantiated the Asperger's diagnosis during the developmental period. In fact, the 2008 evaluation results were inconsistent with a diagnosis of "Autism Spectrum Disorder."

11. At the informal meeting, claimant agreed to provide additional records to IRC for further evaluation. Over the ensuing months, those additional records were provided. Further, claimant's attorney requested that claimant undergo a psychological evaluation with Robert Leark, Ph.D. Dr. Leark performed that evaluation and wrote a

report. In that report, despite no autism-specific testing, he concluded his interviews, the records reviewed, and one adaptive assessment administered "point to a diagnosis of autism spectrum disorder." He also concluded claimant needed "a thorough development[al] evaluation to determine if the spectrum diagnosis is with or without accompanying intellectual impairment."

12. On February 9, 2022, claimant again underwent a mental competency exam pursuant to court order, conducted by Robert L. Suiter, Ph.D., Psy.D. Dr. Suiter concluded that Dr. Leark's opinion regarding an autism diagnosis should be further explored but that nothing indicated claimant was incompetent to stand trial. However, Dr. Suiter opined that claimant should be considered for mental health diversion.

13. In connection with the felony robbery case, RIF2101277, the court authorized IRC to have claimant undergo a second evaluation by an IRC psychologist. On March 4, 2022, Angelika Robinson, Psy.D., conducted a psychological evaluation of claimant. Dr. Robinson conducted a comprehensive and thorough assessment of claimant, including autism-specific testing. Although claimant fell within the range for autism spectrum disorder on two measures, Dr. Robinson concluded claimant "displays some features of autism spectrum that are mild in nature and cause him no substantial impairment." Thus, claimant is ineligible for regional center services.

14. On April 5, 2022, a multidisciplinary team at regional center comprised of Dr. Miller-Sabouhi, Psy.D., a medical doctor, and a program manager made a determination, again, that claimant was not eligible for regional center services under any qualifying category.

15. This hearing commenced on May 9, 2022. It was noted that the only condition mentioned in the fair hearing request and discussed at the informal meeting

was autism. At no time prior to hearing was there an assertion that claimant might be eligible for regional center services under the fifth category. Claimant's attorney indicated at hearing she wanted claimant considered for eligibility under the fifth category. IRC did not object to proceeding on that theory, as well. No contentions were made that claimant qualifies for regional center services under intellectual disability, cerebral palsy, or epilepsy.

16. Accordingly, the issue in this matter is whether claimant qualifies for regional center services based on a diagnosis of autism or under the fifth category, and whether he is substantially disabled within the meaning of applicable law based on either of those qualifying categories.

Applicable Diagnostic Criteria

AUTISM

17. The DSM-5 identifies criteria for the diagnosis of autism. The diagnostic criteria include persistent deficits in social communication and social interaction across multiple contexts; restricted repetitive and stereotyped patterns of behavior, interests, or activities; symptoms that are present in the early developmental period; symptoms that cause clinically significant impairment in social, occupational, or other important areas of function; and disturbances that are not better explained by intellectual disability or global developmental delay. An individual must have a DSM-5 diagnosis of autism spectrum disorder to qualify for regional center services based on autism.

INTELLECTUAL DISABILITY

18. Although there was no assertion that claimant is intellectually disabled, because claimant asserts he is eligible for regional center services under the fifth

category, the diagnostic criterial for intellectual disability are instructive. The essential features of intellectual disability are deficits in general mental abilities and impairment in everyday adaptive functioning, as compared to an individual's age, gender, and socio-culturally matched peers. Intellectual functioning is typically measured using intelligence tests. Individuals with intellectual disability typically have IQ scores in the 65-75 range. In order to have a DSM-5 diagnosis of intellectual disability, three diagnostic criteria must be met. The DSM-5 states in pertinent part as follows:

> Intellectual disability (intellectual developmental disorder) is a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains. The following three criteria must be met:
>
> A. Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing.
>
> B. Deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.

C. Onset of intellectual and adaptive deficits during the developmental period.

[¶] . . . [¶]

Intellectual functioning is typically measured with individually administered and psychometrically valid, comprehensive, culturally appropriate, psychometrically sound tests of intelligence. Individuals 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.

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

Deficits in adaptive functioning (Criterion B) refer to how well a person meets community standards of personal independence and social responsibility, in comparison to others of similar age and socio-cultural background. Adaptive functioning involves adaptive reasoning in three domains: conceptual, social, and practical. The conceptual (academic) domain involves competence in memory, language, reading, writing, math reasoning, acquisition of practical knowledge, problem solving, and judgment in novel situations, among others. The social domain involves awareness of others' thoughts, feelings, and experiences; empathy; interpersonal communication skills; friendship abilities; and social judgment, among others. The practical domain involves learning and self-management across life settings, including personal care, job responsibilities, money management, recreation, self-management of behavior and school and work tasks organization, among others. Intellectual capacity, education, motivation, socialization, personality features, vocational opportunity, cultural experience, and coexisting general medical conditions or mental disorders influence adaptive functioning. . . .

[¶] . . . [¶]

Criterion B is met when at least one domain of adaptive functioning – conceptual, social, or practical – is sufficiently impaired that ongoing support is needed in order for the

> person to perform adequately in one or more life settings at school, at work, at home, or in the community. To meet the diagnostic criteria for intellectual disability, the deficits in adaptive functioning must be directly related to the intellectual impairments described in Criterion A.

THE "FIFTH CATEGORY"

19. Under the fifth category, the Lanterman Act provides assistance to individuals with disabling condition closely related to an intellectual disability or that requires similar treatment as an individual with an intellectual disability but does not include other handicapping conditions that are "solely physical in nature." (Welf. & Inst. Code, § 4512, subd. (a).) A disability involving the fifth category must also have originated before an individual attained 18 years of age, must continue or be expected to continue indefinitely, and must constitute a substantial disability.

The fifth category is not defined in the DSM-5. In *Mason v. Office of Administrative Hearings* (2001) 89 Cal.App.4th 1119, the appellate court held that the fifth category condition must be very similar to intellectual disability, with many of the same, or close to the same, factors required in classifying a person as intellectually disabled. Another appellate decision has also suggested, when considering whether an individual is eligible for regional center services under the fifth category, that eligibility may be based largely on the established need for treatment similar to that provided for individuals with an intellectual disability, notwithstanding an individual's relatively high level of intellectual functioning. (*Samantha C. v. State Department of Developmental Services* (2010) 185 Cal.App.4th 1462.) In *Samantha C.*, the individual applying for regional center services did not meet the criteria for intellectual disability. The court understood and noted that the Association of Regional Center Agencies had

set forth guidelines (ARCA Guidelines)[2] which recommended consideration of the fifth category for those individuals whose "general intellectual functioning is in the low borderline range of intelligence (I.Q. scores ranging from 70-74)." (*Id.* at p. 1477.) However, the court confirmed that individuals may qualify for regional center services under the fifth category on either of two independent bases, with one basis requiring only that an individual require treatment similar to that required for individuals with intellectual disability.

The assistance provided by the ARCA Guidelines in assessing an individual under each prong of the fifth category are discussed below.

Functioning Similar to a Person with an Intellectual Disability

20. A person functions in a manner similar to a person with an intellectual disability if the person has significant sub-average general intellectual functioning that is accompanied by significant functional limitations in adaptive functioning. Intellectual functioning is determined by standardized tests. A person has significant sub-average

[2] On March 16, 2002, in response to the *Mason* case, the Association of Regional Center Agencies approved the *Guidelines for Determining 5th Category Eligibility for the California Regional Centers* (ARCA Guidelines). Of note, the ARCA guidelines have not gone through the formal scrutiny required to become a regulation and were written before the DSM-5 was in effect. Thus, while they are used to help guide professionals in evaluating a person who claims eligibility under the fifth category, the ARCA guidelines are not entitled to be given the same weight as regulations.

intellectual functioning if the person has an IQ of 70 or below. Factors a regional center should consider include: the ability of an individual to solve problems with insight, to adapt to new situations, and to think abstractly and profit from experience. If a person's IQ is above 70, it becomes increasingly essential that the person demonstrate significant and substantial adaptive deficits and that the substantial deficits are related to the cognitive limitations, as opposed to a medical or some other problem. It is also important that, whatever deficits in intelligence are exhibited, the deficits show stability over time.

Significant deficits in adaptive functioning are established based on the clinical judgements supplemented by formal adaptive behavioral assessments administered by qualified personnel. Adaptive skill deficits are deficits related to intellectual limitations that are expressed by an inability to perform essential tasks within adaptive domains or by an inability to perform those tasks with adequate judgement. Adaptive skill deficits are not performance deficits due to factors such as physical limitations, psychiatric conditions, socio-cultural deprivation, poor motivation, substance abuse, or limited experience.

Treatment Similar to a Person with an Intellectual Disability

21. In determining whether a person requires treatment similar to a person with an intellectual disability, a regional center should consider the nature of training and intervention that is most appropriate for the individual who has global cognitive deficits. This includes consideration of the following: individuals demonstrating performance based deficits often need treatment to increase motivation rather than training to develop skills; individuals with skill deficits secondary to socio-cultural deprivation but not secondary to intellectual limitations need short-term, remedial

training, which is not similar to that required by persons with an intellectual disability; persons requiring habilitation may be eligible, but persons primarily requiring rehabilitation are not typically eligible as the term rehabilitation implies recovery; individuals who require long-term training with steps broken down into small, discrete units taught through repetition may be eligible; and the type of educational supports needed to assist children with learning (generally, children with an intellectual disability need more supports, with modifications across many skill areas).

Substantial Disability

22. The ARCA Guidelines also refer to California Code of Regulations, title 17, sections 54000 and 54001, regarding whether a person has a substantial disability. This means the person must have a significant functional limitation in three or more major life areas, as appropriate for the person's age, in the areas of: communication (must have significant deficits in both expressive and receptive language), learning, self-care, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

DIAGNOSTIC CRITERIA FOR ATTENTION DEFICIT HYPERACTIVITY DISORDER[3]

23. Attention Deficit Hyperactivity Disorder (ADHD) is a neurodevelopmental disorder defined by impairing levels of inattention, disorganization, and/or hyperactivity-impulsivity. Inattention and disorganization entail inability to stay on task, seeming not to listen, and losing materials, at levels that are inconsistent with age or developmental level. Hyperactivity-impulsivity entails overactivity, fidgeting, inability to stay seated, intruding into other people's activities, and the inability to wait.

[3] ADHD is not a qualifying diagnosis for regional center services. However, since claimant has been diagnosed with ADHD, the diagnostic criteria is mentioned here.

ADHD often persists into adulthood, with resultant impairments of social, academic, and occupational functioning.

The DSM-5 diagnostic criteria for ADHD includes: persistent pattern of inattention and/or hyperactivity that interferes with functioning or development, as characterized inattention, hyperactivity, or both.

In order to meet the diagnostic criteria under inattention, a person must have six or more of the following symptoms that persist for at least six months in a manner that impacts social and academic/occupational activities: often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or with other activities; often has trouble holding attention on tasks or play activities; often does not seem to listen when spoken to directly; often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., loses focus, side-tracked); often has trouble organizing tasks and activities; often avoids, dislikes, or is reluctant to do tasks that require mental effort over a long period of time (such as schoolwork or homework); often loses things necessary for tasks and activities (e.g. school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones); is often easily distracted; and is often forgetful in daily activities.

In order to meet the diagnostic criteria under hyperactivity and/or impulsivity, a person must have six or more of the following symptoms that persist for at least six months in a manner that is inconsistent with his or her developmental level and negatively impacts social and academic/occupational activities: often fidgets with or taps hands or feet, or squirms in seat; often leaves seat in situations when remaining seated is expected; often runs about or climbs in situations where it is not appropriate (adolescents or adults may be limited to feeling restless); often unable to play or take part in leisure activities quietly; is often “on the go” acting as if “driven by a motor”;

often talks excessively; often blurts out an answer before a question has been completed; often has trouble waiting his/her turn; and often interrupts or intrudes on others (e.g., butts into conversations or games).

In addition, the following conditions must be met: several inattentive or hyperactive-impulsive symptoms were present before age 12; several symptoms are present in two or more settings (home, school or work; with friends or relatives; in other activities); there is clear evidence that the symptoms interfere with, or reduce the quality of, social, school, or work functioning; the symptoms do not happen only during the course of schizophrenia or another psychotic disorder; and the symptoms are not better explained by another mental disorder (e.g. Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

Differential diagnoses for ADHD include, but are not limited to, learning disorders, intellectual disability, autism, reactive attachment disorder, depressive disorders, anxiety disorders, and mood disorders.

DIAGNOSTIC CRITERIA FOR REACTIVE ATTACHMENT DISORDER[4]

24. Reactive attachment disorder (RAD) of infancy or early childhood is characterized by a pattern of markedly disturbed and developmentally inappropriate attachment behaviors, in which a child rarely or minimally turns preferentially to an attachment figure for comfort, support, protection, and nurturance. Features include: a consistent pattern of inhibited, emotionally withdrawn behavior toward adult caregivers; persistent social and emotional disturbance characterized by at least two of

[4] RAD is not a qualifying diagnosis for regional center services. However, since claimant has been diagnosed with RAD, the diagnostic criteria is mentioned here.

the following - minimal social and emotional responsiveness to others, limited positive affect, or episodes of unexplained irritability, sadness, or fearfulness; patterns of insufficient care as displayed by at least one of the following – neglect as evidenced by having basic needs unmet by adult caregivers, repeated changes in primary caregivers, or being raised in unusual settings that severely limit opportunities to form attachments (i.e. institutions with high caregiver ratios).

