BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: CLAIMANT, vs. EASTERN LOS ANGELES REGIONAL CENTER, Service Agency.	Case No. 2015020707

DECISION

Administrative Law Judge Eileen Cohn (ALJ Cohn) heard this matter on May 12, 2015, in Alhambra, California.

Claimant was represented by Mathew M. Pope, Attorney at Law. Claimant and his father, mother and sibling also attended the hearing. Claimant's parents were assisted by a Spanish-language interpreter.[1]

The Eastern Los Angeles Regional Center (ELARC or Service Agency) was represented by Edith Hernandez.

Evidence was presented and testimony heard. The record was closed and the matter submitted for decision on May 12, 2015.

[1] Initials and family titles are used to protect the privacy of claimant and his family.

ISSUES PRESENTED

The parties stipulated to the following issues:

1. Whether claimant is eligible for regional center services and supports under the qualifying category of autism.

2. Whether claimant is eligible for regional center services and supports under the qualifying fifth category, a disabling condition closely related to intellectual disability or requiring treatment similar to that required for individuals with an intellectual disability.

EVIDENCE RELIED ON

In making this Decision, the ALJ relied on exhibits 1-30 submitted by the Service Agency, exhibits A-C and E submitted by claimant, and the testimony of Randi Bienstock, Psy.D., Paul Mancillas, Ph.D., claimant, and claimant's brother, mother and father.[2]

FACTUAL FINDINGS

PROCEDURAL BACKGROUND

1. By letter dated December 17, 2014, Service Agency notified claimant that it had denied his request to reconsider its determination of October 17, 2013, declaring him ineligible for regional center services. Claimant timely submitted a request for fair

[2] Official notice is taken of ALJ Eric Sawyer's Decision, OAH No. 2013110351 (Exhibit 23). (Gov. Code, § 11515.) At the hearing, the parties stipulated to the admission of ALJ Sawyer's Decision by official notice. Many of ALJ Sawyer's Factual Findings were adopted herein, after a review of the records, or where previous testimony was not subject to dispute.

hearing and this hearing ensued. Claimant based his request on a neuropsychological test report by Paul Mancillas, Ph.D. dated November 28, 2014. Service Agency reviewed the report and determined that it did not provide any information that would cause it to change its previous determination that he was ineligible for regional center services. Service Agency also noted that its determination was also adjudicated and upheld by Administrative Law Judge Eric Sawyer on September 9, 2014, in OAH Decision No. 2013110351.

2. This appeal raises the same issues between claimant and Service Agency that was determined by Administrative Law Judge Eric Sawyer in OAH Decision No. 2013110351 (Exhibit 23), on September 9, 2014. (ALJ Sawyer's Decision). ALJ Sawyer denied claimant's prior appeal and upheld Service Agency's determination that claimant was ineligible regional center services under the categories of autism and the fifth category. Claimant did not appeal ALJ Sawyer's Decision.

3. At the May 12, 2015, fair hearing, ALJ Cohn advised claimant that unless he could show new circumstances, ALJ Sawyer's Decision would bar the ALJ from considering the merits of his current appeal under the doctrine of *res judicata*. The claimant was able to show new circumstances to avoid the application of the doctrine. Specifically, claimant established his failure to make progress with his therapy, and his continuing isolation. Additionally, claimant established the use of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)[3] as a reference in determining eligibility which was not available to him before, as well as the testimony

[3] Source: http://www.psychiatry.org/practice/dsm/dsm-history-of-the-manual. The Administrative Law Judge takes official notice of the history and contents of the DSM-IV-TR and its successor DSM-5 as highly respected and generally accepted tools for diagnosing mental and developmental disorders.

and expert report generated by Paul Mancillas, Ph.D., which had not yet been prepared at the time of the last hearing. Dr. Mancillas, pursuant to a neuropsychological assessment prepared by him, considered claimant eligible under the fifth category and under the category of autism.

BACKGROUND AND EARLY HISTORY

4. Claimant is a 24-year-old male requesting services from the Service Agency.

5. Claimant lives at home with his parents and two younger brothers, ages 23 and 20.

6. At an early age, claimant exhibited expressive language delays. Claimant was raised in a bi-lingual household and spoke approximately 10-15 words by the time he was three.

7. In 1993, when claimant was three years old, he was taken to White Memorial Medical Center's (White Memorial) Communication Disorders Department for a speech and language evaluation. His parents told clinicians that claimant had "normal comprehension." Mother reported that claimant used only single words. His hearing was found to be within normal limits, but the screening revealed severe expressive language- speech delays. It was recommended that claimant be placed in a preschool and that he receive speech therapy in the public school system. During his 1993 evaluation, claimant also exhibited inhibited social interaction. Mother reported that he was shy and the examiner reported that claimant's failure to point to pictures "might have been" because claimant was "very shy in the clinic setting." (Exhibit 3.)

8. Claimant received special education services through the public school system beginning in September 1994, when he was placed in a special education preschool day program to address his speech and language delays. In a January 1995 preschool assessment report and individual education program (IEP) plan, it was

reported that he was 60 percent intelligible, but his pragmatic social skills were "basically good" as he maintained good eye contact and responded when spoken to when he became more comfortable, although he said "very little." (Exhibit 4.) Claimant's mother reported that his language articulation improved since starting preschool, and no cognitive deficits were noted as he was able to copy complex block designs created by his mother and do complex puzzles.

9. In 1995, when claimant was approximately five years old, he was given a pediatric screening at White Memorial. His cognitive ability was noted to be "within normal limits," but his speech and language skills were still delayed. It was recommended that he receive speech therapy at school. There was no evidence that standardized assessments were used to determine his cognitive ability.

10. Another IEP was created one year later in 1996. This IEP also targeted claimant's special education services to address his "moderate articulation deficits." He was deemed eligible for services based on "speech/language" delays. No cognitive deficits or behaviors suggestive of an autism spectrum disorder were noted in the IEP.

11. After the 1996 there was no evidence of IEPs developed for claimant, school performance, placement, special education interventions, or any school-based assessments. Little documentary evidence was presented concerning claimant's developmental history between 1997, when he was seven years old and 2008, when he was 18 years old, except for records from the Los Angeles County Department of Health Services indicating that claimant received treatment for substance abuse sometime during that period.

12. Claimant's parents removed claimant from special education during middle school and claimant continued through high school graduation as a general education student without special education classes or services, or evidence of accommodations. It is unknown what claimant's placement or services were at the time

his parents removed him from special education.

13. In June 2008, when he was completing 11th grade, claimant's parents sent a letter to claimant's high school principal, advising him that claimant had a "possible diagnosis of mental retardation," and demanded school authorities conduct assessments to determine claimant's needs for special education services. The school district's Special Education Coordinator advised claimant's parents that such assessments would be conducted at the beginning of the next school year, given the lateness of the request and the fact that school staff were on summer vacation. There was no evidence that assessments were conducted. There was no evidence of claimant's learning difficulties in his classroom setting. At hearing, mother testified that the school system failed claimant.

CLAIMANT'S 2008 SERVICE AGENCY EVALUATION

14. Claimant was given an intake assessment by the Service Agency in July 2008, when he was 17 years and eight months old, and just prior to his senior high school year. The Service Agency Intake Counselor, who met with claimant and his parents, reported that claimant was cooperative, responded to "some questions," made a "social greeting" with "good eye contact," but remained very quiet during the meeting. (Exhibit 6.) She reported his ability to communicate "well about his own experiences," communicate in sentences and maintain a conversation. (*Ibid.*)

15. As part of the intake assessment, claimant's mother reported his medical and developmental milestones including a normal full term delivery with forceps, no medical complications, no reports of accidents or seizures, no medications, and his first words at 12 months of age.

16. The Intake Counselor reported on claimant's general social-emotional, educational, cognitive, and adaptive functioning from parents' and claimant's reports. As to his social interactions, claimant told the Intake Counselor that he had friends and

formerly a girlfriend. He reported that he goes out to movies or dinner with his friends and drives an automobile. He reported as interests playing basketball and Xbox, welding and electronics.

17. Claimant's mother disagreed with claimant's representations of his social life and reported during the past six months, he was socially isolated and had no friends or a girlfriend. As to claimant's emotional status, claimant's parents stated that their son had emotional problems, poor self-esteem and depression, and slept all day. As to his educational status, claimant's parents reported that he had learning problems and claimant's mother also reported that he could not read or write at his age level. As to his cognitive status, claimant's mother reported claimant had problems retaining information. As to his adaptive functioning, claimant's mother reported claimant had a declining interest in his personal hygiene over the past six months. Claimant could access the community, had a driver's license, knew how to use money but needed assistance with budgeting and money management. Claimant was able to take care of his personal self-help needs; he was responsible for domestic chores such as simple cooking and laundry. The Intake Counselor noted that claimant had obtained a driver's license, but recently had been arrested for driving under the influence of alcohol.[4]

18. The Intake Counselor recommended an assessment to determine claimant's eligibility for regional center services. Service Agency referred claimant to psychologist Larry E. Gaines for a psychological evaluation to determine whether claimant had developmental disabilities including intellectual disability and autism. In July 2008, Dr. Gaines conducted the evaluation. He reviewed claimant's records,

[4] Claimant's mother advised Service Agency staff a few years later, in connection with the previous eligibility request, that no criminal case was filed due to a procedural error by the police.

interviewed claimant and his mother, and administered to claimant a series of tests. Dr. Gaines made the following pertinent findings:

A. Claimant was administered the Wechsler Adult Intelligence Scale-III (WAIS 3) and received scores of 83 in Verbal IQ, 100 in Performance IQ, and a 90 Full Scale IQ, scores which Dr. Gaines described as in the average to low-average range of intellectual ability. Dr. Gaines noted that claimant displayed some weakness in verbal tasks, which he related to Claimant's history of auditory and language processing problems. Dr. Gaines maintained that claimant's profile suggested learning disorders.

