BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of the Fair Hearing Request of: CLAIMANT, vs. FRANK D. LANTERMAN REGIONAL CENTER, Service Agency.	OAH Case No. 2014020409

DECISION

This matter was heard by Eric Sawyer, Administrative Law Judge (ALJ), Office of Administrative Hearings, State of California, on July 8-10, 2015, in Los Angeles.

Claimant was represented by Daniel R. Shaw, Esq.[1]

Frank D. Lanterman Regional Center (service agency) was represented by Pat Huth, Esq.

The record was held open for the parties to submit additional documents and closing briefs. Admission of the subsequently submitted documents is discussed in more detail in the ALJ's order dated September 15, 2015. The closing briefs were timely received and marked as follows: claimant's as exhibit C21; the service agency's as exhibit 30.

The record was closed and the matter submitted for decision on September 28, 2015.

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[1] The names of claimant and his family members are omitted to protect their privacy.

ISSUE

Does claimant have a developmental disability (autism spectrum disorder, intellectual disability or a fifth category condition) making him eligible for regional center services under the Lanterman Developmental Disabilities Services Act?

EVIDENCE RELIED ON

In making this Decision, the ALJ relied on exhibits 1-29 submitted by the service agency; exhibits C1-C20 submitted by claimant; and the testimony of Intake Director Hasmig Mandossian; Intake Specialist Yadira Navarro; Dr. Timothy Collister; Dr. Pegeen Cronin; and claimant's mother. The closing briefs were reviewed but are not considered to be evidence.

FACTUAL FINDINGS

PARTIES AND JURISDICTION

1. Claimant is a 22-year-old unconserved male on whose behalf regional center services were requested from the service agency in August 2013.

2. By a letter dated January 2, 2014, claimant and his mother were advised that service agency staff had concluded that claimant was not eligible for regional center services.

3. On February 11, 2014, a Fair Hearing Request on claimant's behalf was submitted to the service agency, by which the decision denying his eligibility was appealed. Claimant designated his mother to serve as his authorized representative.

4. The hearing of this matter was initially scheduled to commence on March 21, 2014. However, the hearing was continued at the request of claimant's mother, on the grounds that she needed additional time to prepare.

5. The matter was next scheduled to commence on May 22, 2014, but was continued at the request of claimant's mother, on the grounds that claimant would receive a neuropsychological evaluation and the results would not be available until July 2014.

6. The matter was next scheduled to commence on August 14, 2014. However, the hearing was continued at the request of counsel designated to serve as claimant's authorized representative, on the grounds that counsel had just been retained and the aforementioned evaluation results were still not available.

7. The matter was next scheduled to commence on December 15, 2014. However, the hearing was continued at the request of the service agency, on the grounds that staff had been unable to obtain records relating to some of claimant's prior hospitalizations.

8. The hearing was next scheduled to commence on March 24, 2015. However, the hearing was continued at the parties' joint request, on the grounds that they were still in the process of obtaining records from claimant's prior hospitalizations. The hearing was next scheduled to commence on July 8, 2015.

9. In connection with their continuance requests, claimant's authorized representatives executed written waivers of the time limit prescribed by law for holding the hearing and for the ALJ to issue a decision.

CLAIMANT'S BACKGROUND

10. Claimant currently lives with his mother and four of his eight siblings. Claimant's parents are legally separated, but claimant's father lives locally. Claimant occasionally spends time with his father.

11. Claimant is from a large, dysfunctional family. Claimant's parents were involved in a chaotic relationship, which his mother describes as involving physical and emotional abuse. No evidence was presented from claimant's father, but various records

indicate claimant has told medical providers his father was physically abusive to his mother and emotionally abusive toward his children.

12. Claimant and his siblings were home-schooled by his mother. This was because the family moved to and from various states several times. Claimant sporadically attended public school, but never long enough for him to integrate. No records from any public school were presented by either party. Claimant's mother testified that she noticed claimant was delayed early in his development and thereafter. However, she testified that she did not seek special education services for claimant because her husband was extremely resistant to that notion; the few times she tried, the family never stayed in the area long enough for the evaluation process to evolve. Whether or not claimant's father is responsible for that dereliction, claimant's mother did little about it herself until recently.

13. As a result of the above, there are no school records, report cards, cognitive or psychological reports, tests or similar documentation available for claimant until about the time he turned 15, as described in more detail below.

14. Due to the dynamics discussed above, only limited information is available concerning claimant during his developmental years. The primary sources of such information are statements from claimant's mother documented in various reports, as well as her testimony during the hearing. This information must be approached with caution, as explained in more detail below. That information is summarized as follows:

A. Claimant's mother noticed her son was slower than and different from her other children by the time he was 15 months old or so.

B. Claimant was different socially from his siblings and peers. He preferred to be alone and he pulled away from groups. He almost always played by himself; when he did play with others, it was awkward. Claimant did not do well when

signed up to play team sports; he could not follow directions and the other kids teased him.

C. It took claimant longer than usual to be toilet trained.

D. Claimant's speech was delayed. He initially did not attempt to talk; when he did, his speech was garbled and hard to understand. His mother could interpret what her son was saying by the sounds he made, but his father often could not understand him. Initially, claimant's parents believed he had a hearing problem. But a doctor who examined claimant found his hearing was within normal limits. Claimant has never been able to express his emotions or advocate for himself; e.g., he does not say when he is hungry and does not emote feeling pain, even when seriously injured.

E. Claimant has never been able to understand social cues.

F. He does not understand simple instructions. Claimant's progress during his mother's home-schooling was much slower than his siblings. In fact, claimant's mother delayed starting his instruction because of his slowness. She decided not to rush him because she simply thought he "was slow." She estimates that he got as far as a third grade curriculum by the time he was a teenager.

G. Claimant does not like change of circumstances or routines. He hates wearing clothes that cause him to itch. He now only wears baggy sweat pants and the same loose t-shirts. He does not like loud sounds, like thunder during storms.

H. He has always liked to wander away on his own. As a small child, fences were necessary around the family home to keep him from wandering too far. As he has grown, he now elopes frequently. Currently, he can disappear for days at a time, which has led to many of his recent hospitalizations discussed below. Because he does not like to wear wrist-bracelets, chains or other identifying

information due to how they feel on his body, claimant's mother has written identifying information on her son's forearm with permanent black ink.

I. When younger, claimant loved to swing for hours, so much so that his mother put a swing in the basement so she could do laundry while he swung. However, there is no other mention of such behavior in the records presented, nor has any other person verified this type of behavior.

15. Claimant's mother has advised recent healthcare providers that her son was diagnosed when he was three or four with "autism" by Dr. Lawrence Dorman, a physician who treated claimant when the family lived in Missouri. However, she admits that she did not advise healthcare professionals in Nevada or Colorado of such a diagnosis when claimant was placed in the treatment facilities discussed below. No documentation from Dr. Dorman's office or any corroborating evidence was submitted.

16. Claimant's family relocated to California from Colorado in approximately 2008, when claimant was about 15 years old. Claimant's mother testified that is when claimant began using marijuana. The amount of claimant's marijuana use is in dispute. Since he does not work or earn any money on his own, he must rely on neighbors or others he meets while wandering to give him the drug. Claimant's mother theorizes that he cannot consume too much for that reason. She also testified that claimant's marijuana consumption is more sporadic, for the same reason. However, claimant has advised various healthcare providers over the years that: he "smokes pot a lot," sometime three or four days in a row; he has used other controlled substances, such as crack cocaine and methamphetamines; and he gets drunk often.

17. According to records reviewed by the service agency's expert examiner involved in this matter, Dr. Timothy D. Collister, claimant had an out-patient visit at the Descanso Family Practice on August 15, 2008. Dr. Collister describes those records as

being unremarkable for any sign or symptom of a developmental disorder. The records were not presented.

18. Dr. Collister similarly describes records he reviewed from Glendale Adventist Medical Center's (GAMC) Psychiatric Institute (which were not presented) for an emergency room visit on July 30, 2010, when claimant was brought in by police under Welfare and Institutions Code section 5150 for presenting as a grave danger to himself (5150 hold). He was reportedly found in Glendale (close to home) running in the middle of the street, disoriented and later combative. Claimant's mother was contacted that day and advised GAMC staff that her son had attention-deficit/hyperactivity disorder (ADHD). She also mentioned that he had been placed in a private school and was doing reasonably well. But she said her son had recently started smoking marijuana and that his behavior had deteriorated as a result. Claimant was given a differential diagnosis for drug abuse, and possibly ADHD.

