BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: CLAIMANT v. GOLDEN GATE REGIONAL CENTER, Service Agency.	OAH No. 2017020461

DECISION

Administrative Law Judge Juliet E. Cox, State of California, Office of Administrative Hearings, heard this matter on October 23, 24, 25, 26, 30, and 31, and November 1 and 2, 2017, in San Francisco, California. Tserendolgor Tseleejav provided interpretation from Russian to English and from English to Russian.

Attorney at Law Louise J. Katz represented claimant, who was not present for the hearing.

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

The record was held open for submission of written argument. Claimant timely submitted written closing argument; GGRC timely submitted written responsive argument; and claimant timely submitted written reply argument.

GGRC submitted written objections to claimant's reply argument. Claimant submitted responses to these objections, and GGRC submitted a reply. These uninvited objections and responses were not considered.

The matter was submitted for decision on February 12, 2018.

ISSUE

Is claimant eligible for services under the Lanterman Developmental Disabilities Services Act (the Lanterman Act, Welf. & Inst. Code, § 4500 et seq.)?

FACTUAL FINDINGS

1. Claimant was born in Azerbaijan, in the former Soviet Union, in 1975. His family immigrated to the United States in 1979, settling in San Francisco among a large community of Jewish Russian-speaking Soviet emigrés. He shares a home with his elderly mother and he is not employed.

2. Claimant alleges that he qualifies under the Lanterman Act for services from GGRC because he has autism spectrum disorder, which constitutes a substantial disability for him. Claimant does not allege that he qualifies for any other reason, and presented no evidence at the hearing regarding other possibly qualifying conditions.

3. Both claimant and GGRC presented voluminous evidence in this matter. The findings below summarize only the most relevant and probative evidence.

DIAGNOSTIC CRITERIA FOR AUTISM

4. The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-V), describes the modern criteria for diagnosis of autism spectrum disorder. According to the DSM-V, a person meeting these criteria has autism spectrum disorder.

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

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

2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

[¶]… [¶]

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

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

[¶]... [¶]

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

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

E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay.

5. Autism spectrum disorder is a developmental disorder. A person's expression of this disorder may vary depending on the person's age, and on the behavioral strategies a person may have learned from experience. Nevertheless, and as diagnostic criterion C reflects, a factor that distinguishes autism spectrum disorder from some other disorders that may produce similar adult behavior is that the diagnostic features of autism spectrum disorder are present from early childhood.

6. Autism spectrum disorder is not a degenerative disorder: Its significant symptoms do not worsen over time. In addition, and as diagnostic criterion A reflects, its significant symptoms are apparent and persistent in multiple contexts. They do not appear and disappear depending on environment or companions, although variations in environment or companions may affect the degree of impairment that symptoms cause.

7. Autism spectrum disorder is not a psychiatric disorder. It does not reflect mood dysregulation, hallucination, or delusion. It often is comorbid with psychiatric disorders, however. The DSM-V notes that "[a]dolescents and adults with autism spectrum disorder are prone to anxiety and depression," and that as many as 70 percent of people with autism spectrum disorder also have at least one other psychological disorder.

8. The DSM-V states that clinicians should not diagnose autism spectrum disorder in a person who "shows impairment in social communication and social interactions but does not show restricted and repetitive behavior or interests." It recommends consideration of a "social (pragmatic) communication disorder, instead of autism spectrum disorder," for such a person.

9. Between 2000 and 2013, the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (DSM-IV-TR), gave diagnostic criteria for several similar disorders grouped generally as "pervasive developmental disorders." In general, the essential features of "autistic disorder" were "markedly abnormal or impaired development in social interaction and communication and a markedly restricted repertoire of activity and interests." "Asperger's disorder" also involved "severe and sustained impairment in social interaction" and "restricted, repetitive patterns of behavior, interest, and activities," but without "clinically significant delays or deviance in language acquisition." In both "autistic disorder" and "Asperger's disorder," "the impairment in reciprocal social interaction is gross and sustained."

