BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: CLAIMANT vs. GOLDEN GATE REGIONAL CENTER, Service Agency.	OAH No. 2018060235

DECISION

Administrative Law Judge Jill Schlichtmann, State of California, Office of Administrative Hearings, heard this matter on January 7, 8, 9 and 24, 2019, in San Francisco, California.

Claimant was represented by Jonathan Gertler, Attorney at Law. Claimant was not present during the hearing.

Rufus Cole and Dirk van Ausdall, Attorneys at Law, represented Golden Gate Regional Center, the service agency.

The record was left open for the filing of closing briefs. Claimant's closing and reply briefs were timely received and marked for identification respectively as Exhibits T and U. Golden Gate Regional Center's closing brief was timely filed and marked for identification as Exhibit 34.

The matter was submitted for decision on March 29, 2019.

ISSUE

Is claimant eligible for regional center services on the grounds that he is substantially disabled by autism?

FACTUAL FINDINGS

PROCEDURAL HISTORY

1. Claimant is 17 years old. He resides with his adoptive mother, "JB."[1]

2. On August 21, 2014, claimant applied for regional center services under the Lanterman Developmental Disabilities Services Act (Act),[2] asserting that he suffered from an intellectual disability. On January 5, 2015, Golden Gate Regional Center (GGRC) notified claimant of the decision of its eligibility team that he did not have a developmental disability as defined in the Act.

3. On February 26, 2015, claimant's mother met with representatives of GGRC and presented additional information for GGRC to consider in determining whether he was eligible for services. The eligibility team reviewed the additional information, which did not change the team's prior conclusion that claimant was not eligible for services.

4. On December 9, 2016, claimant submitted additional information for GGRC to consider, including a report dated August 11, 2016, diagnosing claimant with autism spectrum disorder (ASD). On February 1, 2017, GGRC sent a letter to claimant stating that the new reports were reviewed, but the eligibility team had concluded that

---

[1] Claimant and his family members will not be referred to by name in order to protect claimant's privacy.

[2] Welfare and Institutions Code, section 4500 et seq.

the new information did not establish that claimant had a developmental disability, and therefore GGRC found no basis upon which to reassess claimant.

5. On March 16, 2018, claimant submitted additional information to GGRC, which was considered by the eligibility team. The new information was an assessment by a school psychologist dated October 6, 2017, recommending that claimant be made eligible for special education services under the categories of emotional disturbance, other health impaired and ASD. The eligibility team concluded that the new information did not warrant a reconsideration of claimant's eligibility for services. On April 18, 2018, GGRC sent claimant a Notice of Proposed Action denying eligibility for regional center services.

6. Claimant timely filed a fair hearing request and this hearing followed. Claimant contends that he is eligible for regional center services on the basis of ASD, which he asserts is substantially disabling.

7. By all accounts, claimant presents with a complex set of problems. Claimant has experienced a myriad of emotional, behavioral and psychiatric problems for many years. He has been diagnosed with generalized anxiety disorder, oppositional defiant disorder (ODD), obsessive compulsive disorder (OCD), attention-deficit/hyperactivity disorder (ADHD), Tourette's disorder, and posttraumatic stress disorder (PTSD), and more recently with ASD. The results of his intelligence quotient (IQ) tests have varied over the years, ranging from average to impaired.

CLAIMANT'S EARLY CHILDHOOD AND EDUCATIONAL BACKGROUND

8. Claimant was born by normal spontaneous vaginal delivery without complication to a 44-year-old mother who smoked during pregnancy. No known issues were reported early on in claimant's development.

9. It has been reported that claimant's biological parents were each significantly impaired and dysfunctional. Claimant's half-sister reported in 2014 that as a

child, claimant appeared to be extremely bright; his mother read to him a lot and he had a large vocabulary; he was loving and liked to be cuddled and held. Claimant's biological mother, who had suffered a brain aneurysm when claimant was an infant, struggled with subsequent paranoia, was subjected to domestic violence from claimant's biological father, and later drowned in the bathtub after suffering another aneurysm in October 2005 when claimant was four years old.

10. After his mother died, claimant moved to a cabin in Sonora with his father, who reportedly slept in the same bed with claimant. Claimant's biological father was described as abusive, bizarre and alcoholic. Claimant did not see his three biological half-siblings after his mother died and did not have contact with them again until 2009.

11. At age seven, claimant's father died of a heart attack while sleeping with claimant. Claimant was found alone with his father's body, having spent all day, not knowing what to do or how to call for help. Claimant had been happy living with his father; however, there were signs of neglect, including a less than healthy diet, a lack of medical and dental access and minimal adult supervision.

Claimant was believed to be experiencing persistent physical and emotional abuse, There is a suspicion that claimant was sexually abused by his father. Claimant's half-sister reported that after claimant's father died, claimant touched his half-brother's genitals and told him he would like to see him naked. These emotional scars have left claimant a very vulnerable and troubled child.

12. Claimant attended preschool and kindergarten in Sonora, and part of first grade at Sierra Waldorf School. The Admissions Director of the Sierra Waldorf school recalled the following about claimant during the six months he attended first grade there:

> Claimant's father was not a typical Waldorf parent; claimant appeared to love his father; claimant came to school clean,

well-dressed and fed; claimant did not show emotion at his father's funeral; and "anyone worth their salt could see [claimant] had issues;" claimant's teachers thought he exhibited autistic-like behavior; claimant was "stuck in abstract thinking" not typical for a child his age; claimant made clicks and noises and was in a constant state of movement; claimant had issues with touching others and not respecting others' personal boundaries; he struggled with balance, was immature and his drawings were very primitive. Sierra Waldorf provided claimant with three to six hours of one-on-one teaching per week.

13. Following his father's death, in January 2009, claimant was placed in the home of an adult cousin and his family, who became temporary guardians. Claimant was transferred to Wade Thomas Elementary in the Ross Valley School District, where he completed the first grade. Claimant's guardians reported that claimant had difficulty communicating, often played alone, and his social skills did not conform to normal behavior. Claimant did not interact with others, engaged in parallel play and confronted (hit and choked) other children when he did not get his way. Claimant constantly needed physical movement, had difficulty sharing, was self-centered and shy, easily distracted, talked excessively, displayed temper outbursts, had difficulty learning and could be verbally and physically aggressive. At times he displayed bizarre behavior and destroyed property.

14. In April 2009, claimant's initial speech and language, psychoeducational and occupational therapy evaluations were completed at Wade Thomas. Concerns related to communication, social skills and behavior prompted a referral. The

evaluations revealed a social cognitive deficit, leading to claimant receiving speech services.

15. At the request of his guardians, in April 2009, Tina Perdices completed a psychoeducational assessment to determine whether claimant displayed autistic-like behaviors. Claimant had been receiving counseling services at school. Claimant was quite impulsive and required redirection to complete testing and his concentration waned. Claimant's full scale IQ was measured at 92.

On the BASC-II,[3] claimant's teacher rated his Withdrawal Scale in the clinically significant range and his Social Skills in the at risk range; his guardian rated his Atypicality, Social Skills, Withdrawal, Leadership and Functional Communication skills in the clinically significant range.

On the Asperger's Syndrome Diagnostic Scale, claimant's guardians noted borderline to significant features in all functional areas (language, social skills, maladaptive behaviors, cognitive and sensorimotor), but his teacher only noted significant deficits in social skills.

Perdices concluded:

> Results of behavior rating scales did not consistently and clearly suggest the presence of Asperger Syndrome or other social-emotional delays and adaptive skills deficits characteristic of autism disorders. … Observations by the examiner noted some mild to moderate difficulties with

[3] The Behavior Assessment for Children, Second Edition, is an integrated system designed to facilitate the differential diagnosis and classification of a variety of emotional and behavioral disorders of children.

specific social skills, impulsivity, concentration, gross motor functioning and visual tracking.