B. Based on the results of claimant's performance in the Vineland Adaptive Behavior Scales (Vineland), Dr. Gaines noted claimant had adaptive deficits, particularly in communication and socialization, which he described as in the borderline range. Claimant's language skills fell within the mild range of deficiency, which Dr. Gaines maintained reflected some of claimant's academic difficulties. Claimant showed some difficulties with listening and processing auditory information necessary for reading, and "minor restrictions" in his ability to speak in sentences or maintain a conversation." (Exhibit 7.) Dr. Gaines also considered claimant's adaptive skills consistent with reports to the Intake Counselor (Factual Findings 14-17). Claimant's mother reported she allows him to "go out independently, and he shows appropriate responsibility." (Exhibit 7.)

C. Claimant reported recent depression, nervousness, anxiety, and obsessive thoughts, and he commented that those moods cycled, which Dr. Gaines believed suggested the presence of an affective disorder. Consistent with his report to the Intake Counselor, in the last six months, claimant reported difficulties in emotional functioning, and demonstrated less concern with

hygiene. Additionally he reported to Dr. Gaines that one month prior, he experienced depression and suicidal thoughts, unaccompanied by a plan or action. (Exhibit 7.)

D. Dr. Gaines believed claimant's profile suggested a learning disorder and the possibility of affective disorders. He deferred a diagnosis of Affective Disorder(s) for further mental health evaluation, and he noted that a diagnosis of a Learning Disorder Not Otherwise Specified (NOS) should be ruled out. Dr. Gaines found no presence of mental retardation or autistic features, and made no diagnosis of a developmental disorder.

19. In his diagnosis, Dr. Gaines relied upon the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition-Text Revision (2000)(DSM IV-TR). The DSM IV-TR was the immediate predecessor of the DSM-5, and was also published by the American Psychiatric Association. The most recent edition is the DSM-5, published in May 2013. The DSM is a generally-accepted manual listing the diagnostic criteria and discussing the identifying factors of most known mental disorders.[5] Best practices required that the DSM-5 be used within six months to a year, of its release, or no later than May 2014.

20. Service Agency consulting psychologist, Randi E. Bienstock, Psy.D., reviewed claimant's case file in September 2008, including Dr. Gaines' evaluation report. Based on Dr. Gaines evaluation report, Dr. Bienstock concluded claimant did not have any condition making him eligible for regional center services. She recommended

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[5] Source: http://www.psychiatry.org/practice/dsm/dsm-history-of-the-manual. The Administrative Law Judge takes official notice of the history and contents of the DSM-IV-TR and its successor DSM-5 as highly respected and generally accepted tools for diagnosing mental and developmental disorders.

claimant receive special education services, individual psychotherapy to address mental health concerns, and transition to job training.

21. Dr. Bienstock also testified during the hearing. Her testimony was consistent with her testimony described in ALJ Sawyer's Decision. At the instant hearing, she added her opinion about Dr. Mancillas's testimony as set forth more fully below. She had not evaluated or met with claimant, but she had reviewed his file, the assessments of Drs. Gaines and Roberto Di Candia, Ph.D., and pertinent records. Dr. Bienstock also had the necessary credentials and long-term experience as a regional center psychologist consultant to render an opinion. For reasons more fully discussed below, Dr. Bienstock's testimony was given more weight with regard to claimant's eligibility based upon her expertise and thorough review of records, and the consistency between her testimony and the records she reviewed.

22. The Service Agency denied claimant's 2008 request for eligibility. Claimant's parents did not appeal.

CLAIMANT'S MENTAL HEALTH HISTORY AND EVALUATIONS

23. Records indicated that beginning in September 2008, when claimant was a senior in high school and 18 years old, and continuing through June 2013 claimant was hospitalized between 10 and 13 times for substance abuse, paranoia and/or aggression, including destroying a wardrobe with a hammer and hitting his mother.

24. Claimant graduated high school in spring 2009. He attended a local junior college in 2009, but dropped out after three months because of psychiatric problems and his inability to focus and attend to instruction.

25. In December 2010, Claimant was seen by staff at Pacific Clinics Adult Psychiatric (Pacific), complaining of paranoia, anxiety and aggressive behaviors. Mother also reported that claimant tried to "physically attack" her. (Exhibit 12.) From their interviews with claimant and his mother, Pacific staff diagnosed claimant with

Schizoaffective Disorder, and prescribed anti-psychotic medications. Claimant's intellectual functioning was described as "fair," his affect "constricted," his memory as "unimpaired," but his thought process disturbed by impaired to minimal judgment and insight. (*Ibid.*)

26. In 2012, claimant attended a transition program, the results of which were not established. Claimant had never been employed and there was no record of his participation in any vocational training.

27. Claimant again was seen at Pacific in February 2012, this time complaining of hallucinations that "people were talking about him." He complained of being depressed, having low self-esteem, "sadness, hopelessness, lack of interest in daily activities, and feeling worthless." (Exhibit 13.) Claimant advised staff that his mental health problems had begun when he was 17. Claimant reported he crashed his car crash at 17, while he was intoxicated. When discussing his educational history, claimant reported his graduation from high school with average grades. He also reported his short-lived enrollment in community college in 2008, where he "dropped out due to low grades" because "he could not concentrate" and "did not feel motivated." (*Ibid.*) When discussing his family relations, claimant reported that he did not get along with his brothers, had little communication with them, and did not get along with his father, with whom he had a history of fighting. He reported his "main source "of support was his mother." (*Id.*) From his previous records Pacific staff noted his family mental health history, which included a cousin suffering from depression and a maternal great grandmother with Alzheimer's. Pacific staff noted that claimant's mental health history inhibited him from living independently, finding competitive employment, performing daily activities, building social relationships and continuing with his education.

28. At the conclusion of February 2012, intake Pacific staff gave claimant a diagnosis of Schizoaffective Disorder and Alcohol Abuse. Individual therapy was

recommended to decrease his angry outbursts, paranoia, and increase his coping skills. Claimant was also prescribed a regimen of anti-psychotic medications. In March 2012, Pacific staff modified claimant's diagnosis to Schizoaffective Disorder, Bi-Polar Type, and Alcohol Abuse.

29. Claimant was hospitalized from June 20, 2013 through June 27, 2013 after engaging in a physical fight with his father and two brothers. He was brought to the hospital by the police and voluntary admitted himself for psychiatric treatment. Upon admission claimant reported that he was prescribed medication after he heard voices and saw things "other's don't," and the medication helped. (Exhibit 22.) Claimant reported that he used to cut himself and last did so in October 2012 with over 50 cuts to his arm. He admitted to being anxious, and being a "danger to himself, to his Dad and his two brothers." (*Ibid.*) Shortly after admission, claimant was observed to be preoccupied with his own thoughts, paranoid and guarded of others. He refused to shower and attend to his hygiene. His treating physicians diagnosed him with Schizophrenia, either paranoid type or not otherwise specified, under the DSM-IV-TR. Before discharge claimant acknowledged that he needed to report to a psychiatrist when he was "depressed, anxious, [or] hearing voices." (*Ibid.*) He was prescribed anti-psychotic medication.

30. Claimant began receiving mental health care from Prototypes in 2013. By this time claimant had been hospitalized on 13 occasions due to "self-harm behaviors and physical fights with people," with his most recent hospitalization in June 2013 for three days. In his initial adult assessment report dated August 26, 2013, which was based entirely on interviews with claimant and mother, Mark Powers, Psy.D., of Prototypes diagnosed claimant with Psychotic Disorder NOS and Autistic Disorder. Claimant was referred for adult assessment due to his reported "anxiety, depression, psychotic symptoms, poor attention and concentration and sleep disturbance." (Exhibit 17.)

Claimant reported less anxiety and nervousness when he was on prescribed medication, and his mother confirmed that he was more stable with medication. (*Ibid.*) During claimant's interview, Dr. Powers observed claimant to be "nervous, shy, but cooperative." *(Id.*) He also noted claimant's historical and continued struggles with social interactions.

31. Dr. Power's diagnosis of Autistic Disorder was informed entirely by mother's report that claimant did not start talking until six years old, presented in school as "shy, quiet and isolated," and displayed repetitive patterns and stubbornness in many ways "such as his appetite, daily routine, and the game he played." (*Id.*) Mother's report that claimant did not start talking until he was six years old was contrary to his history and her representation to the school assessor when he was three years old (Factual Findings 6 and 7) and to the Intake Counselor in 2008 (Factual Finding 15).

32. In his diagnostic summary, Dr. Powers wrote claimant had symptoms of anxiety, depression, psychoses, poor attention and concentration, sleep disturbance and "*possible* autistic symptomology according to client's mother's report." (*Emphasis added.*) Using the DSM-IV-TR, Dr. Powers gave claimant an Axis I diagnosis of Psychotic Disorder NOS and an Axis II diagnosis of Autistic Disorder. Autistic Disorder was an Axis I diagnosis in the DSM IV-TR, not an Axis II diagnosis, which was reserved for personality disorders and intellectual disability.