In order to be diagnosed with reactive attachment disorder, the child must also not meet the criteria for autism spectrum disorder. The DSM-5 notes that reactive attachment disorder shares many of the social behavioral features of autism. However, the way to differentiate autism from reactive attachment disorder lies in the history of neglect (which would be more suggestive of reactive attachment disorder) and the presence of restricted or repetitive interests or ritualized behaviors (which would be more suggestive of autism). The DSM-5 gives a lengthy explanation of other symptoms that should be considered in differentiating autism from reactive attachment disorder. Consequently, a psychologist who diagnosis a person with reactive attachment disorder has effectively considered, but rejected, a diagnosis of autism.

Claimant's Background

SUMMARY OF CLAIMANT'S PERSONAL BACKGROUND

25. The following summary of claimant's personal background was derived from multiple expert reports contained in the record: Claimant's actual birthdate is unknown, as he was abandoned on the side of a road as a newborn in Uzbekistan. Based on the birthdate claimant contained in the fair hearing request (November 1, 1993), claimant is approximately 28 years old, however, his exact age is unknown

because throughout the medical records different birthdates were used. Claimant was adopted when he was approximately six months old. Claimant was raised in Texas. Claimant's adoptive mother was a teacher[5] and claimant's adoptive father (hereafter, claimant's parents will be referred to as simply 'mother' and 'father') was a civil engineer. Claimant's mother and claimant have reported multiple times over the years that, during his youth, claimant's father was physically and verbally abusive to claimant (between 2006 and 2008), especially when claimant's father was drinking alcohol. Claimant's parents were together until claimant was approximately 22 or 23 years old.

As an infant, claimant smeared feces on his crib and could not develop a routine sleep cycle. Claimant did not respond to cuddling and was not emotionally attached to anyone. Early in his youth, claimant was thought to suffer from failure to thrive syndrome. He frequently displayed tics and unusual vocal utterings. As a child, claimant was diagnosed with ADHD and placed on psychotropic medications. In school claimant was able to develop early reading skills but struggled with math. Claimant displayed many disruptive behaviors. Claimant's family reported that the schools thought claimant might have autism or Asperger's syndrome. Claimant never received special education services under the category of autism, rather, he received special education services under the category of emotional disturbance. Claimant's mother reported that claimant received special education services for ADHD as well. In that

[5] Claimant's mother's employment is unclear as some reports described her as a teacher, others described her as a substitute teacher, and at least one described her as a teacher's aide.

assessment, autism was not mentioned as a concern. No educational records documenting a concern about autism were offered.

Claimant's mother reported that claimant had been diagnosed in the past with Asperger's syndrome and Pervasive Developmental Disorder – Not Otherwise Specified (PDD-NOS), though no documents provided contained any such diagnosis supported by a formal psychological assessment. Some of the reports included PDD-NOS as a "rule out" diagnosis or "provisional" diagnosis" only. Claimant has been diagnosed over the years with a variety of conditions, including, but not limited to, Tourette's syndrome, Obsessive-Compulsive Disorder (OCD), ADHD - inattentive type, reactive attachment disorder (RAD), mood disorder, disruptive behavior disorder, anxiety disorder, learning disorder (slow processing speed), alcohol abuse disorder, cannabis abuse disorder, and conduct disorder. Claimant participated in psychotherapy over the years and took medications for ADHD and Tourette's syndrome, among others.

According to at least one psychological evaluation, during his school years, claimant enjoyed playing sports and listening to music with his friends, though he did have some failing grades and was suspended at least once. Claimant has a long criminal history dating back to his teenage years, and for a time, was committed to the Texas Youth Commission after he was accused of arson.

Regarding his ability to maintain employment, while claimant has had jobs over the years, he has been unable to keep them. According to at least one report, claimant worked for Walmart as an overnight stocker, in various fast food restaurants, and a retail store in Texas. Around 2018 or 2019, claimant decided to move to California. He had a job lined up for himself at Amazon. On the way out to California, however, he lost his wallet. When he tried to report for work, he could not do so because he did not have identification. Claimant fought with Amazon human resources for almost a

month, while trying to find another job. He was not able to do so and became homeless. Claimant also has a history of drug use according to his aunt, who testified at the hearing. Claimant's drug of choice is marijuana, however, he has used other substances as well, including heroin.

Since coming to California, claimant has been arrested for many offenses, including felony robbery; felony assault with a deadly weapon (other than a firearm); misdemeanor petty theft; misdemeanor willful, unlawful, and malicious vandalism; misdemeanor battery; and use of force or violence against a peace officer. Many of the police reports and/or court documents associated with those arrests or incidents were provided. Claimant is currently incarcerated in Riverside County. Claimant's jail medical records were unremarkable and did not indicate any diagnosis of autism or intellectual disability, or any condition that is similar to or that requires treatment similar to an intellectual disability, that was supported by an assessment or battery of testing. What is clear from the extensive medical records provided is that claimant has no problems communicating his medical concerns to those in charge, or his wants, needs, and concerns, including a desire for therapy. At times, claimant requested specific therapists to discuss his concerns, and identified those with whom he is most comfortable.

While he has been incarcerated, there were three trial competency evaluations completed; two in 2021 and one in 2022. Two of the evaluations (completed by Dr. Berg and Dr. Suiter) found claimant competent. One, completed by Dr. Cheng, in between the evaluations completed by Dr. Berg and Dr. Suiter, was incomplete because claimant presented in such a way that he could not be properly evaluated, leading Dr. Cheng to find claimant incompetent to stand trial at the time of her evaluation.

TESTIMONY OF CLAIMANT'S AUNT

26. Claimant's aunt's testimony is summarized as follows: claimant is currently incarcerated in Riverside County. The last time she spoke with him was the day before the hearing and claimant was very happy to be able to talk to her and the family. She has known claimant since he was about six months old when his parents adopted him. During his developmental years, she saw him five to six times per week. When he was little, she would cuddle him, which he liked. Claimant was very content with her. They would watch movies together. Claimant seemed content with closeness and affection and would allow her to comfort him. She recalled when claimant was in elementary school somebody mentioned he had "Asperger's." Claimant has always had attention issues; he will listen and interact with someone if it is something that interests him. If he is not interested, he will only listen for a few minutes. Claimant has learned to make eye contact over the years.

Claimant had tantrums and meltdowns as a child, but she did not think it was out of the ordinary because that is to be expected in young children. As a child, claimant could dress himself but had to put his clothes on in a specific order. Claimant had "rituals" with food. He is still regimented in the way he prepares food. When claimant was in school, he chewed erasers, pencils, and pulled the tabs off soda cans and knobs off any type of controller. He was always putting things in his mouth. Claimant did not complete high school and ended up at a Texas youth facility for about two years. After claimant was released, claimant's parents brought him back home and tried to enroll him in high school, but it did not work out. Claimant had fights and other difficulties, so he was placed in classes for difficult children.

Claimant did have a girlfriend for two years but not in the traditional sense. Claimant met a girl on the internet – never in person - and was always sending her

money pursuant to her request. This is an example of how claimant is easily exploited by other people. Claimant cannot tell the difference between the truth and exaggerated claims, so he has been victimized many times over the years.

Claimant tends to dominate conversations with the females in the family. Claimant looks up to her son (his cousin), so claimant will listen to him intently. As far as money, whenever claimant gets money, he immediately spends it. Claimant never gives consideration to saving money for things like food or rent. In that respect, he cannot manage money on his own. Claimant would not be able to take medication on his own or seek out health care. When claimant buys food, he buys chips, soda, or candy.[6] Claimant has been able to obtain employment in the past but does not keep the jobs. As soon as he receives a paycheck, he leaves. Sometimes he doesn't even call or quit - he just disappears. Claimant has been fired for stealing from cash registers.

Claimant has always had difficulty coping with fears, anxiety, and frustrations. Claimant uses all kinds of drugs to "numb" how he is feeling. His drug of choice is marijuana. Claimant has also used heroin and pills like Valium and Xanax, as well as something called "K12" which is an herbal powder. Claimant has lied about having a degree in journalism because "he knows he is not where he is supposed to be."

Claimant chose to move to California when he was around 22 years old. He wanted to come to California because his uncle is well-established in the Riverside area in the marijuana industry. Prior to moving, claimant's aunt told claimant he

[6] The police reports support claimant's aunt on this point. In one of the police reports relating to claimant's arrest for robbery at a supermarket, claimant stole things like Kool-Aid, Snapple, candy bars, cheese slices, Starburst, and cookies.

needed to be self-sufficient, but he just did not understand that term. Claimant figured he would just move to California and live in a house with a bunch of bachelors and marijuana and that is the life he wanted. Claimant's aunt woke up one day and claimant was gone. Claimant has complained about the job market in California but also says he cannot get a job because he has no identification. Claimant cannot live independently and ended up homeless. She follows claimant on Facebook because he is happy positing things on Facebook.

Claimant's Records

27. The following is a summary of pertinent parts of claimant's medical and psychological records, spanning from 2003 (when claimant was approximately nine years old) to 2022 (when claimant was approximately 28 years old).

COOK'S CHILDREN MEDICAL RECORD

28. A record from Cook Children's Medical Center in Fort Worth Texas, dated, September 11, 2003, and authored by M. Christine Banner, M.D., shows that on that date, claimant was admitted for psychiatric care due to "out of control behaviors." At that time, the report noted claimant was approximately nine years old. The admission diagnoses were listed as mood disorder, reactive attachment disorder, ADHD, disruptive behavior disorder, and Tourette's syndrome (although there is no documentation to establish where or how those diagnoses were obtained). Claimant's parents reported claimant had been running up bills calling pornographic phone numbers and watching pornographic movies on the television. They described claimant as angry, defiant, and aggressive, at times. Claimant held particular hostility towards his mother and destroyed property.

29. Within the hospital setting, claimant was noted to be cooperative and responded well to the positive reinforcement given to him. Claimant did not exhibit any severe aggression in the hospital environment. He was able to interact more age appropriately with peers and was receptive to staff feedback as the program progressed. As soon as he would leave the hospital he would test limits with his mother, and the report indicated that the author believed it was due to the "mother's severe mental illness." Nonetheless, at the time of his dismissal, claimant was noted to exhibit a brighter mood, more cooperation, and no aggressive behavior.

30. On discharge, claimant was diagnosed with mood disorder, reactive attachment disorder, ADHD, and Tourette's syndrome (due to noticeable involuntary movements consistent with that disorder). There were no concerns in the report regarding autism, PDD-NOS, Asperger's syndrome, or any other developmental disorder that would qualify a person for regional center services.

NOVEMBER 29, 2004, PSYCHOLOGICAL REPORT, ALEDO INDEPENDENT SCHOOL DISTRICT, SPECIAL EDUCATION DEPARTMENT

31. A November 29, 2004, psychological report from claimant's school district, completed when he was approximately 11 years old, assessed claimant's abilities at that time for purposes of special education. The evaluator, Christine Fortman, M.A., is identified in the report as a "licensed specialist in school psychology." She completed a battery of tests, including: parent interview, attempted student interview, attempted Modified Rotter Sentence Completion, Behavior Assessment System for Children (BASC), Teacher Report form, BASC parent form was requested but never returned, House-Tree-Person drawings, Children's Depression Inventory (CDI), Reynolds Children's Manifest Anxiety Scale (RCMAS), and a file review.

During the assessment, claimant exhibited anxiety and rarely made eye contact. He repeatedly asked who signed him up for the assessment and many parts of the assessment could not be completed due to claimant's anxiety. On the CDI and RCMAS, claimant showed signs of anxiety and sadness. The BASC indicated problems with aggression, depression, conduct, hyperactivity, and attention problems. Notably, on many of the other scales such as social skills, study skills, adaptability, and learning, claimant was not above the score of 70, showing there was no significant concern in those areas. Based on the "significant anxiety" and concerns noted on the BASC, CDI, and RCMAS, Ms. Fortman recommended claimant continue to receive special education services under the category of "emotionally disturbed."

JULY 12, 2008, PSYCHOLOGICAL ASSESSMENT, TERRELL COUNSELING

32. A July 12, 2008, psychological assessment administered by Tammy Terrell, LPC, when claimant was approximately 14 years old, was performed after referral by claimant's pediatrician. Ms. Terrell's report is only two pages and contained no information showing an autism specific assessment or other type of thorough assessment. Only the Minnesota Multiphasic Inventory, Adolescent Edition (MMPI) was given. The report also contains claimant's history, which includes a comment that claimant has a past diagnosis of Asperger's syndrome and OCD, but nothing indicates whether any testing or formal assessments were performed to show how those diagnoses were made. Ms. Terrell observed claimant to have slow mental processing when he took the MMPI, which she indicated suggests there could be a major psychological disturbance, severe depression, functional psychosis, or below-average IQ. Ultimately, Ms. Terrell concluded:

> [I]t is the interviewer's opinion that the physical, mental, and emotional abuse reported that occurs at home at the

> hands of adopted father would and [*sic*] account for [claimant's] inhibition of aggression and authority problems. And the fact that he was never given the opportunity to bond with a female figure in his first months of life, many complications could result. His need for affection certainly could be explained this way. There is enough concern about [claimant] to warrant a full psychological evaluation to rule out developmental disorders and intellectual functioning.

JULY 23, 2008, PSYCHOLOGICAL REPORT, BY GRETCHEN LADD, PH.D.