[Claimant] has recently lost his parent and is coping with grief and simultaneously contending with significant adjustment demands in both his new home and school settings.

Claimant did not qualify for special education under the criteria for Autistic-Like Behaviors.

16. In May 2009, claimant's temporary guardians relinquished him to the foster care system as a result of his maladaptive behaviors.

17. Claimant was placed in the home of JB and SB, on June 6, 2009. JB and SB's children were nearing adulthood and they had decided to open their home to a child in need. When she first met claimant, JB considered him to be quirky, cute, charming and shy. Claimant settled in nicely with his new family. Claimant had a bright demeanor, tried to please, and JB believed that with nurturing, he would blossom. Claimant had an active and happy summer and thrived physically and emotionally.

18. In the fall of 2009, claimant began attending Venetia Valley Elementary School in San Rafael. Although he struggled with math, he seemed happy at the school and developed friendships. He was described as timid, quiet, creative and clever. In December 2009, the family enjoyed a happy Christmas. During the initial year after claimant came to live with JB and SB, he was happy. On February 2, 2010, JB and SB formally adopted claimant.

19. In April 2010, the Woodcock-Johnson Test of Achievement III was administered to claimant at Venetia Valley. His broad reading, writing and math scores were in the average range; his math calculation scores were in the low average range.

20. School records reveal that over the summer of 2010, claimant was active and happy; he was described as very sweet, affectionate, talkative, inquisitive, funny and charming.

At hearing, JB recalled some unusual behavior by claimant at that time, such as repeating the word "akoo," throwing tantrums, and licking her face. She also recalls claimant hoarding food in his bedroom, and that he was messy and would break things when he was angry.

21. In August 2010, claimant began third grade at Venetia Valley. A marked change in claimant's mood, attitude and symptoms was observed. He cried frequently, had stomach aches and headaches, became argumentative and generally unhappy, depressed, angry and confused. Claimant had changed from being a happy, confident boy to being fearful and stressed. JB and SB reported that until the fall of 2010, claimant had been likeable, loveable, obedient and compliant, and though impulsive, was making a fine adjustment at home. Due to reports of bullying and escalating behavioral problems, claimant was transferred to Sun Valley Elementary School in November 2010.

22. In 2011, claimant's ability to get along with others at school diminished; he began engaging in sexualized behaviors, he was unable to learn, and cried because he did not want to attend school.

23. On April 7, 2011, Michael Buckley, School Psychologist, at the Marin County Special Education Local Plan Area (SELPA), performed a psychoeducational evaluation of claimant. Claimant was referred for an evaluation following concerns that he was misbehaving in class, including making distracting noises, being intrusive to peer's personal space, and was hyperactive and impulsive. Claimant's strengths were identified as reading decoding, making friends, and being bright and basically good natured. Buckley was asked to determine whether claimant was eligible for special education based on emotional disturbance.

24. Buckley reviewed prior reports and records, interviewed JB and SB, consulted the school counselor, conducted a clinical interview of claimant and administered testing.

25. Claimant scored in the average range overall on intelligence testing. His verbal and non-verbal functioning were in the high average range, working memory in the average range, but his processing speed score was significantly weaker. In the morning, claimant coached himself and was focused. In the afternoon, he was much more distractible, and frequently made motor and other sounds with his mouth. During the test taking, claimant was seen, hands in his pants, playing with his "privates." When the examiner remarked about it, claimant removed his hand and said, "I like to."

26. The responses by claimant's mother to the BASC-II, did not reveal areas of behavior classified as Clinically Significant. Two areas were classified as At Risk: anxiety and attention problems. Responses by claimant's teacher were more problematic. Claimant's behavior was classified in the Clinically Significant range in the following areas: hyperactivity, school problems, atypicality, externalizing problems, learning problems, and bullying. Regarding atypicality, claimant's behavior was described as almost always doing strange things and babbling to himself. Six behavior areas were classified in the At Risk level: aggression, conduct, depression, attention, developmental social disorders and emotional self-control. Claimant's teacher reported problems with staying seated, being easily distracted, acting without thinking, disrupting others, and breaking the rules; and, that claimant was often sad.

27. The Children's Manifest Anxiety Scale and the Children's Depression Inventory did not indicate abnormal anxiety or depression. The Rorschach Interpretation Report indicated that claimant was experiencing a modest amount of intrusive ideation over which he had little control involving worrisome thoughts; claimant tended to think about his experiences in an inflexible manner; he viewed the world and future in a

pessimistic way; and there was evidence of impairment in his ability to think logically and coherently. It also showed problems with processing information and a lack of a consistent and well-defined coping style.

28. Buckley considered the evaluation by Perdices and a report by a school counselor, Lindsay Molinari, who had known claimant at Venetia Valley and at Sun Valley. Molinari reported that at Venetia Valley she had observed claimant to have been mostly withdrawn and distracted in the classroom, having a "people pleaser" personality who got along with adults, and a child who struggled with physical boundaries. At Sun Valley, Molinari noticed a change; in the classroom he would blurt out almost non-stop, and he began to make faces that looked stiff and painful, as if trying to control blurts. She noted that claimant described feeling unable to control his body. In addition, claimant had begun hurting other students.

29. Buckley concluded that claimant had experienced a series of traumas likely to have caused PTSD, which consequentially were the antecedents for his troubled and troubling misbehaviors. He found the following symptoms of PTSD: irritability or outbursts of anger; difficulty concentrating; hypervigilance; and feelings of detachment/estrangement. Buckley concluded that claimant's PTSD caused him clinically significant distress and impairment in school functioning. Buckley concluded that there was no evidence to suggest that claimant had symptoms of autistic-like behaviors, or a learning disability. Buckley recommended that claimant be found eligible for special education services under the category of emotional disturbance, and recommended psychotherapy and school counseling to address historical events that had triggered traumatic stress.

30. Carolyn Vaughn, Psy.D., completed an AB3632 assessment report in June 2011. Dr. Vaughn reported that claimant was described as well-liked by his peers and welcomed their attention. The primary concerns were identified as persistent symptoms

of PTSD, including irritability, impulsivity/acting out, hypervigilance, difficulty concentrating, feelings of detachment or estrangement, and the display of unusual disruptive behaviors which interfered with his and his peers' education. The behaviors appeared to be beyond claimant's ability to control, and included repetitive vocalizations, high levels of physical activity, staring off into space for long periods and impulsivity. Dr. Vaughn reported that claimant's history of multiple traumas (his parents' deaths and school and life changes) had left claimant with impaired functioning; she found his symptoms and presentation to be consistent with PTSD and that the symptoms limited his ability to access education.

31. Around this time, JB began to notice that claimant misunderstood directions. For example, if she directed him to take a basket and pick some apples off the apple tree, he might butcher the tree with an axe. She also recalls him flapping his ears, or flapping her ears. He did not seem to understand personal boundaries or how to keep his hands to himself. Claimant's mother also saw claimant masturbate while reading at night, and he had an anal fixation, and would insert his finger in his anus in front of family members. Despite being told that this was inappropriate, claimant would not be redirected, and would say, "but it feels good."

32. Claimant was referred to Community Mental Health where he began receiving services in June 2011. Claimant saw Hiram Elliott, M.F.T., from June 2011 to June 2012, and then privately until early 2013. Beginning in February 2012, claimant was also seen by child psychiatrist Catherine Kennedy, M.D. for medication assessment and monitoring. In March 2012, Dr. Kennedy began exploring medication to address claimant's ADHD. His active problem list included child abuse by peer, mental/behavioral problems not otherwise specified, and PTSD.