33. Dr. Powers' diagnosis of autism was not persuasive or controlling as a diagnosis under the DSM-5. Dr. Powers statement in his summary that claimant "possibly" had autistic symptoms undercut the firmness of his diagnosis and failed to qualify his diagnosis as a previous "well-established" diagnosis grandfathered under the DSM-5 diagnosis of Autism Spectrum Disorder. (Exhibit 30, DSM-5, p. 51.) Consistent with his "possibly" diagnosis, Dr. Powers' report did not describe any autism tests given to claimant or indicate that any sort of developmental records review was conducted, steps usually taken to confirm a diagnosis. Dr. Powers' "possibly" diagnosis was based

solely upon mother's report which was inconsistent with her previous reports regarding his language development. Additionally, her reports were vague as to claimant's behaviors. As an assessor and not the treating clinician, Dr. Powers' did not have an opportunity to observe claimant over a long period of time to verify his "possibly" diagnosis in the absence of testing.

THE SERVICE AGENCY'S 2013 ASSESSMENT OF CLAIMANT

34. In August and September 2013, Service Agency referred claimant to Dr. Roberto De Candia, Ph.D., for a psychological evaluation to determine whether claimant fell under the diagnostic categories of intellectual disability or autism. Dr. De Candia conducted the assessment in August and September 2013, when claimant was almost 23 years old. Dr. De Candia interviewed claimant and his mother, reviewed available records, and administered to claimant a number of tests.

35. Dr. De Candia considered claimant's history based upon his educational profile, records review, and his interviews with claimant and Mother.

A. As to his communication, claimant was polite and cooperative, spoke in a low volume in sentences of 4 words or more, and appeared "lethargic" as though "he has to struggle to gather the energy to speak." (Exhibit 10.) Although claimant had a history of speech delay, his mother's report to Dr. De Candia that claimant did not speak until five years old was inconsistent with her past reports.

B. As to his cognitive challenges, claimant's mother reported his apparent confusion with details and poor memory.

C. As to his social-emotional behavior, mother reported he used to be more affectionate and sociable when he was younger, but was no longer interested in family members or interacting with other people. Claimant's mother reported he had friends in high school, but not close friends. She reported

that when he got angry, he tantrummed, threatened others, and punched holes in the walls of their home.

D. As to his adaptive functioning, claimant's mother described claimant as "very neat," and reported his ability to dress independently, perform hygiene, although he needed reminders, make a sandwich, make his bed, and use the telephone. Claimant's mother reported his lack of participation in household chores and activities, and his more "recent" behavior of not leaving the house by himself. (*Ibid.*) Claimant's mother described claimant's adaptive functioning as in decline. It was getting more difficult for claimant to leave the house and to cooperate with individual psychotherapy.

E. As to his psychiatric issues, claimant confirmed his anxiety and past visual hallucinations. Dr. De Candia noted claimant's educational history, his attendance at community college for three months, cut short by psychiatric issues, and his mother's concern with his termination of schooling, excessive sleeping, and refusal to leave the house, or cooperate with his therapist who treated him at their home. Dr. De Candia reported a history of alcohol and substance abuse, suicidal thinking and cutting.

36. Based on his evaluation, Dr. De Candia made the following pertinent findings:

A. As measured by the Vineland, where claimant's mother was the informant, claimant's communication skills were below average and corresponded to that of an eight-year-old. The results of the WAIS-IV were scores of 72 in Verbal Comprehension, 96 in Perceptual Reasoning and 81 in General Ability; claimant's vocabulary was measured as being significantly below average. His ability to understand the meaning of words fell significantly below his same-aged peers. In terms of claimant's academic functioning, the results of the

Wide Range Achievement Test, Revision 4 (WRAT 4) were scores of 89 in word reading (ninth grade equivalent) and 87 in math (sixth grade equivalent). Dr. De Candia described these scores as demonstrating high borderline or low average range intellectual functioning, but he commented that the large discrepancy between the verbal and performance scores highlighted the fact that claimant had a verbal processing disorder. Dr. De Candia viewed his test scores as being consistent with Dr. Gaines' test scores in 2008.

B. Claimant's overall adaptive functioning as measured by the Vineland identified the presence of significant deficits in the domains of communication, daily living skills and socialization. Claimant's Adaptive Behavior Composite score was 35, which showed a "severe deficit."

C. Claimant received a score of 18 on the Autism Diagnostic Observation Schedule (ADOS) test, with 10 being the minimum score suggesting Autistic Disorder. Dr. De Candia described claimant's score as elevated, but concluded the score did not establish claimant was autistic. Dr. De Candia observed claimant's limited social involvement and his distractibility, as if "lost in his own thoughts," which explained his limited range of facial expressions, gaze and gestures, his self-involvement, and lack of "shared enjoyment with others." (Exhibit 10.) However, Dr. De Candia believed claimant's psychiatric conditions were causing "emotional blunting," which explained Claimant's depressed manner of communicating. (*Ibid.*) Dr. De Candia also believed claimant's history of hallucinations and increasing anxiety better explained claimant's social and communication deficits. Dr. De Candia maintained "the strongest argument against the presence of autism" was the absence of claimant's documented developmental history consistent with an autistic person, including the lack of historical records indicating stereotypical

patterns of behavior. (*Id.*)

D. Based on the above, Dr. De Candia diagnosed claimant with an unspecified Mental Health Diagnosis, which he deferred to claimant's mental health providers. Dr. De Candia recommended a number of mental health services for claimant, including medication, individual behavior therapy, social work support, and participation in a mental health day treatment program.

37. In October 2013, at the request of Service Agency, Dr. Bienstock reviewed Dr. De Candia's assessment, along with claimant's complete case file which included his previous evaluations and medical records. She agreed with Dr. De Candia's findings, and concluded that claimant was not eligible for regional center services because he did not have a developmental disorder. In support of her opinion that psychiatric problems were the cause of claimant's struggles, she referenced his medical records showing a "history of polysubstance abuse and an arrest for a DUI." (Exhibit 11.) In support of Dr. De Candia's opinion that claimant did not have an intellectual disability from his scores on the WAIS-IV, she noted that claimant's overall IQ, reflected in the General Ability Index as 81, was not controlling, and had to be interpreted with caution due to the significant differences between the composite scores. Nevertheless, she agreed with Dr. De Candia, based upon the consistency between his testing and Dr. Gaines's testing, including measures of academic skills and adaptive deficits. She agreed with Dr. De Candia's view that claimant's low adaptive behavior scores based upon mother's report were consistent with his psychiatric profile, and not a person with an intellectual disability. Similarly she agreed with Dr. De Candia's conclusion that claimant's ADOS scores, although within the range associated with autism, did not qualify claimant as autistic because his developmental history did not support an autism diagnosis. Dr. Bienstock's report and related testimony was persuasive as to claimant's eligibility under the category of autism, as it was supported by Dr. De Candia's thorough and thoughtful

report.

CLAIMANT'S 2014 EVALUATIONS

38. In February 2014, claimant retained Rachael Orlik, MSW, ACSW to assess him for autism. Ms. Orlik's assessment and testimony were considered by ALJ Sawyer in his Decision. Ms. Orlik, did not testify in the instant hearing, but ALJ Sawyer's Decision showed, given her testimony and report, that she had experience working with autistic people, diagnosing autism, and was certified in administering the ADOS. While Ms. Orlik found that claimant was able to communicate with her effectively, and could accurately label the emotions of others during structured ADOS tests, she found him to lack social insight. She noted claimant's high level of anxiety may have diminished his reciprocity with her. She also found claimant's eye contact with her was normal. She did not observe claimant engaging in any stereotypical behaviors or restricted interests. She found that claimant made "occasional social overtures" but the "highest overtures" were limited to discussions of his hobbies and interests which included cars and video games. (Exhibit 18.) During these exchanges, claimant was "much more animated." (*Ibid.*) Claimant also "showed a range of appropriate social response such as laughing with the examiner, answering questions, asking for clarification when needed, and easily performing the various tasks." (*Id.*) Claimant's combined score on the ADOS was 11, which she noted was four points higher than the threshold for an Autism Spectrum Disorder.

39. Ms. Orlik also administered to claimant the Social Responsiveness Scale, Second Edition (SRS 2), which was based on his parents' report. Claimant scored above 90, which Ms. Orlik described as being in the severe range of symptoms associated with autism. Ms. Orlik reviewed claimant's developmental records through 1996; she did not review records thereafter, including those documenting claimant's psychiatric diagnoses and hospitalizations. Based on the above, Ms. Orlik gave claimant a "provisional"

diagnosis of an Autism Spectrum Disorder, without an accompanying intellectual impairment. (Exhibit 18.)

40. Ms. Orlik relied heavily on parents' report through their completion of the Developmental Questionnaire. Their report of claimant's significant language delay was corroborated by his early speech assessments which she reviewed. Parents provided many new reports of claimant's early behaviors which were first mentioned in Dr. Powers' report, (Factual Finding 31) but not in earlier reports. In Ms. Orlik's assessment, parents described claimant's early sensitivity to textures of food, problems with minor changes in his routine, claimant's constant crying and dislike with being touched. Claimant's mother reported claimant got upset when brothers touched his toys or people did not do tasks the way he wanted them done. Claimant's parents described certain behaviors that persist today, like watching a movie many times and his preoccupation with cars.