CLAIMANT'S PLACEMENTS IN NEVADA AND COLORADO IN 2010 AND 2011

19. By the end of 2010, claimant's mother sought help to deal with her son's various problems. She found a residential placement willing to accept claimant named Willow Springs in Reno, Nevada. Willow Springs is a locked residential placement facility and school for teens troubled with mental health issues.

20. Claimant was placed at Willow Springs in November 2010. He was discharged from the program on January 7, 2011, for reasons not clear from the record. Documentation from this placement include the following pertinent information:

A. Upon admission, it was noted that claimant was having a psychosis, was into serious drug use, and was aggressive toward his mother. Claimant was given Axis I diagnoses of generalized anxiety disorder; psychosis not otherwise specified (NOS); cannabis dependence; and alcohol abuse. An Axis II diagnosis (where a developmental disorder would be located) was "deferred."

B. Claimant's mother provided some information at intake, but one note described her as a poor historian, as she seemed to minimize her son's problems.

C. Claimant's educational skills were evaluated. He was given some academic tests, but the information and test scores are not clear. However, handwritten notes indicate that claimant needed to be told what to do numerous times; he could not remember class routines; he could only add or subtract single digit numbers; he completed no school work at all; he was not able to focus; and he needed one-on-one instruction and constant supervision. Overall, in the academic skills area, claimant was noted to be "extremely low." It was recommended that claimant be referred for eligibility for special education services.

D. Claimant was also given some psychological tests. The Revised Children's Manifest Anxiety Scale was given. Despite being given multiple instructions and repeating them, claimant demonstrated significant confusion. The results showed that claimant had difficulty concentrating and had cognitive confusion. On the Children's Depression Inventory, the examiner noted claimant's confusion, and that he was not able to complete the intellectual testing because he could not focus and was restless; the examiner therefore believed the test results would not be valid.

E. The person conducting the psychological testing shifted to less complex testing. Claimant showed serious problems in penmanship and written expression as demonstrated by his responses to the Incomplete Sentence Blank. On the House-Tree-Person Drawing, claimant presented with serious rigidity, disorganization, as well as poor planning and execution. On the

Rorschach Inkblot Test, it was noted that intellectual challenges and learning disorders "may be present."

F. Staff believed claimant was suffering from disordered thought processes. Claimant told them he had ingested a great deal of marijuana the past few years, and had also used rock-formed cocaine (crack). He seemed confused and as if responding to internal stimuli. However, his speech was deemed to be at a regular rate and rhythm. He denied having hallucinations and no findings were made of any delusional behavior.

G. Upon discharge, claimant was given Axis I diagnoses of schizophreniform disorder (a short-term schizophrenic process); anxiety disorder NOS; cannabis dependence and crack (cocaine) abuse. An Axis II diagnosis was "Open." Such a diagnostic term is not standard and the meaning of it is unknown.

21. Claimant was admitted to Mountain Crest, later known as Poudre Valley Hospital (Mountain Crest), on January 20, 2011. Dr. Collister reviewed records from that admission, but the records were not presented. He describes those records as indicating claimant had initially visited Mountain Crest in December 2010. The records describe claimant's gross decompensation and acute psychosis during the relevant times. Claimant's mother was quoted as telling staff that her son craved alcohol, cigarettes and marijuana. Claimant himself was quoted as saying he liked to "smoke 1-2 blunts per day since he was 15." According to Dr. Collister, claimant was discharged from Mountain Crest on February 28, 2011, with final diagnoses including schizoaffective disorder, rule out schizophrenia, chronic, undifferentiated type; rule out delirium; a history of pervasive development disorder (PDD) NOS; and cannabis dependence with alcohol abuse, in early remission.

22. Claimant was subsequently admitted to the Colorado Boys Ranch Youth Connection (CBR) program on February 28, 2011. CBR is also a locked residential setting.

Claimant's mother testified this was supposed to be a two-year school/residential placement. Claimant was thoroughly evaluated at CBR, the results of which are summarized as follows:

A. An educational assessment revealed that claimant presented with limited cognitive capacity and an inability to actively reason with others. His thought process was disorganized. No testing records were available and the evaluator noted that she was unable to give claimant the Woodcock-McGrew-Werder Mini-Battery Assessment because he was too unstable at the time. However, she recommended that claimant be placed in a small classroom with a low teacher-student ratio.

B. Claimant was also given a psychiatric evaluation. He denied overt hallucinations and showed good memory skills, but his insight and judgment were poor. He admitted occasional alcohol use, but regular use of illicit drugs, including marijuana. His cognitive thought processes were described as impaired, but his intellectual ability was described as being "in the average range." He had expressive language deficits.

C. Claimant was deemed to be paranoid and scared. His functioning at CBR was described as poor. Although it was not explicitly noted, CBR documents indicate that claimant was discharged prematurely because he needed a higher level of care. Upon his discharge from CBR, claimant was given diagnoses of psychotic disorder NOS, poly-substance abuse, and a rule out for schizophrenia.

23. Claimant was transferred to the Colorado Mental Health Institute at Pueblo (CMHI) on March 24, 2011. He was to remain there until his emotional and cognitive disorders stabilized.

A. Admission documents indicate that claimant showed signs of severe psychosis and mental disorganization in the prior two months. Statements attributed to claimant's mother indicate that claimant's early development was normal, and that he had close relationships with friends and family and siblings. Claimant's mother denies making those statements.

B. Based on his review of past records and a history taken from claimant and his mother, CMHI psychiatrist Roger Pumphrey described claimant as having a "drug triggered histrionic process which has begun approximately two years ago." Dr. Pumphrey diagnosed claimant with schizophrenia, simple type (Axis I), and deferred for Axis II.

C. Dr. Pumphrey discharged claimant in April 2011, after he determined that claimant was less anxious and paranoid, and his thinking more organized. Claimant was prescribed with anti-psychotic drugs. Claimant's discharge diagnoses on Axis I were schizoaffective disorder and poly-substance abuse (in remission), with no Axis II diagnosis. CMHI records documenting claimant's substance abuse appear to be based on reporting by claimant and his mother, as opposed to positive diagnostic test results.

D. Claimant received out-patient services until May 2011. A social worker discharge summary dated May 5, 2011 noted that claimant's ability to care for himself and tend to his personal needs was "very questionable," that he lacked sound judgment, and that he had a history of marijuana abuse, cognitive impairments, confusion, lack of understanding and difficulty processing information.

CLAIMANT'S VARIOUS HOSPITALIZATIONS IN CALIFORNIA FROM 2012 THROUGH 2014

24. By 2012, claimant returned to California to live with his mother and siblings. Claimant is described by many as an attractive young man. When he sits quietly, he appears to others as typical. When he initially approaches people, they think nothing of it. But when he gets too close to them or says something inappropriate, trouble is afoot. Moreover, claimant still likes to wander off. Because of his age and size, he can wander far from home, sometimes for hours or days. On some occasions, claimant has wandered far from home and been detained by police after others have complained about his behavior. Ultimately, claimant has been subject to several psychiatric hospitalizations over the past few years. Those in which medical records were submitted are summarized below.

25. One such psychiatric hospitalization was on May 30, 2012, when claimant was admitted into Del Amo Hospital in Torrance (far from home) on a 5150 hold. It was reported that claimant had tried to run into traffic and was increasingly anxious and disorganized in thought. Claimant presented to staff as "loose, tangential and responding to internal stimuli," though he denied any hallucinations. His lab results were negative for controlled substances or alcohol (except benzodiazepines, which was probably related to anti-psychotic medications he was previously prescribed). Claimant was diagnosed with schizophrenia, paranoid, chronic with acute exacerbation (Axis I), substance abuse (Axis III), and either "none" or "deferred" for Axis II, depending on the evaluator.

26. On January 14, 2013, claimant was admitted to College Hospital in Cerritos (far from home) on a 5150 hold. He had been found wandering near Los Angeles International Airport, acting bizarrely and taking off his clothes. He was so incoherent and disorganized that he could not identify himself, so he was admitted as "John Doe."

