BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of the Eligibility of: CLAIMANT, and SAN DIEGO REGIONAL CENTER, Service Agency.	OAH No. 2017110110

DECISION

Theresa M. Brehl, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter in San Diego, California, on February 20, 2018.

Ronald R. House, Attorney at Law, represented San Diego Regional Center (SDRC).

Claimant's uncle and authorized representative represented claimant, who was not present during the hearing.

The matter was submitted on February 20, 2018.

ISSUE

Is claimant eligible for regional center services under the Lanterman Developmental Disabilities Services Act (Lanterman Act) based on a diagnosis of Autism Spectrum Disorder or a condition closely related to an intellectual disability or that requires treatment similar to that required for individuals with an intellectual disability ("fifth category")?

FACTUAL FINDINGS

JURISDICTIONAL MATTERS

1. On September 19, 2017, SDRC notified claimant that he was not eligible for regional center services.

2. On October 26, 2017, claimant's uncle and authorized representative filed a fair hearing request, appealing SDRC's decision. In the request, claimant's uncle stated the reason for the request was as follows:

> While [claimant] is somewhat functional, he is not capable of living independently. He cannot complete forms or job applications. SDRC refused him before so Cal DOR[1] paid for testing because they believed he would be best served by SDRC because DOR can't help him. He cannot get help through a program to obtain help in getting a job because it's all thru SDRC.

3. The fair hearing request stated that in order to resolve claimant's complaint, "[h]e should be provided with [illegible] SDRC services."

GENERAL BACKGROUND, ASSESSMENT DURING ELEMENTARY SCHOOL, AND ATTEMPTS TO OBTAIN SERVICES FROM THE DEPARTMENT OF REHABILITATION

4. Claimant is a 23-year-old male. He has lived with his uncle since he was three or four years old. There were no problems reported to SDRC regarding his birth, although it has been suspected his mother may have used controlled substances during

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[1] Claimant referred to the California Department of Rehabilitation using the abbreviations "Cal DOR" and "DOR."

her pregnancy. Claimant suffered a stroke within 24 hours after he was born and was then hospitalized for two weeks. When his uncle obtained custody of claimant, there were concerns about neglect due to substance abuse by his biological parents. Beginning in 2005, claimant received accommodations and special education services from the San Diego City School District based on a "Specific Learning Disability." Claimant graduated from high school in 2012. When he was 18 years old, he was diagnosed with Paranoid Schizophrenia.

5. An Assessment Report was prepared on June 16, 2005, by the San Diego City Schools, Special Education Programs Division, when claimant was 11 years old and in the fifth grade. Based on the report, the school district determined claimant had a specific learning disability and recommended claimant receive special education services. The report included the following description of claimant in the classroom and during testing:

> [Claimant] was observed to be on task doing individual work. He would often look around to see what others were doing, but would resume work after a short time. The classroom teacher has reported that [claimant] is fidgety and hyperactive. He has a tendency to disrupt other [sic] by talking.
>
> During testing, [claimant] was talkative and cooperative. He was eager to try his hardest, and often wanted to know what he had scored. On two occasions I had [sic] re-direct [claimant] back to the test because he attending [sic] to students passing by. He had not heard directions due to this.

> Once attention to the test was re-established the directions were repeated.

As part of the 2005 assessment, the Woodcock Johnson-Revised/Academic Achievement (WJ-R III) was administered. Claimant's reading and writing scores were in the low end of the average range, and his math scores were in the above average range. Additionally, his teacher reported that he was then reading at a third-grade level, writing at a fourth-grade level, and his math skills were at the fifth-grade level.

The Woodcock Johnson Psychoeducational Battery-Revised, selected Subtest-Cognitive Battery (WJ-III Cog) was also administered. Claimant's fluid reasoning ability, thinking ability, visual-spatial thinking, working memory, and broad attention were in the average range. His short-term memory was in the low average or average range. His verbal ability, cognitive efficiency, comprehensive-knowledge, auditory processing, and processing speed were in the low average range. Claimant exhibited significant deficits in long term retrieval ability, and very low abilities in cognitive fluency. His phonetic awareness appeared low for his age, and one measure used to assess this area put him at a level commensurate with a second-grade aged student. (At the time he was in fifth grade.)