41. Ms. Orlik's "provisional" diagnosis of autism spectrum disorder was not definitive, and could not be measured without reference to more comprehensive assessments, such as the assessments administered by Drs. Gaines and De Candia. Ms. Orlik used one standardized autism observation measure, the ADOS-2 which was supported primarily by parents' reports. She did not conduct a complete record review. As previously reported by Dr. Bienstock in ALJ Sawyer's Decision, Ms. Orlik's assessment was deficient and evidence presented in the instant hearing, including Dr. Mancillas's report and testimony did not change the weight to be given her "provisional" diagnosis. The ADOS manual itself stated that the ADOS alone should not form the basis of an autism diagnosis, as additional information was required, including a lengthier observation, record review and other testing. Ms. Orlik had not reviewed any of claimant's records after 1996, including his psychiatric records, which were an important part of his developmental history. Thus, the results of Ms. Orlik's ADOS and her

provisional diagnosis of an autistic spectrum disorder were informative, but incomplete and not definitive of whether claimant met the DSM-5 criteria of Autism Spectrum Disorder.

DR. MANCILLAS'S NEUROPSYCHOLOGICAL EVALUATION

42. After ALJ Sawyer's Decision, claimant's condition remained unchanged. He remained isolated in his room, unresponsive to therapy, and would not leave to attend this hearing without substantial prodding and assistance from his brother and parents. Claimant remained in his room focused on his cars and did not participate in family activities or household chores. At hearing, his family members, including his brother, father and mother, confirmed his lack of any progress with his therapy, and his deteriorating condition, exemplified by his disinterest with learning, his anxiety leaving his room, his lack of responsibility with household chores, and general inability to navigate the community independently, or make simple store purchases. Claimant testified that he wanted to progress, particularly stop smoking, although it was unclear whether he was referring to cigarettes or cannabis. The testimony of claimant's family was heartfelt and sincere, clearly described claimant's current adaptive functioning, but did not provide any additional clarity as to whether claimant's current behaviors satisfied autism or the fifth category eligibility. Claimant's mother confirmed his fixed interests in eating the same food (fish), his model cars, which fill display cabinets in her home, her failure to fully appreciate what his behaviors meant during his school years, and her belief that his school district and now the mental health system has failed her son. Their testimony was pertinent to his eligibility and where it was consistent with their past reports, or was otherwise substantiated, was given great weight.

43. Claimant's attorney referred him to Paul Mancillas, Ph.D., a clinical psychologist and neuropsychologist, to determine whether claimant met the fifth category of regional center eligibility, and also to re-visit whether or not claimant met

the criteria for autism under the DSM-5. Fifth category eligibility was considered in ALJ Sawyer's Decision, but the assessments provided did not directly address this this category.

44. On November 10, 18, 24 and 25, 2014, Dr. Mancillas, who testified at hearing, evaluated claimant. Claimant was 24 years of age at the time of Dr. Mancillas' assessment. Dr. Mancillas had extensive academic qualifications, and experience as a clinician and assessor. For 27 years Dr. Mancillas was affiliated with the Lanterman Developmental Center in Pomona, California. During that time, for approximately 17 of those years, he was associated with the acute medical facility of the Lanterman Developmental Center in Pomona California where he administered assessments of intellectual, adaptive and neuropsychological functioning of individuals with severe brain damage. Early in his affiliation, for approximately four years, he developed behavior modification programs for institutionalized patients with severe intellectual disability, autism and brain damage. He also administered assessments and training programs for psychologists.

45. Dr. Mancillas relied upon claimant's parents for records, but he was not provided with all the records introduced in the hearing before ALJ Sawyer. Specifically, Dr. Mancillas was not provided with claimants limited early education records, his preliminary speech and language evaluation, Dr. Gaines assessment, psychiatric intake assessments and related psychiatric records from claimant's hospitalizations or mental health treatment from 2008 to the present.

46. At hearing, Dr. Mancillas conceded his preference was to see all available records but generally denied that his opinion would have been changed by them. As to the school records his assumption was that the school system failed Spanish-language speaking families, like claimant and his parents. As to Dr. Gaines assessment, he assumed from reading ALJ Sawyer's Decision that his one IQ test did not address the

discreet cognitive domains of his own neuropsychological assessment and was irrelevant to his diagnosis of Neurocognitive Impairment Not Otherwise Specified under DSM-5, and eligibility under the fifth category. As to the psychiatric records, he maintained that mental health professionals and clinics do not have expertise in diagnosing autism and would not generally consider autism as a diagnosis.

47. Dr. Mancillas's acknowledged "some" limitations in his assessment including: the lack of available Spanish-speaking Autism Spectrum Rating Scale for claimant's age-range; other autism measures, such as the Gilliam Autism Rating Scale-III, was standardized to age 22, and not claimant's age of 24; the Vineland Adaptive Behavior Scales completed by claimant's mother were invalid as they "suggested significant pathology and [was] inconsistent with a previous assessment;" a direct interview with claimant's mother was never completed; and there was no assessment of claimant's academic skills. (Exhibit E.) Dr. Mancillas had recommended follow-up interviews and supplemental testing to compensate for these limitations, but they were never done. Nevertheless, he considered mother's invalid report of claimant's behaviors in his findings to the extent they indicated claimant required substantial support. Dr. Mancillas also acknowledged his assessment of claimant's memory was incomplete and its etiology was unknown. At hearing, he conceded parents did not report that claimant had once driven a car and had a driver's license.

48. Dr. Mancillas further acknowledged that his testing revealed claimant had learning difficulties. He identified the absence of sufficient academic testing to assess deficient development in reading and math and possible diagnoses of learning disorders, such as Dyslexia and Dyscalculia.

49. Dr. Mancillas observed claimant during test-taking and reported the results of his mental status exam. When he greeted claimant, claimant was wearing dark sunglasses, displayed "no affect," but appropriately shook his hand. During testing

claimant maintained appropriate eye contact but his verbalizations were limited and he did not engage in reciprocal communication. His speech was flat without tonal variations and his affect was consistently flat. Claimant was more confident on perceptual reasoning tests, such as the Block Design subtest of the WAIS-IV, but he struggled with tasks assessing executive functioning, memory, and certain aspects of attention. His "content of thought indicated no preoccupations or obsessions;" although he appeared to be knowledgeable about cars, he did not speak extensively about them.

50. Dr. Mancillas addressed the fifth category of eligibility by using his training as a neuropsychologist to assess claimant's neurocognitive functioning in discreet areas in order to identify whether his deficits closely aligned with intellectual disability and associative adaptive impairments. Dr. Mancillas used the standardized measure relied upon by Dr. De Candia, the WAIS-IV, but also looked more particularly at the components of cognition; specifically, executive functioning, language, memory and visual spatial perception. Dr. Mancillas insisted that Dr. De Candia's assessment was deficient because it did not test discreet cognitive functioning which more fully identified the source of claimant's disability, which throughout his school years was thought to be limited to a speech and language disorder. However, Dr. Mancillas's tests and report are largely consistent with Dr. De Candia's cognitive testing.

51. Dr. Mancillas made the following findings regarding claimant's cognitive functioning and abilities pertinent to his fifth category assessment.

A. Consistent with Dr. De Candia's administration of the WAIS-IV, complainant functioned in the low average to borderline range of intellectual competency when compared with his same-aged peers, with a full-scale IQ of 80, with a relative high average score of 104 on the perceptual reasoning index, an average working memory index score of 95, a verbal comprehension score in the borderline range of 72, and a processing speed index score at the

intellectually impaired level of 65, or the one percentile rank. His perceptual reasoning was a relative strength with his scores ranging from high average on a measure which required visual spatial analysis to integrate various block design, and average on other subtests which also involved deductive reasoning. His verbal scores were consistently in the borderline range. His verbal subtest scores showed "definite indications" of a lack of language development, and his vocabulary word knowledge measured in the borderline range limited his verbal expression and reading comprehension. His discrepancy between verbal comprehension and perceptual reasoning confirmed complainant's language impairment, and his impaired processing speed reflected deficits in visual motor processing and sustained attention. His language impairment impacted his ability to understand abstract concepts and his impaired processing speed affected his ability to keep pace with every day demands, including a job.

B. On measurements of executive functioning, claimant generally demonstrated he "[was] able to problem solve utilizing information that [was] presented to him, yet perform[ed] in the average to low average range." (Exhibit E.) He performed in the borderline to well below average on the Color Word Interference Test which required him to sustain attention and use new concepts fluently, and required him to switch focus fluently. He performed in the impaired level on the Trail-Making Test-Part B which required him to show cognitive flexibly as well as visual processing fluency to sequence numbers and letters in an alternating format. He performed in the average to low average range on the Wisconsin Card Sorting Test which required him to categorize cards according to shape, color or quantity. He showed he could correctly categorize cards and switch his focus to accurately interpret

additional feedback. He showed "no inclination to perseverate," and completed sufficient trials to achieve a score in the average range. Dr. Mancillas also considered his "history of impulsive and aggressive acting out." Dr. Mancillas concluded that historical factors and his assessment demonstrated limitations in executive functioning.

C. On measurements of attention and concentration, in the area of auditory attention, claimant generally performed in the average to low average level, with the exception of one more complicated task which required counting forward and backward based on tonal cues, where he performed in the impaired level. On the working memory index of the WAIS-IV, Dr. Mancillas confirmed, consistent with previous tests, claimant's overall auditory attention was in the average range as he was able to hold onto auditory information while manipulating the information for to her purposes. On the Tests of Everyday Attention he performed within normal limits on tasks of sustained auditory attention, the low average range when a distracting component was included and in the impaired range, on a numbers-related task, as stated above. Dr. Mancillas described these results as variable "without much consistency," but his opinion of claimant's performance appeared exaggerated given that only one test resulted in an impaired score.