He appeared to staff as being paranoid, delusional, confused, with active auditory hallucinations. After being held for a few weeks, claimant was discharged with a diagnosis of psychotic disorder NOS. Laboratory testing was negative for alcohol and drugs, per a record note dated January 17, 2013.

27. On June 23, 2013, claimant was again placed on a 5150 hold, this time for running into traffic in Glendale (closer to his home). He was admitted into the GAMC Psychiatric Institute. He had been there several times before and after this particular admission. However, this admission is significant for the following reasons:

A. Claimant was initially admitted by psychiatrist Judith Vukov. He was confused and incoherent. He denied using illicit drugs or alcohol. Nonetheless, a toxicology report from samples collected at the emergency room on June 23, 2013, were positive for marijuana. He made poor eye contact. He was illogical, tangential, suspicious and showed poor judgment. He also displayed some level of aggression and Dr. Vukov also described him as being delusional and having hallucinations, but no specifics were listed.

B. Based on the above, Dr. Vukov diagnosed claimant with schizophrenia, paranoid and chronic type.

C. A note from Dr. Vukov on June 24, 2013, indicates that she spoke with claimant's mother sometime that day and was informed that claimant previously had been diagnosed with schizophrenia and "a mild form of autism."

D. Claimant was also seen on June 24, 2013, by GAMC physician Helena Gerundo. By that time, Dr. Gerundo was privy to Dr. Vukov's initial conclusions about claimant. Claimant advised Dr. Gerundo that he had recently visited Las Vegas and used marijuana there. Dr. Gerundo noted many of the same observations about claimant's appearance and behavior as Dr. Vukov, and she

concurred with the schizophrenia diagnosis. Based on the positive marijuana toxicology test result, Dr. Gerundo added an impression of "marijuana use dating at least back to 2010." Dr. Gerundo also added impressions to look into whether claimant was "[m]ildly mentally disabled versus developmental delay," and that he had a "[p]ossible form of autism (Asberger's) [sic]."

E. By the time that Dr. Vukov discharged claimant later in July 2013, she believed that claimant may have a pervasive developmental disorder, and she added a "rule out" diagnosis of "autism spectrum" for claimant. GAMC records do not show that claimant was subjected to any psychological testing or that Dr. Vukov evaluated claimant's condition under criteria established by the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5), which was published in May 2013. It appears that this initial diagnosis was based on the comments claimant's mother made to Dr. Vukov as well as Dr. Vukov's observations.

28. On August 6, 2013, claimant was again admitted to GAMC's psychiatric unit, this time for acting bizarrely, wandering the streets and stating that he was a "demon psychopath."

A. Claimant advised Dr. Vukov that he went to random houses to get illicit drugs. Toxicology tests were apparently not done upon claimant's admission. However, toxicology tests from samples collected on August 12th were negative for illicit drugs or alcohol and only positive for benzodiazepines.

B. Claimant appeared to Dr. Vukov to exhibit visual and auditory hallucinations. She also noted that he was mumbling, tangential, disorganized and had no insight. Dr. Vukov continued to diagnose claimant with schizophrenia, "PDD, Autism Spectrum," and she added a "provisional" diagnosis for "substance abuse."

C. Claimant was also seen by Dr. Gerundo during this admission. In a report, Dr. Gerundo noted her impressions that claimant was schizophrenic, had PDD, and "autism spectrum." It appears that diagnosis was based on Dr. Vukov's prior assessments and conclusions, though that is not clear.

29. On September 13, 2013, claimant was admitted to Kaiser Permanente Hospital (Kaiser) in Panorama City (not close to home) on a 5150 hold, after being detained for running naked through the streets in an "altered condition." Initially, claimant was incoherent and did not know his name or address. An initial toxicology test from samples taken upon admission were positive for methamphetamine, opiates, amphetamine and TCA (TCA is typically associated with anti-depressant medications). Claimant became more coherent after a few hours and provided staff with more information, including statements that he was bipolar and that he had consumed methamphetamine and crack cocaine. He was initially diagnosed by the emergency room physician as having bipolar disorder and suffering from an amphetamine induced psychotic disorder. The following evening, however, claimant told staff, "I don't do drugs," and he denied any recent or past drug use. Claimant was discharged on September 15, 2013. He was diagnosed by a social worker as having bipolar disorder and amphetamine abuse.

30. On October 31, 2013, claimant was admitted to BHC Alhambra Hospital (closer to home) on a 5150 hold after being found on the sidewalk licking the ground. Upon admission, he appeared psychotic, tangential and could not identify himself. He later appeared paranoid and responding to internal stimuli with bizarre thoughts. At some point, he stated that he had used methamphetamine. However, laboratory results were described as "normal/unremarkable," although it is unknown if claimant was tested for alcohol or illicit drugs. Claimant was initially diagnosed with "psychosis NOS versus chronic paranoid schizophrenia," and "probable substance abuse." However, claimant

later denied using any illicit drugs or alcohol. Thus, by the time he was discharged on November 8, 2013, claimant was diagnosed with simply "chronic paranoid schizophrenia."

31. In his record review, Dr. Collister describes reviewing documentation from several psychiatric admissions for claimant at GAMC's Psychiatric Institute from October 2013 through June 2014. Dr. Collister's description of those admissions is similar to those admissions discussed above, in which claimant was admitted on a 5150 hold, usually for running into the street, and acting bizarrely. There is no mention by Dr. Collister in his record review of any toxicology testing of claimant for alcohol or illicit drugs during those admissions.

32. However, some records from claimant's admissions to GAMC from October 2013 through June 2014 were presented, essentially laboratory reports. Toxicology reports for samples taken on October 11, 2013, as well as February 7, April 14, April 15, and May 23, 2014, were positive for cannabis.

33. On October 10, 2014, claimant was admitted to the Los Angeles County USC Medical Center (LAC + USC) on a 5150 hold after running in and out of a MacDonald's restaurant and into traffic. Upon admission, claimant exhibited poor eye contact, laughed inappropriately and said he was hearing voices in his head. He was described as being tangential, bizarre, and suspicious. Claimant initially told the evaluating psychiatrist that he had been smoking methamphetamine. However, it does not appear that any toxicology tests were conducted, and other records stated claimant was negative for alcohol or drugs. Claimant was diagnosed with "psychotic disorder NOS versus schizophrenia." He was discharged on October 11, 2014.

THE SERVICE AGENCY'S ASSESSMENT OF CLAIMANT

34. One of claimant's neighbors works for a regional center. The neighbor urged claimant's mother to take her son to a nearby regional center for an assessment.

35. On August 26, 2013, claimant and his mother visited the service agency and participated in an intake assessment conducted by Intake Specialist Yadira Navarro. The pertinent details are as follows:

A. Ms. Navarro interviewed claimant and his mother. She asked claimant questions, but he was not responsive to most of them. He did not misbehave, but he did not pay attention either. He maintained some eye contact with Ms. Navarro, but maintained a serious expression. She also noted that he appeared to talk to himself and played with a ring he recently found. Toward the end of the interview, claimant began pacing around the room and wanted to leave.

B. Claimant's mother indicated that her son had been diagnosed with schizophrenia recently and with autism many years ago by Dr. Dorman when the family lived in Missouri. Claimant's mother described claimant's developmental years similarly to what is discussed above. She stated that one of her older sons has Asperger's Disorder and that there was otherwise a family history for mental retardation, bipolar disorder, and ADHD. Ms. Navarro believed claimant's mother was a poor historian, in that it was hard to get good examples or dates from her.

C. Ms. Navarro obtained signed consent forms from claimant and his mother in order to allow the service agency to seek and obtain relevant records. She also decided to refer claimant for a psychological evaluation.

36. The service agency referred claimant to psychologist Timothy D. Collister for a psychological evaluation, which was conducted over the course of three days in September and October 2013. Dr. Collister reviewed records from claimant's various placements and psychiatric admissions, interviewed claimant and his mother, and administered to claimant psychological tests. Dr. Collister subsequently reviewed

voluminous records from many of claimant's other hospitalizations and placements. Dr. Collister's evaluation report is summarized as follows:

A. Dr. Collister administered to claimant the Wechsler Adult Intelligence Scale - Fourth Edition (WAIS-IV). The results of the WAIS-IV showed that claimant had, at the time of the testing, a full scale IQ of 43. (The evaluation report states that the full scale IQ was 33; however, it was agreed at the hearing that that number was an error and the actual score was 43.) Dr. Collister described claimant's answers to many questions as "unusual."