The portion of the report summarizing the observations and tests performed stated:

> [Claimant] is a boy with a significant social and medical history who exhibits above average cognitive ability. A significant discrepancy is evident between ability and academic achievement in the area of reading. Written language is reported to be impacted as well however current testing does not reflect this. Work samples should be

reviewed. Processing deficits are evident in auditory processing and association (memory). It is recommended to the Individual Education Planning Team that eligibility for special education services based on the handicapping condition of specific learning disability is met per state guidelines.

[Claimant's] personality has and will be one of his greatest assets, as well as one of the sources of frustration for those adults working with him. He tends to see things in "black and white" and be frustrated by ambiguity. Words used to describe him include: tenacious; intense; purposeful; singleminded [sic]; stubborn; hypervigilant; energetic and determined. Each of these terms can be either positive or negative, depending upon who is the observer and recipient of [claimant's] attention and efforts to bring order and understanding to his world. His energy and effort need to be channeled.

6. Claimant recently sought services from the Department of Rehabilitation to help him find employment. The Department of Rehabilitation referred claimant to Career Services, Inc. for a comprehensive vocational evaluation. That evaluation was conducted on August 1, 2, 3, 4, and 8, 2016, and a report was issued dated August 19, 2016. The report concluded, "[claimant's] overall performance indicated that he is not employable at the present time. Inconsistency in overall performance was evident throughout the evaluation due to difficulty with concentration and focus, as well as remembering and following directions, preoccupation with somatic issues, and frequent

and unscheduled restroom breaks will not be acceptable in a work setting." The report also noted, "[claimant] demonstrated strength in the areas of nonverbal reasoning and memory, arithmetic computation, performance of routine hands-on tasks, and the ability to use computer programs that are utilized in many work settings. A sheltered or transitional work environment such as the program at ARC San Diego or Goodwill Industries might be considered to provide him with the support to develop necessary work and social skills while continuing his therapy."

7. The Department of Rehabilitation referred claimant to SDRC. When claimant's uncle completed SDRC's Intake Questionnaire on May 11, 2017, he listed the following behaviors which may apply to claimant: sleep problems, temper tantrums, restlessness, eating problems, aggressiveness, problems getting along with others, and problems conversing. He also listed the following concerns: Eating, "very picky eater"; sensitive to noise and to touch; interactions with family; and solitary. Claimant's uncle wrote the following in response to a question regarding the services claimant requested:

> [Claimant's] primary interest is for help finding employment. He needs help with a group home (or possibly) independent (with help) living. I am meeting his needs now; but health concerns of my own mean that he needs to have a support system in place for doctor visits, Social Security (and other) paperwork. Simply put he cannot function on his own, needing help with employment, socialization, housing, Medical, bill pay and all other concerns.

8. During a face-to-face intake meeting at SDRC on June 19, 2017, claimant and his uncle provided additional information about claimant's background. While he was in high school and 16 years old, claimant worked for about one year at Kentucky

Fried Chicken as a cashier and packing food orders, cleaning, and taking drive-thru orders. He lost that job after he missed work for two weeks without calling in. After he graduated from high school in 2012, claimant took classes at San Diego City College for approximately four semesters. Claimant enjoys riding his bike, playing video games, watching movies, and listening to music. He primarily uses his bike to get around, he has a monthly bus pass, and he is not interested in driving. Claimant is able to communicate, but he has mumbled speech. Claimant reported that although he was interested in having friends, he did not have any at the time of the intake meeting.

PSYCHOLOGICAL ASSESSMENTS, SCREENINGS, AND EVALUATIONS

October 10, 2013, Mental Impairment Residual Functional Capacity Questionnaire

9. On October 10, 2013, Joseph Sheridan, M.D., completed a Mental Impairment Residual Functional Questionnaire regarding claimant. In that document, Dr. Sheridan wrote that claimant's DSM-IV Axis I diagnosis was Schizophrenia, with an onset date of June 2012. Dr. Sheridan also wrote that "due to symptoms of schizophrenia patient is unable to work in any capacity due to delusions, paranoia, suspiciousness, emotional withdrawal, intolerance to stress, cognitive decline, etc." While it was unclear why Dr. Sheridan completed this questionnaire, in the document, Dr. Sheridan noted that events related to claimant's psychiatric condition prompted claimant to stop attending community college.