33. A July 23, 2008, psychological report written by Gretchen Ladd, Ph.D., completed when claimant was approximately 14 years old, was performed to seek a "diagnostic clarification" and identify "treatment goals." As in the other reports, in the "background information" portion, Dr. Ladd noted the prior diagnosed conditions of Asperger's syndrome, Tourette's syndrome, OCD, and ADHD. Claimant's mother told Dr. Ladd claimant has poor eye contact and sucks on objects, but his social skills had improved and he was no longer sensitive to stimuli. Claimant was reported to be disorganized and impulsive and exhibiting repetitive behaviors and obsessive thoughts, though it was not clarified what claimant's mother meant by those claims. The report indicated claimant received special education due to ADHD. Claimant reported enjoying playing sports and listening to music with his friends. Claimant's mother approved of claimant's selection of friends. At the time of this assessment, claimant had been charged with arson and was detailed at a juvenile detention facility.

During the evaluation claimant interacted well with Dr. Ladd. Her report indicates claimant asked questions about each assessment to find out what was being

tested. Claimant responded to Dr. Ladd's questions politely, but showed flat affect, poor eye contact, and eye twitching. Claimant did not want to talk about his history of abuse because he was afraid of being removed from his home. Claimant expressed a desire to be released from custody.

Dr. Ladd administered 17 different assessments in addition to the diagnostic interview, which included the Australian Scale for Asperger's Syndrome (ASAS), the Children's Yale-Brown Obsessive Compulsive Scale (CYBOCS) Childhood Autism Rating Scale (CARS), and the Wechsler Intelligence Scale for Children – Fourth Edition (WISC).

On the WISC, claimant's full-scale IQ score was determined to be 84, which is in the low average range. However, Dr. Ladd noted that he scored in the average range in many of the domains for that test, suggesting his IQ was actually in the average range.

On the CARS, which was completed by claimant's mother, claimant fell outside of the autistic range. On the ASAS, also completed by claimant's mother, claimant's mother denied the following: avoids social interaction with peers, is not interested in competitive sports, takes a literal interpretation to comments, reads books primarily for information, and is fascinated with a particular topic. She did report claimant chews objects and tries hard to be accepted among his peers. On the CYBOCS, claimant's mother reported claimant likes to rewind programs and hear portions he likes and mimic certain expressions. She reported claimant had a specific idea of how he wanted to dress and will not deviate from that idea. She reported claimant removed battery covers on things like the remote control and his Gameboy. Dr. Ladd opined, based on these measures, claimant did not fall within the autism range.

Overall, Dr. Ladd diagnosed claimant with a learning disorder (slow processing speed), ADHD (predominantly inattentive type), anxiety disorder, and Tourette's

syndrome. Dr. Ladd assigned PDD-NOS as a rule-out diagnosis based on the historical reporting of Asperger's syndrome.

OCTOBER 10, 2008, HICKORY TRAIL ASSESSMENT

34. The October 10, 2008, Hickory Trail Assessment appeared to have been completed to assess claimant's risk upon admission to that hospital. Claimant was approximately 14 years old. Many portions of the report were difficult to read given that it was completed in handwriting as opposed to being typed. Claimant was noted to be anxious, depressed, monotone, and having flat affect. His speech was noted as "retarded" and he was noted to have poor judgement but average intelligence. Claimant was also noted to be obsessed with fire setting and stealing.

According to the typewritten portion of the report, claimant struggled with severe OCD and reported that when he gets thoughts in his head, he felt he had to carry them out. Claimant, at that time, was obsessed with fire. He set fire to grass, to the toilet paper at school, and had burned holes in couch cushions at home. Claimant had 12 incidents of setting fires in 30 days. Claimant reported liking to chew metal objects. The report showed claimant had problems with aggression, anxiety, and impulsivity. There were no formal assessments administered for autism or any other qualifying condition. It is also unclear who wrote any portion of this report because there is an attending doctor's name, but it appeared the report was completed by a person with an illegible signature and the title "LMSW."

DECEMBER 12, 2008, PSYCHOLOGICAL INTAKE ASSESSMENT, TEXAS YOUTH COMMISSION

35. A December 12, 2008, psychological intake assessment was completed when claimant was approximately 15 years of age and committed to the Texas Youth

Commission for engaging in arson. He was classified as a Violent B offender with a 12-month minimum stay. Quentin Baack, M.S., who is not a psychologist, assessed claimant. Mr. Baack completed only a mental status exam, clinical interview, and file review. No autism specific testing was conducted. In the interview portion of the report, Mr. Baack indicated the diagnostic history of ADHD, Tourette's syndrome, and Asperger's syndrome, OCD, and anxiety disorder. He also summarized the diagnoses given by Ms. Terrell, which included the rule-out diagnosis for PDD-NOS.

The mental status exam noted that claimant was polite and cooperative. Claimant had no problems with instructions or communication. He made some eye contact during the interview but would look away on occasion. Claimant's speech content was logical, and claimant presented no evidence of a "psychotic disorder." Claimant exhibited the ability to engage in abstract reasoning. Claimant reported feeling depressed and bored but was also noted to be nervous. Claimant reported he did not have hallucinations but would get intrusive thoughts in his head that consumed him until he took action. Claimant reported he often has plastic in his mouth because he has a strong urge to chew. Claimant reported he has no control over impulses, like, for example, when he tore down the shower curtain in his bathroom. He said he will just get a thought in his head and have to carry out whatever the thought is.

In the diagnostic portion of the report, which was based only on a review of other reports, his interview, and the mental status exam, Mr. Baack concluded claimant met the diagnostic criteria for conduct disorder and OCD, but there no concerns noted regarding autism. Mr. Baack said that claimant did not meet the diagnostic criteria for Asperger's syndrome, but because there had been a diagnosis of that in the past and there were some behaviors consistent with PDD-NOS, a provisional diagnosis of PDD-

NOS was given. He also diagnosed claimant with alcohol abuse disorder, and cannabis use disorder.

SEPTEMBER 4, 2010, COOK CHILDREN'S MEDICAL CENTER NOTES

36. Notes taken at the Cook Children's Medical Center from September 4, 2010, when claimant was approximately 16 years old, did not contain any psychological assessments or other pertinent information regarding whether claimant would qualify for regional center services. As with the previous reports, there is a list of previous diagnoses (mood disorder, OCD, Tourette's syndrome, and ADHD) but no records to show why or how those diagnoses were reached. There were no concerns documented regarding autism and no psychological assessments were completed.

JUNE 23, 2011, NOTES OF MARILYN JANKE, M.D.

37. The notes of Dr. Janke from June 23, 2011, when claimant was approximately 17 years old, recall prior diagnoses of mood disorder, OCD, Tourette's syndrome, and ADHD. Dr. Janke noted claimant stopped taking his medication but noticed when he started retaking his medication he felt more calm. There were no concerns documented regarding autism and no psychological assessments were completed.

TRIAL COMPETENCY EVALUATIONS

38. A June 3, 2021, trial competency evaluation, administered by Dr. Berg, when claimant was approximately 27 years old, was completed because claimant had been charged with multiple crimes (including robbery and commission of a crime while on bail) and the court desired the evaluation to assess competency for trial. The purpose of the evaluation was not to diagnose claimant with a developmental disorder

or conduct an extensive psychological assessment. Rather, it was to answer the following questions: 1) whether claimant had a basic understanding of the court proceedings, and 2) whether claimant had the ability to assist counsel in his own defense.

Dr. Berg interviewed claimant in the attorney-client booth at the jail where claimant was in custody. During the interview, claimant was hesitant to talk but his speech was clear and average. Claimant was wearing a mask due to COVID-19. Claimant was alert and oriented, and his thinking was logical, coherent, and organized. Claimant appeared anxious. He was oriented as to time and place. Claimant did not have any symptoms of major psychotic disorders. Claimant appeared reasoned in his thinking. When asked questions to determine whether he understood court proceedings or could assist his counsel (the Competency Assessment Instrument), claimant answered appropriately.

Following the interview, Dr. Berg concluded claimant was able to understand the nature and purpose of the criminal proceedings against him and was able to assist his counsel in a rational manner. Dr. Berg further concluded:

> In conjunction with any probation or after care program, the defendant should be referred to behavioral health for additional assistance with obtaining services for a neurodevelopmental disorder characterized by significant difficulties with social interaction, non-verbal communication, along with ritualistic and repetitive patterns of behavior and interests.

39. A July 20, 2021, trial competency evaluation, administered by Dr. Cheng, when claimant was approximately 27 years old, was completed because claimant had been charged with multiple crimes and needed to be evaluated for competency to stand trial. This evaluation was completed a little over a month after Dr. Berg's evaluation, but claimant presented very differently. Claimant exhibited anxiety and was not presenting in a clear or coherent manner. Claimant had difficulty maintaining attention and was "hyper verbal." Dr. Cheng could not properly evaluate claimant because of his presentation. Dr. Cheng found claimant incompetent to stand trial or assist counsel and recommended involuntary medication to restore claimant's stability.

40. A February 9, 2022, psychological evaluation, administered by Dr. Suiter, when claimant was approximately 28 years old, was completed because claimant had been charged with multiple crimes. Dr. Suiter conducted a clinical interview and mental status examination. Dr. Suiter found claimant was alert, cooperative and oriented in all spheres. His speech was sufficient, and his behavior was normal. Claimant maintained good eye contact, and rapport was easy to establish. Claimant's thought processes were logical and goal-directed. Claimant adequately understood the proceedings against him and indicated he understood the role of his public defender. Dr Suiter concluded claimant was competent to stand trial.

There were no autism-specific assessments administered, or for that matter, any assessments at all. Dr. Suiter referenced in his report that he "reviewed the anecdotal information regarding [claimant] provided by his attorney." This "anecdotal information" included Dr. Leark's "brief" report, wherein no autism-specific assessments were conducted. Without any supporting data, Dr. Suiter wrote that claimant had a history that raised "reasonable consideration" of autism and that

autism "may have been a factor in the commission of certain of his pending charges." Dr. Suiter recommended claimant be considered for mental health diversion.

CLAIMANT'S JAIL MEDICAL RECORDS

41. Claimant's jail medical records (mostly from 2021) were lengthy but relatively unremarkable. They demonstrated that claimant was able to effectively communicate with jail staff regarding his medical and psychological concerns and ask for what he needed. He asked on many occasions to "speak with mental health." Claimant asked for books and pencils because he liked to write as a "coping" mechanism. Claimant asked for hygiene items at times (i.e. mouthwash) and communicated with staff regarding the desire to apply for a "social security income check." Claimant communicated when he needed glasses because he recognized that his distance vision was not good. He communicated when he was in pain from something, and when he had what sounded like a potential urinary tract infection. Claimant communicated when he had dental problems. Claimant communicated when he wanted to speak with someone in behavioral health, and he was clear regarding the specific persons he wanted to speak with because he felt most comfortable with those individuals. On a few occasions, claimant requested to be removed from "mental health" housing but did not state why.

Testimony and Report of Claimant's Expert

42. The following is a summary of the testimony and curriculum vitae of Robert A. Leark, Ph.D., as well as the February 15, 2022, report completed by Dr. Leark after, what he described, as a "brief evaluation" of claimant.

Dr. Leark earned his Ph.D. in psychology in 1981. He also holds a Master of Arts in Psychology and a Bachelor of Science in psychology. He completed a post-doctoral

fellowship in neuropsychology and is currently a forensic and consulting neuropsychologist in the San Diego area. Dr. Leark has been a licensed psychologist since 1984 and has served as a clinical professor, lecturer, adjunct professor, and assistant professor in psychology. Dr. Leark is professionally associated with several academic and professional groups and he has published and served as a reviewer in academic journals having to do with the field of psychology. Dr. Leark has also made many presentations to others in his field regarding various subjects in psychology and neuropsychology. Dr. Leark is an expert in psychology and neuropsychology.

According to Dr. Leark's testimony and report, he "met" with claimant via video on February 15, 2022. Dr. Leark's conducted a "brief" evaluation of claimant, he did not perform a full psychological assessment. He also met with claimant's aunt and reviewed several criminal reports, as well as claimant's "attorney's work product notes" that contained an interview with an unknown family member. There was nothing in Dr. Leark's report indicating he reviewed the extensive records submitted in this case prior to rendering a conclusion in his report. He did, however, review some of the submitted records prior to the hearing because he commented on them during his testimony.

Dr. Leark learned that as an infant and toddler, claimant was difficult to parent. Claimant smeared feces on his crib and could not develop a routine sleep cycle. Claimant did not respond to cuddling and was not emotionally attached to anyone. Early in his youth, claimant was thought to suffer from failure to thrive syndrome and failure to attach. He frequently displayed tics and vocal utterings. As a child, claimant was diagnosed with ADHD and placed on psychotropic medications. In school claimant was able to develop early reading skills but struggled with math. Claimant displayed many disruptive behaviors. Claimant's family reported that "the schools thought"

claimant might have autism or Asperger's syndrome. Claimant did not graduate high school. He earned a GED while incarcerated for check fraud in Texas.

Dr. Leark administered the Adaptive Behavior Assessment Scale, Third Edition (ABAS-3), which is a self-reporting test that was filled out by claimant regarding how claimant feels he is functioning in specific areas. Those areas include communication, community use, functional academics, home living, health and safety, leisure, self-care, self-direction, and social skills. No autism specific testing or no testing for intellectual disability was completed. No standardized/objective testing was completed. Dr. Leark admitted that a person can have low scores on the ABAS-3 and not have autism. He testified he has used the Autism Diagnostic Observation Scale (ADOS) in the past to assess for autism, but when asked if he had used it recently to conclude a person had autism, he said, "not lately." He also pointed out that the DSM-5 does not require any specific test for autism.