33. A speech and language report dated April 5, 2012, found claimant eligible for speech and language services at school. Overall expressive and receptive language

skills were informally assessed and judged to be within functional levels for his age. However, claimant had pragmatic language deficits that adversely impacted his ability to access the general education curriculum both academically and socially. In addition, there was an indication of weaknesses in critical thinking and his ability to draw upon various aspects of social knowledge. During the assessment, claimant avoided eye contact, laughed inappropriately, and used unusual mannerisms. Claimant had difficulty making inferences, sequencing information, answering negative questions and seeing the relationship between actions and outcomes. Claimant had inefficient perspective taking skills, use of his own body language and facial expressions, limited ability to self-monitor how his language is interpreted by others and difficulty self-regulating. Speech and language impairment was added to his Individualized Education Program (IEP), and claimant began to receive speech services.

34. A Marin SELPA assessment summary dated April 5, 2012, described claimant as a kind, intelligent, creative boy who wanted to do well. He was active and loved playing handball with peers. On the Woodcock Johnson III (WJ III), which measures academic achievement in reading, written language and math, claimant scored in the average range in all areas of reading overall. His broad written language skill fell within the average range, however, his writing fluency and written expression were quite low. Math remained claimant's greatest area of weakness.

35. On May 24, 2012, an education-related mental health services update report was submitted by Hiram Elliott. Elliott reported that claimant had been seen by him for individual counseling to reduce his anxiety by addressing attachment seeking behaviors which had become more disorganized in connection with the loss of both parents by age seven. Claimant had established a warm and stable bond with Elliott. Elliott described claimant as a bright and articulate individual with a well-developed sense of humor who was prone to rapid escalation, emotional flooding and loss of

impulse control in response to environmental stressors, especially those which might involve his having displeased an attachment figure. While motivated to "do the right thing," claimant had not established reliable internal controls and methods for self-soothing. Strength-based interventions and positive reinforcement were most effective in helping claimant address disruptive behaviors. Elliott recommended the continuation of weekly counseling to address mental health symptoms that interfered with claimant's educational progress.

36. In January 2014, claimant's care at Community Mental Health was transferred to Hollis Byers, M.F.T. Claimant saw Byers one to two times per week. Byers reported that claimant's PTSD was the basis for his acting out behavior. Byers noted that claimant had significant attachment problems with his adoptive parents. His behavior toward his parents could be threatening and intimidating. Claimant's behavior at home was often out of control. Claimant was embarrassed by his home behavior and reluctant to talk about it. He felt substantial shame about his disorders, and unusual, quirky behavior.

37. On March 25, 2014, an IEP meeting was held. Claimant was in the sixth grade. The IEP documented that claimant was receiving special education services based primarily on emotional disturbance, and to a lesser extent for speech and language impairment. The IEP documents that claimant's behavior had improved over the course of the year, although he still had significant difficulty staying focused and completing classroom assignments independently. His speech services included 60 minutes per week of speech therapy with goals targeting pragmatic language, problem solving and predicting. He had made great progress in the preceding year and had met all three goals. During preferred activities, claimant was attentive, polite and exhibited appropriate behaviors approximately 90 percent of the time. During activities he did not like or during "boring moments" claimant appeared distracted and displayed

"unexpected" behaviors such as looking away from the speaker, making noises, talking, being off-topic and fidgeting.

Claimant's psychologist and speech pathologist observed that claimant needed guidance when determining if he was experiencing a social obstacle. Claimant was able to identify behaviors that were appropriate and those that were not. Once the issue was raised, claimant was able to brainstorm possible solutions.

38. On April 25, 2014, Dr. Kennedy, documented that she was treating claimant for: 1) ADHD; 2) PTSD; 3) Generalized Anxiety Disorder; 4) Tourette's Syndrome; 5) OCD; and 6) encopresis at home.[4]

39. Steve Grue, M.S., a school psychologist with the San Rafael City Schools, wrote a persuasive, thorough and detailed report of his psychoeducational evaluation of claimant dated October 15, 2014. Claimant was 13 years old and was in the seventh grade at the time. Grue reviewed claimant's educational history and reports from teachers, physicians, therapists and parents, and administered testing. Grue noted that claimant's teachers painted quite a variable picture of his functioning and behavior. In his regular education history class, claimant presented as being appropriate; he was generally quiet and was receiving a passing grade. However, in his special education reading and social studies classes, he engaged in aberrant behavior, where his elevated level of "annoying" behaviors led him to be the classroom "pariah."

40. Grue noted that claimant's behavior at home was much worse than his behavior at school. With Grue, claimant presented as a friendly, appropriately dressed student. During testing, claimant was pleasant and cooperative, and seemed to enjoy the individual attention he received. Claimant persevered on difficult tasks, monitored

[4] Encopresis is fecal soiling.

his performance and spent more time on difficult problems. He found it difficult to restrain his physical impulses or to work without talking.

41. Grue reported that claimant was continuing to see Dr. Kennedy twice per month.[5] Grue reported being advised that Dr. Kennedy had diagnosed claimant with ADHD, PTSD, generalized anxiety disorder, Tourette's Syndrome, OCD, and "probable Pervasive Developmental Disorder."[6] In July 2014, claimant experienced a brief anxiety attack with psychotic features; Dr. Kennedy prescribed Risperdal, an antipsychotic medication. Dr. Kennedy had reported that claimant made a huge effort to present as normal in school. Claimant frequently sat in class focused on suppressing his compulsions, aberrant behavior, perseverations (such as making noises or baby talk), inappropriate touching and unusual speech, to the detriment of learning. Claimant's behaviors, and his echolalia and neologisms were frequently not under his control. Claimant displayed extremely aberrant behavior at home, including smearing feces, putting his face in food, following his parents around while repeating phrases and inappropriately touching JB.

42. Testing indicated that claimant displayed below average verbal ability and nonverbal ability, average spatial ability, and below average working memory. He was classified as above average in phonological awareness, average in phonological memory, well below average in rapid naming, and extremely below average in alternate rapid naming. On the BASC-II, claimant displayed elevated level of conduct problems at home and at school. He annoyed his peers, which Grue attributed to his Tourette's

[5] Neither party produced any records from Dr. Kennedy after September 2014.

[6] Dr. Kennedy did not include Pervasive Developmental Disorder (probable or otherwise) in her list of diagnoses in her records through September 2014.

Syndrome, OCD and ADHD.

Further testing revealed that claimant displayed social, emotional and behavioral problems at school and at home. He had significant problems making and keeping relationships, especially with peers. At school, claimant developed adequate relationships with many staff members; he valued and cultivated those relationships. At school, claimant's inappropriate behaviors included blurting out and making noises, repeating phrases or words over and over, being impulsive, neologisms and echolalia. He also, however, frequently displayed appropriate behavior at school. At home, claimant's emotions were poorly regulated. The testing indicated that claimant displayed emotional, cognitive and physical signs of unhappiness and depression. Claimant's performance revealed symptoms of ADHD, which was consistent with classroom observations.

Grue found that current testing indicated that claimant's overall cognitive ability was in the average range. He did not find that claimant qualified for special education services under the category of learning disabled.

Grue evaluated whether claimant qualified under the category of autism. He found that autism was not an area of suspected disability. Grue based his opinion on the following factors: 1) claimant was able to use oral language for appropriate communication; 2) despite social skills deficits, claimant did not exhibit extreme withdrawal from people, and related well with adults and could relate appropriately with peers; 3) claimant did not display an obsession to maintain sameness; 4) claimant did not display an extreme preoccupation with objects or inappropriate use of objects or both; 5) claimant did not display an extreme resistance to controls; 6) claimant did not display peculiar motoric mannerisms and motility patterns; or 7) self-stimulating, ritualistic behavior.

Grue found that claimant was eligible for special education services under the

categories of Other Health Impaired (based on his ADHD) and Emotional Disturbance (based on his long history of an inability to maintain satisfactory interpersonal relationships with peers; displaying inappropriate types of behavior and feelings, and a tendency to develop fears associated with personal or school problems).