February 24, 2017, Confidential Psychological Screening by Joseph M. McCullaugh, Ph.D.

10. The Department of Rehabilitation referred claimant to Joseph M. McCullaugh, Ph.D., for a psychological screening. Dr. McCullaugh conducted his evaluation on February 24, 2017, and issued a report dated March 14, 2017. He

interviewed claimant and his uncle, reviewed available records, conducted a mental status examination, and administered the Vineland Adaptive Behavior Scales-Second Edition (Vineland II), Gilliam Autism Rating Scale-Third Edition (GARS-3), and Kaufman Brief Intelligence Test-Second Edition (KBIT-2).

Dr. McCullaugh described his behavioral observations of claimant as follows:

> [Claimant] presented as somewhat younger than his stated age, dressed in a long-sleeve, hooded sweatshirt, long pants, casual shoes, baseball cap, and sunglasses, a small-framed young man who was somewhat apprehensive upon initial contact. . . . As the assessment progressed, rapport with [claimant] was quite formal, yet was established and maintained. He maintained poor eye contact, expressed no range of affective expression, yet maintained a flat, yet calm demeanor throughout. [Claimant] appeared to concentrate and respond adequately to interview questions posed, at times responding in a slow and deliberate manner. Information was difficult to obtain, providing few details spontaneously, and requiring this writer to elicit and ask follow up questions to both [claimant] and [claimant's uncle]. [Claimant's] gait was within normal limits and there were no observable gross body impairments. His speech was quiet and impoverished at times, yet evidenced no difficulties in articulation. In conducting a mental status exam, he was oriented to person, place, time and purpose of the evaluation. He denied suicidal or homicidal ideation and stated that his appetite and sleep patterns were within

> normal limits. [Claimant] appeared able to maintain adequate attention and concentration in a one-on-one setting, providing sufficient effort in completing the interview.

Claimant's uncle completed the Vineland II, and according to Dr. McCullaugh's report, the responses indicated claimant was a "generally impaired young man who exhibited gross deficiencies in the areas of communication, socialization with others, and the employment of maladaptive behaviors to sufficiently respond to environmental cues, each consistent and [*sic*] gross difficulties observed in individuals afflicted with Autism Spectrum Disorders." Dr. McCullaugh noted claimant exhibited strengths in the area of daily living skills and basic skills for interacting with the world at large, and he struggled with "basic, daily expectations and abilities, failing to recognize the need for and appropriate methods to employ adaptive coping behaviors. . . ." Claimant's uncle also completed the GARS-3, and his responses placed claimant in the '"Very Likely' range for the presence of an ASD."[2]

Claimant completed the KBIT-2, which was administered to measure his cognitive functioning. His composite intelligence quotient (IQ) score was 83, in the below average range; his verbal score was 77, in the below average range; and his non-verbal score was 94, in the average range. In his report, Dr. McCullaugh stated the following regarding these scores: "His scores were lower than one would expect for his age, reported academic achievement, and collateral reports documenting his general, cognitive functioning. Nonetheless, the limitations observed are not egregious, such that with minor assistances and resources, he most likely can achieve adequately."

[2] "ASD" is an abbreviation of Autism Spectrum Disorder.

Under the heading, "DSM-IV-TR DIAGNOSTIC CONSIDERATIONS," Dr. McCullaugh listed: "Unspecified Neurodevelopmental Disorder-Autism Spectrum" and "Unspecified Schizophrenia Spectrum Disorder."

August 28, 2017, Evaluation by Uri Kugel, Ph.D.

11. SDRC referred claimant to Uri Kugel, Ph.D., for a psychological evaluation to assess his functioning, diagnosis, and eligibility for regional center services. Dr. Kugel interviewed claimant and his uncle; reviewed records; and administered the Wechsler Adult Intelligence Scale-Fourth Edition (WAIS-IV); Vineland Adaptive Behavior Scales, Third Edition; Childhood Autism Rating Scale, Second Edition, Standardized Edition (CARS2-HF); and Gilliam Autism Rating Scale-Second Edition (GARS-3).