B. Because Dr. Collister was concerned about the level of effort exhibited by claimant during the WAIS-IV, he gave claimant two "effort" tests. Those were the Dot Counting Test and the 15 Item Memory Test. The results of these tests were interpreted by Dr. Collister as showing that claimant was not performing at his true level of ability or function. Dr. Collister opined in his report that he did not believe claimant was malingering; rather, claimant was "presenting in such a noncredible fashion out of flagrant, striking oppositional defiance."

C. For the reasons above, Dr. Collister did not believe that his cognitive test results (namely the WAIS-IV) were valid and he declined to conduct further testing because the results would also be invalid based on claimant's effort and performance. However, Dr. Collister conceded in his report that, at face value, the WAIS-IV score was at the lower end of the moderate range of intellectual disability, and close to the margin for severe delay.

D. In terms of examining the potential for autism, Dr. Collister decided to administer the Gilliam Autism Rating Scale – Second Edition (GARS), as opposed to the Autism Diagnostic Observation Schedule, Second Edition (ADOS). Dr. Collister wrote in his report that, "It was not possible to complete a measure such as the ADOS, given his [claimant's] entire lack of interactivity

at the second interview." The index score from the GARS, based on information provided by claimant's mother, indicated claimant was very likely autistic. Dr. Collister discounted the GARS results mainly because he did not view claimant's mother as a good historian.

E. Dr. Collister administered the Vineland Adaptive Behavior Scales (VABS). The information was mainly provided by claimant's mother. The test results showed scores signifying a substantial handicap in the areas of expressive communication, receptive communication, daily living skills, socializations, and motor skills.

F. Based on the above, Dr. Collister provided the following diagnoses for claimant pursuant to the DSM-5: (Rule out) Schizoaffective Disorder (by history, justified); (Rule out) Unspecified Schizophrenia Spectrum and Other Psychotic Disorders; Poly- Substance Abuse (marijuana and alcohol, reported heavy previously; as recently as August 2013 by records, current usage unknown.); (Rule out) Posttraumatic Stress Disorder; Personal History (past history) of Physical Abuse in Childhood (reported); Psychological Abuse (past history) in Childhood, via exposure to domestic violence (up to once weekly per mother's report); Other diagnoses deferred.

G. In the summary section of his report, Dr. Collister did not necessarily opine whether claimant was intellectually disabled.[2] Because Dr. Collister did not obtain any valid cognitive test results, he had no valid IQ scores for claimant. Nor could he discern any such testing from the voluminous records he

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[2] In the DSM-5, the term mental retardation has been replaced with the diagnostic term "Intellectual Disability."

reviewed. Dr. Collister did not believe that claimant was in a psychotic state during his evaluation, per se, but he did believe claimant was defiant with him. He commented that the lack of prior school records made diagnosis more difficult, as well as his belief that claimant's mother was a poor historian. However, he noted that "there is a possibility of a developmental disorder more relating to his [claimant's] level of intellectual function." Dr. Collister believed claimant's cognitive functioning could be clarified given his cooperation with testing, but he viewed that as a remote prospect.

H. Ultimately, Dr. Collister was swayed by the various reports from different hospitals and facilities documenting observations of claimant engaging in psychotic processes and behaviors and containing various diagnoses of psychosis, ranging from psychosis NOS to schizophrenia. Because Dr. Collister found no evidence of intellectual disability or an autism spectrum disorder (ASD) in any of the records he reviewed (other than GAMC), he believed claimant's problems were best explained by his psychosis.

I. Dr. Collister opined that Claimant did not have an ASD because there was insufficient evidence that claimant met the criteria established in the DSM-5 for that disorder. Namely, Dr. Collister believed claimant's social and communication deficits were better explained by his psychotic features; there was a lack of evidence demonstrating claimant engaged in restricted, repetitive patterns of behavior, interests and activities; there was a lack of evidence of claimant's insistence on sameness; and there was a lack of evidence of claimant exhibiting hyper- or hyporeactivity to sensory input or unusual interests in sensory aspects of the environment. Primarily, Dr. Collister found no mention of such interests, activities or behaviors in the records concerning claimant's placements in Nevada and Colorado. He is also dubious

of the accounts of claimant's mother; even the activities she mentioned do not rise to the level of intensity or frequency required by the DSM-5.

37. Dr. Collister also testified during the hearing. The pertinent parts of his testimony are as follows:

A. It is hard for him to believable that claimant has ASD or intellectual disability (ID) when none of the many doctors, social workers, psychologists and psychiatrists who had seen claimant over the years after hospitalizations and placements have described or diagnosed claimant as suffering from such a disorder, let alone at the level of impairment suggested by the WAIS-IV score he obtained or the cognitive testing scores obtained by UCLA (discussed in detail below). Instead, the volumes of medical records consistently and clearly point to schizophrenia or similar psychosis.

B. He is dubious of much of the information provided by claimant's mother, because he believes she is not a good historian; he saw a note regarding the same in some of the Nevada documentation.

C. He is also dubious of the testing and evaluation conducted by UCLA because records of claimant's admission at GAMC from May 23, 2014, through June 9, 2014, showed he was acutely psychotic and that he presented as a danger to himself and gravely disabled during that hospitalization until the day before claimant was released and evaluated at UCLA.

D. After reviewing all the available records, including some obtained subsequent to his evaluation, Dr. Collister changed his opinion that claimant had behaved defiantly during the psychological testing. Instead, Dr. Collister now believes claimant's behavior was most likely the manifestation of acute psychotic processing. For that reason, Dr. Collister testified that he could now diagnose claimant with schizoaffective disorder. This constituted a change in his

thinking, in that he had previously stated in his report that claimant's low cognitive scores were not the "result of a psychotic disorder" and "[t]hat is only believed to be a remote possibility."

E. Based on the above, he also opined that claimant did not have ID.

CLAIMANT'S EVIDENCE

38. After receiving the service agency's letter advising her that claimant was deemed to be ineligible for services, claimant's mother was dispirited. She investigated her options and ultimately was referred to the UCLA Semel Institute for Neuroscience and Human Behavior (UCLA) for a neurodevelopmental evaluation of her son.

39. In June of 2014, UCLA completed a comprehensive assessment over the course of three days. The UCLA team interviewed claimant and his mother, administered psychological tests, and reviewed some of the aforementioned records from claimant's prior placements and psychiatric admissions. The UCLA team was led by psychologist Tamar Apelian, who conducted most of the work, as well as other psychologists, a speech and language pathologist, neurologist, pediatrician, and three psychiatrists.

A. UCLA selected testing formats to best match claimant's cognitive skill and ability to concentrate. As a result, they found all test results valid and experienced none of the concerns that Dr. Collister had with resistance or what he perceived to be a psychosis.

B. For example, UCLA selected the Stanford-Binet Intelligence Scale, Fifth Edition (Stanford) to evaluate claimant's cognitive ability. The Stanford was selected because it has enhanced non-verbal content which allowed an individual with poor language to work through the evaluation despite language deficits. Additionally, the Stanford has a low floor so cognitive abilities can be captured from the two-year-old level through adulthood. The test seemed well adapted for use on someone like claimant. On the Stanford, claimant

obtained a full scale IQ of 40, which places him in the range of having a moderate intellectual disability. Significantly, claimant was able to produce raw scores on nearly all the sub-tests, which confirmed the cognitive testing was valid.

C. UCLA interviewed claimant's mother using the Autism Diagnostic Interview-Revised (ADIR). The ADIR is viewed as a gold-standard test for interviewing parents of children suspected of having autism. The ADIR takes about three hours to administer and helps tease apart what is typical developmental history from non-typical history. Department of Developmental Services' (DDS) Guidelines recognize that the older the individual suspected of ASD, the more "in-depth investigation" is required. Claimant was 21 years old at the time. Claimant's mother's report of his younger years, discussed in detail above, provided details which the UCLA team believed was consistent for a child with autism and low cognition.

D. UCLA also administered to claimant the ADOS, which is also considered a gold-standard test for interviewing a person suspected of autism. The test was administered without issue. Claimant displayed a high level of autism spectrum symptoms when compared to others with autism at the same age level. Simply put, claimant far exceeded the cut-off criteria on the ADOS, which indicated to the UCLA team that he was an individual with autism.