43. On October 17, 2014, Elizabeth Bernhardi, M.S., CCC-SLP, performed a speech and language assessment. She described claimant as a creative seventh grade student with a sense of humor. He had difficulties in the areas of Pragmatic Language and Social Language, and had notable difficulties with perspective taking and interpretation of nonverbal communication. Bernhardi noted that claimant had made progress but continued to require prompts and clues to generalize the concepts he had learned into social situations.

44. On October 23, 2014, claimant was evaluated by child developmental specialist Joseph Gumina, Ph.D., of Sutter Health, at the recommendation of Dr. Kennedy. The purpose of the evaluation was to further investigate the psychiatric and psychological issues raised by his considerable behavior issues. Dr. Gumina conducted a parent interview, a clinical interview of claimant, a review of school district evaluations, correspondence with Dr. Kennedy, and he administered various testing instruments.

Dr. Gumina reported that claimant exhibited multiple symptoms from the anxiety spectrum, was likely the victim of past abuse and trauma, and was a young man with relatively underdeveloped cognitive abilities. Claimant acknowledged losing his temper and having a lot of anger; he was able to discuss his outbursts, but lacked insight into the root cause of his escalations. Dr. Gumina found claimant to have a "truly compromised ability to deal with even the smallest of stressors, resulting in an escalating pattern of aggression, dysregulation and chaos in his relationship with his parents."

Dr. Gumina diagnosed claimant with OCD and generalized anxiety disorder. He

also suspected claimant suffered from an iteration of PTSD that might be referred to as Developmental Trauma, a form of anxiety that resides in his nervous system, related to early childhood loss and possibly explicit abuse. Dr. Gumina also diagnosed claimant with a thought disorder reflective of the intersection of low cognitive abilities being overwhelmed by anxiety. Dr. Gumina supported the school qualifying claimant for special education services under the category of Emotional Disturbance.

45. In November 2014, an IEP meeting was held at claimant's school. JB asked why he was not eligible for special education under the category of autistic-like behaviors. The IEP team explained that the team felt that claimant did not meet the criteria for autistic-like behaviors under educational criteria based on present and historical information.

GGRC'S 2014 EVALUATION OF CLAIMANT

46. Claimant applied for regional center services in August 2014 under the categories of intellectual disability or a condition similar to intellectual disability or requiring treatment similar to individuals with intellectual disability. JB had been referred to GGRC by other parents. Social worker Benisse Valete Reyes met with claimant and his adoptive parents on September 4, 2014. At the meeting, JB and SB also voiced concerns about autism. Claimant's diagnoses were ADHD, PTSD, OCD, ODD and Tourette's Syndrome. JB and SB were seeking an assessment, remedial education, advocacy with the IEP process, residential care for claimant and respite services.

At the time of the social assessment meeting, claimant was well-groomed and appropriately dressed. He was ambulatory with a full range of motion. Claimant spoke in full, clear sentences and was capable of having a very simple conversation, which mainly consisted of Reyes asking questions and him replying. He largely answered in correlation to questions asked, but tended to ramble or talk off topic. He provided consistent eye contact and appropriate voice tone, volume and fluency when he spoke.

Reyes did not observe repetitive, aggressive, hyperactive or self-stimulatory behaviors during the assessment. JB and SB reported that claimant was not often physically aggressive, but had no sense of personal boundaries. Claimant had an interest in tennis shoes, but did not demonstrate a deep knowledge of shoes. Following the assessment, Reyes recommended obtaining available records and documentation, and further evaluating claimant's eligibility for regional center services.

47. On November 20, 2014, Telford Moore, Ph.D., evaluated claimant to determine his eligibility for regional center services. Dr. Moore has been employed as a behavioral and staff psychologist at GGRC since 1998. Dr. Moore reviewed the psychological assessment by Michael Buckley, M.S.; the report by Hiram Elliott, M.F.T.; the March 25, 2014 IEP; Dr. Kennedy's diagnoses; application materials completed by JB; the psychoeducational evaluation by Steve Grue, M.S., dated October, 15, 2014; a draft academic assessment by Dominique Ryan, dated October 15, 2014; the speech and language assessment by Elizabeth Bernhardi, M.S., dated October 17, 2014; and Dr. Gumina's evaluation. Dr. Moore met with SB and claimant, then performed an evaluation of claimant.

Dr. Moore administered the ABAS-II, the Bender Visual-Motor Gestalt Test-Second Edition (Bender Gestalt-II), the Grooved Pegboard Test and the WISC-IV. The result of the ABAS-II, completed by JB, placed claimant in the Extremely Low classification, indicating that claimant was functionally very ineffective.

The Bender Gestalt-II score of 107 indicated average functioning in copying, but borderline/very low in recall, which is consistent with attentional problems and a variable working memory.

The Grooved Pegboard Test is a sensorimotor test that assesses finger and hand dexterity, and fine motor coordination. Claimant's scores were consistent with the absence of significant neurocognitive compromise.

On the WISC-IV, claimant's full scale IQ was measured at 67, which is extremely low. The scores, when compared with previous WISC testing, indicated a significant decline in claimant's intellectual functioning. Dr. Moore commented that the magnitude of decline was rare and typically the result of brain damage and/or severe emotional disorders.

48. On December 18, 2014, Dr. Moore reported the findings of the GGRC interdisciplinary team, made up of Reyes, Theresa Keyes, M.D., and Dr. Moore. The interdisciplinary team acknowledged that claimant was functioning at a low level intellectually, but felt that there was substantial evidence of severe emotional problems, that could be the cause. Because severe emotional problems are not developmental disabilities, the team concluded that claimant's intellectual functioning was not a form of intellectual disability. The team found that claimant did not meet the diagnostic criteria of autism spectrum disorder, cerebral palsy, a seizure disorder, intellectual disability, or a condition similar to intellectual disability or requiring treatment similar to individuals with intellectual disability. Therefore, claimant was found ineligible for regional center services.

LATER EVALUATIONS AND TREATMENT

49. In the fall of 2014, claimant's behavior was becoming more unmanageable at home, leading claimant's parents to begin exploring residential placement options. On November 24, 2014, JB and SB met with claimant's IEP team at the Marin County SELPA. Claimant's goals and progress were reviewed. The school psychologist acknowledged that claimant's issues were seen at school and impacted him at school. JB and SB inquired as to whether claimant had friends; the school psychologist responded that claimant did have peer relationships and was seen socializing at lunch and in the classroom. Claimant's mother inquired about his eligibility for special education under the category of autistic-like behaviors; the psychologist explained that the team did not

feel that claimant met the criteria for autistic-like behaviors under educational criteria based on present and historical information. JB and SB were extremely concerned about his behavior. The district recommended Braun High School, a small school that services special day students in the ninth grade.

50. On February 26, 2015, JB and SB met with Dominique Gallagher, L.C.S.W., GGRC Intake and Assessment Manager, and Mai Nguyen, Psy.D., GGRC psychologist. JB and SB advised that Dr. Kennedy had added Pervasive Developmental Disorder to the current list of diagnoses; however, this was not confirmed by Dr. Kennedy and formal autism evaluation had been completed by Dr. Kennedy. Gallagher and Dr. Nguyen reviewed claimant's history; they advised JB and SB that in their opinion, claimant's current cognitive functioning and adaptive skills were impaired by severe psychiatric symptoms, rather than by intellectual disability or autism, as had been documented in previous assessments.

51. In February 2015 claimant began treatment at Edgewood School for Children and Families in San Francisco. Edgewood is a level 14 locked residential program tailored to treat emotionally disturbed children and adolescents. Claimant lived in the dormitories on the property, attended school from 8:00 a.m. to 3:00 p.m. and participated in structured activities and therapy in the afternoon and evenings. He went home on Friday through Sunday. Claimant did well but disliked the program. He remained at Edgewood until February 2016.

