BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT

vs.

SAN ANDREAS REGIONAL CENTER, Service Agency

OAH No. 2019051105

DECISION

Administrative Law Judge Michael C. Starkey, State of California, Office of Administrative Hearings, heard this matter on July 18 and 19, 2019, in San Jose, California.

Cristina Kinsella and Cherri Alcantara, Attorneys at Law, represented claimant, who was not present at the hearing.

James Elliott represented San Andreas Regional Center (SARC), the service agency.

The record was held open for briefing. On July 26, 2019, claimant submitted a closing brief, which was marked for identification as Exhibit C65. On July 31, 2019, SARC submitted a closing brief, which was marked for identification as Exhibit 37. On

August 9, 2019, claimant submitted a reply brief, which was marked for identification as Exhibit C66. The record closed and the matter was submitted on August 9, 2019.

ISSUE

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

FACTUAL FINDINGS

Introduction and Procedural History

1. Claimant is 21 years old.[1] He lives with his mother and father.

2. Claimant sought regional center services in September 2016, June 2018, and February 2019 and was denied each time. In response to the last denial on May 16, 2019, claimant timely requested a hearing and this proceeding followed.

3. Claimant contends he is eligible for regional center services because he is substantially disabled by autism spectrum disorder (ASD). SARC contends that claimant does not suffer from ASD, but rather his symptoms are best explained by schizophrenia spectrum disorder (SSD), a non-eligible condition.

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

4. At hearing, SARC acknowledged that claimant is substantially disabled and that, if he were found to suffer from ASD, he would be eligible for regional center services. Based upon that admission, claimant's representatives limited their introduction of evidence of substantial disability and focused on the issue of whether claimant has ASD. SARC also acknowledged that, if claimant were found to suffer from ASD, he would be eligible for regional center services, regardless of whether he also suffers from a comorbid mental illness such as SSD.

5. The determination of whether claimant suffers from ASD largely rests on the persuasiveness of two experts who testified on behalf of claimant versus that of SARC's expert. Claimant's experts believe that he meets all the ASD criteria and does not suffer from a comorbid mental illness such as SSD. SARC's expert disagrees, but acknowledges that claimant meets many of the ASD criteria.

DSM-5 Criteria for ASD and for SSD

6. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) was published by the American Psychiatric Association in 2013. It currently serves as the principal authority for psychiatric diagnoses in the United States.

7. The diagnostic criteria for ASD set forth in the DSM-5 are:

> A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history:
>
> > 1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to

reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.

2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.

3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

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

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).

2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or

nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).

3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).

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

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

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

E. These disturbances are not better explained by intellectual disability (intellectual development disorder) or

> global development delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

(DSM-5, at p. 50-51.)

8. The diagnostic criteria for schizophrenia, schizophreniform disorder, SSD and other psychotic disorders differ, but the key features of all include: delusions (fixed beliefs not amenable to change in light of conflicting evidence); hallucinations (perception-like experiences that occur without external stimulus); disorganized thinking (typically derived from the individual's speech); grossly disorganized or abnormal motor behavior, including catatonia; and "negative symptoms" (e.g. diminished emotional expression and avolition). (DSM-5, at pp. 87–88.)

9. The experts who testified in this matter agreed that it can be difficult to distinguish ASD from a psychotic disorder such as SSD.

Developmental and Social History

10. Claimant was born in January 1998. As an infant, claimant did not like to be touched, was sensitive to sound, and did not make eye contact. He did not speak more than a few words until he was approximately three years old, despite efforts to teach him.

11. Claimant and his parents emigrated to the United States from Singapore when he was approximately two years old. Claimant speaks Mandarin and English.

12. As a toddler and preschooler, he played alone and did not like to interact with other children. He did not learn to use eating utensils until he was approximately five and one-half years old. Claimant has engaged in some self-harm behaviors such as biting himself since he was approximately two or three years old.

13. His mother was a class volunteer at his kindergarten and reports that he mostly bowed his head and would not play with other children or join class activities. He was able to speak, but did not engage in "back and forth" conversation. He insisted on speaking on specific topics like "T-Rex" dinosaurs, regardless of the interest of the listener. Claimant needed help going to the toilet until he was 10 or 11 years old.

14. Claimant was unable to learn how to tie the laces of his shoes and wore shoes with hook and loop closures through elementary school. Later he was unable to master the use of "slip-on" shoes, confusing the left from right. He almost exclusively wears slip-on sandals to this day.

15. Since claimant was approximately five years old, he has regularly insisted that his mother repeat verbatim his words and phrases. If his mother refuses or makes a mistake in echoing his words, claimant becomes very frustrated and has temper tantrums.