D. On testing of visual attention, claimant demonstrated variable scores between above average and impaired. Claimant's slow response speed to computer testing involving the rapid display of letters was "atypical" and his reaction time was "inconsistent," with his response time becoming more "erratic" with longer intervals between tasks. Claimant did have a low number of commission and omission errors and did not perseverate. On a measure of visual-mental concentration involving counting forward and backward based

on visual cues, he performed above average, but his timing was in the impaired range. He measured in the impaired level on a task involving sustained visual attention in sequencing numbers across a page.

E. Claimant demonstrated defects in memory. On measures of claimant's memory, in the area of auditory memory using words and stories, claimant scored in the impaired level. On a measure which required sequential processing of numbers requiring auditory memory, claimant performed "better," indicating a relative strength in encoding numbers versus words. (Exhibit E.) In the area of visual memory he scored in the average range on a measure of visual-spatial encoding. He scored in the average range when asked to copy a complex figure requiring visual organization and planning, demonstrating good drawing and copying skills, but scored in the impaired range, below the one percentile rank, after a four minute delay and 30 minute delay was required before reproducing a figure from memory. On another measure he scored in the borderline range when asked to reproduce five designs from memory, and he scored in the impaired level when asked to identify missing items from pictures.

F. Consistent with previous assessments of language functioning and his previous diagnosis of a speech and language impairment, claimant scored in the low average or borderline range on measures of receptive and expressive language.

G. In the area of visual processing claimant's performance was adequate in most areas, but his performance was impaired in the area of processing speed.

52. At hearing, Dr. Mancillas elaborated that disorders in cognitive functioning, such as memory and executive functioning, which he considered his most pronounced deficits, were due to impairments in the area of the brain that controlled

these functions, and accordingly, a neurocognitive disorder was a developmental disorder. Dr. Mancillas explained that claimant's memory deficits impacted his ability to learn new information and he required repetition. Impairments with executive functioning made it difficult for claimant to organize information and to control emotions. Dr. Mancillas was generally dismissive of a query involving the impact of medication on testing, conceding that the scores could be lowered a "notch." Dr. Mancillas provided conflicting opinions of fifth category eligibility based upon claimant's memory defects by his concession that more testing of claimant's memory was required to ascertain the etiology of his memory impairment. Dr. Mancillas's failure to fully consider claimant's history of drug and alcohol abuse, and medication, and his failure to explore with claimant his possible usage prior to testing, to check the accuracy of his measures of claimant's cognitive impairments, further undermined his opinion.

53. Dr. Mancillas minimally assessed claimant's general psychological functioning using two rating scales claimant completed. Claimant reported being nervous and unable moderate anxieties manifested by his inability to relax and ignore his "fears the worst is happening." (Exhibit 10.) He reported at least moderate levels of depression described as his view of his failures and disappointment in himself. Claimant reported low energy and lack of interest in anything. He acknowledged being more irritable than usual, tired and fatigued.

54. Based upon his testing, observations, review of Dr. De Candia's assessment and limited record review, Dr. Mancillas diagnosed claimant with an Unspecific Neurocognitive Disorder. He additionally offered a diagnosis of a Major Neurocognitive Disorder due to deficits in the areas of memory, executive functioning, attention, language and visual-spatial processing. He referenced an "unknown etiology" with suspicion of prenatal influences of "stress and perinatal trauma associated with abnormal use of forceps during delivery." (Exhibit E). His reference to the use of forceps

as a stress was based only on the fact that forceps were used in claimant's birth, and not on any substantive medical information, and as such, served to discredit the veracity of his diagnosis and scientific rigor.

55. At hearing Dr. Mancillas was asked to contrast claimant's adaptive needs with that of an individual eligible for regional center services under the category of intellectual disability. He responded by referring to the individual program plan meeting team for particular services tailored to his needs, but also offered that claimant required extensive and "constant" interventions including special programs to learn socialization skills and how to function in "everyday society" at frequency between one to three times weekly. He was not optimistic that claimant could maintain a job, given his processing speed, but maintained that he needed to be evaluated and would initially require a job coach.

56. Dr. Mancillas revisited claimant's autism eligibility with reference to his interview with claimant and claimant's answers to the Social Responsiveness Scale, with the understanding that it might be limited by claimant's reading deficits. During Dr. Mancillas's interview, claimant reported he was bullied at school, had lots of anxiety around people and was afraid of "everyone." Claimant did not understand how to talk about his feelings, or how to modulate his feelings. (Exhibit E.) Dr. Mancillas reported there was no reciprocal social communication between himself and claimant. Claimant reported his problem being socially motivated to interact with others in the Social Responsiveness Scale.

57. Dr. Mancillas's evaluation by his own admission was heavily reliant upon parents' reports and their accuracy. In his review of claimant's autism eligibility, Dr. Mancillas primarily relied upon rating scales he provided to claimant's parents and brother, the Gilliam Autism Rating Scale-III, which he admitted was invalid, where they reported severe deficiencies in all areas pertinent to an Autism Spectrum Disorder

diagnosis: rigidity and inflexible pattern of thinking when under stress, strong preference to be alone; discomfort in social situations; talking about the same thing; concentrating too much on the parts of things rather than seeing the whole picture; difficulty understanding other people; preoccupation and obsession with specific stimuli and interests; and repetitive and ritualistic behavior. It is unclear from their answers whether the behavior they observed occurred during the developmental period or more recently. Mother's invalid responses to the Vineland were inconsistent with past reports and suggested functioning in the two-year old range.

58. From claimant's family's invalid rating scales or mother's interview, which he admitted was incomplete, Dr. Mancillas procured information about claimant's early childhood experience consistent with previous reports, including what mother previously reported as shyness, but was now articulated as difficulty making friends. Mother added information about his early development that was not contained in early reports before Ms. Orlik's assessment, that he disliked being touched, which contradicted her early report that he was affectionate with her. Mother added that claimant avoided eye contact which contradicted reports of every assessor beginning in his early childhood that claimant made appropriate eye contact. Contrary to her earliest reports, and his speech reports, Mother insisted that he began speaking single words at age five. As she had before, claimant's mother reported he was toilet trained after the age of two, but it was never established that this was unusual or atypical. Parents reported claimant's difficulty sharing and interacting with others as early as pre-school and kindergarten was also consistent with earlier reports shyness. They also reported he "exhibited emotional impulsivity" at school, which resulted in a "history of violence and aggression." (Exhibit E.) Claimant's parents' also reported other behaviors previously reported including his habit of lining up cars, which "later" became a fixation with cars. (Exhibit E.)

59. From his review of previous ADOS tests, the rating scales administered to claimant's father and brother, his interview with claimant and claimant's mother's invalid responses to the ASRC, where she identified without specificity stereotypical behaviors and sensory sensitivity before the age of 18, Dr. Mancillas diagnosed claimant with Autism Spectrum disorder, with co-morbid features of Attention Deficit Hyperactivity Disorder (ADHD) along with obsessive-compulsive symptoms. Dr. Mancillas reached his diagnosis of ADHD "features" from claimant's lack of consistency in his auditory and visual attention scores and parents' responses to the ADHD rating scale.

60. Dr. Mancini strongly argued for a diagnosis of Autism Spectrum Disorder, and placed more emphasis in his report on this diagnosis then his fifth category diagnosis of Neurocognitive Disorder. In his report, Dr. Mancillas referenced weaknesses with his neurocognitive assessment, particularly in the area of memory, while maintaining claimant's poor neurocognitive functioning qualified him for the fifth category. (Exhibit 10.) Dr. Mancillas minimized the absence of early records in his diagnosis, while questioning the failure of the school district to provide a complete evaluation psychoeducational evaluation of claimant which would have identified his deficits, including his neurocognitive impairments. Dr. Mancillas conceded that his diagnosis was primarily based on the history presented to him by claimant's mother and family and their reports of his poor social communication and "sensory" sensitivity which remained unspecified in Dr. Mancillas's report. The invalidity of mother's rating scale, her inconsistent report of his developmental milestones and history, and Dr. Mancillas's incomplete interview with claimant's mother undermined his reliance on mother's report of claimant's earlier behavior. Where mother's report to Dr. Mancillas was inconsistent with previous reports it was disregarded.

61. Dr. Mancillas' most persuasive contribution to the question of claimant's eligibility, based on his training as a neuropsychologist, and his extensive and direct

clinical work experience with regional center clients, which distinguished him from previous assessors, including Dr. Bienstock, was his understanding of the co-morbidity of Autism Spectrum Disorder with other disorders, including psychiatric disorders. As Dr. Mancillas explained autism is a developmental disorder of the frontostriatal system and since it is the same part of the brain that governs other cognitive functioning, other conditions that arise from the same brain area are co-morbid with autism, including ADHD and obsessive compulsive disorder (OCD), depression and anxiety, and at "its most extreme," schizophrenia and depression. (Exhibit E.) Dr. Mancillas did not have enough information to include schizophrenia in this diagnosis; nevertheless, he "hypothesized" based upon his expertise and extensive experience, that the mental health professionals were not experienced with autism and missed this diagnosis. (Exhibit 10.) Overall, Dr. Mancillas's understanding of co-morbidity was not contradicted by the DSM-5, or Dr. Bienstock, who admitted that she was not fully familiar with the incidence of co-morbidity. Nevertheless, the statistical significance of co-morbidity did not automatically translate into sufficient evidence of co-morbidity in the instant case, given the other deficiencies in his report.