Dr. Kugel's report noted that the following information was provided by claimant's uncle:

> [Claimant's uncle] shared that until 6th grade, [claimant] seemed to be doing okay. However, around that time, he began having problems with resenting authority and his living situation became inconsistent as [claimant's uncle] lost his residence. In high school, [claimant] was bullied and was frequently disobedient. He began socializing with a group of peers that took advantage of him and also began smoking marijuana and drinking alcohol on a regular basis. By age 17 years old, [claimant] became even more withdrawn, aggressive, and isolated. His behavior turned more erratic and agitated and he had no friends. At 18 years old, [claimant] began exhibiting auditory and visual hallucinations and delusions of paranoia. [Claimant's uncle] shared that

> "[claimant] lost his personality." [Claimant] was treated at a psychiatric hospital, Sharp Mesa Vista several times and was eventually diagnosed with Schizophrenia. . . .

Based on information from claimant's uncle, Dr. Kugel noted that when claimant was between three and four years of age, he exhibited healthy imagination and did not display significant social problems, was able to engage in reciprocal communications with others, his social skills appeared to be intact, and his sense of humor and laughter were within normal limits. Also relying on reports from claimant's uncle, Dr. Kugel noted that beginning after he was five years old and progressing through puberty, claimant became more withdrawn and isolated; his reciprocal communication and conversational skills became more impaired; while in fifth grade, he became defiant, disobedient, and uncaring; and after the onset of his schizophrenia, his facial expressions and tone of voice became flat, he did not show any humor or attempt to make jokes, and he had a hard time understanding sarcasm.

> Dr. Kugel described his observations of claimant as follows:
>
> He met with me in the waiting room and was casually dressed with good hygiene. He greeted me in return, smiled, was wearing sunglasses which he did not remove, and reluctantly shook my hand.
>
> [Claimant] kept his sunglasses on throughout the rest of the appointment and reported feeling uncomfortable without them. He expressed feeling "okay" but his affect was flat and inexpressive. His affect remained flat throughout the rest of the appointment. [Claimant] did not initiate any conversation with me. His speech production was minimal and he often

answered with "yes" no [sic] "no" responses or sentences consisting out [sic] of 2-3 words. When speaking, [claimant's] speech volume and tone were flat and in low volume. I had a hard time hearing him and requested him to repeat himself several times. He did not demonstrate scripted speech, echolalia or any other speech problems.

[Claimant] did not display any visible stereotypical behaviors or audible vocalizations. His overall demeanor was reserved and distant.

[Claimant] was cooperative and respectful throughout the testing. His response time was slow. He would let me know when he did not know the answer to a given question. He showed motivation to perform well but appeared anxious. He was able to follow one, two, and three-step instructions. [Claimant's] memory appeared to be below normal limits. He demonstrated significant difficulty with retaining auditory information . . . and at times answered questions with out of context answers. . . . However, he did employ a memory strategy by counting with his hands. His thought content and process appeared to be within normal limits. He admitted having a diagnosis of schizophrenia but reported being under medications and having no current hallucinations or delusions.

During the interview, I attempted to invite [claimant] to demonstrate social reciprocity. On all occasions, he ignored

> me and was unable to sustain a back and forth conversation. When asked about his social life, [claimant] shared that he has no friends and no interest in making friends due to past negative experiences. . . .

Dr. Kugel reported that claimant's overall score on the WAIS-IV, which measures cognitive functioning in adults, was 78, in the very low range. He performed in the very low range on the Verbal Comprehension Index and Processing Speed Index and within the low average range on the Working Memory Index. His overall Vineland Adaptive Behavior Scale scores were in the low range and reflected adaptive functioning in the low range in the communications skills domain. Based on Dr. Kugel's CARS2-HF observations, claimant's scores reflected mild to moderate symptoms of Autism Spectrum Disorder, and his GARS-3 scores indicated "a Very Likely range of Autism Spectrum diagnosis. More specifically, he experiences significant difficulties [*sic*] the areas of social interaction, social communications, emotional response, and maladaptive speech. His difficulties are relatively less significant in the areas of restricted behavior and cognitive style."