16. In 2004, when claimant was six years old, his kindergarten teacher referred him for a speech evaluation due to difficulty speaking clearly. On May 7, 2004, a speech-language pathologist administered an articulation test and reported that claimant exhibited some articulation errors, typical for a bilingual Mandarin/English speaker, but his errors were beyond the developmental age for acquisition. The pathologist recommended that claimant receive speech services to address articulation

of certain phonemes. Claimant was found to qualify for special education services due to "articulation disorder."

17. Claimant's kindergarten teacher noted that he needed improvement in eye contact and listening. Claimant received extended school year support, after which it was noted that he was "sociable." Claimant's mother believes that report is inaccurate, due to the teacher attempting to be "nice."

18. In a letter dated May 4, 2010, Paul Protter, M.D., expressed concern that "both Allergic rhinitis as well as Tourette's Syndrome cause eye blinking and throat clearing, both beyond his control" in claimant, however no other information about this report was introduced at hearing.

19. Claimant's mother reports that, in her culture, any kind of mental illness or disability is considered shameful, and because of that, she resisted any diagnosis or treatment of claimant for many years. She was also concerned, among other things, that claimant might be taken away from her. For those same reasons, claimant's parents did not seek an evaluation from his pediatrician. Claimant's mother hoped that his deficits would improve with time and training. Claimant was placed in after-school academic programs from kindergarten through sixth grade, which his mother regarded as similar to special education. After his mother came home from work at approximately 6:00 p.m., she would further tutor claimant for hours until it was time for him to go to bed. The amount of time she spent tutoring him increased to approximately three hours per night as he got older, because this was required in order for him to pass his classes in school.

20. In claimant's third grade after-school academic program, he would shout seemingly random words or phrases, for example "Hillary Clinton." When redirected,

he would stop for a short period, but then repeat the behavior. He also appeared not to understand personal space and would touch or sit too close to other students. As a result, he did not make friends. After personnel from the academic program communicated those observations to claimant's parents and suggested claimant be formally evaluated, claimant's parents removed him from the program.

21. From approximately 2006 through 2009, claimant received one-on-one bible training from a Jehovah's Witness minister. The sessions were weekly and lasted approximately 45 minutes to one hour. Claimant was instructed about God, Satan, and the Bible, including the Book of Revelations. Claimant would ask questions about Satan, such as whether or not he had the power to do certain things, or could force one to lie. The minister testified at hearing that claimant did not "really" engage in conversations. He noticed that claimant lacked eye contact, squinted often, and did not appear to readily grasp the concepts instructed. The minister suggested to claimant's mother that claimant be evaluated and she shortly thereafter terminated the bible study sessions.

22. In October 2010, claimant's school district sought to assess him for special education services eligibility due to "low scores" and "social issues." Claimant's school psychologist tried to administer special education testing of claimant, but claimant became too upset to continue that day. Claimant's mother revoked consent and the evaluation was not completed.

23. In March 2013, claimant's school recommended to his parents that he see a health professional to "discuss concerning behaviors, such as shouting Africa during the middle of a lesson and laughing to himself." In February 2014 another school meeting was held to discuss concerns about claimant's disengagement and lack of successful interactions with his classmates. An evaluation was recommended to

determine whether he met special education services criteria. Claimant's mother declined consent.

24. In December 2014, when claimant was in the eleventh grade, he underwent a psychoeducational evaluation. The evaluation included: review of records, observation, reports from parents and teachers, a student interview, and use of standardized assessment instruments. On December 16, 2014, claimant's school psychologist reported:

> Based on this initial psychoeducational evaluation, [claimant] demonstrates characteristics commonly associated with Autism which include cognitive inflexibility, a restricted/perseverative range of interests, stereotypic behaviors (eye blinking), hyperactivity, attention and emotional regulation difficulties and social thinking and communication skill deficiencies including a literal interpretation of language. These areas of need are significantly impacting his educational performance in the general education setting, causing him to require special education support services.

25. Claimant's evaluation included administration of the Wechsler Intelligence Scale for Children-Fourth Edition (WISC-IV). Claimant's Full Scale IQ score was 96 (39th percentile, within the average range).

26. Molly Coppel testified at hearing. Coppel was a school psychologist at claimant's high school. She provided behavioral intervention services to claimant throughout 2015. She observed claimant in class and also in one-on-one sessions. She

reports that he lacked social skills and was preoccupied with animals, and racial and cultural differences.

27. Coppel reports that claimant has an "encyclopedic knowledge of animals." He would often draw animals in class. They all had the same expression, but claimant would write different descriptions, consistent with her perception that he did not understand emotions.