62. As a result of Dr. Mancillas's assessment, Heather Kurera, D.O, Psychiatrist and Medical Director of Prototypes and claimant's treating psychiatrist changed claimant's diagnosis to Autistic Spectrum Disorder, Noncompliance with Treatment Plan, Cannabis Abuse and Alcohol Abuse. Dr. Kurera reported that claimant had not "benefitted or improved significantly" from Prototypes treatment program intended for client's suffering primarily from a psychotic or mood disorder. She reported as problems "client's lack of insight, rigidity of thinking and lack of behavioral control, along with his parents' inability to manage his behaviors as the primary obstacles." (Exhibit F.) She reported that claimant's presentation was "atypical for a psychotic disorder." Dr. Kurera did not testify at hearing and her report was not considered by any assessment in

evidence, so there was no opportunity to examine the basis of her observations, her diagnosis or claimant's progress or his status as "atypical. Further her expertise in determining autism was unknown, her opportunity to observe him as a "treating psychiatrist" as opposed to a therapist was unclear. Dr. Kurera also prescribed several medications for claimant, one which addressed his agitation, paranoia and anxiety, and given his other diagnosis of cannabis and alcohol abuse, there was no discussion or analysis of these disorders or medications. As such, Dr. Kurera's letter confirmed claimant's continuing struggles, but otherwise was given little weight in determining his eligibility for regional center services.

63. Dr. Bienstock reviewed Dr. Mancillas's report and Dr. Kurera's letter for the Service Agency, disagreed with their conclusions and, at hearing she clarified the basis of her disagreements.

64. Dr. Bienstock also opined, as she did in ALJ Sawyer's Decision, that Claimant did not have a fifth category condition, and her opinion, based on the review of the records and the deficiencies in Dr. Mancillas's assessment, was persuasive.

A. Dr. Mancillas's testing results of claimant's cognitive abilities was consistent with Drs. Gaines and De Candia and confirmed that his verbal processing was in the borderline range, which as Dr. De Candia noted and Dr. Bienstock previously confirmed was probably depreciated by claimant's language processing disorder and his psychiatric problems, both of which would restricted his verbal output.

B. Under the DSM-5 category of neurocognitive disorders (DSM-5, p. 591), claimant's cognitive functioning must have declined; here, claimant's cognitive functioning remained the same, while his adaptive functioning declined. Based on valid administrations of the Vineland, claimant's adaptive scores worsened between 2008 and 2013, and his scores showed significant

impairment. The diagnosis of Intellectual Disability, under the DSM-5 places heavier emphasis on adaptive deficits than cognitive deficits. Nevertheless, Dr. Mancillas's assessment failed to show that claimant's current adaptive performance was reflective of his adaptive ability, or was not otherwise explained by his psychiatric issues, particularly his depression. Claimant used to drive, lost the privilege of doing so after driving under the influence, but no longer wants to drive. He no longer wants to leave the bedroom or bathe, but he had not evidenced problems in these areas in the past.

C. As a clinician, it was important for Dr. Mancillas to review all of claimant's records, including his previous assessments and considerable psychiatric records, which Dr. Mancillas did not do, before reaching an opinion. Dr. Mancillas failed to adequately consider claimant's previous diagnoses.

D. Based on the above, Dr. Bienstock opined that claimant was not eligible for regional center services because he did not have a qualifying developmental disorder.

65. Dr. Bienstock, opined as she had previously before ALJ Sawyer, that claimant did not have an Autism Spectrum Disorder, and Dr. Mancillas's or Dr. Kurera's letter failed to provide any new information that would change her opinion.

A. Claimant's records were bereft of the kind of observations of autistic behaviors typical of someone with that condition. Claimant's social and communication delays were significant, but Dr. Bienstock did not agree that Dr. Mancillas showed that they were part of an Autistic Spectrum Disorder, and not related to his verbal processing disorders or his psychiatric diagnoses, as previously reported by Dr. De Candia.

B. Based upon previous assessments and claimant's history, he did not have a history of repetitive behaviors that impaired his daily functioning. Dr.

Mancillas did not observe any behaviors in his assessment. Dr. Mancillas report was overly reliant upon invalid family reports, exemplified by mother's exaggerated reports of claimant's adaptive functioning which placed him at the functional age of a toddler.

C. Dr. Mancillas failed to consider claimant's psychiatric history, noting the absence of claimant's cannabis and alcohol use which formed the basis of Dr. Kurera's diagnosis, and his omission of a discussion of other disorders as contradictory to the diagnostic guidelines requirements of DSM-5.

D. The diagnoses of Dr. Gaines and De Candi were not wrong because they used the DSM-IV-TR, and their diagnoses would be the same under the DSM-5. The DSM-5 is more restrictive as it provides for a diagnoses relating to communication disorders where the criteria for Autism Spectrum Disorder are not satisfied. Given that claimant's previous diagnoses under the DSM-IV-TR were not well-established, his past provisional diagnoses were not grandfathered under the DSM-5.

66. Dr. Bienstock accurately described claimant's history, past reports, and evidence, and given her expertise, provided reliable testimony about the gaps in Dr. Mancillas's report, most of which Dr. Mancillas conceded. Dr. Mancillas provided no separate analysis of the psychiatric diagnoses from claimant's records. He spoke of a "psychotic episode," with no reference to claimant's 13 admissions, so it is unclear where he is getting his information that his schizophrenia diagnosis was limited. Dr. Mancillas did not explain claimant's continued use of anti-psychotic medications, or his cannabis and alcohol abuse referenced below by claimant's psychiatrist.

67. As to claimant's eligibility under the DSM-5 category of Autism Spectrum Disorder, despite her understanding of claimant's record, Dr. Bienstock's analysis and testimony were deficient in two important respects. Dr. Mancillas provided compelling

testimony regarding the presence of autism with co-morbid diagnoses. Dr. Bienstock, was vague as to whether restrictive interests, as opposed to repetitive behaviors, were sufficient to satisfy criterion B of Autism Spectrum Disorder under the DSM-5. Nevertheless, despite the deficiencies in Dr. Bienstock's testimony when Drs. Gaines and Dr. De Candia's assessment results are reconsidered in view of the prevalence of autism with co-morbid disorders, the weight of the evidence did not support a finding that claimant met each criterion for a DSM-5 Autism Spectrum Disorder diagnosis and eligibility for regional center services under the category of autism.

LEGAL CONCLUSIONS

Based upon the foregoing Factual Findings, the Administrative Law Judges makes the following Legal Conclusions:

1. The Lanterman Developmental Disabilities Services Act (Lanterman Act) governs this case. (Welf. & Inst. Code, § 4500 et seq.)[6] An administrative "fair hearing" to determine the rights and obligations of the parties, if any, is available under the Lanterman Act. (§§ 4700-4716.) Proper jurisdiction was established by virtue of ELARC's denial of the request for funding and the Fair Hearing Request on behalf of Claimant.

2. 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.) In meeting the burden of proof by a preponderance of the evidence, the complainant "must produce substantial evidence, contradicted or un-contradicted, which supports the finding." (*In re Shelley J.* (1998) 68

[6] All further statutory references are to the Welfare and Institutions Code.

Cal.App.4th 322, 339.)

3. With regard to the issue of 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.) Based on the above, claimant in this case has the burden of proving by a preponderance of the evidence that his evidence regarding eligibility is more persuasive than that of the Service Agency's.

4. It is settled that the trier of fact may accept any part of the testimony of a witness and reject another part even though the latter contradicts the part accepted. (*Stevens v. Parke Davis & Co*. (1973) 9 Cal.3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected material." (*Id*., at 67-68, quoting *Neverov v. Caldwell* (1958) 161 Cal.App.2d 762, 767.) Furthermore, the trier of fact may reject the testimony of a witness, even an expert, although not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.) The testimony of one credible witness, including that of a single expert witness, may constitute substantial evidence. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.) An expert's credibility may be evaluated by looking to his or her qualifications. (*Grimshaw v. Ford Motor Co*. (1981) 119 Cal.App.3d 757, 786.) It may also be evaluated by examining the reasons and factual data upon which the expert's opinions are based. (*Griffith v. County of Los Angeles* (1968) 267 Cal.App.2d 837, 847.) Further, the weight to be given to

expert opinion may be evaluated by their reasoning. The following statement taken from *Jennings v. Palomar Pomerado Health Systems, Inc*. (2003) 114 Cal.App.4th 1108, 117, is apropos: "[A]n expert's conclusory opinion that something did occur, when unaccompanied by a reasoned explanation illuminating how the expert employed his or her superior knowledge and training to connect the facts with the ultimate conclusion, does not assist the [factfinder]." (See also, Evid. Code, § 801.)

5. 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 closely related to intellectual disability or to require treatment similar to that required for individuals with intellectual disability. (§ 4512, subd. (a).) A qualifying condition must originate before one's 18th birthday and continue indefinitely thereafter. (§ 4512.)