Dr. Kugel concluded that claimant did not meet the diagnostic criteria for an Intellectual Disability or Autism Spectrum Disorder. Dr. Kugel summarized his opinions as follows (italic and boldened emphasis in original):

> [Claimant's] performance on the psychological evaluation reflects overall cognitive skills in the Very Low range with some abilities in the Average range. Scores of [claimant's] adaptive functioning fell in the Low range. Current testing report, previous cognitive testing, and interview with

[claimant] and [claimant's uncle], indicate that [claimant] does not meet criteria for Intellectual Disability.

Although [claimant] shows some history of difficulty with social communication and interaction, his symptoms are not consistent with the diagnosis of Autism Spectrum Disorder. He does not show a significant history of repetitive/stereotypical behavior or sensory problem [sic] which eliminate Autism as possible diagnosis. [Claimant's] impairment in social interactions and communication are better explained by emotional problems stemming from his volatile early childhood, neglect, and onset of schizophrenia which is often preceded by other mental health and cognitive symptoms. In summary, based on current data, [claimant] does not meet criteria for Autism Spectrum Disorder.

Note: The current evaluation is limited to assessment for intellectual disability and autism, but it is not sufficient to assess for other possible DSM 5 disorders.

January 19, 2018, Psychological Evaluation By Beatriz E. C. Netter, Ph.D.

12. SDRC referred claimant for another psychological evaluation with Beatriz E.C. Netter, Ph.D., which she conducted on January 19, 2018. Dr. Netter interviewed claimant and his uncle, reviewed records, and administered the Autism Diagnostic Observations Schedule-2 (ADOS2) and Social Responsiveness Scale-2nd edition (SRS-2). Because claimant's cognitive abilities had recently been evaluated with standardized measures, Dr. Netter determined that re-evaluation was not necessary. She also

determined that there was sufficient recent information in the records regarding his adaptive functioning, so she did not administer additional tests to re-assess his adaptive functioning.

Dr. Netter described her behavioral observations of claimant as follows (italics in original):

> [Claimant] was wearing a hooded sweatshirt and he kept his hood on until well into the evaluation. He responded to the examiner's greeting, establishing eye contact, but was socially awkward and withdrawn. He maintained eye contact throughout the evaluation.
>
> [Claimant] attempted to answer all questions asked of him, but he often struggled to know what to say, particularly when asked open-ended questions about emotions and relationships. He had overly long reaction times and after a minute or two he would often ask: "wait, what was the question?" He did that multiple times and appeared to genuinely not remember the question that had just been asked. He often appeared confused and slightly incoherent and tended to perseverate and return to certain topics in a manner that was not applicable to the context and rather repetitive and appeared to reflect excessive preoccupations such as with his physical health. There also appeared to be impoverished speech and/or an overall absence of thought. He clearly struggled when attempting to express himself verbally. For example, when asked to name something that

> makes him feel scared or anxious: "I'm not sure . . . I don't know . . . (long pause) when I'm home I just need to smoke a cigarette . . . what did you ask me? . . . ."
>
> In general, [claimant] was not able to engage in a back-and-forth conversational exchange. He appeared to have significant difficulty processing language and knowing how to respond. When asked to tell a story based on pictures he was overly concrete in describing the pictures and missed the central coherence of the story. . . .
>
> During this evaluation, [claimant] did not engage in any repetitive or stereotyped behaviors.

Dr. Netter described claimant's ADOS2 scores as "meets the classification for autism." However, Dr. Netter cautioned that the ADOS2 scores were not enough for a diagnosis of autism and "must be taken within the context of all other observations and historical information." She also noted the following regarding her administration of the ADOS2 to claimant:

> Although not overtly odd, [claimant] tended to be somewhat repetitive in his phrases and statements, often in a way that was not well integrated into the conversation or the context. He answered questions, but did not engage in reciprocal conversation. . . . He did establish eye contact but showed a limited range of gestures and of facial expressions to communicate affect. The quality of his social overtures and social responses were slightly unusual to the context. In

> addition, [claimant] showed very limited insight into typical social relationships and emotions.

When claimant's uncle completed the SRS-2, the score obtained was in the "severe" range. According to Dr. Netter, "[a] score at this level is described as being: 'strongly associated with a clinical diagnosis of autism spectrum disorder' although studies have shown that elevations may also occur due to factors other than autism."