10. The DSM-V collapses the distinction between these disorders, noting that "many individuals previously diagnosed with Asperger's disorder would now receive a diagnosis of autism spectrum disorder without language or intellectual impairment."

CLAIMANT'S CURRENT PRESENTATION

11. Claimant presented testimony from clinicians (Lisa Barry, Psy.D., and Cheryl Bowers, Ph.D.) and employment counselors (John Comegys, Cindy Zoeller, and Bruce Tingwall) who have observed and interacted with him within the last several years.

Common Observations

12. Claimant's social skills are very poor. He has great difficulty sustaining a reciprocal conversation (as opposed to a monologue) on subjects of mutual interest,

and difficulty sustaining any conversation at all on subjects that do not interest him. Several of these observers also noted that claimant simply cannot control his desire to correct factual errors he believes that others have made in conversation, even when he knows or should know from repeated experience that correction is inappropriate (such as in a classroom lecture), unwelcome, or unimportant.

13. Claimant rarely makes eye contact in conversation, and he speaks with little intonation or stress variation.

14. Claimant is rarely able to answer open-ended questions that call for him to generate information spontaneously or imaginatively, or to select information that will help the questioner most. He can ask and answer specific questions, however, sometimes in great detail.

15. Claimant has few, if any, social relationships outside his immediate family. He is or recently has been a member of several clubs, but clubs and classes in recent years have been his only in-person social activities with people outside his family.[1]

16. Claimant prefers soft, loose clothing. He often wears the same clothing for many days in a row—not just similar or identical shirts and pants but the very same items. As a result, and also because he bathes infrequently, claimant often looks disheveled and frequently has noticeable body odor. He does not keep his hair or fingernails trimmed short.

17. Claimant has taken a wide variety of psychotropic medications, always under psychiatric management, since childhood. The evidence did not establish that claimant uses any unprescribed mood-altering drugs. All of the clinicians and counselors

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[1] The evidence did not establish whether or in what manner claimant uses the Internet to socialize, such as by participating in online discussion forums.

who described claimant's adult behavior were describing him as he behaves from day to day, under the therapeutic influence of medication.

Lisa Barry, Psy.D.

18. Dr. Barry treated claimant as a psychotherapeutic patient between March 2012 and March 2014. Her treatment focus was to assist claimant in learning strategies for managing anxiety and stress, and for communicating more effectively so as to develop and sustain more fulfilling interpersonal relationships. She did not attempt a formal diagnosis of claimant's mental disability.

19. In treatment with Dr. Barry, claimant learned several relaxation and mindfulness techniques that appeared to help him address anxiety. He was unable, however, either to identify circumstances outside his treatment sessions in which he might use these techniques effectively, or even to practice the techniques in preparation for stressful circumstances.

20. Claimant asked Dr. Barry to email him every day to remind him to practice, and refused her suggestion that he adopt another strategy, such as using an alarm clock, to take personal responsibility for reminding himself. Dr. Barry doubted in any event that claimant would have been able to respond effectively either to her email or to an alarm as a reminder, because his cognitive inflexibility would have made him unable, upon a reminder, to stop one task and switch to another. They terminated their treatment relationship after Dr. Barry told claimant that she did not believe further treatment would be effective unless he developed a way to generalize the techniques he had learned from their in-office sessions to other circumstances.

Cheryl Bowers, Ph.D.

21. Dr. Bowers's training is in clinical psychology. Her private practice emphasizes diagnosing mental disabilities through neuropsychological assessment, and

assisting clients in developing treatment plans to promote educational, social, and vocational success.

22. In late 2015 and early 2016, at claimant's request, Dr. Bowers interviewed and tested claimant to diagnose his mental disorder.[2] She administered a battery of standardized psychological tests, and observed claimant in a field exercise giving him the opportunity to show his strengths and weaknesses in performing ordinary adult activities in an unfamiliar setting.