E. Dr. Apelian summarized pertinent findings after reviewing some of claimant's records. She noted that Willow Springs' records documented claimant's repetitive pacing, calling for his mother over and over, perseverating on other subjects and wandering. She also noted that Intake Specialist Navarro had observed claimant talking to himself and playing with his ring, which Dr. Apelian believed was consistent with repetitive behaviors she also observed.

Dr. Apelian observed that claimant's language was stereotyped and repetitive while she interviewed him, e.g., he echoed rules several times that his mother and Dr. Apelian said to him. Claimant also frequently paced and ran back and forth in a hallway; he made repetitive requests and references to the police and dogs; and he engaged in sensory-seeking behaviors, such as mouthing small objects and rubbing textures. He also repetitively tapped and spun various objects. Dr. Apelian noted that claimant wore the same Batman pajama drawstring pants on both appointment days. She also saw that claimant had his mother's phone number written with permanent black ink on his forearm.

F. Dr. Apelian concluded that claimant meets the criteria established by the DSM-5 for ASD. Based on claimant's history provided by his mother, claimant has displayed social and communication deficits since an early age. He does not engage in reciprocal social interaction. His verbal and non-verbal communication skills are abnormal. In terms of restrictive, repetitive interests, Dr. Apelian noted comments by claimant's mother that her son has strong interests in video games, Disney shows and movies, the police and military. In terms of repetitive behaviors, claimant constantly seeks out small items such as trash, which many times he tries to eat. He also likes to pace. Dr. Apelian describes many other mannerisms described by claimant's mother, almost all of which are not documented in the voluminous records from claimant's placements and admissions.

G. Claimant was also administered the VABS. Claimant's scores showed that he is significantly behind same-aged peers in all domains. His score of 33 fell in the low range, demonstrating a significant intellectual disability. Specifically,

claimant's scores in the communication, daily living skills and socialization domains were all in the low range.

H. UCLA ultimately diagnosed Claimant with ASD, as well as ID. The UCLA team concluded that claimant qualified for regional center services under the categories of ASD and as a result of moderate ID. Dr. Apelian states that claimant needs several services that are typically funded by regional centers, such as independent living support, vocational training, social skills training, family/caregiver training, general behavioral interventions, language and communication evaluations and interventions, and motor/sensory skills training.

I. Based on information provided by claimant and his mother, Dr. Apelian concluded that claimant has used marijuana sporadically since he was 16 or 17. Dr. Apelian describes claimant as engaging in binge usage, when he will not use marijuana for weeks at a time and then later use it several times per week when he gets it. Dr. Apelian believes claimant's marijuana use explains his bizarre behavior that had led to his various recent psychiatric admissions. Instead of being diagnosed with schizoaffective disorder, she believes claimant was suffering from substance-induced psychotic disorder, as claimant's symptoms occurred exclusively during intoxication. Dr. Apelian notes that when claimant has consumed marijuana or other illicit drugs, that is when others have observed him to engage in grandiose delusions or experience hallucinations. Otherwise, when claimant is at home or in the community, and has not consumed such substances, Dr. Apelian believes claimant is free of such symptoms.

40. Claimant was subsequently evaluated by Pegeen Cronin, Ph.D., on November 22, 2014. Dr. Cronin met with claimant and his mother, reviewed available

records, including the reports from UCLA and Dr. Collister, and gave claimant some tests. In her report, Dr. Cronin concurred with the UCLA team's opinion that claimant suffered from ASD and ID. She describes claimant as like a three-year-old trapped in a 21-year-old body: he was wearing a football jersey, sweatpants, and slippers, and he arrived to the evaluation with a number of small items in his hand. She attempted to administer the Street Survival Questionnaire to claimant, but he was not able to get very far through the assessment. Dr. Cronin believes claimant would have kept trying to answer particular questions even though he was not getting them right; he simply did not understand what was being presented to him, which she feels is consistent with an individual with an intellectual disability.

41. Claimant's older sister, Danielle, was subsequently interviewed by Dr. Cronin in December 2014. Danielle described for Dr. Cronin claimant's current situation as follows:

A. She sees her brother on a daily basis and assists her mother in supervising him. Caring for her brother is like baby-sitting a toddler, a job she knows well after being a nanny for toddlers a few years ago. Her brother enjoys the same sort of activities as toddlers and very young children, such as coloring and playing with small toys.

B. Her brother infrequently speaks. When he does, it is usually simple sentences or questions.

C. Claimant requires frequent redirection and requires the same safety instructions over and over, such as not putting random things in his mouth, not picking up trash, etc. She must hold her brother's hand when crossing the street. Claimant has no awareness about strangers. He will indiscriminately approach others so intimately that he has been assaulted by some who feared for their safety.

D. Her brother is socially inept. He will not initiate a conversation, although if he does say something, it is unrelated to the activity in question and awkward. He does not seem to understand context or circumstances. Once, when she was sad over the death of her cat, claimant was acting silly and giggly around her, oblivious to her sorrow.

42. Dr. Cronin similarly contacted Dr. Vukov of GAMC in December 2014. Dr. Vukov advised Dr. Cronin that while she initially diagnosed claimant with schizophrenia, her impression was that claimant was also developmentally delayed and had a possible PDD. She reviewed some of the reports from claimant's placements in Nevada and Colorado. She believes that claimant should be diagnosed with ASD. Dr. Vukov indicated that she frequently works with regional center clients and finds claimant to be more severely handicapped than many of those patients. Dr. Vukov also advised Dr. Cronin that claimant does not present as typical for someone with marijuana intoxication, as those types of patients are paranoid and talkative; claimant rarely speaks and does not respond to questions.

43. Dr. Cronin's testimony at hearing is summarized as follows:

A. She does not believe claimant was actively psychotic when she evaluated him; his behavior is explained by his ID. She does not believe he is schizophrenic, mainly because the DSM-5 requires cognitive testing be conducted to determine one's intelligence before resorting to a schizophrenia diagnosis. Because she sees no evidence of anyone else obtaining valid cognitive testing, she puts little stock in the various psychiatric diagnoses given to claimant. Also, claimant does not fit the classic schizophrenia profile of someone who suffered an abrupt deterioration in functioning over a very short period of time.

B. The collateral sources she contacted, i.e., claimant's sister and Dr. Vukov, have reinforced her opinions that claimant has ASD and ID. In terms of ASD, Dr. Cronin believes claimant has always been impaired in his social and communication domains. She also cites to his well-documented wandering away as an intense, repetitive behavior, as well as a sign that he avoids social contacts and reciprocal activity.

C. Finally, Dr. Cronin does not agree that a poly-substance abuse diagnosis is supported by the records. A person must have six months of persistent use of three different substances to warrant such a diagnosis. In claimant's case, the documentation and verification of his drug use has been sporadic, inconsistent and not persistent.

CAUTION REGARDING CLAIMANT'S VARIOUS PSYCHIATRIC DIAGNOSES

44. Dr. Cronin agrees that claimant may indeed suffer from a psychiatric disorder; she conceded on cross-examination that he may even be psychotic. In addition to Dr. Collister, many other psychiatrists and psychologists who have treated claimant from 2010 through 2014 have diagnosed him with various psychiatric disorders. The number and variety of such diagnoses, as well as the supporting documentation, taken together, establish by a preponderance of the evidence that claimant has a psychiatric disorder, ranging to perhaps a psychosis NOS or schizoaffective disorder.

45. However, claimant's diagnosis of a psychiatric disorder must still be approached with some level of caution, for the following reasons:

A. Dr. Apelian commented in her evaluation report that approximately 70 percent of individuals with ASD have at least one co-morbid psychiatric disorder. There is nothing in the DSM-5 indicates that a psychiatric disorder is mutually exclusive from a developmental disorder, such as ID or ASD.

B. At no time during claimant's multiple placements or hospitalizations did anyone attempt a developmental assessment of claimant. Dr. Collister and UCLA were the first to conduct a comprehensive psychological evaluation of him. It is clear from claimant's placements in Nevada and Colorado that his evaluators were unsure of his Axis II diagnoses, where they consistently noted "deferred" or "open."