Dr. Leark concluded claimant struggles to engage in social contexts and his behaviors are consistent with a person who has struggled in that respect his whole life. Dr. Leark concluded claimant's deficits in conceptual, social, and practical domains are consistent with a "neurobehavioral developmental disorder" or "developmental disability." He further concluded:

> The deficits in attention, focus and ability to inhibit behaviors are symptomatic of neurobehavioral development disabilities and immature brain development. He has deficits in communication and social interaction with others, as well as inattentive and impulsive behaviors. Add to that the emotional reactivity and poor sleeping patterns. All these point to a diagnosis of autism spectrum disorder.

> He needs a thorough development evaluation to determine if the spectrum diagnosis is with or without an accompanying intellectual impairment. He needs additional care, housing, and security. In addition to the evaluation for neurobehavioral developmental disorders, including autism spectrum, he needs a neurological evaluation to determine what, if any, deficits to the brain contribute to his decreased impulse control and struggles with concentration. The world is overwhelming to him, and he needs safety and security assistance.

Dr. Leark's report did not contain any assessment as to why he felt claimant likely had autism as opposed to the variety of other mental health disorders he had been diagnosed with over the years, except to say claimant "has been treated by symptoms rather than by diagnosis." During his testimony, however, he acknowledged the prior diagnoses such as ADHD and RAD. He testified that claimant likely received a RAD diagnosis because of "his history." He pointed out to various behaviors noted in the other records submitted at the hearing (for example, in the Cook's Children's medical center notes, he referenced things like tantrums, poor eye contact, verbally intrusive behavior, fixations on ideas, and a low Global Assessment of Functioning score) as indicative of autism. He testified because of the "severity" of claimant's autism, claimant needs long term care as his disability is "profound" and he will "take it to his grave." He believes claimant needs assistance such as being in a structured setting, obtaining job skills, vocational training, and supportive housing.

Dr. Leark disagreed with IRC's expert's, Dr. Singleton's, use of the Independent Living Scales (ILS) as an adaptive assessment because that test has only been

normalized for those who are 65 years of age and older who have psychiatric and cognitive decline. Despite Dr. Singleton's comprehensive psychological assessment, Dr. Leark testified he did not place any validity in Dr. Singleton's conclusion. He also felt Dr. Singleton's statement in the assessment that there were no records regarding Asperger's syndrome was not correct.[7]

Testimony and Reports of IRC's Experts

OCTOBER 30, 2021, PSYCHOLOGICAL EVALUATION, C. SHERIN SINGLETON, PSY.D.

43. Dr. Singleton did not testify, but the comprehensive psychological assessment she completed of claimant on October 30, 2021, when he was approximately 28 years old, was used by IRC to render its original eligibility determination. Dr. Singleton specifically conducted the psychological evaluation to determine eligibility for regional center services. She was aware of claimant's criminal charge of robbery at the time of her evaluation, and that there were at least five other criminal cases against him, but she did not have reports for any of the cases.

Dr. Singleton conducted a face-to-face assessment with claimant. Other than interviewing claimant, she conducted the ILS test and the Wechsler Adult Intelligence Scale, Fourth Edition (WAIS-4). Her report indicated that she reviewed a court minute order, as well as the following prior records: Psychological Intake Assessment, Texas Youth Commission (Quentin Baack, M.S.) dated December 12, 2008; Hickory Trails

[7] It is noted that this was a correct statement because, to date, there has never been a record produced that contains a diagnosis of Asperger's syndrome supported by any testing or assessment.

Hospital Psychosocial Risk Assessment dated October 10, 2008; Psychological Report by Dr. Ladd, dated July 23, 2008; Psychological Evaluation completed by Christine Fortman, M.A., dated November 29, 2004; and the Psychological Assessment by Tammy Terrell, LPC, dated July 12, 2008.

Dr. Singleton noted that in the past, according to claimant, he had been diagnosed with Tourette's syndrome, Asperger's, OCD and ADHD. Claimant said he used to take almost every medication out there, including Zoloft, Ritalin, Risperdal, Strattera, and Concerta, but stopped taking them because he did not like the way they made him feel. Claimant told her his OCD is more about wanting things to be neat and tidy and is not extreme, but he likes to do things a particular way. Claimant will often ask questions because he wants to understand things better, even if it means repeating the same question over and over. Claimant told Dr. Singleton he tends to "fixate" on things but did not give examples. Claimant told Dr. Singleton he likes to socialize but is more comfortable being by himself. Claimant said the following about his substance abuse history:

> The first time [claimant] smoked marijuana was at the age of 11 years. He smoked marijuana "every now and then," and he got it from his aunt, who had cancer.[8] He smoked off and on a few times a month when he was in Texas. In California, he smokes "every time I [he] can afford it." He uses methamphetamine every few weeks, spending about 20 or 30 dollars a month. He uses it to stay up because "it's

[8] It was not mentioned in the report whether this was a different aunt or claimant's aunt who testified at the hearing.

> hard to sleep on the streets and I need to keep moving." He smokes heroin "every now and then." He smokes cigarettes (about ½ pack a day) and has smoked intermittently since he was 14 years old. He does not drink alcohol ("I don't like that."). He does not use other substances but has tried "everything except for crack." He has tried ecstasy, LSD, mushrooms, MDMA but does not use them "unless it's in a setting and it's around." He emphatically stated that he has never used PCP.

Regarding his appointment, claimant arrived on time. He was oriented as to person, time, and place. He was well-groomed. His speech was normal. He repeated some questions, but said that was because he was trying to understand. His mood was "fine" and his affect was "bright." Claimant was "engaged" in the evaluation. Claimant responded well when he was told "great job." Claimant seemed interested in knowing whether he got answers right. Claimant "fixated" multiple times on having been diagnosed with Asperger's syndrome. Claimant said he was told by his attorney that because he had this disorder, Dr. Singleton would automatically find him eligible for regional center services. Claimant continuously insisted he was eligible for regional center services because of Asperger's syndrome.

Claimant reported he has had girlfriends before and that one relationship lasted two years. When asked why, claimant said having a girlfriend gives him someone to depend on and makes him feel good and needed. When asked if claimant knew what skills he needed to live independently, claimant said money would be difficult but understood he needs to get a job and earn money. He understands he would need to pay bills. Claimant said he does not like to depend on anyone and does not have any

money, which is why he engages in theft. He admitted he has made a lot of bad choices, such as spending all of his "COVID relief money." Dr. Robinson explained that these comments show claimant has good insight into money management, despite poor judgement, but also showed remorse over his poor judgment.

The ILS tested claimant in memory and orientation, managing money, managing home and transportation, health and safety, social adjustment, problem solving, and performance. Dr. Singleton's report states the following regarding the ILS:

> The ILS is an assessment of an adult's ability to manage instrumental activities of daily living. It is comprised of five subscales and two factors. It was originally developed for use with older adults to provide an understanding of their ability to care for themselves. It has been demonstrated to have utility in the evaluation of adults with psychiatric diagnoses. Additionally, it has been found to differentiate between those people who live in a highly structured boarding home and those who require minimal supervision.

On the ILS, claimant scored "high"[9] and "independent" in virtually all areas across all domains. His full-scale score fell within the high range. Claimant demonstrated no adaptive or functional deficits.

[9] In one domain on the ILS, "social adjustment," Dr. Singleton's scoring indicating claimant was in the "low" range. Between hearing days, IRC consulted with Dr. Singleton and obtained a corrected report which noted that the word "low" was a typo, as it should have been "high." The error was minor and did not bear on the

On the WAIS-4, which is used to assess the general intellectual ability of individuals aged 16-89, claimant had a full-scale IQ of 87. He scored in the average, low average, and borderline ranges across four domains. Dr. Singleton concluded claimant's overall performance on the WISC-4 suggested there were no significant deficits in his cognitive ability consistent with intellectual disability.

Dr. Singleton diagnosed claimant with stimulant use disorder, moderate; and cannabis use disorder, moderate. Based on her evaluation, she did not find claimant eligible for regional center services because there was no evidence of a developmental disorder. As to claimant's claim of Asperger's syndrome, she wrote:

> Although [claimant] reported being previously diagnosed with Asperger's, Tourette's, and OCD, he did not describe, throughout the course of the evaluation, any present symptoms that would meet diagnostic criteria for any of the aforementioned disorders. There were no records provided that substantiated the Asperger's diagnosis during the developmental period. In fact, the 2008 evaluation results were inconsistent with a diagnosis of Autism Spectrum Disorder. Additionally, he does not take psychiatric medication, so the absence of these symptoms could not be due to the impact of medications. During this present evaluation, he did not evidence any symptoms of Tourette's or OCD. His behavior during the evaluation did not indicate

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overall credibility of the report, the overall results of the ILS, or Dr. Singleton's conclusions.

> that if an autism spectrum disorder was present (aka his "Asperger's,") it was impairing his independent living skills. Additionally, I found no overt evidence of any psychiatric disorders, including mood or psychotic spectrum illnesses that were interfering with his functioning. [Claimant] was evaluated for the presence of Intellectual Disability and for deficits in adaptive functioning. His IQ fell well above the cutoff for Intellectual Disability, in the Low Average range. His scores on the adaptive living measure fell in the independent range on all subscales and one of two factors. There was no evidence of any adaptive functioning deficit based on his performance.

ANGELIKA ROBINSON, PSY.D.

44. The following is a summary of the testimony and curriculum vitae of Angelika Robinson, Psy.D., as well as the March 4, 2022, psychological evaluation of claimant conducted by Dr. Robinson.

Dr. Robinson holds a Bachelor of Science in sociology, a Master of Science in clinical psychology, and a doctor of psychology. She has been a licensed clinical psychologist for over 20 years. Dr. Robinson has been a contract psychologist for the California Department of Corrections and Rehabilitation and The Counseling Team. She currently serves as a consulting forensic psychologist for IRC, where she assesses individuals for eligibility pursuant to the Lanterman Act. She also serves as a psychologist in private practice. Dr. Robinson works as a forensic psychologist for Liberty Healthcare, where she conducts competency evaluations for the superior courts. Dr. Robinson is a member of several professional organizations and has

published in a peer reviewed journal. She has evaluated over 2,000 individuals for developmental disabilities. Dr. Robinson is an expert in clinical psychology and in the assessment of individuals for regional center eligibility.

Dr. Robinson described the features of RAD, and qualifying diagnoses for regional center services. She explained that in treating adults for RAD or intellectual disability, there is a bit of overlap in the types of treatments. Things like occupational therapy, speech therapy, and physical therapy used for those who are intellectually disabled are not "treatments," rather, they are interventions and services that help guide an individual to perform daily functions and hold employment. Individuals who have RAD may benefit from the same services, but the primary treatment is talk therapy to address dysfunctional experiences in order to help the individual function more optimally in their day-to-day relationships. Talk therapy is not a standard of care or treatment for an intellectually disabled individual.

Autism typically becomes evident within the first two years of life. There are many different types of testing for autism, such as the CARS, CARS – HF (high functioning), the Autism Diagnostic Interview – Revised (ADIR), and Autism Diagnostic Observation Scale (ADOS). The ADOS is a very thorough standardized assessment that taps into the nuances of the condition, and also largely eliminates any rater bias that might exist with other assessments. In that respect, the ADOS is considered the "gold standard" of autism assessments.

Prior to conducting her psychological assessment of claimant, Dr. Robinson reviewed over 800 pages of prior records, which included claimant's childhood records, jail medical records, discharge summaries from Cook Children's Medical Center, the Psychological Intake Assessment from the Texas Youth Commission, the trial competency evaluations completed by Dr. Berg, Dr. Cheng, and Dr. Suiter, and

numerous court records. Dr. Robinson was also aware of claimant's current criminal charges.

On March 4, 2022, Dr. Robinson met with claimant at the jail. She interviewed claimant and obtained his history, which was consistent with what other evaluators had obtained. Her interview revealed that claimant had no problems communicating with her. She found claimant to be very friendly, engaged, and able to participate in a back-and-forth dialogue. Dr. Robinson also interviewed claimant's mother by telephone. Claimant's mother reported claimant played well with toys as a child but also chewed on many objects. Claimant wanted his meals prepared and presented in a certain manner as a child, as well. Claimant's mother reported claimant has learned what is expected of him in social interactions over the years but lacks emotion. During his educational years, claimant was impulsive, distracted, and disorganized, and received mostly "B" and "C" grades.

Dr. Robinson used the following three assessments to evaluate claimant: the ADOS, the CARS-HF, and the Vineland -3. During the ADOS, claimant did not demonstrate any restricted or repetitive behaviors. His fine and gross motor skills were intact. Claimant did not engage in any abnormal body movements consistent with autism. Claimant did not evidence any abnormal visual response such as prolonged gazing or seeking out specific objects. Claimant showed adequate visual and normal verbal communication. Claimant did not perseverate on any specific topics. Claimant described in great detail the difficulty he encountered trying to replace his documents due to being born outside of the United States and this inability to secure documents led to his homelessness. Dr. Robinson observed claimant proactively took a course of action to fix his situation, but his narrative illustrated multiple rigid, concrete and poorly thought out decisions and actions on his part that contributed to a poor

outcome. Claimant showed no difficulties in identifying examples of situations that corresponded to certain emotions, and indicated a desire for friendships, relationships, and personal closeness. Claimant was able to identify the potential difficulties of becoming self-sufficient, such as identifying living situations, obtaining employment, securing transportation, and paying bills. He identified wanting to work in technology or as a sports journalist. Although he has the capacity to rationally and logically speak about such responsibilities, he did not seem to recognize the incongruency between his future plans and his significant history of criminal behavior, indicating a concreteness in thinking and an inability to consider consequences to behaviors. On the ADOS, a person who achieves a total score of six or less is considered not on the spectrum. A person who achieves a score between 7 and 9 is considered "autism spectrum." A person who scores 10 or above is considered "autism." Claimant scored a 7, which places him at the low end of the spectrum range.