23. Dr. Bowers spoke several times with claimant by telephone. He rarely either began or ended a call with the conventional "hello" and "goodbye"; he "would instead just launch into his comments and then when completed would hang up."

24. Claimant had several in-person appointments with Dr. Bowers, and was on time or early for each one. His mother accompanied him, but Dr. Bowers understood that claimant had driven between their home in San Francisco and Dr. Bowers's office in Santa Cruz.

25. Throughout several interview and testing sessions spaced a few months apart, Dr. Bowers did not observe that claimant kept trying to turn the conversation to some topic that only he thought interesting. Instead, she noted that he conversed with her, albeit sometimes in a brusque and halting manner, and that he cooperated in each of the test procedures she asked him to follow.

26. Dr. Bowers did not report having observed claimant engaging in any rituals or odd, repetitive mannerisms. Her report noted that claimant experiences significant symptoms characteristic of obsessive-compulsive disorder, and that he told

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[2] Dr. Bowers's diagnosis also reflected her review of claimant's developmental history, as she understood it both from documentary evidence and from claimant's mother's report.

her that he "falls into checking and rechecking loops and he very frequently gets caught up in the detail of doing something so that he spends longer than needed to finish a daily activity."

27. Dr. Bowers testified that she did not ask claimant directly why he wore the same clothing day after day, or why he showered so infrequently. Nevertheless, he told her: Her report states that he explained to her that he neglected his personal hygiene because he found the process too time-consuming and stressful. She wrote, "when he does try to wash or clean (such as in the shower), he falls into cognitive loops of wondering if he has already scrubbed an area and can't keep track so must do it again."[3]

CLAIMANT'S DEVELOPMENTAL HISTORY

28. Evidence was scant regarding claimant's infant and toddler years, but greater evidence was available from claimant's school years. This evidence showed that claimant was unusual and unhappy throughout much or all of his childhood, and that psychologists, psychiatrists, and educators have agreed since claimant was young that he has a mental disability. As set forth in more detail below, however, clinicians disagreed and still disagree regarding the best diagnosis for claimant's indisputable disability.

29. Numerous records in evidence from claimant's childhood included paraphrases of statements by claimant's mother describing his development and behavior. In addition, claimant's mother testified to describe claimant throughout infancy and childhood. Her descriptions at the hearing differed frequently from the more contemporaneous descriptions claimant's treatment providers had attributed to

[3] Other evidence confirmed that although claimant showers infrequently, he spends an unusually long time doing so when he does.

her in the past. Because these past statements occurred in other contexts and may have been inaccurately or incompletely reported, they are not very strong evidence regarding claimant's behavior in infancy and early childhood. At the same time, most of claimant's mother's testimony at the hearing was not credible.[4]

a. The evidence established that claimant's mother is a well-educated, intellectually strong person who has lived in San Francisco for more than 35 years. She prefers to communicate in Russian. Since immigrating to the United States, however, she has interacted frequently and successfully with a wide variety of people, including with many of claimant's teachers and medical providers, using English. Her insistence at the hearing that her command of English is and always has been poor, and that she often allowed conversations about claimant to occur around her without really comprehending them, was not credible.

b. Claimant's mother testified that claimant's primary treating pediatrician during his childhood and adolescence in San Francisco, Cyril Ramer, M.D., had no special connections to San Francisco's Russian-speaking immigrant community. She testified further that she did not recall why she had selected Dr. Ramer for claimant and that Dr. Ramer did not speak Russian. Other evidence directly contradicted this testimony. Dr. Ramer treated many Russian-speaking children in the 1980's and 1990's and had a strong reputation in San Francisco's medical community for her expertise regarding

[4] For similar reasons, her retrospective descriptions to Dr. Govindappa and Dr. Bowers of claimant as a small child were less credible than the descriptions attributed to her in contemporaneous medical, psychological, and educational records.

emotional and behavioral problems in this patient population.[5] Furthermore, Dr. Ramer attended at least one social event at claimant's family's home, in the company of other Russian-immigrant children. These contradictions further undermined claimant's mother's credibility.