Dr. Netter concluded that although claimant exhibited some symptoms characteristic of a developmental disability and severe deficits in adaptive functioning, he "does not meet full criteria for the diagnosis of Autism Spectrum Disorder." (Dr. Netter's report did not discuss the fifth category.) She explained that the nature of claimant's condition complicated her diagnostic analysis as follows:

> Although it is evident that [claimant] is significantly debilitated, he presents with a complex clinical picture, making it difficult to place him into one clearly delineated diagnostic category. The main question being presented for this evaluation is whether he does meet criteria for Autism Spectrum Disorder, or whether his significant deficits in adaptive functioning are better explained by other diagnoses, namely schizophrenia. There is a significant amount of overlap in the deficits associated with autism (particularly high functioning autism) and those associated with schizophrenia, most notably social and communication deficits, and when evaluating an adult, it is often difficult to distinguish the two based on test results such as ADOS as both disorders are likely to produce elevated scores on the

> test. It is thus important to attempt to integrate as much as possible information regarding developmental history. Adding to the complexity in this case, is [claimant's] early history of parental neglect leading to complete removal from parents; early disruptions in attachment can lead to future difficulties in the establishment of social relationships. This however is not enough to explain the extent of his difficulties.

Dr. Netter stressed that it was extremely important that claimant continue his psychiatric care, with careful assessment of his medications.[3]

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DR. GYURJYAN'S EXPERT OPINION TESTIMONY

13. Gohar Gyurjyan, Ph.D., is a psychologist licensed by the State of California. She obtained her Bachelor of Science Degree in Psychology from the University of California San Diego in 1999 and her Doctorate in Clinical Psychology from Pacific Graduate School of Psychology (now known as Palo Alto University) in 2004. Dr. Gyurjyan is the Coordinator of Psychology Services for SDRC, which position she has held since November 2017. Before taking on that position, Dr. Gyurjyan served as a

[3] Dr. Netter also noted that recently claimant had experienced two grand mal seizures, which she had been told resulted in a diagnosis of epilepsy or could have been a side effect of claimant's anti-psychotic medication. Claimant's recent request for regional center services was not based on a diagnosis of epilepsy, SDRC has not evaluated whether claimant may be eligible based on a diagnosis of epilepsy, and no evidence was presented confirming whether claimant suffers from epilepsy.

consulting psychologist for SDRC and other regional centers for approximately 10 years. In that role, she conducted psychological assessments to aid in determining eligibility for regional center services.

Dr. Gyurjyan noted that Autism Spectrum Disorder diagnoses are made by psychologists using the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-5*). As Dr. Gyurjyan explained, the criteria necessary to support a diagnosis of Autism Spectrum Disorder include: Deficits in social communication, including non-verbal communication, social emotional reciprocity, and interaction with peers; and restricted, repetitive patterns of behavior, such as verbal repetition, motor mannerisms, and pre-occupation with certain topics. The symptoms are usually present during early childhood.

Dr. Gyurjyan reviewed all the records SDRC received regarding claimant, including his school records, the psychological screening and career assessment considered by the Department of Rehabilitation, and the evaluations by psychologists to whom SDRC referred claimant. She also spoke to claimant's uncle about claimant's history. Based on her review of all the records, including the standard scores and scales measured by the diagnostic tools used, and the information claimant's uncle provided, Dr. Gyurjyan opined that claimant is not eligible for regional center services because he does not meet the diagnostic criteria for Autism Spectrum Disorder and he does not suffer from a condition similar to Intellectual Disability, or that requires treatment similar to Intellectual Disability (the "fifth category"). In Dr. Gyurjyan's opinion, claimant has suffered a decline in his cognitive skills and adaptive functioning due his schizophrenia.

While Dr. Gyurjyan acknowledged that claimant suffers from deficits in his adaptive functioning, she opined that his deficits may be explained by his schizophrenia as opposed to a developmental disability. She emphasized that because symptoms of schizophrenia and autism may overlap, it was critical to look at claimant's

developmental history. She pointed to his school records, which indicated that when he was 11 years old he suffered from a specific learning disability and did not indicate any concern that he had characteristics of autism or that he had cognitive deficits similar to an intellectual disability.

Dr. Gyurjyan also explained that to be eligible for regional center services, the disability would need to have originated before age 18 and claimant's condition appeared to have originated after that age. Autism is usually present in childhood and usually does not present with a decline in functioning. According to Dr. Gyurjyan, claimant's decline in functioning, including his current difficulties with conversations and social withdrawal, would more likely be accounted for by his schizophrenia.