C. Claimant received various psychiatric diagnoses, ranging from schizophreniform disorder in November 2010, to psychotic disorder NOS and a rule out of schizophrenia paranoid type in March 2011, to schizoaffective disorder in May 2011, to a number of other psychiatric diagnoses from 2012 through 2014 during claimant's serial 5150 hold admissions. Even Dr. Collister later changed his opinion concerning whether claimant was actively psychotic when he evaluated him in 2013. This shows that there is not a clear consensus of claimant's condition or psychiatric disorder.

D. The DSM-5 specifies that a clinician needs to know a patient's cognitive ability before making a diagnosis of a psychotic disorder or schizophrenia. One must be able to correlate an individual's developmental age (which can be obtained through cognitive assessment) with the behaviors he is displaying. However, none of the psychiatric hospitals or placements ever conducted a cognitive assessment to determine claimant's level of intellectual functioning. This lack of testing softens the psychiatric diagnoses.

E. Claimant has remained mostly unchanged throughout these various mental health placements, even after complying with the anti-psychotic medications he has been prescribed. If his psychosis is what has caused his problems, deficits and delays, one would suspect that the psychiatric treatment and

medications would remedy them. But the evidence indicates that claimant has suffered from the same problems and disabilities for the past several years.

F. The vast majority of mental health records provided in this case were from short-term placements in psychiatric and/or mental health settings. Claimant did not stay in any of these places for extended periods of time and each setting only offered a brief snapshot of his needs. It is worth noting that since 2010, GAMC is the location of the majority of claimant's psychiatric visits. Dr. Vukov of GAMC was the first professional to add a developmental disorder to claimant's constellation of maladies.

46. Finally, claimant at times has been diagnosed with psychosis induced by the consumption of illicit drugs. The parties are at odds on how such diagnoses impact claimant's developmental condition, as is the evidence. For example, claimant frequently advised those treating him that he had consumed various types of illicit drugs, only to recant shortly after. Toxicology reports are also mixed; some were negative for illicit drugs, some positive. Dr. Collister correctly notes that claimant would not have had access to illicit drugs when he was placed in the facilities in Nevada and Colorado, and yet he still acted bizarrely well after his initial placements. On the other hand, many of claimant's recent 5150 holds were accentuated by his statements that he had consumed drugs, and tests results confirmed the same. And his behavior during those placements and admissions was described as being different than his behavior while at home. Based on this conflicting evidence, it was simply established by a preponderance of the evidence that claimant has consistently consumed marijuana since October 2013, based on his statements and various toxicology reports confirming the presence of such in his system. The frequency and amount of his marijuana consumption was not established. Nonetheless, it was not established that claimant's use of illicit drugs undercuts either a valid diagnosis of a developmental disability or a serious psychiatric disorder.

CREDIBILITY FINDINGS REGARDING THE EXPERT OPINIONS ON INTELLECTUAL DISABILITY

47. Claimant established by a preponderance of the evidence that his expert witnesses' opinions that he is intellectually disabled sufficiently refuted the contrary opinion expressed by the service agency's expert, Dr. Collister, as follows:

A. UCLA is the only evaluator or treating entity to conduct and complete valid cognitive testing on claimant. The UCLA results show that claimant has a full-scale IQ placing him in the range of moderate intellectual disability. The UCLA testing also showed that claimant has commensurate adaptive limitations. Dr. Collister conceded during his cross-examination that he could not state that the UCLA cognitive testing was invalid; he simply maintained that either claimant performed better for Dr. Apelian or she was simply wrong in interpreting her data. Dr. Collister's own report acknowledged that "there may be deficits in intellectual function as well as academic achievement," and that that "there is a possibility of a developmental disorder more relating to his [claimant's] level of intellectual function." In fact, it must be remembered that although Dr. Collister invalidated his cognitive tests on claimant, the results still showed a full-scale IQ score close to UCLA's.

B. There is no known cognitive testing showing that claimant has greater cognitive ability. The placements in Nevada or Colorado either abandoned initial efforts to conduct cognitive testing or failed to do them at all. Nonetheless, the initial tests at Willow Springs showed claimant's academic skills were very low and there was a recommendation to refer him to special education.

C. Dr. Cronin credibly corroborated the report of UCLA's Dr. Apelian, both with her own evaluation of claimant, as well as the information she learned from contacting collateral sources.

D. The cognitive testing conducted by UCLA was better suited for claimant and more in-line with DDS Guidelines than those chosen by Dr. Collister.

48. The service agency made a number of arguments attempting to undercut the credibility of claimant's experts. Those arguments were not persuasive as follows:

A. The service agency contends that the cognitive testing conducted by Dr. Apelian was invalid because the UCLA evaluation began on the heels of Claimant's release from GAMC on June 9, 2014, and that one week later claimant was again hospitalized at GAMC. The service agency points to Dr. Collister's testimony that with such frequent psychotic episodes, claimant would not have been stable when tested by Dr. Apelian. However, the UCLA team did not find claimant to be actively psychotic during their evaluation and they believed their cognitive testing was valid. Dr. Collister was not able to refute the validity of UCLA's testing. Moreover, Dr. Collister has changed his own opinion whether claimant was actively psychotic when he saw him, leaving room to question his critique of Dr. Apelian's observations. Moreover, the UCLA team consisted of several professionals who observed claimant at various times during his evaluation; none of them believed claimant was actively psychotic.

B. The service agency argues that Dr. Apelian relied almost entirely on information given to her by claimant's mother to form her conclusions, but that it is documented that claimant's mother is not a reliable witness, as stated by Intake Specialist Navarro, Dr. Collister, and alluded to in records from Willow Springs. The service agency also points out a number of

inconsistent statements claimant's mother has made to various professionals about her son. The service agency also points out that while claimant's mother testified credibly at the hearing when questioned by claimant's counsel, her memory was not as good and her cooperation was not as robust when cross-examined. These arguments, individually, have merit. However, the cognitive testing conducted by UCLA was based on claimant's input, not his mother's. While the VABS testing for adaptive deficits, which is also crucial for an ID diagnosis, was based on information provided by claimant's mother, both UCLA and Dr. Collister reached similar VABS test scores. Dr. Collister did not testify that either VABS score was invalid.

C. The service agency also argues that there are several errors in the UCLA report, which undercuts Dr. Apelian's credibility. However, the items noted by the service agency from the UCLA report do not appear to be errors, but rather a different interpretation of the voluminous records reviewed from that offered by Dr. Collister. Even if those references were in error, they would hardly invalidate Dr. Apelian's ultimate conclusions.

D. The service agency questions how claimant could have ID when none of the many professionals who came into contact with him before GAMC and UCLA diagnosed him with ID. The service agency also points out that during interviews claimant showed the ability and interests of a person who functions without an ID by making statements that he "likes rap, cops (video games per mother) and 'BJs.'" However, as discussed above, none of the other professionals completed valid cognitive testing, so whatever conclusions they reached on claimant's cognitive ability is limited. Moreover, the ALJ is aware of no science-based evidence presented in this case indicating that a person

with ID is not capable of making the type of cultural references attributed to claimant.

Credibility Findings Regarding the Expert Opinions on Autism Spectrum Disorder

49. Claimant established by a preponderance of the evidence that his expert witnesses' opinions that he has ASD sufficiently refuted the contrary opinion expressed by the service agency's expert, Dr. Collister.

50. The DSM-5 diagnostic criteria for ASD include "persistent deficits in social communication and social interaction across multiple contexts." In this case, it was amply established that claimant has displayed such deficits since a young age, well before his psychiatric placements and admissions, and subsequently, to the present time. However, the DSM-5 criteria for ASD also include "restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history:

a) Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
b) Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).
c) Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).
d) Hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature,

adverse response to specific sound or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

51. Dr. Collister concedes that claimant's deficits in social interaction, communication, and developing/maintaining social relationships, are well documented. His primary reason for concluding that claimant does not have ASD is because he believes there is a lack of evidence from the voluminous records he reviewed demonstrating the type of restricted, repetitive patterns of behaviors, interests or activities described in the DSM-5 and noted above. Dr. Collister's concern is warranted, as the voluminous records available do not necessarily depict claimant as engaging in such repetitive and restrictive interests or activities. However, Dr. Apelian and Dr. Cronin believe the records should be approached with caution, because the involved professionals were evaluating claimant from a psychiatric perspective, as opposed to a psychological developmental perspective. For example, where claimant was described in the records as pacing or talking to himself, Dr. Apelian, in her record review, describes those activities as perseveration and echoing speech, which she believes are hallmarks of autism.