Early Childhood

30. The evidence did not establish any unusual or significant delay in claimant's speech and language development.

31. The evidence established that claimant's motor coordination developed somewhat slowly, and that he learned to crawl and to walk later than many infants. It did not establish any unusual, repetitive, or purposeless movement patterns, and it did not establish that he ever preferred strongly to walk on his toes.

32. Claimant accepted physical affection as a small child, especially from his mother. He never sought it, however, and resisted age-appropriate cuddling from his father and uncles.

Later Childhood and Adolescence

33. The evidence established that claimant was restless, undisciplined, and overactive in his elementary school classrooms. His teachers reported that he often refused to keep his seat and that he went out of his way to disturb other students; but

[5] Despite claimant's mother's testimony attempting to minimize Dr. Ramer's acquaintance with claimant, claimant also offered as Exhibit EEE a written statement by Dr. Ramer purporting to offer Dr. Ramer's current expert opinion regarding proper diagnosis of claimant's lifelong disabilities. Exhibit EEE was hearsay admitted solely to explain or supplement other evidence. It was not admitted, and Dr. Ramer's statements were not considered, as evidence of her expert opinion regarding claimant.

the evidence did not establish that he engaged in unusual, repetitive, or purposeless mannerisms.

34. The evidence established that claimant enjoyed disassembling objects, as if to determine how they worked. It also established that claimant hoarded (and still hoards) books, papers, and other small items, and always has resisted his family's attempts either to organize them or to dispose of unnecessary items. The evidence did not establish that claimant ever used objects for repetitive or idiosyncratic play, such as by lining them up or turning one item over and over.

35. The evidence did not establish that claimant ever showed an obsessive focus on one or a few unusual topics, to the exclusion of other age-appropriate interests.

36. The evidence did not establish that claimant ever has been either unusually sensitive or unusually insensitive to sensory stimuli.

37. During youth and adolescence, claimant was extremely emotionally volatile. He suffered several episodes of severe depression, involving suicidal gestures and hospitalization. His teachers and treatment providers stated that when he was unhappy or under severe stress, his speech became disorganized and sometimes illogical; some suspected, particularly in claimant's late teens, that claimant was experiencing hallucinations or delusions that interfered with his ability to organize and communicate his thoughts. When claimant was calm or happy, however, teachers and treatment providers praised his ability to communicate logically and effectively.

38. As a child, claimant resisted efforts to establish routine in his day-to-day life, and displayed anxiety and distress when teachers attempted to impose rules and schedules on him in the classroom. He maintained an erratic sleep schedule, for example, and missed school frequently due to illness. As he attempted to make the transition from childhood dependency to adult independence, his inability to establish a

routine enabling him to attend courses, appointments, and similar events regularly and on time proved to be a significant barrier to independent living and to further personal and academic success.

39. Between September 1992 and June 1994, claimant was an inpatient at Kings View Center, a psychiatric hospital in the Central Valley. He received psychotherapy and medication, and clinicians there reported that his ability to function improved markedly during his treatment. They also noted that claimant "adjusts very poorly to change. He resists having to modify established routines. He can be oppositional whenever a major change occurs in his life."

Young Adulthood

40. In June 1997, claimant had a further outpatient psychiatric evaluation at the University of California, San Francisco (UCSF), Langley-Porter Psychiatric Institute. The psychiatrist (Robert S. Streett, M.D.) described complainant as argumentative and articulate, but showing "striking deficits in emotional awareness." He also noted that claimant "lacks the obsessive interests so often noted" in people with autism.

41. During February 1998, claimant participated in a research study at UCSF. The study included a neuropsychological assessment. The researcher (John H. Poole, Ph.D.) reported that testing showed claimant to have "above average verbal intelligence," but "significant difficulty when required to process verbal information rapidly. Dr. Poole described these results as indicating "a learning disability," involving "a deficit in the domain of receptive and expressive language functions."