6. California Code of Regulations, title 17 (CCR), section 54000 further defines "developmental disability" as follows:

> (a) "Developmental Disability" means a disability that is attributable to [intellectual disability][7], cerebral palsy, epilepsy, autism, or disabling conditions found to be closely related to [intellectual disability] or to require treatment similar to that required for individuals with [intellectual disability].
>
> (b) The Developmental Disability shall:
>
> (1) Originate before age eighteen;
>
> (2) Be likely to continue indefinitely;
>
> (3) Constitute a substantial disability for the individual . . . ;

[7] The term mental retardation still appears in the CCR, but to be consistent with the Welfare and Institutions Code and current practice it has been changed to intellectual disability in this Decision.

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

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

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

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

7. Establishing the existence of a developmental disability within the meaning of section 4512, subdivision (a), requires claimant to additionally prove that the developmental disability is a "substantial disability," defined in CCR section 54001, subdivision (a), as follows:

(1) A condition which results in a 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.

DOES CLAIMANT HAVE AUTISM?

8. The Lanterman Act and its implementing regulations contain no definition of the neurodevelopmental condition autism. The customary practice has been to import the American Psychiatric Association's DSM-IV-TR definition of "autistic disorder" into the Lanterman Act and its implementing regulations when determining eligibility for services and supports on the basis of autism. That definition 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 Pervasive Developmental Disorder – Not Otherwise Specified (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.)

9. The DMS-5 diagnostic criteria for Autism Spectrum Disorder are as follows:

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

1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

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

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).
3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).

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

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

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

10. 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).

11. Criterion B may be met "when restricted, repetitive patterns of behavior, interests or activities were clearly present during childhood or at some time in the past, even if symptoms are no longer present." (DSM-5, supra, at p. 54.) Excessive adherence to routines and restricted patterns of behavior may be manifest in resistance to change (e.g., distress at apparently small changes, such as in packaging of a favorite food; insistence on adherence to rules; rigidity of thinking) or ritualized patterns of verbal or nonverbal behavior (e.g., repetitive questioning, pacing a perimeter)." (*Id.*) According to DSM-5, "[h]ighly restricted, fixated interests in autism spectrum disorder tend to be abnormal in intensity or focus (e.g., a toddler strongly attached to a pan; a child preoccupied with vacuum cleaners; an adult spending hours writing out the timetables). Some fascinations and routines may relate to apparent hyper- or hyporeactivity to sensory input, manifested through extreme responses to specific sounds or textures, excessive smelling or touching of objects, fascination with lights or

spinning objects, and sometime apparent indifference to pain, heat, or cold. Extreme reaction to or rituals involving taste, smell, texture, or appearance of food or excessive food restrictions are common and may be a presenting feature of autism spectrum disorder." (*Id.*)

12. Claimant's addition of Dr. Mancillas's assessment and report with reference to the DSM-5 required a reexamination of the evidence previously presented in ALJ Sawyer's Decision and again in this hearing. However, even after a thorough reexamination of the record with regard to the DSM-5, claimant has not met his burden of establishing by a preponderance of evidence his eligibility for Lanterman Act services and supports under the qualifying category of autism as provided for in section 4512, subdivision (a) of the Welfare and Institutions Code.

13. Dr. Mancillas's assessment and testimony as to the emphasis in the DSM-5 on co-morbid disorders was compelling, but did not change the weight accorded to the results of Drs. Gaines and De Candia's assessment regarding claimant's autism diagnosis. In 2008 and again in 2013, clinical psychologists evaluated claimant using the DSM-IV-TR and concluded that his communication and social deficits were related to expressive and psychiatric disorders, not autism. Even given the prevalence of co-morbidity among disorders, acknowledged in the DSM-5, Drs. Gaines and De Candia appropriately considered autism as an independent ground for eligibility, but also, as required, considered alternative diagnoses of psychiatric or learning disorders and assessed whether claimant's deficits were solely caused by these ineligible diagnoses. Based on the history presented to Dr. Gaines of claimant's social interactions, his intellectual testing and the results of the Vineland Dr. Gaines concluded that although there were some limitations in claimant's communication, he did not present with autistic features. At the time Dr. Gaines assessed claimant, he complained of anxiety and depression, but his mother still reported fairly typical adaptive functioning, namely his

participation in the household and exploration of the community. At the time of Dr. De Candia's assessment, claimant's functioning had further declined, and he had a strong history of psychiatric interventions. Dr. De Candia conceded his principle reason for rejecting the autism diagnosis, despite claimant's performance on the ADOS, was claimant's historical lack of stereotypical behaviors. Dr. De Candia also considered other diagnoses and determined that autism was inappropriate. Under the DSM-5, eligibility for Autism Spectrum Disorder was not limited to stereotypical behaviors, but extended to restrictive interests in criterion B. Nevertheless, given the weak history of restrictive interests, claimant had not met his burden of proof that he is eligible for regional center services under the category of autism.

14. Claimant's history supports criterion A of the Autism Spectrum diagnosis. There was little dispute from Service Agency assessors and Dr. Bienstock that claimant had severe speech and language-related deficits that existed across multiple settings. Claimant's difficulties with verbal comprehension and processing were well-documented in every assessment, and were profound. Claimant's mother characterized his early social interactions as "shyness" which could be interpreted as social impairments, and reported them to be limited. In most assessments, claimant's speech output was relatively low; every assessment from preschool onward reported claimant's limited communication and engagement even where the assessors chose to characterize, as they did in early school reports, that his pragmatic skills were "basically good." Claimant reported in his earlier assessments that he had friends, went to movies and drove a car. Claimant later reported to Dr. Mancillas that he was bullied and admitted to difficulty with social interactions. Claimant's mother reported his social interactions became more restricted and began their progressive decline just before his 18th birthday, not before, at around the time of his car accident and psychiatric interventions. After claimant obtained more extensive psychiatric intervention and medication his communication became even

more restricted as referenced in criterion A(1). There was evidence to support criterion A(2) from his flat affect during assessments after 2008, his limited responses and his lack of reciprocity most recently with Dr. Mancillas, but there was no historical evidence of his lack of eye contact. As suggested by criterion A(3), claimant's report to Dr. Mancillas, and his more recent isolation from peers, shows he had withdrawn from social interaction.

15. Claimant failed to meet his burden of proof that he satisfied at least two categories of criterion B due to the well-noted inconsistencies in claimant's mother's reports and the absence of behaviors with the requisite intensity. There was no evidence of stereotypical behaviors. In claimant's most recent assessment with Dr. Mancillas, he did not observe stereotypical behavior. There was some evidence that claimant's current restricted interests in cars began with lining up cars as a child, but the intensity of this interest as a child was undocumented and Dr. Mancillas did not observe perseverative interests. Although claimant's mother reported limited food interests and difficulty with transitions, again these were not documented to be of the intensity associated with autism. His current display of rigid thinking to Dr. Kurera was insufficiently documented prior to age of 18. Similarly claimant failed to provide convincing evidence that he had sensory issues with being touched. In reports, claimant was affectionate with mother and they were close despite his more antagonistic relationship with his brothers and father.

16. Claimant failed to satisfy criterion C and D of Autism Spectrum Disorder in that there was insufficient evidence of the criteria in the early developmental period, and there was insufficient evidence that any autism-related symptoms, not his psychiatric issues caused clinically significant impairment in social, occupational, or other important areas of current functioning.

17. Dr. Mancillas's report did not include a comprehensive review and analysis

of claimant's other diagnoses and Dr. Mancillas readily admitted the absence of data regarding claimant's psychiatric disorders. Claimant contends that his lack of response to therapy demonstrates that Drs. Gaines and De Candia were wrong, and that his psychiatric diagnoses were co-morbid with autism. Nevertheless, given the prevalence of claimant's language and psychiatric disorders identified in the assessments of Drs. Gaines and De Candia, there was insufficient evidence of autism as a distinct and co-morbid diagnosis. Dr. Mancillas's failure to review Dr. Gaines assessment and claimant's complete psychiatric history, and adequately account for his depression and anxiety, was not excused by the emphasis on co-morbidity in the DSM-5. As such, claimant failed to meet his burden of proof that any symptoms associated with an Autism Spectrum Disorder satisfied its criteria, and were not solely due to his diagnoses of psychiatric disorders.

DOES CLAIMANT HAVE A FIFTH CATEGORY CONDITION?

18. As claimant is additionally asserting eligibility for Lanterman Act services and supports under the "fifth category," he must establish by a preponderance of evidence a disabling condition "closely related to intellectual disability" or a disabling condition requiring "treatment similar to that required for individuals with intellectual disability." (Welf. & Inst. Code, § 4512, subd. (a).)

19. Claimant did not claim eligibility for regional center services as a person with an intellectual disability. Nevertheless, the requirements of eligibility for intellectual disability inform the analysis of fifth category eligibility. 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 mentally retarded individuals." (§ 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 [intellectual disability], with many of the same, or close to the same, factors required in classifying a person as [intellectually disabled]." (*Mason v. Office of Administrative Hearings*, *supra*, 89 Cal.App.4th at p. 1129.)[8]

20. Like autism, the term intellectual disability (formerly mental retardation) is similarly used throughout the Lanterman Act and its implementing regulations without definition. As in the case with the term autism, the customary practice has been to turn to the APA for elucidation on the etiology of this neurodevelopmental condition. Under the APA's DSM-IV-TR, the essential features of intellectual disability were identified as significantly sub-average general intellectual functioning accompanied by significant limitations in adaptive functioning in certain specified skill areas. (DSM-IV-TR at pp 39-43.) With the May 2013 publication of DSM-5, the term mental retardation has been 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.)