The CARS-HF was completed based on observations and reports from claimant's mother and his aunt. The CARS-HF is a behavioral rating scale developed to identify individuals with autism. The CARS-HF distinguishes behaviors associated with autism from behaviors associated with developmental delays, and uses information provided by caregivers or self-report, as well as direct observation. On the CARS-HF, claimant scored within the "mild" range of autism.

The Vineland-3 is a standardized measure of adaptive behavior that focuses on what the individual being tested can do in everyday life. Claimant's mother completed the form. Overall, claimant's behaviors fell within the low range. Dr. Robinson noted that the Vineland-3 results were markedly lower than the ILS results that were found by Dr. Singleton. She explained that the different results were likely attributable to the following factors: the Vineland-3 is a rater instrument, relying on the report of a parent

or caregiver, and is therefore susceptible to subjective over/under reporting than the ILS. Although the ILS is normalized for individuals age 65 and older, the ILS is not only for that population. The ILS can be administered to people under 65. The ILS, unlike the Vineland-3, actually tests the individual's capability to perform instrumental daily living activities. Consequently, the ILS may in some cases be a more robust representation of an individual's current abilities.

Dr. Robinson noted in her report that there was no documented substantiation of an Asperger's diagnosis in claimant's history. She further explained in testimony that what she meant was that there were no "formal" diagnoses of Asperger's syndrome, PDD-NOS, or autism. She noted that other assessments mention a possible diagnosis of autism, however, "it should be noted that these impressions were based on reports and informal observations as opposed to standardized testing." She acknowledged that claimant performed low on the Vineland-3, but that in previous assessments his adaptive skills were noted to be "high" and "likely yielded a more accurate illustration of his capabilities." She also noted that claimant has been known to manipulate jail staff to gain additional privileges. Based on all available information, Dr. Robinson felt claimant's "daily functioning is not impaired."

Dr. Robinson commented on the three trial competency evaluations and pointed out that Dr. Suiter's and Dr. Berg's evaluations did not indicate any substantially disabling behavior. Regarding the unusual manner in which claimant presented to Dr. Cheng, such as rambling, anxious, disorganized, and racing thoughts, those are indicative of something other than autism. She also found fault with Dr. Berg's conclusion that claimant might have autism because there was nothing in Dr. Berg's report to suggest as much.

Dr. Robinson testified that she was "hard pressed to find any substantive evidence of autism." Dr. Robinson indicated that if she had gone just based on her reports, she could not have diagnosed him with autism – not even mild autism, despite the scores on the ADOS and CARS-HF. She explained that he was just one point above the cutoff for autism spectrum, and that stemmed mostly from his mild social and emotional reciprocity scores, which can also be attributable to ADHD or RAD. Nonetheless, she gave claimant the benefit of the doubt in diagnosing him with autism because of the historical reports of autistic-like behaviors but noted he does not require substantial support.

HOLLY A. MILLER-SABOUHI, PSY.D.

45. Dr. Miller-Sabouhi is a staff psychologist at IRC. Dr. Miller-Sabouhi holds a Ph.D. in psychology, a Master of Science degree in psychology, and a Bachelor of Arts in psychology. She has been a licensed psychologist since 2013. As a staff psychologist at IRC, a position she has held since 2016, Dr. Miller-Sabouhi conducts psychological evaluations of children, adolescents, and adults to determine eligibility for regional center services under the Lanterman Act. Prior to serving as a staff psychologist at IRC, Dr. Miller-Sabouhi worked as a clinical psychologist and clinical supervisor in different settings, where she conducted psychological evaluations of individuals, engaged in psychotherapy and family therapy services to adults and children, and conducted both counseling and trainings in the field of mental health services, among other things. Dr. Miller-Sabouhi has published in a peer-reviewed journal and received awards during her pre-doctoral study. Dr. Miller-Sabouhi is an expert in the field of psychology, and specifically, in the assessment of individuals for regional center services under the Lanterman Act.

Dr. Miller-Sabouhi did not conduct her own psychological assessment because the assessment had already been conducted for IRC by Dr. Robinson. However. Dr. Miller-Sabouhi was on the eligibility team, thus, it was her job to review and interpret all of the records in this case and determine whether claimant was eligible for regional center services. Thus, her testimony and overall assessment is highly relevant to this matter and pertinent parts are summarized below.

Dr. Miller-Sabouhi explained that, for purposes of regional center services under the fifth category, there is a distinction between treatment and services. Services might be helpful and benefit someone, but the fact they would benefit a person is not the standard. Similarly, individuals can have substantially disabling conditions but not be eligible; any number of things can cause substantial disability in an individual but regional center services are restricted to specific conditions.

Dr. Miller-Sabouhi concluded, in both eligibility determinations of claimant, that he was not eligible for regional center services. Her opinion remained the same at hearing. The following is a summary of her testimony.

Regarding ADHD, Dr. Miller-Sabouhi explained that it is typically not diagnosed before the age of five. However, signs of it may be seen in the early years of life in the form of social deficits and restricted or repetitive behaviors. Children who have autism or ADHD might receive (and benefit) from things like behavioral services and social training, but typically with ADHD, the primary treatment is always going to be medication because that is highly effective at treating ADHD. The primary treatment for autism is behavioral therapy.

The Global Assessment of Functioning (GAF) scale is no longer a part of a DSM-5 diagnosis but it was previously part of the diagnosis system under the DSM-IV. The

GAF is a global number that is used by a professional, in conjunction with other factors, to render specific diagnoses. The GAF is a structured scale that ranges from 20s to the 100s and it is not specific to any condition. There is no standardized way to develop the ultimate GAF number since it is purely a matter of clinical judgement. Dr. Miller-Sabouhi pointed out that claimant's GAF scores in the Cook Children's Medical Record ranged from 40 to 50. It appeared claimant's behaviors were possibly affecting his functioning, at least according to his parents, and by the time he received treatment he was functioning at a moderate level. The type of inpatient treatment claimant received is not typical of what would be done for a person with autism; inpatient treatment is typically for someone who has significant behavioral or psychiatric problems, and the treatment is focused on medication management and therapy, which is what claimant received. Nothing in his childhood records showed claimant had any significant deficits in cognitive functioning or any impairment as a result of autism.

In the Cook's Children's Medical Record, there were behavioral concerns of impulsivity, setting fires, enjoying pornography, and worsening aggression. None of these behaviors are specific to autism and are attributable, in her opinion to other psychiatric disorders. The record also shows claimant was screened for a variety of psychiatric disorders, including PDD and autism, and the screening form marked he did not have any features of either disorder. It did, however, show he had symptoms of ADHD. Also within these records was a description of very deliberate behaviors – such as having good eye contact and responsiveness, descriptors that are inconsistent with a person who has autism. Although one portion of the records indicate claimant engages in "repetitive behaviors," the report does not indicate what those were. Moreover, when in group therapy, claimant was described in the records as cooperative and participatory, which is not characteristic of autism.

There are also instances in the records where it describes claimant as trying to do things to minimize his behaviors or anxiety or build himself up – such as lying about having a degree in journalism, which he does not have. This shows a sophisticated social understanding because claimant was lying to make himself out to be more than he was. A person with autism typically has a deficit or inability to understand social consequences or reactions of individuals, they do not really have the sophistication to lie.

Dr. Miller-Sabouhi found the fact that claimant was never served in special education for autism to be important. What it means is that to the extent claimant had even mild autism, his presentation was so subtle or mild that it was not causing any impact in the school setting. The criteria for special education as it relates to autism is not as stringent as the Lanterman Act criteria, and given that they assess children every year, it is likely an autism diagnosis would have been made if that is what was affecting his school performance.

Dr. Miller-Sabouhi reviewed the psychological assessment by Ms. Terrell. She said she had no idea what "LPC-S," the appendage/title after Ms. Terrell's name, means. She said the treatments recommended after the brief evaluation (anger management, consulting with a licensed psychologist, family therapy, and evaluation for mood stabilizing drugs to manage anxiety) are more indicative of a mental health problem and are not the types of treatment one would typically receive for autism.

The July 23, 2008, psychological report completed by Dr. Ladd showed claimant had an overall IQ of 84 and was ultimately placed in the low average range for intellectual functioning. Dr. Miller-Sabouhi pointed out that in every area tested claimant scored in the average range and only one score – processing speed – was lower, and that one area dragged down the overall score. As far as IQ scores go, 69

and below would be extremely low, 70 is borderline, 80s is low average, and 90s and above is average to superior. The farther away a person gets from borderline, the less likely it is that he functions similar to person with an intellectual disability. Dr. Miller-Sabouhi also pointed out that even Dr. Ladd, because of the scores, concluded claimant likely had average overall intelligence.

Also in Dr. Ladd's report, Dr. Miller-Sabouhi found it important that on the CARS, claimant fell within the non-autistic range. Dr. Miller-Sabouhi pointed out that claimant completed and participated in the lengthy testing, and this is not normally possible for someone with an intellectual disability. Though Dr. Ladd mentioned a PDD-NOS "rule-out" diagnosis, a "rule-out" diagnosis is not an actual diagnosis based on data.

Regarding the psychological intake assessment of Mr. Baack when claimant entered the Texas Youth Commission, Dr. Miller-Sabouhi pointed out he was not a licensed clinical psychologist, though some states permit persons with graduate degrees to conduct such assessments and render diagnoses. She noted in the report that claimant acknowledged anxiety and depression, some obsessive thoughts and impulsivity, and described obsessive thoughts that made claimant feel compelled to engage in certain behaviors. These are descriptors of OCD, and there is nothing in this report unique to autism. There was no adaptive testing completed in this assessment. Consequently, a diagnosis of PDD-NOS, even provisional, was not justified. The report does not contain any information to show how that provisional diagnosis was reached so Dr. Miller-Sabouhi opined it might have been a carry-over diagnosis from prior reports. Even assuming the diagnosis of PDD-NOS was correct and justified, a person would not have qualified for regional center services for either PDD-NOS or Asperger's

syndrome because those disorders were not qualifying conditions and in both conditions any symptoms that are mild in nature do not necessarily impair functioning.

Regarding Dr. Singleton's 2021 psychological evaluation, Dr. Miller-Sabouhi noted claimant was able to reliably communicate with Dr. Singleton in great detail. This is not suggestive of someone who has a substantial impairment. At the time of Dr. Singleton's report, claimant appeared to be psychiatrically stable. The ILS showed claimant to have no functional impairments. Dr. Miller-Sabouhi explained that the ILS has been validated for individuals 17 years of age and older with varying psychiatric needs. Her understanding is that it was originally validated for individuals 65 and older as well, but is not restricted to only that population. The ILS was an appropriate assessment to administer to claimant to test his adaptive functioning.

Dr. Miller-Sabouhi was highly critical of Dr. Leark's "brief" evaluation of claimant. She noted Dr. Leark did not administer any test or assessment specifically geared towards autism. He did not review anything other than police reports and attorney work product notes. The report showed he did not meet claimant in person. No standardized objective measures were conducted. Dr. Miller-Sabouhi said that although Dr. Leark administered the ABAS-3, a diagnosis of autism cannot be made on that alone.

Regarding Dr. Suiter's February 9, 2022, trial competency evaluation, Dr. Miller-Sabouhi was concerned because the only document he seemed to review was the report completed by Dr. Leark, which was problematic as previously noted. During the interview, claimant was able to relay his history, claimant had good hygiene, good eye contact, good rapport, good insight and judgement, his thought processes were logical and appropriate. Nothing in this report suggested unusual behaviors or anything consistent with autism.

Regarding Dr. Robinson's psychological evaluation, Dr. Miller-Sabouhi described it as a comprehensive assessment and an example of what is considered to be the best practices in psychology. Dr. Robinson administered the CARS-HF. The CARS HF was developed to help assess for autism among higher functioning individuals, which is people who have an IQ in excess of 80. Claimant "just barely hit the range for "mild to moderate" which is why he was classified as mild. A person is not considered to have autism because they score appropriately on the CARS-HF; it is merely a test that suggests whether a person, upon further assessment, is "likely" to meet diagnostic criteria for autism. To diagnose someone with autism, further assessment and direct observation, among other things, are needed.

The ADOS is a very different diagnostic tool than the CARS or CARS-HF. It also utilizes direct observation and interaction, but it structures the information obtained. There are four modules that are structured standardized activities the evaluator goes through and specific responses expected, which is how the ultimate score becomes standardized.

No one test can make a diagnosis. It is the evaluator's job to look at the entirety of information collected, review the DMS-5, and make a recommendation.

Conditions like ADHD and RAD, among others, can affect autism testing and diagnosis. Similarly, drug use can affect a person's functional abilities. Engaging in criminal activity alone does not indicate a person is substantially disabled; Dr. Miller-Sabouhi did not believe anything in the police reports submitted suggested a pattern associated with being substantially disabled as a result of autism.