42. In December 1999, claimant obtained an evaluation from the San Francisco State University Communicative Disorders Clinic. He explained to the clinicians that he had difficulty "not with spelling, vocabulary, and comprehension of meanings but with auditory comprehension, verbal expression, and word finding." Based on their administration of several standardized tests, the clinicians concluded that claimant had

"an auditory processing and pragmatics disorder characterized by difficulty in the areas of auditory memory, abstract processing, and social skills."

43. The Communicative Disorders Clinic team also reported several pertinent observations regarding claimant's behavior:

a. He made no eye contact and did not participate in reciprocal conversation;

b. He fidgeted and paced;

c. When a fire alarm interrupted the evaluation session, he was "responsive to the examiners and understanding regarding the extenuating circumstances";

d. He struggled to answer open-ended questions; and

e. He displayed little imagination when the examiners gave him a picture and asked him to write a story about it.

44. The evidence about claimant's life between about 1995 and 2015 was not merely inconclusive, but mysterious. During some portions of this period claimant lived in Sacramento, with friends or in organized supportive living facilities; during other portions he lived in San Francisco. Claimant has been married and divorced, although the evidence did not establish precisely how he met and courted his wife, when they married, or when or why they divorced. Claimant holds or has held a driver's license and has at times commuted between San Francisco and Sacramento; but some witnesses stated that they believed that the Department of Motor Vehicles had suspended or revoked claimant's driving privileges. Although claimant's mother testified that claimant neither shops for food nor cooks, Dr. Bowers observed that claimant knew how to operate a self-checkout machine in a supermarket and that he mentioned "normally"

placing his groceries in his car's passenger seat. Claimant's employment history, including any history of gainful self-employment, was unclear.[6]

DIAGNOSTIC EVALUATIONS

45. Claimant has received many psychiatric and psychological diagnoses since his childhood. Among these, three clinicians or clinical teams have opined that claimant meets DSM-IV-TR criteria for autistic disorder or DSM-V criteria for autism spectrum disorder.

Evaluation by Bryna Siegel, Ph.D.

46. In January 2001, claimant received a diagnostic evaluation at the UCSF Pervasive Developmental Disorders Clinic, led by Bryna Siegel, Ph.D. The report of this evaluation gives no detail regarding the evaluation's components, other than to note that the evaluators interviewed claimant and that they had evaluated him previously more than three years earlier. The evaluators concluded that claimant fell "somewhere within the autistic spectrum," as described in the DSM-IV-TR, because:

a. He had failed to develop appropriate peer relationships;

b. He did not spontaneously seek to share experiences with other people;

c. He lacked social or emotional reciprocity; and

d. He had poor skills for initiating or sustaining conversation.

[6] Zoeller testified that claimant had advised her to search the Internet for his name so that she could understand his employment qualifications. She did, and was "amazed" by claimant's apparent experience and accomplishments with "sophisticated software applications." The specific information that amazed Zoeller was not in evidence, however.

Evaluation by Kushma Govindappa, M.D.

47. In 2012, Kushma Govindappa, M.D., was a Developmental-Behavioral Pediatrics Fellow at the University of California, Davis, Medical Investigation of Neurodevelopmental Disorders (MIND) Institute. In consultation with Randi Hagerman, M.D., Medical Director of the MIND Institute, Dr. Govindappa assessed and evaluated claimant to determine whether he met criteria for autism spectrum disorder.

48. In February 2012, MIND Institute staff members administered cognitive tests to claimant, showing overall that he has average to above average intelligence. They also administered the Autism Diagnostic Observation Schedule (ADOS), a "semi-structured, play-based measure"; they used Module 4, which includes questions and observation cues appropriate for older adolescents and adults. Although Dr. Govindappa's report does not explain the ADOS observations in detail, it states that claimant's ADOS scores for communication and for reciprocal social interaction were well above minimum scores indicating a likely autism spectrum disorder.