52. On January 8, 2016, JB and SB filed a complaint against the County of Marin for fraud, alleging that they were induced to adopt claimant through misrepresentation and concealment. JB and SB alleged that the County was aware that claimant had social, behavioral and psychological issues that were concealed from them, including that claimant exhibited persistent lying, dishonesty and violence, and behaviors suggestive of past molestation, an inability to form normal relationships with

other children or adults, an inability to understand right and wrong and additional serious behavioral signs of the potential for the development of severe mental illness.

53. In April 2016, claimant began therapy with Michael Popplewell, L.M.F.T., at Marin County Behavioral Health and Recovery Services. Popplewell wrote a letter dated September 4, 2018, in which he reported that he had met with claimant on a regular basis and that claimant had demonstrated some improvement. Popplewell reported that claimant continued to have difficulty utilizing appropriate coping skills, and that he struggled with understanding how his behaviors and symptoms continued to affect his ability to do well with regard to controlling his impulsivity and anger, making positive decisions, and becoming independent at age 18.

54. At 15 and one-half years old, claimant learned to drive. He received his driver's license at age 16. Claimant is able to drive on his own.

EVALUATION BY DR. MACLEAMY AND GGRC'S RECONSIDERATION

55. On July 6, 2016, claimant met with Patrick MacLeamy, Psy.D. for an evaluation of claimant's social, communication, behavioral and cognitive functioning in order to determine whether claimant met the criteria for ASD. Dr. MacLeamy wrote a detailed report of his findings dated August 11, 2016. Claimant was 15 years old at the time, was attending Braun High School, had an IEP under an emotional disturbance designation and his current services included counseling with a school psychologist.

Dr. MacLeamy conducted a clinical interview of claimant and SB; he observed claimant and he administered the Wechsler Abbreviated Scale of Intelligence (WASI-II), ABAS-3, and the Autism Diagnostic Observation Schedule-2 (ADOS-2).

SB reported that claimant did not have social tact, and often stated the wrong thing at the wrong time; did not seem to care for others; tended to be reserved socially, but would initiate games with his parents; was connected to his cat; and had limited eye contact with others, which was described as "darting and furtive." SB also reported that

claimant had difficulty making and keeping friends. He reported further that when claimant was younger, he would make repetitive and frequent non-word noises like "a-koo … a-koo." He also historically repeated phrases excessively, like "I like your pants" despite being told by his parents to stop. Claimant's father reported that claimant had had an unusual preoccupation with shoes for many years.

During the clinical interview, claimant made some facial expressions, though not a great many. His speech was odd at times in regard to the lack of fluctuation in pitch and tone; his speech was overall rather flat in delivery. Claimant spoke in complete sentences and phrases.

Claimant's full scale IQ was measured on the WASI-II at 103, which was in the average range for his age overall.

The ADOS-2 was administered by Sheila Katz, Ph.D., and Deborah McGrew, Psy.D., psychological assistants. As to claimant's language and communication, the following were observed: a) claimant's language was largely correct in grammar and complex sentence structure; b) he had an appropriate rate of speech, but vocal inflection was a bit flat; c) no immediate echolalia was heard; d) claimant offered a good deal of information about himself; e) claimant did not inquire about the examiner; f) claimant provided an account of several non-routine events; g) conversation in general had limited times when it flowed back and forth; h) claimant used a good deal of descriptive gestures; and i) muted emphatic gestures were seen.

Concerning reciprocal social interaction, the following was observed: a) claimant's eye contact was appropriate; b) he directed a range of facial expressions to the examiner, linked with appropriate gaze and gestures; c) he appeared to enjoy the interaction; d) he did an adequate job of communicating some of his own emotional experience verbally, predominantly expressing feelings of anger; e) he communicated an understanding of others' emotional experience; f) he had difficulty when asked to

provide insight into social relationships and situations, especially those involving peers; g) he demonstrated some understanding of personal responsibility; h) the quality of his social overtures was mostly adequate; i) the quality of his social response was restricted; j) he used some reasonable verbal and nonverbal behaviors; and k) the rapport was significantly impacted overall, as claimant predominantly provided answers without carrying the conversation further.

Based on the combined communication and reciprocal social interaction domains, Drs. Katz and McGrew found claimant met the autism cutoff with a comparison score in the moderate range.

56. The ABAS-3 measures the functional skills of individuals from birth to adulthood necessary for daily living. SB rated claimant's abilities; the ratings suggested that claimant's functioning in most areas was at the level of a younger child.

57. Based on behavioral observations, descriptions of current functioning, assessments, and developmental history, Dr. MacLeamy opined that claimant met the criteria for a DSM-5[7] diagnosis of ASD. Dr. MacLeamy concluded that claimant met each one of the diagnostic criteria both at present and historically. Dr. MacLeamy did not analyze or differentiate his diagnosis from the numerous previous evaluations in which the evaluators did not find that claimant had ASD.

58. On December 9, 2016, claimant submitted Dr. MacLeamy's report to GGRC for its consideration. SB and JB provided additional information at intake, including: claimant's gross motor, bathing and dressing skills were of no concern; he needed reminders to comb his hair or to use a fork; he was doing fine in his ninth grade special education class; he had problem solving skills; his eyes darted around; he answered questions and babbled a lot but did not ask questions; he was emotionally immature,

[7] Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).

but happy; he had been recently suspended from school for hitting a girl; he liked to play toddler games, crawl and bark like a dog; he exhibited echolalia all day; he could not keep his hands to himself; he had one friend; and he was able to make a sandwich, but not cook.

59. Dr. Moore wrote a report of his eligibility reconsideration dated January 20, 2017. Dr. Moore noted that Marin County Mental Health had reported that claimant had attachment problems and several mental health providers had commented about his increased anxiety around authority figures. Dr. Moore felt that this was due to claimant's extremely traumatic childhood. Dr. Moore found that Dr. MacLeamy's scores on the WASI-II demonstrated that when claimant was motivated and put forth good effort, his scores were significantly better than when he was not motivated, and that despite suffering horrible experiences as a child, he had maintained intellectual ability to think rationally, act purposefully, and deal effectively with his environment.

60. Dr. Moore concluded that claimant's behavior problems, adaptive deficiencies, poor judgment, erratic learning, unacceptable behavior and related behaviors, were due to factors other than ASD. Dr. Moore reported that emotional disturbance, attachment disorder, PTSD, ADHD, Generalized Anxiety Disorder, ODD, and OCD, especially when severe, significantly affect thinking, functional effectiveness, social relationships, communication skills, academic achievement, vocational success, marital success, and adaptive behavior. Dr. Moore disagreed with Dr. MacLeamy's diagnosis of ASD.

61. On February 1, 2017, GGRC notified JB and SB that claimant had been found ineligible for regional center services.

DR. BIERMANN'S ASSESSMENT AND GGRC'S RECONSIDERATION

62. Mitchell Biermann, Ph.D., a school psychologist employed by Marin County SELPA, wrote an assessment summary dated October 6, 2017. At that time, claimant was

16 years old and in the 10th grade at Compass Academy. Claimant's teachers reported concerns of claimant being distractible, reactive, easily talked into situations, angry, taking things personally, and doing things over and over again. Dr. Biermann reported that Dr. Kennedy had diagnosed claimant PTSD, OCD and Tourette's Disorder, Encopresis and Generalized Anxiety Disorder (with no mention of Pervasive Development Disorder). JB reported that she was concerned that claimant was not able to care for himself. SB expressed the concern that claimant would be unable to support himself when he finished school. Claimant's adoptive parents and his teachers described claimant as having a good heart and being kind and generous. Claimant was employed at Safeway as a bagger at the time.