In conclusion, Dr. Miller-Sabouhi believed that ADHD, RAD, and claimant's previously diagnosed conduct disorder were justified diagnoses and well documented

in the records from the developmental period; it also seemed the professionals were treating symptoms common to those disorders that were most impairing at the time and those that were causing claimant the biggest problems. Although there were some concerns throughout claimant's history with social communication and sensory seeking behaviors, those who saw claimant during his developmental period would have been aware these behaviors could suggest autism but were clearly not concerned with autism. None of the reports show claimant had marked deficits in communication requiring substantial support. None of the reports show *persistent* repetitive behavior or *patterns* of restricted or unusual interests (that were consistent over a period of time, which is what would be seen in autism). Though some movements were noted in his history that were repetitive, claimant had a diagnosis of Tourette's syndrome, and involuntary movements are different than the repetitive movements seen in autism. None of the reports show claimant has significant functional limitations in three or more areas of a major life activity. While claimant may have some level of deficit in certain areas, whatever deficits he may have are attributable to his other diagnoses.

LEGAL CONCLUSIONS

Applicable Law

1. The Legislature enacted a comprehensive statutory scheme known as the Lanterman Act (Welf. & Inst. Code, § 4500 et seq.) to provide a pattern of facilities and services sufficiently complete to meet the needs of each person with developmental disabilities, regardless of age or degree of handicap, and at each stage of life. The purpose of the statutory scheme is twofold: To prevent or minimize the institutionalization of developmentally disabled persons and their dislocation from family and community, and to enable them to approximate the pattern of everyday

living of nondisabled persons of the same age and to lead more independent and productive lives in the community. (*Assn. for Retarded Citizens v. Dept. of Developmental Services* (1985) 38 Cal.3d 384, 388.) Welfare and Institutions Code section 4501 outlines the state's responsibility for persons with developmental disabilities and the state's duty to establish services for those individuals.

2. The Department of Developmental Services is the public agency in California responsible for carrying out the laws related to the care, custody and treatment of individuals with developmental disabilities under the Lanterman Act. (Welf. & Inst. Code, § 4416.)

3. The Lanterman Act is set forth at Welfare and Institutions Code section 4500 et seq. Welfare and Institutions Code section 4501 provides:

> The State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge. Affecting hundreds of thousands of children and adults directly, and having an important impact on the lives of their families, neighbors and whole communities, developmental disabilities present social, medical, economic, and legal problems of extreme importance . . .
>
> An array of services and supports should be established which is sufficiently complete to meet the needs and choices of each person with developmental disabilities, regardless of age or degree of disability, and at each stage of life and to support their integration into the mainstream

> life of the community. To the maximum extent feasible, services and supports should be available throughout the state to prevent the dislocation of persons with developmental disabilities from their home communities.

4. Welfare and Institutions Code section 4512, subdivision (a), defines developmental disability as 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." A developmental disability includes "disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability." (*Ibid.*) Handicapping conditions that are "solely physical in nature" do not qualify as developmental disabilities under the Lanterman Act. (*Ibid.*)

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

> (a) "Developmental Disability" means a disability that is attributable to intellectual disability[10], cerebral palsy, epilepsy, autism, or disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with intellectual disability.
>
> (b) The Developmental Disability shall:

[10] Although the Lanterman Act has been amended to eliminate the term "mental retardation" and replace it with "intellectual disability," the California Code of Regulations has not been amended to reflect the currently used terms.

(1) Originate before age eighteen;

(2) Be likely to continue indefinitely;

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

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

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

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

(a) "Substantial disability" means:

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

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

(A) Receptive and expressive language;

(B) Learning;

(C) Self-care;

(D) Mobility;

(E) Self-direction;

(F) Capacity for independent living;

(G) Economic self-sufficiency.

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

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

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

7. Welfare and Institutions Code section 4643.5, subdivision (b), provides:

An individual who is determined by any regional center to have a developmental disability shall remain eligible for services from regional centers unless a regional center, following a comprehensive reassessment, concludes that the original determination that the individual has a developmental disability is clearly erroneous.

Evaluation

8. A person must have **both** a qualifying condition and a substantial disability (significant functional limitations in three or more areas of a major life activity) attributable to a qualifying condition to be found eligible for regional center services under the Lanterman Act. In other words, if the evidence does not establish that claimant has autism or meets the criteria under either prong of the fifth category, it is irrelevant if he has significant functional limitations in three or more areas of a major life activity. If an individual has a qualifying diagnosis, he must have a substantial disability in three or more areas that is caused by that diagnosis. The Legislature specifically requires both a qualifying condition and a substantial disability. A preponderance of the evidence did not establish that claimant has a qualifying condition or a substantial disability within the meaning of applicable law.

9. Along with the documentary evidence submitted for review in this case, three experts testified: Dr. Robinson, Dr. Miller-Sabouhi, and Dr. Leark. A person is qualified to testify as an expert if he or she has special knowledge, skill, experience, training, or education sufficient to qualify as an expert on the subject to which the testimony relates. (*Chavez v. Glock, Inc.* (2012) 207 Cal.App.4th 1283, 1318-1319.) An expert witness may give opinion testimony based on matter (including the expert's special knowledge, skill, experience, training, and education) perceived by or personally known to the witness or made known to the expert at or before the hearing, whether or not admissible, that is of a type that reasonably may be relied upon by an expert in forming an opinion upon the subject to which his testimony relates, unless an expert is precluded by law from using such matter as a basis for the expert's opinion. The trial court's determination that a witness qualifies as an expert is a matter

of discretion that will not be disturbed absent a showing of manifest abuse. (*People v. Brown* (2014) 59 Cal.4th 86, 100, quoting *People v. Jones* (2012) 54 Cal.4th 1, 57.)

10. The trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke Davis & Co.* (1973) 9 Cal.3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected material." (*Id.* at pp. 67-68, quoting from *Neverov v. Caldwell* (1958) 161 Cal.App.2d 762, 767.) Further, the fact finder may reject the testimony of a witness, even an expert, although not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.)

11. All three experts were well-qualified to provide testimony in this matter, however, Dr. Robinson and Dr. Miller-Sabouhi's opinions that claimant does not qualify for regional center services were given more weight over those of Dr. Leark, for the reasons discussed more fully below.

CLAIMANT DOES NOT QUALIFY FOR REGIONAL CENTER SERVICES BASED ON A SUBSTANTIAL DISABILITY ATTRIBUTABLE TO AUTISM

12. Claimant has a long history of mental illness and other disorders, including, but not limited to, mood disorder, RAD, ADHD, OCD, disruptive behavior disorder, and Tourette's syndrome. While claimant may have had behaviors or "symptoms" over the years that can be found in an autistic person, they can also be found in a person who has any one of the many mental disorders experienced by claimant. Thus, it cannot be said that simply because claimant has some "behaviors"

that a diagnosis of autism is warranted. Indeed, the wealth of the evidence indicates quite to the contrary.

13. In all of claimant's developmental years, he was never served in special education under the category of autism (or, at least there is no documentation indicating as much). Rather, the evidence showed he was served under emotional disturbance according to Ms. Fortman's report, and his mother reported he received special education services due to ADHD. It would be unusual for a child with autism to have every teacher, every counselor, every school psychologist, and every person connected with his educational years in any way to have missed or overlooked autism throughout claimant's entire developmental history. One would expect somewhere in claimant's educational life that, if autism had been suspected, it would have been either assessed, or at least mentioned, in an educational report. But the record is completely devoid of any educational records showing concerns of autism.

14. The only record from an educational institution was the November 29, 2004, psychological report completed by Ms. Fortman. During the assessment, claimant exhibited anxiety, rarely made eye contact, repeatedly asked who signed him up for the assessment, showed signs of anxiety and sadness, and the BASC indicated problems with aggression, depression, conduct, depression, hyperactivity, and attention problems. Notably, on many of the other scales such as social skills, study skills, adaptability, and learning, claimant was not above the score of 70, showing there were no significant concerns in those areas. Ms. Fortman recommended claimant continue to receive special education services under the category of "emotionally disturbed" and did not mention any concerns regarding autism. This is but one example where a person could have behaviors that might be found in a person with autism, but which are attributable to other psychiatric conditions.

15. Similarly, the unsupported diagnoses over the years concerning PDD-NOS and Asperger's syndrome (neither of which were ever qualifying conditions for regional center services under the DSM-IV and which have been eliminated in the DSM-5), were inconsistent and lacked foundation. No record submitted ever showed a comprehensive psychological evaluation which contained a formal assessment or battery of psychological testing for PDD-NOS or Asperger's syndrome. Rather, these diagnoses are mentioned in reports over time after review of other reports, which contained anecdotal information of those alleged diagnoses from claimant and claimant's mother. Subsequent evaluators merely carried over the diagnoses "by history," or listed them as rule-out diagnoses. The only report to list PDD-NOS as a "provisional" diagnosis was the December 12, 2008, psychological intake assessment completed when claimant was 15 years of age and committed to the Texas Youth Commission for engaging in arson. That "assessment," however, was not completed by a licensed psychologist. Further, Mr. Baack's s report showed no concerns regarding Asperger's syndrome, or any other condition that would qualify claimant for regional center services. The provisional diagnosis of PDD-NOS was simply not supported by the minimal evaluation that was completed, nor any subsequent evaluation of claimant.

16. The records are similarly scant with any evidence of autism. There were no concerns in the Cook Children's Medical Record regarding autism or any other developmental disorder that would qualify a person for regional center services. There were no psychological assessments or formal diagnoses of any qualifying condition. The Cook Children's Medical Record also does not show any of the paramount features of autism such as persistent deficits in social communication or social interaction or restricted or repetitive interests or patterns of behavior. Although on admission it was reported claimant was interested in pornography, it was not reported

that was his only interest to the detriment of all others. It is also not unusual for a young child to have a focused interest on a particular thing. What differentiates a normal functional child from one who has a developmental disorder is one who has consistent restricted or repetitive interests during the developmental years, not just on certain occasions. The admitting physician did not have a concern of autism, and the discharge diagnoses reflected as much. On discharge, claimant did not exhibit any features of autism. In sum, the Cook Children's Medical Record is not supportive of a diagnosis of autism.

17. The July 12, 2008, psychological assessment administered by Tammy Terrell, LPC, was also unpersuasive. Other than noting that claimant had a slow mental processing speed when he took the MMPI, which Ms. Terrell said could indicate a major psychological disturbance, severe depression, functional psychosis, or below-average IQ, there was nothing in this report that indicated any concern of autism, PDD-NOS, Asperger's syndrome, or any other developmental disorder that would qualify a person for regional center services. Claimant also has never been shown to have a below-average IQ. The individual who administered this "assessment" was not a licensed psychologist and although the document was termed an assessment, no autism-specific tests or adaptive skills tests were performed. In that respect, it was a very cursory evaluation regarding claimant's functioning, based solely on the MMPI. There is no mention in the report regarding persistent deficits in social communication and social interaction across multiple contexts; restricted repetitive and stereotyped patterns of behavior, interests, or activities; or symptoms that cause clinically significant impairment in social, occupational, or other important areas of function. Ultimately, the interviewer attributed claimant's aggression and need for attention, as well as his authority problems, to the abuse claimant received at home and his inability to bond with his mother at an early age, which sounds very characteristic of RAD, a

diagnosis that followed claimant throughout his developmental years. In sum, the July 12, 2008, assessment by Ms. Terrell is not supportive of a diagnosis of autism.

18. In Dr. Ladd's July 23, 2008, assessment, though some isolated behaviors that a person with autism might have were noted, it is compelling that claimant tested in the non-autistic range on three separate measures (the ASAS, CYBOCS, and CARS). Also, with respect to some common features of autism, such as avoiding social interaction with peers, not being interested in competitive sports, taking a literal interpretation to comments, and a fascination with certain topics (fixated interests), claimant was reported not to have any issues in those areas. Notably, some of the behaviors claimant's mother attributed to "autistic-like" behavior, such as chewing objects or being obsessed with certain portions of television shows, are also characteristic of disorders such as OCD or ADHD. The only reason claimant was given a rule-out diagnosis of PDD-NOS, which is not an actual diagnosis, was because of the historical reports of a diagnosis of Asperger's syndrome, but no records were ever provided to support that diagnosis.

19. The October 10, 2008, Hickory Trail Assessment was completed when claimant was 14 years old and admitted to a hospital after being arrested for arson. Claimant was noted to be anxious, depressed, monotone, and having flat affect. His speech was listed as "retarded" and he was noted to have poor judgement but average intelligence. Claimant was also noted to be obsessed with fire setting and stealing. Nothing in this report indicated an assessment for autism was completed or that any mental health or medical profession had a concern regarding autism. It is unknown if this report was completed by any type of licensed psychologist, doctor, or other individual. Portions of the report appeared to have different signatures. Again, as with many of the other reports, the behaviors noted in this report are more consistent with

OCD, ADHD, or anxiety disorders. Claimant appeared during a 30-day period to have a fixation with setting fires; however, that fixation, according to claimant, came from the thoughts in his head telling him he needed to set fires. That is not typical of the restricted/repetitive interests common in autism. In sum, this report was unremarkable and unpersuasive.

20. The December 12, 2008, Psychological Intake Assessment was completed by Mr. Baack, who is not a licensed psychologist. That assessment concluded claimant did not meet any criteria for Asperger's syndrome, but gave a provisional diagnosis of PDD-NOS anyway. This report was not given weight because there is insufficient information in the report to support that provisional diagnosis, which appeared to be based more on reading the historical reports regarding claimant having been diagnosed with Asperger's syndrome. No objective measures were used to assess claimant and no autism specific measures were administered. No adaptive tests were conducted. Thus, the ultimate provisional diagnosis of PDD-NOS was not supported by the record.