52. Dr. Collister criticized Dr. Apelian and Dr. Cronin for relying too heavily on claimant's mother's input for information they believed fit within the restrictive and repetitive interests/activities criteria of the DSM-5. Again, Dr. Collister's concern is warranted. As discussed above, claimant's mother was not proven to be an accurate or reliable historian. Though she has had numerous opportunities to give detailed accounts of her son's behavior over the years, the documentation does not describe copious instances of restrictive behaviors and interests required by the DSM-5. In fact, many of the restrictive interests and activities noted in the UCLA report are seen for the first time in any documentation concerning claimant. Claimant's mother testified about a few such restricted interests and activities. But her testimony is approached with caution, for

various reasons: a) she has made inconsistent statements about her son to various professionals; b) her demeanor and cooperation seemed to change during the hearing, depending on who was examining her; c) she has been less forthcoming with information when questioned by Intake Specialist Navarro and Dr. Collister, as opposed to UCLA or Dr. Cronin; and d) she has a self-interest in the outcome of this case. Thus, her statements and testimony on this issue is of limited weight, unless it can be corroborated by other sources.

53. Based on the statements and testimony of claimant's mother, as corroborated by the medical documentation and statements made by claimant's sister, as well as the observations of Dr. Apelian and Dr. Cronin, it was established that claimant has, for many years, engaged in repetitive behaviors such as pacing, wandering away and walking into streets. It was similarly established that he likes to grab small objects, any small objects, and put them in his mouth. Claimant's mother's testimony that her son has a tactile resistance to certain clothes and textures was corroborated by the observations of Dr. Apelian and Dr. Cronin, who confirmed that claimant will not wear certain articles of clothing or accessories. Instead, his identifying information has to be written on his arm in ink. Dr. Apelian also observed claimant repetitively check textures of objects with his hands, face and mouth.

54. Based on the above, it was established that claimant meets three of the four restrictive, repetitive categories. He has engaged in "stereotyped or repetitive motor movements, use of objects, or speech," such as pacing, wandering away, echoing comments and instructions and fiddling with small objects. Dr. Apelian considers claimant's obsessive taste for putting small objects in his mouth as falling into the category of "highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests)." Moreover, claimant has a tactile aversion

causing him to shun certain articles of clothing or accessories, mouthing certain objects he finds and engaging in persistent tactile curiosity with the texture of objects. Dr. Apelian considers such activity to fall within the category of "hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment." Dr. Apelian notes in her report that claimant would have also met the prior diagnosis of autistic disorder under the DSM, fourth edition, text revision (DSM-IV-TR), had he been evaluated by the UCLA team before his 18th birthday. Under these circumstances, the ASD diagnoses of Dr. Apelian and Dr. Cronin are supported by the record in this regard.

55. As there is no corroboration of Dr. Dorman's alleged autism diagnosis of claimant when he was a young boy in Missouri, claimant's mother's testimony in that regard is not persuasive.

56. It is also true that Dr. Vukov's diagnosis of ASD for claimant should be viewed as preliminary because she engaged in no psychological testing and did not appear to evaluate claimant based on the DSM-5 criteria. However, Dr. Vukov's suspicion of autism for claimant was later confirmed by the work of the UCLA team, which in turn was corroborated by Dr. Cronin. It is this chronology of ASD diagnoses which is persuasive.

57. In addition, Dr. Apelian and the UCLA team used interview techniques and testing better suited to analyze claimant for ASD than did Dr. Collister. UCLA used both the ADIR and ADOS tests, which are gold-standard; Dr. Collister used only the GARS. Nonetheless, Dr. Collister's preliminary results from the GARS showed a likelihood of autism for claimant.

58. Dr. Collister questioned whether claimant's behaviors and deficits are better explained by his psychiatric disorder. But, as discussed above, claimant's various psychiatric diagnoses do not rule out ASD. The two disorders can be co-morbid. Moreover, there was a lack of evidence showing that claimant's persistent social

withdrawal, communication deficits, and persistent and repetitive behaviors are caused by a psychosis. Many of those traits were observed in claimant before he began using illicit drugs or was first placed in Willow Springs. Even after claimant's most severe behavior problems leading to his serial 5150 holds, and his psychiatric treatments, he remains socially withdrawn, uninterested in social interaction, unable to appropriately communicate, and obsessed with a few persistent and restricted interests and behaviors.

FINDINGS REGARDING THE EXTENT OF CLAIMANT'S DISABILITY

59. By no later than June 7, 2013, claimant was determined to be eligible for Supplemental Security Income (SSI) payments by the federal Social Security Administration (SSA) for an unspecified disability which "began on November 30, 2010."

60. Claimant is significantly impaired in both expressive and receptive communication, as well as learning. He is substantially disabled in the area of self-direction. Without the frequent support of others, claimant will wander at will with no purpose. Claimant is substantially disabled in the areas of self-care and independent living, as he cannot care for himself and requires constant prompts to engage in basic self-care activities such as bathing. He is substantially handicapped in the area of economic self-sufficiency in that he has no realistic possibility of holding a job or living on his own.

61. The findings above are bolstered by the various adaptive testing performed on claimant by UCLA, as well as Dr. Collister. In the VABS tests administered by UCLA and Dr. Collister, claimant received scores falling well below a substantial handicap in the areas of expressive communication, receptive communication, daily living skills, socializations, and motor skills.

62. Both Dr. Collister and Dr. Cronin testified that cognition does not change much over time absent some catastrophic event. Specifically, Dr. Cronin testified that a

person's IQ could drop by just a few points during adolescence, but not more significantly.

LEGAL CONCLUSIONS

JURISDICTION AND BURDEN OF PROOF

1. The Lanterman Developmental Disabilities Services Act (Lanterman Act) governs this case. (Welf. & Inst. Code, § 4500 et seq.) An administrative hearing to determine the rights and obligations of the parties is available under the Lanterman Act to appeal a contrary regional center decision. (§§ 4700-4716.) Claimant requested a hearing and therefore jurisdiction for this appeal was established. (Factual Findings 1-9.)

2. A. Where an applicant seeks to establish eligibility for government benefits or services, the burden of proof is on him. (See, e.g., *Lindsay v. San Diego Retirement Bd.* (1964) 231 Cal.App.2d 156, 161 [disability benefits].) The standard of proof in this case is the preponderance of the evidence, because no law or statute (including the Lanterman Act) requires otherwise. (Evid. Code, § 115.) "'Preponderance of the evidence means evidence that has more convincing force than that opposed to it.' (Citations.) . . . [T]he sole focus of the legal definition of 'preponderance' in the phrase 'preponderance of the evidence' is the quality of the evidence. The quantity of the evidence presented by each side is irrelevant." (*Glage v. Hawes Firearms Company* (1990) 226 Cal.App.3d 314, 324-325.)

B. With regard to eligibility for regional center services, "the Lanterman Act and implementing regulations clearly defer to the expertise of the DDS (California Department of Developmental Services) and RC (regional center) professionals' determination as to whether an individual is developmentally disabled." (*Mason v. Office of Administrative Hearings* (2001) 89 Cal.App.4th 1119, 1127.) In *Mason*, the court focused on whether the applicant's expert witnesses' opinions on eligibility

"sufficiently refuted" those expressed by the regional center's experts that the applicant was not eligible. (*Id.*, at p. 1137.)

C. Based on the above, claimant has the burden of proving by a preponderance of the evidence that his evidence regarding eligibility is more persuasive than the service agency's.

3. One is eligible for services under the Lanterman Act if it is established that he is suffering from a substantial disability that is attributable to intellectual disability, cerebral palsy, epilepsy, autism or what is referred to as the fifth category. (Welf. & Inst. Code, § 4512, subd. (a).)[3] A qualifying condition must originate before one's 18th birthday and continue indefinitely thereafter. (§ 4512.)

DOES CLAIMANT HAVE INTELLECTUAL DISABILITY?

4. With the APA's May 2013 publication of the DSM-5, the previous diagnostic term "Mental Retardation" was replaced with the diagnostic term "Intellectual Disability," which, according to the APA "has come into common use over the past two decades among medical, educational, and other professionals, and by the lay public and advocacy groups." (DSM-5 at p. 809.) Section 4512, subdivision (a), was subsequently amended to reflect that intellectual disability has replaced mental retardation as a qualifying condition.