For a fifth category diagnosis, Dr. Gyurjyan would expect to see scores measuring his cognitive abilities in the low borderline range. Claimant's overall IQ scores were in the average and low average range. Based on claimant's cognitive scores, Dr. Gyurjyan did not see the type of cognitive deficits that would place him in the fifth category. The fact that his math skills were substantially higher than his reading and writing skills was also not consistent with inclusion in the fifth category. Instead, that variation between scores was better explained by his learning disability.

In Dr. Gyurjyan's opinion, claimant may benefit most from treatment for his psychiatric condition in the form of medication and psychotherapy, which are not the type of services provided by SDRC. Although Dr. Gyurjyan acknowledged during cross-examination that there has been some research regarding possible genetic links between schizophrenia and autism, she noted that the issues involved with such research were very complicated, and the fact such studies may exist did not change her opinions.

CLAIMANT'S UNCLE'S TESTIMONY

14. Claimant's uncle, who has cared for claimant since he was three or four-years-old, is very concerned about how claimant will care for himself going forward, and he wants his nephew to receive all the services available because he is afraid that, without appropriate services, claimant may end up on the street. Claimant's uncle has seen articles regarding genetic links between schizophrenia and autism, and he believes such links should be considered when determining regional center eligibility. Claimant's uncle also has experience working for an SDRC vendor, during which he interacted with some regional center consumers who were able to do things claimant cannot do. The Department of Rehabilitation could not help clamant, and someone from the Department of Rehabilitation told claimant's uncle that claimant might qualify for regional center services under the fifth category.

Claimant's uncle described claimant as "always alone." He never had close friends, except for a while in fifth grade, and he did not get along well with his peers. In school, he always needed help in all areas except math. He now needs help dealing with doctor's appointments, following up with things, and making sure he eats. Claimant can brush his teeth, make a sandwich, and put on his shoes, but he cannot advocate for himself. When claimant was in the hospital, he could not adequately advocate for himself or understand his situation. He needs some type of supervision or he will quickly deteriorate. He cannot function on his own. His uncle believes claimant should receive regional center services because "all the things have been in claimant's body since birth."

Claimant's uncle also mentioned that claimant recently suffered seizures, and his uncle believed claimant may suffer from epilepsy.[4]

[4] SDRC has not assessed whether claimant may be eligible for services based on a diagnosis of epilepsy. This decision does not preclude claimant from submitting

LEGAL CONCLUSIONS

BURDEN OF PROOF

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

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

STATUTORY AUTHORITY

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

4. Welfare and Institutions Code section 4501 states:

> The State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge. Affecting hundreds of thousands of children and adults directly, and having an important impact

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evidence to SDRC and seeking services from SDRC based on a diagnosis of epilepsy that is a substantially disabling condition.

on the lives of their families, neighbors, and whole communities, developmental disabilities present social, medical, economic, and legal problems of extreme importance.

[¶] . . . [¶]

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

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

"Developmental disability" means a disability that originates before an individual attains 18 years of age; continues, or can be expected to continue, indefinitely; and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include intellectual disability, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to intellectual disability or to require

treatment similar to that required for individuals with an intellectual disability, but shall not include other handicapping conditions that are solely physical in nature.

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

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

(b) The Developmental Disability shall:

(1) Originate before age eighteen;

(2) Be likely to continue indefinitely;

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

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

(1) Solely psychiatric disorders where there is impaired intellectual or social functioning which originated as a result of the psychiatric disorder or treatment given for such a disorder. Such psychiatric disorders include psycho-social deprivation and/or psychosis, severe neurosis or personality disorders even where social and intellectual functioning have

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

become seriously impaired as an integral manifestation of the disorder.

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

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

7. California Code of Regulations, title 17, section 54001, provides:
(a) "Substantial disability" means:

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

(2) The existence of significant functional limitations, as determined by the regional center, in three or more of the

following areas of major life activity, as appropriate to the person's age:

(A) Receptive and expressive language;

(B) Learning;

(C) Self-care;

(D) Mobility;

(E) Self-direction;

(F) Capacity for independent living;

(G) Economic self-sufficiency.