21. The notes taken at the Cook Children's Medical Center from September 4, 2010, when claimant was approximately 16 years old, did not contain any psychological assessments or other pertinent information concerning whether claimant would qualify for regional center services. As with the previous reports, there is a list of previous diagnoses (mood disorder, OCD, Tourette's syndrome, and ADHD) but no records to show why or how those diagnoses were reached. There were no concerns regarding autism and no psychological assessments were completed. These records/notes did not support a finding of eligibility for regional center services.

22. Similarly, the notes of Dr. Janke from June 23, 2011, when claimant was approximately 17 years old, were similarly unremarkable regarding autism. The notes

recall prior diagnoses of mood disorder, OCD, Tourette's syndrome, and ADHD. They note claimant stopped taking his medication but noticed when he started retaking his medication he felt more calm. There were no concerns regarding autism and no psychological assessments were completed. These records/notes did not support a finding of eligibility for regional center services.

23. There are also no records regarding claimant that were provided between the years of 2011 and 2021. If claimant had autism, it would be expected that some record would exist during this lengthy time period, medical or otherwise, that would support such qualifying diagnoses. Even though these years were not during claimant's developmental period, a person who is substantially disabled due to a developmental disability would typically have records throughout their lifetime of that developmental disability. This gap raises significant questions regarding what was happening with claimant during this time.

24. The next records provided were three trial competency evaluations completed by Dr. Berg, Dr. Suiter, and Dr. Cheng that similarly do not suggest or support a diagnosis of autism. Dr. Berg's June 3, 2021, evaluation concluded claimant was competent to stand trial and Dr. Berg did not observe any typical autistic-like behaviors. Claimant had clear and average speech, was alert and oriented, had a logical and coherent thinking pattern, and was organized. Although Dr. Berg concluded claimant should receive services for a "neurodevelopmental disorder characterized by significant difficulties with social interaction, non-verbal communication, along with ritualistic and repetitive patterns of behavior and interests," which is language taken directly from the DSM-5 diagnostic criteria for autism, no autism testing was completed and Dr. Berg's report did not contain any

observations to support that recommendation. Thus, that recommendation cannot be given any weight.

25. The same goes for the report of Dr. Suiter, who also found claimant to be competent to stand trial. Dr. Suiter's report did not indicate any autistic-like behaviors. Dr. Suiter's report found claimant to have no issues with expressive and receptive communication, no problems with interaction, no problems with eye contact, no problems keeping his thoughts organized, and no problems articulating the nature of the proceedings against him or his responsibilities in assisting counsel. It was only after talking to claimant about his historical diagnoses of Asperger's syndrome and claimant's attorney, and reviewing the brief report completed by Dr. Leark (which contained no autism-specific assessments), that Dr. Suiter decided "reasonable consideration" should be given to autism. Dr. Suiter's report did not contain any data to support that conclusion, and thus, the recommendation was not reliable.

26. Dr. Cheng's trial competency report was of no assistance because she did not complete the assessment. Given that the other two competency examinations, and many other reports throughout claimant's history show claimant can communicate and undergo testing, Dr. Cheng's inability to engage claimant and conduct an assessment is an unusual anomaly, and suggestive of claimant possibly being off medications or experiencing some other problems. It is noted that Dr. Berg's and Dr. Cheng's evaluations were completed only a little over a month and a half apart but showed a markedly different person from the one Dr. Cheng encountered. Autism is not a fleeting condition; the deficits and problems are consistent throughout the developmental period and beyond. Thus, there must be some reason other than autism as to why claimant presented to Dr. Cheng in the manner that he did. Consequently, none of the trial competency evaluations were suggestive of autism.

27. Dr. Leark's "brief" evaluation of claimant was similarly not persuasive and not supported by formal testing designed to flesh out autism as opposed to other mental illnesses. Dr. Leark completed only one adaptive assessment, the ABAS-3, which is not a standardized or objective test, and was only completed by claimant regarding how claimant felt he functioned in specific areas. While certainly an important tool, the ABAS-3 is simply not sufficient, in and of itself, to support a diagnosis of autism. Dr. Leark mentioned a variety of behaviors from claimant's history, such as deficits in attention, focus, and inability to inhibit behaviors, poor sleep patterns, and deficits in social communication/interaction with others, and concluded that "all these point to a diagnosis of autism spectrum disorder." He also concluded that the world is "overwhelming" to claimant and he needs "safety and security" assistance. However, missing from Dr. Leark's conclusions are the fact that many, if not all, of the conditions claimant has been diagnosed with over the years share the same type of behaviors reported in autism, and there was no effort to differentiate why Dr. Leark felt claimant might have autism as opposed to any of the other conditions he has been diagnosed with during his lifetime. Dr. Leark's statement that over the years other mental health professionals appeared to treat claimant's symptoms rather than make diagnoses, was not supported by the evidence, as virtually every record provided contained formal diagnoses. Moreover, it is noted that in his report, Dr. Leark did not indicate, at the time of his evaluation, that he reviewed the multitude of records from claimant's past that were submitted in this case which did not show claimant has autism. Although it was clear that prior to the hearing Dr. Leark reviewed some of the records, because he provided testimony about them, those records did not change his conclusion. He continued to believe claimant had "severe" autism and a "profound disability" and needed "long term care." However, most of his testimony focused only on behaviors and he did not account for the fact that claimant has never been shown

to meet the diagnostic criteria for autism. Except, of course, in Dr. Robinson's evaluation. However, that evaluation contained an ADOS score that placed claimant barely within the autistic range – certainly not the "profound" disability that Dr. Leark opined claimant had. Dr. Leark also did not account for the inconsistency that existed regarding the fact that over the years, claimant was found in several evaluations not to be within the autistic range or not to have Asperger's or PDD-NOS. In sum, though certainly a qualified expert with impressive credentials, Dr. Leark's report and testimony was not persuasive because his conclusion that claimant likely has autism was not supported by the overwhelming evidence introduced in this hearing that showed claimant did not have autism and which indicated claimant's challenges are attributable to other conditions.

28. Dr. Singleton's evaluation was more comprehensive than that or Dr. Leark. She conducted her testing in person and reviewed many records contained in claimant's history concerning his developmental years, in addition to conducting both an adaptive assessment (the ILS) and an intelligence test (the WISC-4). Although there was no autism specific testing completed, as Dr. Singleton explained in her report, claimant's intelligence was in the low average range and claimant did not show any deficit in his adaptive or functional skills. Nothing during her interview or testing of claimant indicated that autism was present. In fact, claimant was pretty clear about communicating his needs, thoughts and desires regarding drug use. The manner in which claimant communicated how he goes about using drugs is very telling about his adaptive abilities: he knows what drugs he likes, how to get money to obtain drugs, knows how much the drugs cost, and uses different drugs to stay up or go to sleep. While certainly bad choices, they are choices that show a reasoned process.

29. Moreover, Dr. Singleton pointed out that although claimant was insistent that he had been diagnosed with Asperger's syndrome, she correctly noted that there were no records to support that assertion. Although Dr. Leark felt that the ILS test was not appropriate to test adaptive skills, Dr. Singleton explained in her report that the ILS has been found to be useful in the evaluation of adults with psychiatric diagnoses, a profile claimant certainly meets. Dr. Singleton's conclusion that claimant was not eligible for regional center services, and thus by corollary did not meet the criteria for autism, intellectual disability or the fifth category, was supported by the evidence and given great weight.

30. Dr. Robinson's assessment was also much more comprehensive and persuasive than that of Dr. Leark. Dr. Robinson is a qualified expert with impressive credentials and both her testimony and report were credible.[11] Unlike Dr. Leark, she conducted a face-to-face assessment and administered the ADOS, the CARS-HF, and Vineland-3. Although claimant scored in the autism spectrum range on the CARS-HF and ADOS, Dr. Robinson noted it was very mild and a diagnosis of autism would not be supported by just those tests. The only reason she gave a diagnosis of autism, even in light of the scores barely in the autism spectrum range, was because of the historical reports of Asperger's syndrome. During her assessment, claimant did not display any typical features of autism. Claimant did not demonstrate any restricted or

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[11] Claimant went to great length to point out inconsistencies between Dr. Robinson's report and the voluminous amount of records submitted in this case. The few points of inconsistency, however, were on collateral matters unrelated to the issues in this case and did not render the pertinent parts of Dr. Robinson's psychological assessment unreliable.

repetitive behaviors. His fine and gross motor skills were intact. Claimant did not engage in any abnormal body movements consistent with autism. Claimant did not evidence any abnormal visual response such as prolonged gazing or seeking out of specific objects. Claimant showed adequate visual and normal verbal communication. Claimant did not perseverate on any specific topics. Claimant described in great detail the difficulty he encountered trying to replace his documents due to being born outside of the United States and how this inability to secure documents led to his homelessness. Dr. Robinson observed that claimant proactively took a course of action to fix his situation even though his actions led to poor outcomes. Claimant showed no difficulties in identifying examples of situations that corresponded to certain emotions, and indicated a desire for friendships, relationships, and personal closeness. Claimant was able to identify the potential difficulties of becoming self-sufficient, such as identifying living situations, obtaining employment, securing transportation, and paying bills. None of these behaviors or thought processes are consistent with autism.

31. Most important, Dr. Robinson's interview with claimant showed claimant knows how to communicate, knows how to live independently and manage money, but chooses to engage in theft or other ways because, despite trying, he has not been able to obtain a job. Claimant expressed remorse over his poor judgement. Put another way, there is a difference between being substantially disabled due to a developmental disability and being unable to be successful in life because of poor choices. In claimant's case, Dr. Robinson concluded claimant showed insight and knows what to do to live independently and shows a thought process – but makes the wrong decisions. In sum, Dr. Robinson's report is credited with respect to her diagnosis of autism, but, the records as a whole do not support that diagnosis. Dr. Robinson gave claimant the benefit of the doubt as she explained, because of the historical mentions of Asperger's syndrome. Even with a diagnosis of autism, however, Dr.

Robinson explained that she was "hard-pressed" to give that diagnosis because the data simply did not support it.

32. Dr. Miller-Sabouhi's testimony largely echoed that of Dr. Robinson and concurred with Dr. Robinson that claimant does not qualify for regional center services. Dr. Miller-Sabouhi did not conduct her own evaluation, but her job on a daily basis is conducting assessments or reviewing records to determine whether someone is eligible for regional center services. In that respect, she is the most qualified expert who rendered an opinion in this case because her experiences relates directly to the issue at hand.

Dr. Miller-Sabouhi explained that, for purposes of regional center services under the fifth category, there is a distinction between treatment and services. Services might be helpful and benefit someone, but the fact they would benefit a person is not the standard. Similarly, individuals can have substantially disabling conditions but not be eligible; any number of things can cause substantial disability in an individual but regional center services are restricted to specific conditions. The records did not determine claimant has received the type of treatment that would normally be given to a person with autism. Rather, the conditions or symptoms claimant has been treated for over the years (i.e. ADHD, RAD, and conduct disorder) better explain claimant's challenges.

Claimant's behavioral concerns over the years (such as impulsivity, setting fires, enjoying pornography, and worsening aggression) were not the type of persistent patterns of behaviors you see in individuals with autism. There has never been a formal diagnosis of Asperger's syndrome or PDD-NOS. Even if there had been, those conditions never qualified a person for regional center services and are mild. There are also instances in the records where it describes claimant as trying to do things to

minimize his behaviors or anxiety or build himself up – which a person who has substantially disabling autism is incapable of doing. Dr. Miller-Sabouhi also pointed out in special education, nobody ever served claimant for autism, suggesting any behaviors observed by his teachers were not attributed to autism.

Additionally, Dr. Miller-Sabouhi was unimpressed with many of the assessments conducted by non-licensed individuals. For example, the psychological assessment by Ms. Terrell recommended treatments after a brief evaluation (anger management, consulting with a licensed psychologist, family therapy, and evaluation for mood stabilizing drugs to manage anxiety) that are indicative of a mental health problems and not autism. Similarly, as with Dr. Ladd's evaluation, Dr. Miller-Sabouhi pointed out that claimant completed and participated in the lengthy testing, which is not normally possible for someone with an intellectual disability. Though Dr. Ladd mentioned a PDD-NOS "rule-out" diagnosis, a "rule-out" diagnosis is not an actual diagnosis based on data and it was likely given because of the mention of PDD-NOS in the prior records.

Regarding the psychological intake assessment of Mr. Baack when claimant entered the Texas Youth Commission, Dr. Miller-Sabouhi pointed out he was not a licensed clinical psychologist, though some states permit persons with graduate degrees to conduct such assessments and render diagnoses. She noted in the report that claimant acknowledged anxiety and depression, some obsessive thoughts and impulsivity, and described obsessive thoughts that made claimant feel compelled to engage in behaviors. These are descriptors of OCD, and there is nothing in this report unique to autism.

Regarding Dr. Singleton's 2021 psychological evaluation, Dr. Miller-Sabouhi noted claimant was able to reliably communicate with Dr. Singleton in great detail and

appeared to be psychiatrically stable. The ILS was a proper adaptive test to give and it showed claimant to have no functional impairments.

Dr. Miller-Sabouhi was highly critical of Dr. Leark's "brief" evaluation of claimant, as he did not administer any test or assessment specifically geared towards autism. He did not review anything other than police reports and attorney work product notes. He did not meet claimant in person. No standardized objective measures were conducted, and a diagnosis of autism cannot be made on the basis of the ABAS-3 alone.

Regarding Dr. Suiter's February 9, 2022, trial competency evaluation, Dr. Miller-Sabouhi was similarly concerned because the only document he reviewed was the report completed by Dr. Leark, which itself was not reliable. During the interview, claimant was able to relay his history, claimant had good hygiene, good eye contact, good rapport, good insight and judgement, and his thought processes were logical and appropriate. Nothing in this report suggested unusual behaviors or anything consistent with autism.