5. The DSM-5 defines intellectual disability as "a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains." (*Id.* at 33.) The APA notes that the most significant change in diagnostic categorization accompanying the change from

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[3] All further statutory references are to the Welfare and Institutions Code, unless otherwise specified.

DSM-IV-TR to DSM-5 nomenclature of intellectual disability is emphasis on the need for an assessment of both cognitive capacity and adaptive functioning, and that the severity of intellectual disability is determined by adaptive functioning rather than simply an IQ score. The APA notes no other significant changes.

6. In this case, claimant's expert witnesses have persuasively opined that claimant has ID, and have credibly refuted the contrary opinion held by the service agency's expert witness, Dr. Collister. Testing done by UCLA shows claimant's cognitive level is in the moderate range of intellectual disability and that his adaptive skills are in the low range, which also shows significant intellectual disability. (Factual Findings 10-48.)

DOES CLAIMANT HAVE AUTISM?

7. The Lanterman Act and its implementing regulations similarly contain no definition of the neurodevelopmental condition of autism. The customary practice has been to import the DSM-IV-TR definition of "autistic disorder" into the Lanterman Act when determining eligibility for services and supports on the basis of autism. That definition also has been revised with the May 2013 publication of the DSM-5. "Autism Spectrum Disorder" is the APA's new diagnostic nomenclature encompassing the DSM-IV-TR's diagnoses of autistic disorder, Asperger's disorder, childhood disintegrative disorder, Rett's syndrome, and PDD-NOS. (DSM-5 at p. 809.) Thus, individuals with a well-established DSM-IV-TR diagnosis of autistic disorder, Asperger's disorder, or PDD-NOS are now given the diagnosis of Autism Spectrum Disorder. (*Id.* at 51.)

8. These essential diagnostic features of Autism Spectrum Disorder—deficits in social communication and social interaction (Criterion A) and restricted repetitive patterns of behavior, interests and activities (Criterion B)—must be present from early childhood and limit or impair everyday functioning (Criteria C and D).

9. The DSM-5 provides that, with respect to individuals presenting for diagnosis in adulthood, "where clinical observation suggests criteria are currently met, autism spectrum disorder may be diagnosed, provided there is no evidence of good social communication skills in childhood." (*Id.* at 56.) In the case of the adult individual, the DSM-5 provides that "the report (by parents or another relative) that the individual had ordinary and sustained reciprocal friendships and good nonverbal communication skills throughout childhood would rule out a diagnosis of autism spectrum disorder; however, the absence of developmental information in itself should not do so." (*Id.*)

10. In this case, claimant's expert witnesses persuasively established by a preponderance of the evidence that he has ASD, a disorder in current parlance which meets the Lanterman Act's stated qualifying condition of autism. Based on the record presented, claimant's social withdrawal, lack of interest in social interaction, communication deficits, and persistent and restricted interests and behaviors have been consistently documented from the time he was a young boy, through when he was placed at Willow Springs as a teenager, to the present time. While the statements and testimony of claimant's mother are subject to limited weight, there is no information (other than a few vague statements attributed to claimant's mother) that claimant has ever had typical social or communication abilities. Implicit in Dr. Apelian's and Dr. Cronin's diagnoses of ASD is that claimant has suffered from that condition since his early childhood. (Factual Findings 10-46, 49-58.)

DOES CLAIMANT HAVE A FIFTH CATEGORY CONDITION?

11. The "fifth category" is described as "disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability." (§ 4512, subd. (a).) A more specific definition of a "fifth category" condition is not provided in the statutes or regulations. Whereas the first four categories of eligibility are specific (e.g., epilepsy or cerebral

palsy), the disabling conditions under this residual fifth category are intentionally broad so as to encompass unspecified conditions and disorders. But the Legislature requires that the condition be "closely related" (§ 4512) or "similar" (Cal. Code Regs., tit. 17, § 54000) to intellectual disability. "The fifth category condition must be very similar to mental retardation [the prior diagnostic term for intellectual disability], with many of the same, or close to the same, factors required in classifying a person as mentally retarded." (*Mason v. Office of Administrative Hearings*, *supra*, 89 Cal.App.4th at p. 1129.)

12. In light of the revisions brought about by the DSM-5, a contemporary reading of the Lanterman Act and cases interpreting it is that the fifth category condition must be closely related to intellectual disability. Since claimant has established that he is intellectually disabled, a determination of whether he could also be classified as eligible for services under the closely related companion fifth category condition is unnecessary.

CLAIMANT IS SUBSTANTIALLY DISABLED

13. The qualifying condition(s) must also cause a substantial disability. (§ 4512, subd. (a); Cal. Code Regs., tit. 17, § 54000, subd. (b)(3).) A "substantial disability" is defined by California Code of Regulations, title 17, section 54001, subdivision (a), as:

(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.[4]

14. In this case, applying the evidence to the above-described categories reveals claimant is substantially disabled by virtue of his ID and ASD. Claimant's condition has resulted in a major impairment of his cognitive and social functioning, as required by California Code of Regulations, title 17, section 54001, subdivision (a)(1). He has significant functional limitations in all areas of his major life activity listed in section 54001, subdivision (a)(2), except for mobility. As established by the UCLA team's report, claimant requires interdisciplinary planning and coordination of special or generic services to assist him in achieving his maximum potential. (Factual Findings 10-62.)

DOES CLAIMANT HAVE A CONDITION EXCLUDING HIM FROM ELIGIBILITY?

15. A. Excluded from eligibility are handicapping conditions that are solely psychiatric disorders, learning disabilities and/or disorders solely physical in nature. (Cal. Code Regs., tit. 17, § 54000.) If an applicant's condition is *solely* caused by one or more of these three "handicapping conditions," he is not entitled to eligibility.

B. "Solely psychiatric disorders" are defined as "impaired intellectual or social functioning which originated as a result of the psychiatric disorder or treatment given for such a disorder." (Cal. Code Regs., tit. 17, § 54000, subd. (c)(1).)

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[4] Section 4512, subdivision (l), defines "substantial disability" similar to that of California Code of Regulations, title 17, section 54001, subdivision (a)(2).

C. "Learning disorders" are defined as a significant discrepancy between estimated cognitive potential and actual level of educational performance which is not "the result of generalized mental retardation, educational or psycho-social deprivation, [or] psychiatric disorder. . . ." (Cal. Code Regs., tit. 17, § 54000, subd. (c)(2).)

16. The fact that an individual has received or requires mental health treatment does not disqualify that individual from regional center services if he otherwise meets the requirements of section 4512 discussed herein. (*Samantha C. v. State Department of Developmental Services* (2010) 185 Cal.App.4th 1462.)

17. In this case, although it was established that claimant has some sort of psychiatric disorder, it was not established that such is the sole cause of his impaired cognitive and social functioning. Claimant's social, communication and cognitive deficits have been present since he was a young boy, well before his first documented psychiatric diagnoses. In addition, despite being diagnosed with psychiatric disorders and prescribed medications and treatments, claimant remains impaired in terms of his social, communicative and cognitive functions. Although Dr. Collister points to claimant's psychiatric hospitalizations and diagnoses, he did not effectively opine or conclude that they are the sole cause of claimant's problems. (Factual Findings 10-62.)

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IS CLAIMANT ELIGIBLE FOR SERVICES?

18. Since claimant established by a preponderance of the evidence that he has two of the five qualifying developmental disabilities, i.e., intellectual disability and autism, he established a basis of eligibility for regional center services under the Lanterman Act. He similarly established that those two qualifying conditions have caused him to be substantially disabled. The behaviors underlying his conditions were

first observed when he was a young boy through when he was first placed at Willow Springs as a teenager. Although the only valid cognitive testing was conducted after claimant turned 18, the expert witnesses agree that his IQ score could not have depreciated enough from before he was 18 through when the tests were done. Thus, it was established that claimant's qualifying conditions occurred before he was 18 and that they will continue indefinitely thereafter. Under these circumstances, his appeal must be granted. (Factual Findings 1-62; Legal Conclusions 1-17.)

ORDER

Claimant established that he is eligible for services under the Lanterman Developmental Disabilities Services Act. Claimant's appeal of the Frank D. Lanterman Regional Center's determination that he is not eligible for regional center services is therefore granted.

DATED: October 8, 2015

/s/

ERIC SAWYER,

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.