63. Dr. Biermann administered the Achenbach Child Behavioral Checklist, which is a questionnaire that evaluates a student's emotional and behavioral functioning. JB and SB completed the questionnaire. Claimant's emotional and behavioral functioning in the school environment was found to be similar to his behavior at home. Areas falling into the clinical range or borderline range included: anxious/depressed, withdrawn/depressed, somatic complaints, social problems, thought problems, attention problems, rule-breaking behavior, and aggressive behavior.

64. Dr. Biermann administered the Gilliam Autism Rating Scale – Third Edition (GARS-3). JB participated in the use of the GARS-3. The extent to which the following findings were based on observations or information obtained from sources other than claimant's adoptive mother is unclear in the report, and Dr. Biermann was not called as a witness at hearing. Dr. Biermann made the following conclusions in assessing whether claimant has autism:

a. Claimant displays some restricted/repetitive behaviors similar to those students who have been diagnosed with autism, including making high-pitched noises and making sounds over and over.

b. Claimant displays social interaction behaviors similar to those seen in students who have been diagnosed with autism; specifically, JB noted that claimant sometimes does not initiate conversations, pays little attention to what peers are doing, sometimes does not follow other's cues, sometimes shows minimal or no response when others attempt to interact with him, and seems unwilling to get others to interact positively with him.
c. Claimant displays some social communication behaviors similar to those seen in students who have been diagnosed with autism; claimant does not necessarily understand jokes, slang expressions, teasing, and different thoughts and feelings of others.
d. Claimant displays some emotional responses similar to those students who have been diagnosed with autism. For example, he needs significant reassurance related to changes in environment or schedule; he becomes very frustrated when he encounters difficulty; and he at times reacts negatively to requests or directions.
e. Claimant displays a cognitive style similar to those seen in students who have been diagnosed with autism. He attaches concrete meanings to words and at times mentions a single subject excessively.
f. Claimant displays some maladaptive speech similar to those students diagnosed with autism; for example, at times he repeats words or phrases.

The results indicated to Dr. Biermann that the descriptor "very likely for the presence of autistic spectrum disorder" applied to claimant, and that he would require substantial support (Level 3 in the DSM-5).

65. Dr. Biermann reported that claimant appeared to be eligible for special education services under the categories of emotional disturbance, other health impaired and ASD. Whether Dr. Biermann's recommendation that claimant receive special

education services based on ASD was accepted by the IEP team was not established by the evidence.

66. JB and SB submitted Dr. Biermann's assessment for consideration by GGRC. Dr. Moore wrote a report of his findings dated March 16, 2018. Dr. Moore noted that the definition of a "pupil with autism" in the Education Code does not determine eligibility for services under the Lanterman Act, and does not constitute a clinical diagnosis. Dr. Biermann's assessment did not change Dr. Moore's opinion that claimant is ineligible for regional center services. On March 19, 2018, GGRC denied claimant's reapplication for regional center services.

CLAIMANT'S CURRENT BEHAVIOR

67. Claimant's adoptive mother and brother testified with credibility at hearing. Their love for claimant was evident at hearing. It is clear that claimant's adoptive family members have done everything they can to provide claimant with a loving home.

68. Claimant is now 17 years old; he is a large boy, approximately 5 feet 10 inches tall and weighing 210 pounds. Claimant continues to repeat phrases often, such as "gravy baby." He often spills beverages when trying to pour into a cup. Claimant will dive into a hot bowl of soup despite being told to wait until it cools. He is very affectionate with the family cat, and holds it tightly around the neck, frightening the cat. Claimant continues to invade others' personal boundaries and does not understand that affection should be mutual. For example, he will give a bear hug from behind while his mother is cooking.

69. Claimant now attends a special education school; overall, claimant likes school. In June his teachers told him that if his behavior does not improve, he may need to live in a more restrictive environment. Claimant has improved in the past few months with regard to unwanted touching.

70. Twice in the past couple of years, while at the movies, claimant will pour his soft drink into his popcorn, and eat it anyway, stating that he "just thought it would be more convenient."

71. Claimant has exhibited paranoid behavior recently. For example, at the doctor's office, claimant became very angry when the receptionist called his name out – he felt everyone was staring at him as a result. On another occasion, while waiting for the car at the car wash, claimant noticed other people getting into their clean cars and leaving; he thought people were leaving to get away from him rather than because their cars were ready. Claimant has a lot of social anxiety and requires reassurance.

72. Claimant loves to wash the car and wants it to always be clean. Recently claimant spray painted the tailgate of the truck black, stating that it had some mud on it and he needed to practice his spray painting. Claimant also frequently steals money from JB's wallet; he will deny it, then later admit it.

73. Claimant began shaving at age 15; he shaves obsessively, sometime three times in one day, which aggravates his acne. Claimant also obsessively looks at himself in the mirror and takes "selfies"; he seems fascinated by his own image.

74. Claimant is unable to follow written or detailed verbal instructions. Claimant has been unable to learn to cook. When SB would read to him, he would have no recall of the substance of the story. Claimant is unable to think rationally.

75. Claimant is a big-hearted young man who wants friendships, but he mistakes an acquaintance for a dear friend and frequently has difficulties in his relationships with peers due to his annoying or disturbing behaviors.

76. Claimant has worked as a bagger and stocker at Safeway for 18 months. He arrives on time most of the time and is motivated by earning a paycheck. Claimant immediately spends all of his money when he receives his check. Claimant began a relationship with a 35-year-old woman at work who took advantage of him; the family

had to obtain a restraining order against her. Claimant gets angry at his boss and has been warned that he is close to being fired.

77. Claimant has had a girlfriend for two months. They met at a special needs youth program.

78. Claimant's hygiene is poor and he needs prompting to brush his teeth, put on clean clothing, wash his hair and put dirty clothes in the hamper.

79. Claimant does not engage in group activities at school and has no interest in sports or other activities.

80. Claimant's adoptive family used to have large family dinners on Sundays. After claimant's behaviors began to escalate, the family shied away and no longer attends. Claimant misreads social cues. For example, he will masturbate in church or pick his nose in front of others. JB describes his conversational style as limited and monotone, and he takes words very literally.

81. Claimant is unable to take "no" for an answer. When JB denies him something, claimant will keep arguing and badgering her. Claimant can be relentless over a period of months, becoming threatening, angry and volatile. He will tell his mother, "if you want peace in this house, you will give me what I want." Claimant's mother retreats to her bedroom and locks the door when claimant becomes angry and defiant. At times the confrontations escalate and he will pound on her door screaming obscenities.

82. In March 2018, claimant assaulted JB and SB. Claimant had stolen $100 the previous night by taking a debit card to the bank and withdrawing money. When he came home the following evening, JB told him there was something they needed to discuss when she finished cooking. Claimant repeated "Hi mommy" over and over, then out of the blue punched JB in the face twice. She fell back against the kitchen island then ran to her bedroom, bleeding. SB exclaimed, "look at her face, look what you did to

her." Claimant was screaming obscenities. JB heard a crash and learned that claimant had pushed SB down some steps; he was badly hurt and crying in pain. JB called 911 from the bedroom and paramedics arrived. The police also arrived and claimant was arrested. JB had suffered a concussion from which she developed double vision which has not gone away. She also developed tinnitus after the assault, and experienced dizziness and confusion for approximately four months. SB's hand was swollen.

At a court hearing, claimant admitted his guilt. He was sent to juvenile hall for a few weeks, put on probation and ordered to perform community service. He was ordered to follow family and house rules, to meet with his counselor and probation officer and to be compliant with medications. Claimant has been on medication since 2014, he is currently on Abilify, an antidepressant and a drug cocktail to control his anxiety, impulsivity and blurting repetitive words. Claimant's parents were afraid to have him return home because they were physically and emotionally sore and scared of him; however, the criminal justice system offered them no alternatives – there was no group home or therapeutic environment for which he qualified.