Regarding Dr. Robinson's psychological evaluation, Dr. Miller-Sabouhi described it as a comprehensive assessment and an example of what is considered to be the best practices in psychology. Dr. Robinson administered the CARS-HF, which placed claimant "barely" in the scale for autism, suggesting a possibility that claimant might meet the diagnostic criteria for autism. To diagnose someone with autism, further assessment and direct observation, among other things, are needed. As such, Dr. Robinson completed the ADOS, which showed claimant to barely be at the lowest level to be considered in the autism spectrum range.

No one test can make a diagnosis. It is the evaluator's job to look at the entirety of information collected and review the DMS-5, and make a recommendation. Based on Dr. Miller-Sabouhi's opinion, the entirety of the information collected does not show claimant is substantially disabled as a result of autism. Conditions like ADHD and RAD, among others, can affect autism testing and diagnosis. Similarly, drug use can affect a person's functional abilities. Dr. Miller-Sabouhi believed that ADHD, RAD, and claimant's previously diagnosed conduct disorder was justified and well documented in the records during the developmental period; it also seemed the professionals were treating symptoms common to those disorders that were most impairing at the time and those that were causing claimant the biggest problems. Although there were some concerns throughout claimant's history with social communication and sensory seeking behaviors, those who saw claimant during his developmental period would have been aware these behaviors could suggest autism but were clearly not concerned with autism. None of the reports show claimant had marked deficits in communication requiring substantial support. None of the reports show *persistent* repetitive behavior or *patterns* of restricted or unusual interests (that were consistent over a period of time, which is what would be seen in autism). Though some repetitive movements were noted in his history, claimant had a diagnosis of Tourette's syndrome, and involuntary movements are different than the repetitive movements seen in autism. None of the reports show claimant has significant functional limitations in three or more areas of a major life activity. While claimant may have some level of deficit in certain areas, whatever deficits he may have were attributable to his other diagnoses.

33. Overall, the records as a whole, do not indicate claimant is substantially disabled due to a diagnosis of autism. Though Dr. Robinson found claimant was barely above the cutoff for autism, the weight of every other report in claimant's history indicates to the contrary. Claimant's overall behaviors do not present like someone

with autism. At times, of course, claimant is inattentive or fixated on certain things (like asking questions, setting fires, or chewing on things as a child). But these behaviors do not exist in a vacuum and are easily explained by other diagnoses such as ADHD and OCD. They are also not persistent over time. The weight of the records do not suggest claimant has persistent deficits in social communication and social interaction across multiple contexts, or symptoms that cause clinically significant impairment in social, occupational, or other important areas of function. Looking at just the three trial competency evaluations alone, it is clear claimant's social and communication abilities fluctuate. The jail records indicate claimant has no problem communicating exactly what he wants, needs, and feels. Even in Dr. Singleton's interview, claimant had no problem communicating what he had been told to communicate by his attorney at the time according to claimant – that he had Asperger's syndrome and would automatically be qualified for regional center services. Indeed, other than Dr. Cheng's trial competency evaluation, claimant does not appear to have deficits in communication, despite the fact that he may prefer, according to Dr. Singleton's evaluation, to be by himself.

34. Nor is there significant evidence of restricted repetitive and stereotyped patterns of behavior, interests, or activities. Although one can point to isolated instances throughout the records of claimant being fixated on certain things (like setting fires, chewing on things as a child, or pornography), these restricted interests were not *persistent* throughout his life and the record was relatively devoid of "patterns" of such behavior. These types of behaviors are also consistent with claimant's longstanding other diagnoses such as ADHD and OCD.

35. It is also telling that, over claimant's entire psychiatric history, claimant has been diagnosed with RAD. According to the DSM-5, a RAD diagnosis is not

permitted if a person meets the criteria for autism. Thus, the fact that claimant has consistently had the diagnosis of RAD suggests that the psychological professionals considered, and rejected, that claimant's behaviors or other symptoms were attributable to autism.

36. Finally, even if one were to ignore the weight of the evidence demonstrating claimant does not meet the diagnostic criteria for autism and focus solely on the fact that Dr. Robinson found claimant's score on the ADOS to place claimant in the autism range, it is noted that this score, along with his CARS-HF score, were the only two scores ever to do so, and at that, both scores barely placed claimant within the score required for autism. As such, the scores indicate, even if claimant does have autism, it is extremely mild and did not support a finding that he is substantially disabled as a result of it.. Such low scores would also be more consistent with conditions such as Asperger's syndrome and PDD-NOS, which were eliminated in the DSM-5. And, under the DSM-IV, neither of these conditions rendered a person eligible for regional center services.

37. While it is easy to search through the records and select various behaviors that a person with autism might have, many behaviors are consistent with a multitude of other developmental and mental disorders, none of which qualify an individual for regional center services. In claimant's case, the evidence as a whole, does not suggest claimant ever met the diagnostic criteria for autism during his developmental years, or that he is substantially disabled because of autism.

CLAIMANT DOES NOT HAVE A CONDITION CLOSELY RELATED TO INTELLECTUAL DISABILITY

38. Claimant does not qualify for services under the fifth category because a preponderance of the evidence did not establish that he suffers from a condition closely related to an intellectual disability.

39. In *Mason, supra,* 89 Cal.App.4th 1119, the appellate court held that "the fifth category condition must be very similar to [intellectual disability], with many of the same, or close to the same, factors required in classifying a person as [intellectually disabled]." (*Id.* at p. 1129 [emphasis added].) Further, the presence of adaptive deficits alone, **absent cognitive impairment**, is also not sufficient to establish that a person has a condition closely related to an intellectual disability. (*Samantha C., supra,* 185 Cal.App.4th at p. 1486 [intellectual disability "includes both a cognitive element and an adaptive functioning element"].)

40. Giving claimant the benefit of the doubt regarding adaptive deficits as reported by Dr. Leark or as the results showed on the Vineland-3 administered by Dr. Robinson, it must still be shown that claimant has an accompanying cognitive impairment. However, claimant has not shown a cognitive impairment over the years. Specifically, it was not claimed that claimant is intellectually disabled. He has never been diagnosed as being intellectually disabled. Dr. Ladd's report from July 23, 2008, showed claimant had an IQ of 84 which is in the low average range, but also noted it was likely higher and within the average range based on claimant's overall abilities (in other words, the full-scale IQ was not the best estimate of claimant's true abilities). Dr. Singleton, over a decade later, found a similar full-scale IQ, rating him at 87. Thus, while claimant had many diagnoses over the years that impacted his adaptive functioning, he still nonetheless functions in the low average to average range. Finally,

based on the analysis below regarding substantial disability, it cannot be said that claimant suffers from the level of adaptive impairment that would be needed to meet the first prong of the fifth category given his low average to average intellectual functioning. It is therefore concluded that claimant does not suffer from a condition closely related to intellectual disability.

CLAIMANT DOES NOT HAVE A CONDITION THAT REQUIRES TREATMENT SIMILAR TO A PERSON WITH AN INTELLECTUAL DISABILITY

41. A preponderance of the evidence did not establish that claimant requires treatment similar to a person with an intellectual disability.

42. Determining whether claimant's condition "requires treatment similar to that required" for persons with an intellectual disability is not simply an exercise in reviewing the broad array of services provided by regional centers (*e.g.*, counseling, vocational training, living skills training, supervision) and finding merely that a person would benefit from those services. Indeed, the appellate court has been abundantly clear that "services" and "treatment" are two different things. As one court held:

> That the Legislature intended the term "treatment" to have a different and narrower meaning than "services" is evident in the statutory scheme as a whole. The term "services and supports for persons with developmental disabilities" is broadly defined in subdivision (b) of section 4512 to include those services cited by the court in *Samantha C.*, e.g., cooking, public transportation, money management, and rehabilitative and vocational training, and many others as well. (§ 4512, subd. (b); *Samantha C., supra*, 185 Cal.App.4th

at p. 1493, 112 Cal.Rptr.3d 415.) "Treatment" is listed as one of the services available under section 4512, subdivision (b), indicating that it is narrower in meaning and scope than "services and supports for persons with developmental disabilities."

The term "treatment," as distinct from "services" also appears in section 4502, which accords persons with developmental disabilities "[a] right to treatment and habilitation services and supports in the least restrictive environment. Treatment and habilitation services and supports should foster the developmental potential of the person and be directed toward the achievement of the most independent, productive, and normal lives possible. Such services shall protect the personal liberty of the individual and shall be provided with the least restrictive conditions necessary to achieve the purposes of the treatment, services, or supports." (§ 4502, subd. (b)(1).) The Lanterman Act thus distinguishes between "treatment" and "services" as two different types of benefits available under the statute. (*Ronald F. v. Dept. of Developmental Services* (2017) 8 Cal.App.5th 84, 98-99.)

43. Thus, claimant must show that he requires "treatment" similar to a person with an intellectual disability as opposed to merely benefitting from "services" similar to a person with an intellectual disability. Put another way, a person who is intellectually disabled has difficulties because of his inability to comprehend – his

inability to cognitively process – certain things. The evidence did not show claimant has any condition that *requires* treatment because he has an inability to cognitively process things. Cognitively, claimant functions in the low average to average range. Dr. Leark's testimony established claimant would benefit from "services" regional center might offer – but that is not the standard. Claimant's adaptive functioning on the ILS showed he had no impairment. His functioning on the Vineland-3 and ABAS-3 showed low impairment, however, the Vineland-3 and ABAS-3 are more subject to rater bias than the ILS. Moreover, treatments claimant received over the years have not been directed towards someone who has an intellectual disability; rather, they were drug therapy treatments and inpatient treatments due to behaviors likely attributable to ADHD and OCD. His jail records also show he engages in talk therapy. That is also not a treatment consistent with intellectual disability. Simply put, claimant functions intellectually in the low average to average range and does not have the corresponding adaptive deficits needed to qualify under this prong of the fifth category.

CLAIMANT IS NOT SUBSTANTIALLY DISABLED AS A RESULT OF A QUALIFYING CONDITION

44. Even if one were to argue claimant did have autism or met either prong of the fifth category, a preponderance of the evidence did not show claimant is substantially disabled because of those conditions.

45. The "substantial disability" standard is set forth in California Code of Regulations, title 17, section 54001. Eligibility for regional center services requires not only a qualifying condition but also a substantial disability. In order to meet this standard, it is not enough to show that claimant merely has general adaptive challenges or requires assistance to meet his full potential. California Code of

Regulations, title 17, section 54001, subdivision (a)(1), requires that the qualifying condition result in "major impairment" of cognitive and/or social functioning so as to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential; and the existence of "significant functional limitations" in three or more areas of specified life activities, as appropriate to the person's age. (*Ibid.*) Those areas are: receptive and expressive language, learning, self-care, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

46. Based on the record as a whole, there was no evidence of "major impairment" in these areas. Throughout claimant's history (and as discussed thoroughly above in connection with all the reports and assessments), though there were isolated occasions where an evaluator had difficulty assessing claimant, the wealth of other assessments and all the communications claimant had with the various evaluators and jail officials show claimant can communicate wants and needs, can communicate health and/or medical needs, knows when he needs therapy and requests specific therapists (as evidenced by the jail records), presented with adequate hygiene, and knows how to make his own decisions. Claimant knows what he wants, whether it be a job a girlfriend or his drug of choice – and takes what steps he believes necessary to achieve those desires. His childhood years indicate he had friends. Claimant was close with his aunt. Claimant knows he needs to eat. Claimant knows how to dress himself. Claimant knows he needs to earn money and get a job. Claimant knows he needs to fix his situation with his identification to get a job and tried to take steps to rectify that situation. Because he cannot get a job, claimant instead has chosen to commit crimes. Claimant expresses remorse for these crimes, showing a cognitive thought process and an acknowledgement of the difference between right and wrong. Further, claimant has expressed to two psychologists that he understands

the criminal proceedings against him, understands the criminal justice process, and knows how to go about assisting his attorney.

47. Being unsuccessful or having some challenges in any of the areas of a major life activity because of poor choices is not the same as being unsuccessful in any of these areas because of a major cognitive impairment. Nothing in the records show a *cognitive* impairment that is affecting claimant's adaptive skills. While the Vineland-3 and ABAS-3 showed claimant to have lower adaptive skills, the ILS showed claimant's adaptive skills were not impaired. Dr. Singleton found claimant not to be substantially disabled. Most of the other reports throughout claimant's history do not evidence significant functional limitations.

48. Accordingly, for the reasons discussed above in the analysis of the various reports and assessments, it is concluded claimant did not display significant functional limitations in three or more areas of a major life activity and is not substantially disabled as a result of autism, a condition closely related to an intellectual disability, or a condition that requires treatment similar to a person with an intellectual disability.

Conclusion

49. A preponderance of the evidence did not establish that claimant is eligible for regional center services. The evidence did not demonstrate that claimant has autism or a disabling condition closely related to, or that requires treatment similar to, a person with an intellectual disability. The evidence did not demonstrate that claimant is substantially disabled due to a regional center qualifying diagnosis.

ORDER

1. Claimant's appeal from Inland Regional Center's determination that he is not eligible for services based on being substantially disabled as a result of autism spectrum disorder is denied.

2. Claimant's appeal from Inland Regional Center's determination that he is not substantially disabled from a condition closely related to, or that requires treatment similar to, a person with an intellectual disability (fifth category), is denied.

3. Claimant is not eligible for regional center services.

DATE: July 20, 2022

KIMBERLY J. BELVEDERE
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.