21. The APA notes that the most significant change in diagnostic categorization accompanying the change from 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 IQ score. (*Id*. at 37.) The APA notes no other significant changes. CCR section 54002 defines "cognitive" as "the ability of an

[8] As noted above, the DSM-5 has replaced the diagnosis of "Mental Retardation" with "Intellectual Disability."

individual to solve problems with insight to adapt to new situations, to think abstractly, and to profit from experience."

22. The DSM-5 revisions appear not to have altered the Lanterman Act's fifth category eligibility analysis. A claimant asserting fifth category eligibility is required to establish by a preponderance of evidence significant deficits in intellectual functions or deficits in adaptive functioning, or both. Fifth category eligibility does not require strict replication of all of the diagnostic features of Intellectual Disability. If this were so, the fifth category would be redundant. Eligibility under the fifth category requires an analysis of the quality of a claimant's cognitive and adaptive functioning and a determination of how well that claimant meets community standards of personal independence and social responsibility in comparison to others of similar age and sociocultural background. The evidence must establish that a claimant has a disabling condition that does not fall within CCR section 5400, subdivision (c), exclusions set forth in Legal Conclusion 6 (i.e., solely psychiatric disorders, solely learning disabilities, solely physical in nature). Furthermore, the evidence must establish that the claimant's disabling condition requires treatment similar to the treatment needs of an individual with intellectual disability.

23. The case of *Samantha C. v. Department of Developmental Services* (2010) 185 Cal.App.4th 1462 provides more insight into fifth category eligibility. In that case, a person seeking eligibility for regional center services, Samantha C., was born prematurely and with hypoxia (oxygen deprivation). In elementary school, her cognitive abilities were measured to be in the average range, though she was provided with special education services because she had deficits in auditory processing, language, speech and memory. She was later diagnosed with attention deficit disorder. She ultimately graduated from high school and enrolled in a junior college. She received SSI disability benefits and qualified for services from the Department of Rehabilitation.

During the process of requesting regional center services, Samantha was given cognitive tests, which yielded scores of 92 and 87, with a full-scale IQ score of 90, placing her in the average range. The Vineland testing revealed Samantha functioned adequately in daily living and social skills, but that she functioned on a moderately low level in the area of communication. While various experts arrived at different conclusions, at least two experts (whom the court found persuasive) opined that that Samantha had major adaptive impairments and that she functioned in the range of someone with [intellectual disability]. The same experts opined that Samantha's hypoxia affected her brain and created a neurocognitive disorder explaining her various deficits. One expert diagnosed Samantha with a Cognitive Disorder Not Otherwise Specified.

24. The court determined that Samantha had a fifth category condition and therefore was eligible for regional center services. First, the court concluded that Samantha had a disabling developmental condition, i.e., she had "suffered birth injuries which affected her brain and that her cognitive disabilities and adaptive functioning deficits stem, wholly or in part, from such birth injuries." (*Samantha C. v. Department of Developmental Services*, *supra*, 185 Cal.App.4th at pp. 1492-1493.) Since the evidence established that her cognitive and adaptive deficits were related to her hypoxic birth episode, there was no substantial evidence that her disabilities were solely related to psychiatric or learning disorders. (*Ibid.*) Second, the court concluded that Samantha's disabling condition required treatment similar to that needed by individuals with [intellectual disability]. (*Id.*, at p. 1493.) Specifically, the court found convincing an expert witness's testimony that those with intellectual disability and fifth category eligibility needed many of the same kinds of treatment, such as help with cooking, public transportation, money management, job training and independent living skills, and that Samantha needed those same services. (*Ibid.*)

25. With the exception of Dr. Mancillas's report and testimony, ALJ Sawyer

based his Decision on the same evidence provided in this case of claimant's educational and , psychiatric history. When claimant was three, he was diagnosed with expressive language delays. When he was five, his cognitive abilities were measured as within normal limits. In 2008, claimant was referred to Dr. Gaines, who measured claimant's IQ scores to be average to low average. Dr. Gaines did not diagnose claimant with any intellectual or cognitive disability. In 2010, while being treated for psychiatric problems by Pacific Clinics Adult Psychiatric, claimant's intellectual functioning was described as fair. In 2013, claimant's psychiatrist, Dr. Powers suspected claimant had autism, but not that he had an intellectual disorder. In 2013, claimant was again tested, this time by Dr. De Candia, who basically obtained the same cognitive measurements as Dr. Gaines. Dr. De Candia did not believe any diagnosis of an intellectual or cognitive disorder was warranted. During ALJ Sawyer's hearing Dr. Bienstock, testified that claimant's developmental history and Drs. Gaines and De Candia's test results did not suggest that claimant had an intellectual disability or that he functioned like one who did, or that he needed services similar to those who had such a disorder. Instead, Dr. Bienstock attributed claimant's initial delays and deficits to his expressive learning disorder, which had been compounded recently by his psychiatric disorders, both of which are excluded from eligibility consideration.

26. In this case, additional evidence from Dr. Mancillas's assessment or testimony of claimant's scattered cognitive abilities and severely deficient current adaptive functioning failed to satisfy claimant's burden of establishing by a preponderance of the evidence that he has a fifth category condition that is not solely caused by an excluded condition. In his fifth category analysis Dr. Mancillas relied upon the DSM-5 diagnosis of Neurocognitive Impairment Not Otherwise Specified and offered an additional diagnosis of Major Neurocognitive Impairment. Neurocognitive Impairment Not Otherwise Specified is part of a package of neurocognitive disorders in

the DSM-5, which by presentation "cause clinically significant distress or impairment in social, occupational, or other areas of functioning" but is applied where the precise etiology of the condition cannot be determined with certainty. (DSM-5, p. 643.) Under the DSM-5, major and mild neurocognitive disorders present as cognitive declines from previous levels of performance in domains such as complex attention, executive function, learning and memory, and language, the deficits interfere with everyday living requiring assistance, and the cognitive deficits cannot be explained by another mental disorder. (DSM-5, p. 602). Dr. Mancillas failed to show that the cognitive deficits were not explained by another mental disorder, or that claimant declined from his from previous assessments. Dr. Mancillas failed to account for claimant's cognitive deficits based upon his psychiatric disorders, medication, cannabis and alcohol abuse, which were noted in Dr. Kurera's letter, and which Dr. Mancillas admitted could suppress cognitive scores a "notch." Dr. Mancillas's cognitive test results were similar to that of Dr. Grimes and Dr. De Candia, and his additional neurocognitive tests, showed impairments of specific cognitive domains, but were not explained as declines.

27. As ALJ Sawyer stated, at first blush, there are elements of Claimant's case similar to those presented in the *Samantha C.* case. Claimant has IQ scores mostly in the low average range, but he had a few sub-test scores in the 70s and therefore at the borderline of intellectual functioning. His adaptive functioning scores in 2008 were borderline, and by 2013 had plummeted to the significantly impaired range and have not improved to date. Dr. Mancillas's tests reveal severely depressed cognitive abilities, including his processing speed. Although claimant graduated from high school and took junior college classes, he had been unable to advance academically and had been unable to get a job. Claimant rarely left his room and home, did not share in any household chores, ignored his hygiene, and could not manage to negotiate his way around the community to purchase goods.

28. Deeper analysis, however, reveals that there are significant differences between claimant's and the *Samantha C.* case even under the DSM-5. Primarily, Samantha established that she had an underlying organic developmental disorder other than the excluded conditions of learning or psychiatric disorders, i.e., hypoxia at birth which resulted in a brain injury. The *Samantha C.* court viewed that as a qualifying disabling disorder. In this case, although claimant's mother suggested that claimant suffered an injury from his forceps delivery, there is nothing in the record supporting Dr. Mancillas's theory, particularly medical-expert witness evidence. Dr. Mancillas failed to identify the qualifying etiology of his lowered cognitive scores, particularly in memory, and most significantly failed to fully account for excluded conditions, which Service Agency persuasively argued were solely responsible for claimant's disabling condition, such as a psychiatric disorder (Drs. Gaines and De Candia) or learning disorder (Dr. Gaines).

29. Dr. Mancillas persuasively opined that claimant would benefit from more intensive interventions, which were similar to interventions provided to the intellectually disabled clients of the regional center. However, Dr. Bienstock also persuasively noted that unlike intellectually disabled individuals, claimant had a history of typical adaptive functioning in a variety of settings and only started to decline just prior to his 18th birthday, and his dormant abilities distinguished him from individuals who did not have these skills, and was due to his other disorders. According to earlier reports claimant was "neat," he shared in household chores, could navigate the community, use money and drove a car until his psychiatric issues became pronounced. Claimant was not substantially disabled, as required by California Code of Regulations, title 17, section 5400 (Legal Conclusion 7), until at or about his 18th birthday.

30. Under these circumstances, it cannot be concluded that the *Samantha C.* case applies to claimant's situation. Based upon the Factual Findings in the instant case,

claimant failed to produce a preponderance of evidence establishing that his intellectual or adaptive functioning is closely related or similar to that of an individual with Intellectual Disability.

31. In sum, based on Factual Findings 1-67, and Legal Conclusions 1-30, claimant is not eligible for regional center services under the category of autism or the fifth category.

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ORDER

1. Claimant's appeal of the East Los Angeles Regional Center's denial of eligibility under the categories of autism and the fifth category is denied.

2. Claimant is not eligible for regional center services under the category of autism or the fifth category.

DATED: May 27, 2015.

/s/

EILEEN COHN

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.