83. Claimant has hit SB numerous times. He has threatened JB with a cricket bat. JB is frightened of claimant when he loses control. JB and claimant have agreed to a safety plan. JB will: 1) state the behavior; 2) give claimant instructions; 3) take her own space; and 4) call for help if claimant's behavior continues to escalate. She is required to call for help approximately twice per month; claimant becomes visibly angry three to four times per week.

84. In September 2018, there was another incident. Claimant had stolen money from JB, but would not admit it. He became irate and hit her forearm and kicked her leg. She called claimant's therapist, Popplewell, from her bedroom. She calls him often for help and sometimes he can come to the home in an emergency. Other times Popplewell is able to calm claimant down over the telephone.

85. Recently JB's son was present when claimant became very angry; JB's son took claimant on a 15-minute walk through the neighborhood while claimant yelled, until he finally calmed down. Initially, claimant was too angry to listen. Claimant responds differently to JB because she is in a position of authority.

86. SB passed away in the fall of 2018. Claimant expressed grief and cried over SB's passing. Claimant receives daily counseling at school from the school psychologist and weekly counseling from Popplewell. Claimant sees a psychiatrist once per month for medication management. JB is working to put wraparound services in place for claimant over the next 18 months.

EXPERT TESTIMONY

87. Dr. Moore testified at hearing at the request of GGRC. Dr. Moore earned a bachelor's degree in psychology from Washington University in 1965. He earned a master's degree in social sciences from California State University, Fullerton, in 1966. In 1970, Dr. Moore earned a doctor of philosophy in educational psychology from the University of Southern California. He attended postdoctoral training in developmental neuropsychology and behavioral neurology at the California Department of Developmental Services, Lanterman and at the University of California, Los Angeles, from 1986 to 1988. Dr. Moore earned a postdoctoral master of science degree in clinical psychopharmacology in 2001 at the California School of Professional Psychology. From 2003 to 2004, Dr. Moore obtained a master of public health degree at the University of California, Berkeley (UC Berkeley). He also earned a certificate in loss and grief at UC Berkeley. Over his 20 years as an employee of GGRC, Dr. Moore has evaluated thousands of individuals to determine their eligibility for regional center services.

88. Robert McBurnett, Ph.D., testified at hearing at claimant's request. Dr. McBurnett graduated from the University of Georgia in 1976, with a bachelor's degree in psychology. He earned a master's degree in psychology from the same institution in

1979. In 1989, Dr. McBurnett earned a doctorate in clinical psychology, specializing in child and adolescent psychology, also from the University of Georgia. Dr. McBurnett was a fellow at the ADHD Summer Treatment, Western Psychiatric Institute and Clinic Program at the University of Pittsburgh Medical Center in 1988. From 1988 to 1989, Dr. McBurnett was a fellow in rehabilitation, psychology/neurology at New York University. Dr. McBurnett was employed as an assistant professor at University of California, Irvine, from 1990 to 1997; at the University of Chicago from 1997 to 2001, and at the University of California, San Francisco (UCSF) beginning in 2001; he has been an adjunct professor at UCSF since 2010. Dr. McBurnett's key areas of interest include child and adolescent externalizing behavior disorders, consisting of ADHD, ODD, and Conduct Disorder, and psychometrics. From 2002 until 2016, Dr. McBurnett was an attending psychologist at the Hyperactivity, Attention and Learning Problems Clinic.

89. Both experts provided credible testimony and have impressive credentials. It is noted, however, that Dr. McBurnett has not met or evaluated claimant, or interviewed his family members, and did not diagnose claimant, which significantly weakens the persuasiveness of his expert opinions concerning claimant's condition. Also, unlike Dr. Moore, Dr. McBurnett does not appear to have significant experience in treating, assessing or diagnosing individuals with developmental disabilities.

90. The experts agree that whether claimant has ASD is determined by evaluating him against the diagnostic criteria set forth in section 299.00 of the DSM-5. The diagnostic criteria for ASD is set forth in the DSM-5 as follows:

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (must meet all three symptoms):

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 (must meet two of four symptoms):

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.

91. 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).

92. Dr. McBurnett reviewed all of the various reports, IEP's and assessments, including Dr. Moore's. He agrees with Dr. Moore that the evidence does not support a diagnosis of intellectual disability.

93. Dr. McBurnett explained that originally ASD was diagnosed by clinical judgment, "you know it when you see it." This led to differences between diagnosticians. Later, ratings scales were introduced, and administered to persons who knew the individual over time and well. Information was balanced against known cases and, if ASD were found, it was rated mild or moderate. ADOS is a tool that added structured observation; the test is still somewhat subjective, but there is significant training for certified administrators. Dr. McBurnett has never used ADOS clinically, but considers the ADOS to be the most respected tool for diagnosing ASD.

94. Dr. McBurnett notes the GARS is a tool used widely by school districts to determine whether a student should have an IEP under the category of autism; he has not administered GARS. Dr. McBurnett considers GARS to be helpful in forming an opinion regarding whether a student meets the diagnostic criteria of ASD.

95. Because Dr. McBurnett has not met or evaluated claimant, he has not formed a diagnosis of him. However, Dr. McBurnett considers the testing by Dr. Biermann and Dr. MacLeamy to be the most relevant and comprehensive. The fact that two doctoral level examiners at Dr. MacLeamy's clinic scored claimant to be in the moderate range (above borderline) in diagnosing autism, indicates reliability to Dr. McBurnett – although he acknowledged that he does not know the clinician or the psychological assistants, and cannot attest to their competency.

96. Dr. McBurnett considered the tests administered by Dr. Moore to be a good standard battery of tests, especially for evaluating whether intellectual disability exists. The tests help to gain an understanding of the overall picture, but none of them focuses on whether ASD is present. Although he considers the testing by Dr. MacLeamy and Dr. Biermann to be more focused, Dr. McBurnett acknowledges that Dr. Moore's testing was sufficient. Dr. McBurnett agrees that claimant may suffer from anxiety, an attachment disorder, and emotional disturbance, but notes that comorbidity is to be expected, and claimant may also suffer from ASD. The presence of complicating factors, such as comorbid conditions, contributes to confusion in the diagnosis. Dr. McBurnett notes that when an individual exhibits extreme symptoms the diagnosis is easier to make; claimant did not exhibit those extreme behaviors.

97. Dr. McBurnett points out that claimant had difficulties with pragmatic language, which is a hallmark of ASD. Deficits in forming social relationships and in communication skills are also important indicators of ASD. Based on his review of the various reports, Dr. McBurnett feels that the evidence strongly indicates that claimant has ASD, but he cannot make the diagnosis.

98. Dr. McBurnett acknowledges that ASD symptoms typically manifest themselves at an early age. Claimant was not diagnosed with autism until he was 15 years old. Dr. McBurnett suspects that the clinical cues were not pronounced and

because of the complicated history and diagnostic picture, clinical attention was diverted. Dr. McBurnett saw evidence of symptoms consistent with ASD in the records at age 13, including fleeting eye contact, atypical volume and mannerisms, and tangential language.

99. Dr. Moore has had significant experience working with the developmentally disabled. Dr. Moore is very sensitive to the distinction between developmental disabilities and mental illnesses. Developmental disabilities under the Lanterman Act include cerebral palsy, epilepsy, autism, intellectual disability and conditions similar to, or requiring similar treatment to intellectual disability. Developmental disabilities commonly arise from the impairment of the brain or spinal cord.