49. Dr. Govindappa also evaluated claimant against the diagnostic criteria in the then-applicable DSM-IV. Although her report does not explain the observations in detail, it concludes that claimant met the DSM-IV criteria for "Autism disorder." In particular:

a. He showed marked impairment in nonverbal behavior to regulate social interaction;
b. He had failed to develop appropriate peer relationships;
c. He did not spontaneously seek to share experiences with other people;
d. He lacked social or emotional reciprocity;
e. He had poor skills for initiating or sustaining conversation;
f. Particularly when younger, he had used stereotyped or idiosyncratic language;
g. He was not imaginative or socially imitative;

h. He had narrow, intense interests;

i. He followed rigid routines; and

j. Particularly when younger, he had displayed motor mannerisms.

Evaluation by Cheryl Bowers, Ph.D.

50. Dr. Bowers evaluated claimant against the diagnostic criteria in the DSM-V. She concluded that claimant meets the DSM-V criteria for autism spectrum disorder. In particular:

a. He lacks "social and emotional reciprocity" (criterion A.1);

b. He struggles with "nonverbal communicative behaviors" (criterion A.2);

c. He has "lifelong deficits" in interpersonal relationships (criterion A.3);

d. He displays "stereotyped behaviors," in particular pacing under stress (criterion B.1);

e. He insists on "inflexible adherence to routines" (criterion B.2);

f. He is hypersensitive to certain sensory stimuli (criterion B.4);

g. Each of these symptoms existed throughout claimant's childhood (criterion C); and

h. These symptoms result in significant disability (criterion D).

Review by Telford Moore, Ph.D.

51. Telford Moore, Ph.D., has been a staff psychologist at GGRC for more than 20 years. His training is in educational psychology, and his prior experience included service as a school psychologist and as a staff psychologist at the Lanterman Developmental Center, in Pomona. His role at GGRC includes reviewing applications for Lanterman Act services.

52. Dr. Moore reviewed claimant's mental health treatment history since childhood. Beginning in claimant's elementary school years, these records describe

profound anxiety and mood dysregulation; in claimant's adolescence, they describe hallucinations, delusions, and at times grossly disordered cognition.

53. Dr. Moore acknowledged, as stated in Finding 7, that psychiatric disorders may be comorbid with autism spectrum disorder. At the same time, he cautioned that psychiatric disorders may produce symptoms very similar to autism spectrum disorder. Most notably, both major depression and schizophrenia may produce significant deficits in the ability to engage in social and emotional reciprocity with other people.

54. Dr. Moore testified that pacing is such a common response to stress that it is at best weakly diagnostic for autism spectrum disorder. In the absence of any other similar mannerisms, he does not believe that pacing under stress satisfies DSM-V criterion B.1. This testimony was persuasive.

Analysis

55. The evidence established that since early childhood, claimant has demonstrated consistent and significant deficits in his ability to engage in social and emotional reciprocity with others. Each clinician who has compared claimant's behavior against the DSM-IV-TR criteria for autistic disorder or the DSM-V criteria for autism spectrum disorder has drawn this conclusion; and it is consistent with reports from multiple sources since early childhood about claimant's behavior. Dr. Bowers's opinion that claimant meets, and since early childhood has met, autism spectrum disorder diagnostic criteria A.1, A.2 and A.3 is persuasive.

56. The other major feature of autism spectrum disorder, however, is a restricted, repetitive pattern of behavior, interests, or activities. The DSM-V states that a clinician should confirm this feature in a patient who meets at least two of diagnostic criteria B.1, B.2, B.3, or B.4. Although the DSM-IV-TR used somewhat different language, it too emphasized restricted behaviors or interests as one of the two major features of both autistic disorder and Asperger's disorder.

57. The 2001 "autistic spectrum" diagnosis from the UCSF Pervasive Developmental Disorders clinic described above in Finding 46 is not persuasive, because it cites no diagnostic criterion resembling any of the criteria currently stated in part B of the DSM-V criteria for autism spectrum disorder.