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

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

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

8. A regional center is required to perform initial intake and assessment

services for "any person believed to have a developmental disability." (Welf. & Inst. Code, § 4642.) "Assessment may include collection and review of available historical diagnostic data, provision or procurement of necessary tests and evaluations, and summarization of developmental levels and service needs . . . ." (Welf. & Inst. Code, § 4643, subd. (a).) To determine if an individual has a qualifying developmental disability, "the regional center may consider evaluations and tests . . . that have been performed by, and are available from, other sources." (Welf. & Inst. Code, § 4643, subd. (b).)

9. California Code of Regulations, title 5, section 3030, provides the eligibility criteria for special education services required under the California Education Code. However, the criteria for special education eligibility are not the same as the eligibility criteria for regional center services found in the Lanterman Act and California Code of Regulations, title 17. The fact that a school may be providing services to a student based on the school's determination of an autism disability is not sufficient to establish eligibility for regional center services.

APPLICABLE CASE LAW

10. In *Mason v. Office of Administrative Hearings* (2001) 89 Cal.App.4th 1119, 1127, the Fourth District Court of Appeal discussed the language in the Lanterman Act regarding the fifth category and determined the language was not impermissibly vague. The appellate court explained that finding as follows (*Ibid.* at pp. 1128-1130.):

> In the instant case, the terms "closely related to" and "similar treatment" are general, somewhat imprecise terms. However, section 4512(a) does not exist, and we do not apply it, in isolation. "[W]here the language of a statute fails to provide an objective standard by which conduct can be judged, the required specificity may nonetheless be provided by the

common knowledge and understanding of members of the particular vocation or profession to which the statute applies." [Footnote omitted.] Here, the Lanterman Act and implementing regulations clearly defer to the expertise of the DDS and RC professionals and their determination as to whether an individual is developmentally disabled. General, as well as specific guidelines are provided in the Lanterman Act and regulations to assist such RC professionals in making this difficult, complex determination. Some degree of generality and, hence, vagueness is thus tolerable.

The language defining the fifth category does not allow such subjectivity and unbridled discretion as to render section 4512 impermissibly vague. The fifth category condition must be very similar to mental retardation, with many of the same, or close to the same, factors required in classifying a person as mentally retarded. Furthermore, the various additional factors required in designating an individual developmentally disabled and substantially handicapped must apply as well.

While there is some subjectivity involved in determining whether the condition is substantially similar to mental retardation and requires similar treatment, it is not enough to render the statute unconstitutionally vague, particularly when developmentally [sic] disabilities are widely differing and difficult to define with precision. Section 4512 and the implementing regulations prescribe an adequate standard or

policy directive for the guidance of the RCs in their determinations of eligibility for services.

EVALUATION

11. The Lanterman Act and the applicable regulations set forth criteria that a claimant must meet to qualify for regional center services. There is no question that claimant suffers from deficits in his functioning. His uncle justifiably wants to make sure claimant receives any and all services for which he is eligible. SDRC took claimant's request for services seriously, and given the complex nature of his condition, referred him for two separate psychological evaluations. Based on those evaluations and a review of claimant's records, including school records, SDRC determined that claimant does not meet the diagnostic criteria for Autism Spectrum Disorder or fall within the fifth category. Instead, claimant's symptomology and the deficits he has experienced were more consistent with his schizophrenia diagnosis. The evidence introduced in this hearing was not sufficient to prove by a preponderance of the evidence that claimant suffers from Autism Spectrum Disorder or meets the criteria for eligibility under the fifth category, or that his condition was present during the developmental stage before he was 18 years old. Accordingly, claimant is not eligible to receive regional center services at this time. Thus, his appeal from SDRC's determination that he is ineligible to receive regional center services must be denied.[6]

[6] Although it was mentioned during the hearing that claimant recently suffered seizures, there was no evidence presented that SDRC has had an opportunity to evaluate, and this decision does not address, whether claimant may be eligible for regional center services based on a diagnosis of epilepsy.

ORDER

Claimant's appeal from San Diego Regional Center's determination that he is not eligible for regional center services and supports is denied.

DATED: March 5, 2018

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THERESA M. BREHL

Administrative Law Judge

Office of Administrative Hearings

NOTICE

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