100. Dr. Moore explained that an important issue in diagnosing autism is whether the symptoms manifest themselves at an early age. The evidence indicates that claimant was very bright, very attached to his mother, and very loving, at that age. Moreover, whether claimant was exhibiting autistic-like behaviors at an early age was considered and rejected by several evaluators. The earliest formal assessment available for review was Buckley's, dated April 7, 2011. In that report, he discussed a 2009 evaluation by Perdices in which she considered but did not make a diagnosis of ASD. Dr. Moore considered these reports to be important because at a relatively early age claimant was evaluated for autism and symptoms supporting the diagnosis were not present. ASD is not acquired; it is a genetic disorder. Pursuant to the DSM-4, symptoms of ASD typically manifest themselves by age three; the DSM-5 states that symptoms should occur in the early developmental period. The Perdices evaluation occurred when claimant was eight years old, and the Buckley evaluation occurred when claimant was 10 years old. This is not a case where the symptoms were present, but not documented due to the lack of an evaluation. Dr. Moore noted that in the Buckley report, claimant's areas

of strength included making friends, which is inconsistent with ASD. Dr. Moore found the Buckley and Grue assessments to be very consistent and persuasive.

101. Dr. Moore considered the multiple very traumatic experiences claimant suffered as a child, including the death of his parents, to be very significant. Claimant's parents were compromised and he may have suffered from emotional problems before they died. PTSD is a likely consequence of such horrible childhood experiences. Claimant was then placed in the care of cousins, who released him to foster care within one year; again, this was very traumatic. Dr. Moore considers claimant's placement in his adoptive home to be the best thing that happened to him.

102. Dr. Moore noted that claimant did relatively well in his first year in his adoptive home, and he was good-natured and made friends at school. Then something changed markedly. In August 2010, claimant became unhappy, argumentative, confused and angry. This is inconsistent with a diagnosis of ASD because symptoms do not first become manifest at age nine.

103. Dr. Moore attributes claimant's blurting out and stiff facial expressions to a tic disorder, and claimant's comment that it feels like he does not have control over his body, as being consistent with his diagnosis of Tourette's Syndrome. Making distracting noises in class is also consistent with a tic. Claimant's difficulty with personal boundaries and being active are consistent with ADHD. Dr. Moore opines that claimant is not intellectually disabled, but his learning is impaired by his various disorders. Dr. Moore considered claimant's habit of playing with his privates because he "liked to," to be a primitive regressive act that is consistent with PTSD and sexual abuse. The act makes him feel comfortable but is maladaptive and antisocial. Dr. Moore also found claimant's responses to a Rorschach test to be inconsistent with ASD.

104. Dr. Moore considers claimant's angry outbursts at his adoptive parents to be a function of his anxiety, frustration and failure to cope. At times, claimant's behavior

is different at school and at home, which was noted by a number of professionals who wrote reports. This is more consistent with PTSD than ASD.

105. Dr. Moore persuasively opined that the evidence does not support diagnosing claimant with a developmental disability.

ULTIMATE CONCLUSIONS

106. Dr. Moore has assessed thousands of individuals to determine whether they have a developmental disability; his experience is on point and deep. Dr. Moore evaluated claimant and administered testing, in addition to reviewing his educational history, his familial history and prior assessments. The conclusions drawn by Dr. Moore were well-supported by claimant's history and previous evaluations, several of which considered and ruled out ASD.

Moreover, as explained by Dr. Moore, some information in claimant's history is inconsistent with ASD, such as being a loving young child who liked to be held, and making friends, both in his first year while living with his adoptive parents and in later years.

In contrast, Dr. McBurnett did not meet or assess claimant, and, unlike Dr. Moore, he has not had significant experience in diagnosing and treating individuals with developmental disabilities; these factors made his opinions about claimant less persuasive.

No report or testimony was offered from claimant's treating psychiatrist, Dr. Kennedy, or Elliott, claimant's longtime therapist. Popplewell's September 2018 letter did not identify autistic-like behavior or mention a developmental disability diagnosis. The records offered from the Marin Department of Health and Human Services date back to 2014, and nowhere mention a developmental disability diagnosis. No reports were offered from Edgewood School for Children and Families, where claimant lived and received counseling from February 2015 to February 2016.

The two clinicians who diagnosed claimant with ASD, Dr. Biermann and Dr. MacLeamy, did not testify at hearing and their opinions were not subject to the rigors of cross-examination. Although some of the information gathered by them fit the profile of ASD, without their testimony at hearing, the source of the findings and their significance were not brought to life or explained. Evidence that was inconsistent with an ASD diagnosis (such as claimant liking to be held as a young child, settling in well and experiencing a happy first year with SB and JB, having a bright demeanor, and making friends at school) was not mentioned or explained by either Dr. Biermann or Dr. MacLeamy. Dr. MacLeamy did not discuss claimant's other diagnoses, such as PTSD or Tourette's Disorder, and why although symptoms of those disorders may be similar to symptoms of ASD, he diagnosed ASD.

The training and experience of Dr. MacLeamy and Dr. Biermann, and the training of Dr. MacLeamy's psychological assistants, was not described or examined. Moreover, Dr. Biermann performed an educational assessment, which is measured differently than a diagnosis for purposes of eligibility of regional center services. Drs. MacLeamy and Biermann did not account for the abundance of reports and findings to the contrary, including the findings and testimony of Dr. Moore. Finally, both reports appeared to be based largely, if not entirely, on information obtained from claimant's adoptive parents; other sources of information were not clearly identified.

The only direct evidence from an expert concerning claimant's condition and diagnosis came from Dr. Moore; his opinions were derived through the lens of extensive experience, were consistent with claimant's history, and were persuasive. The reports of Dr. Biermann and Dr. MacLeamy, without live testimony, were insufficient to overcome the opinions of the many other clinicians who have treated and/or assessed claimant, and the testimony of Dr. Moore.

For these reasons, claimant did not present sufficient evidence to establish that he suffers from a developmental disability as that term is defined in the Lanterman Act.

LEGAL CONCLUSIONS

1. The State of California accepts responsibility for persons with developmental disabilities under the Act. The purpose of the Act is to rectify the problem of inadequate treatment and services for the developmentally disabled, and to enable developmentally disabled individuals to lead independent and productive lives in the least restrictive setting possible. (Welf. & Inst. Code, §§ 4501, 4502; *Association for Retarded Citizens v. Department of Developmental Services* (1985) 38 Cal.3d 384.) The Act is a remedial statute; as such it must be interpreted broadly. (*California State Restaurant Association v. Whitlow* (1976) 58 Cal.App.3d 340, 347.)

2. As claimant is seeking to establish eligibility for government benefits or services, he has the burden of proving by a preponderance of the evidence that he has met the criteria for eligibility. (*Lindsay v. San Diego Retirement Bd.* (1964) 231 Cal.App.2d 156, 161 [disability benefits]; *Greatoroex v. Board of Admin.* (1979) 91 Cal.App.3d 54, 57 [retirement benefits]; Evid. Code, § 500.)

3. A developmental disability is a "disability which originates before an individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual." The term "developmental disability" includes mental retardation, cerebral palsy, epilepsy, autism, or a condition closely related to mental retardation, or requiring treatment similar to that required for individuals with mental retardation. (Welf. & Inst. Code, § 4512, subd. (a).) It is claimant's burden to establish that he has a developmental disability and that the developmental disability is substantially disabling.

4. Claimant has not met his burden of establishing by a preponderance of the evidence that he is substantially disabled by a developmental disability as that term

is defined in the Lanterman Act. (Factual Findings 87 to 106.) Accordingly, he has failed to meet the criteria for eligibility under Welfare and Institutions Code section 4512, and his appeal must be denied.

ORDER

Claimant's appeal from the denial of eligibility for regional center services is denied. Claimant is not eligible for regional center services.

DATED: April 10, 2019

_____

JILL SCHLICHTMANN

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.