58. Although both Dr. Govindappa and Dr. Bowers did conclude that claimant met such criteria, their opinions rest largely on facts about claimant's developmental history that the evidence at the hearing did not support.

a. Dr. Govindappa did not explain what stereotyped or idiosyncratic language she believed claimant had used as a child, but the evidence as summarized in Findings 23, 30, and 37 did not establish that he ever had used any.

b. Instead of relying on stereotyped language, Dr. Bowers relied on motor mannerisms as support for her conclusion that claimant satisfied diagnostic criterion B.1. The evidence, in particular as summarized in Finding 33, established that since childhood claimant often has behaved restlessly in stressful settings. Especially in light of the matters stated in Finding 54, the evidence did not support Dr. Bowers's characterization of claimant's physical behavior as stereotyped or repetitive, however, across many contexts and throughout many years.

c. Both Dr. Govindappa and Dr. Bowers cited claimant's strong preference for routine as support for their diagnoses, and in Dr. Bowers's case for her opinion that claimant satisfied diagnostic criterion B.2. The evidence, and particularly the matters stated in Findings 26, 34, and 38, did not establish that claimant has such a lifelong preference.

d. The evidence, as summarized particularly in Findings 25, 35, and 40, did not establish that claimant ever had displayed narrow, intense, and unusual

interests, as diagnostic criterion B.3 requires. Dr. Govindappa's statement that he had was unsupported.

e. Finally, Dr. Bowers's opinion that claimant meets diagnostic criterion B.4 rested chiefly on her understanding that claimant avoids bathing because it causes sensory overload. The evidence did not establish that this understanding was accurate. Rather, and as stated in Finding 27, the evidence established that claimant avoids bathing because it triggers unpleasant, compulsive behavior for him. Moreover, the evidence did not establish any other potentially unusual sensory hypersensitivity in claimant.

59. Neither Dr. Bowers's nor Dr. Govindappa's opinion was persuasive evidence that claimant satisfies at least two of the four criteria in part B of the DSM-V for diagnosing autism spectrum disorder.

60. As stated in Findings 8 and 53, even severe impairments in reciprocal social interaction are not, by themselves, diagnostic of autism spectrum disorder. In light of the matters stated in Findings 56 through 59, the evidence did not establish that claimant has autism spectrum disorder.

LEGAL CONCLUSIONS

1. The State of California accepts responsibility for persons with developmental disabilities under the Lanterman Act. (Welf. & Inst. Code, § 4500 et seq.) Lanterman Act services are provided through a statewide network of private, nonprofit regional centers, including GGRC. (*Id.*, § 4620.)

2. A "developmental disability" qualifying a person for services under the Lanterman Act is "intellectual disability, cerebral palsy, epilepsy, [or] autism," or any other condition "closely related to intellectual disability or [requiring] treatment similar to that required for individuals with an intellectual disability." (Welf. & Inst. Code, § 4512, subd. (a); see Cal. Code Regs., tit. 17, § 54000, subd. (a).)

3. Conditions that are solely psychiatric in nature, or solely learning disabilities, are not "developmental disabilities" under the Lanterman Act, even if they cause significant intellectual or social impairment. (Cal. Code Regs., tit. 17, § 54000, subds. (c)(1), (c)(2).)

4. As set forth in Finding 2, claimant did not contend that he is eligible for Lanterman Act services because of intellectual disability, cerebral palsy, epilepsy, or a condition similar to intellectual disability. As set forth in Finding 60, the evidence did not demonstrate that claimant has autism spectrum disorder.

ORDER

Claimant's appeal from GGRC's determination that claimant is ineligible for services under the Lanterman Act is denied.

DATED: February 26, 2018

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JULIET E. COX

Administrative Law Judge

Office of Administrative Hearings

NOTICE

This decision is the final administrative decision in this matter. Both parties are bound by this decision. Either party may appeal this decision to a court of competent jurisdiction within 90 days.