28. Claimant primarily classified people by race/ethnicity. He did not understand what topics were considered appropriate, despite repeated explanations. He was punched by another student after making a racially insensitive comment. Claimant did not have friends and his parents did not seek additional support. They wanted the school to simply accept claimant as he was. Coppel reports that other students would sometimes prompt claimant to say inappropriate things and then they would laugh when he got in trouble and could not explain himself. Claimant's mother confirms that claimant does not understand the concept of a "friend," and instead believes that anyone who does not walk away from him or visibly get annoyed is his friend. Claimant viewed those students as his friends, but they were not.

29. Coppel noticed a change in claimant when he returned to school in August 2015 for his senior year. She wrote a Functional Behavior Assessment Report, dated September 16, 2015. She noted his perseveration on the topics of race and animals, atypical behaviors such as "laughing out of nowhere or growling at others," and that he was easily influenced by peers to speak or act inappropriately. She reported that his behavior was not typical of other students, including those with autism and that more information was needed. She recommended a medical/psychiatric evaluation. However, Coppel does not believe that she observed claimant experiencing hallucinations or delusions.

30. In a November 6, 2015 Educationally Related Mental Health Services Assessment report, claimant's school psychologist and a student advocate reported that he was referred to the school's mental health team because of concerns about observed changes in his mood and affect, specifically, on August 20, 2015, he asked a stranger in a grocery store "Why do white people hate Asians? Would it be illegal to hit someone here in the store?" Claimant was also seen handling a knife in culinary class in an unsafe manner, he reportedly yelled racial slurs in classrooms and campus halls, and he exposed his penis to classmates, reportedly to "make them go away." A mental status examination was conducted and claimant was found to be oriented to person, place, and situation, but not date. Blunt affect was observed and claimant spoke in a whisper. When asked if he was feeling low, he replied "A little low sometimes when people are weird and creepy." When asked if he thinks someone or some group intends to harm him in some way, he replied "The devil in different forms; house, air, cars, people; and Asians with glasses" and perseverated on those topics. He "frequently referred to the devil coming to him in different forms, including historic European women in white dresses." He reported "seeing, smelling and hearing things including the devil in different forms, hearing ghosts in the wind, and smelling 'toxic, fart like smells.'" When answering a question about what he would do if he found an envelope on the street, he replied "Leave it be. It's a letter from the devil."

31. In the November 6, 2015 report, an October 16, 2015 student interview with claimant was also discussed. Claimant reported being "moody" and sad. He repeatedly referred to the devil in ways that appeared at times literal and at other times metaphorical. Then he said "most men with glasses are cold hearted and are like the devil." Claimant reported that his family read the Bible together and his mother sometimes talked about the devil and told him to "stay away from the devil."

32. Claimant's school psychologist and a student advocate concluded:

> At the present time, [claimant's] disorganized thoughts and behaviors indicate that he is decompensating and requires intensive therapeutic services and monitoring. The strict interpretation of the Mental Status Examination indicates delusions and hallucinations. When considering a diagnosis of a thought disorder, [claimant's] educational diagnosis of Autism, medical diagnosis of Tourette's Syndrome and his cultural background must be taken into account as possible mitigating factors. In the opinion of the assessors, [claimant] does have a mental health condition that likely affects his ability to benefit from his education.
>
> In addition, [claimant] appears to meet the eligibility criteria as a student with an emotional disturbance due to exhibiting inappropriate types of behaviors or feelings under normal circumstances over a long period of time and to a marked degree. It is recommended that the IEP team consider [claimant] being eligible for special education support services with a primary disability of autism and secondary disability of emotional disturbance as the characteristics of these areas appear to be adversely affecting his educational performance.

33. On December 11, 2015, an IEP was issued by claimant's school district. In the IEP, claimant's primary disability was listed as autism. One of his teachers reported:

> [Claimant] would enter the Academic Communications classroom with a smile and often would verbally greet one of his fellow classmates with a brief nod and smile. When prompted, he would verbally state "Hi" to his peers. Within [that class, claimant] demonstrated limited or minimal ability to actively participate in group discussions by adding a comment/question or opinion to a discussion. Additionally, he would frequently interject comments that were unexpected and off topic, often about his area of preferred interest- animals, racism, global injustices. When topics were unexpected, and he was given verbal prompting, [claimant] would apologize repeatedly, and would not mention the topic again for 10-15 minutes, or until the next class period.

34. On January 20, 2016, claimant was evaluated by Sarah R. Cheyette, M.D., a pediatric neurologist. Dr. Cheyette interviewed claimant's parents and examined claimant. In the medical record, Dr. Cheyette lists the DSM-5 criteria for ASD and concludes that claimant met all three sub-criteria for persistent deficits in social communication across contexts; met three sub-criteria (two required) for restricted repetitive patterns of behavior, interests or activities, and probably met the fourth sub-criteria. Dr. Cheyette concluded that claimant "has autism."

35. Claimant graduated from high school in June 2016.

36. Claimant still insists multiple times per day that his mother echo his speech precisely. The routines are lengthy and he becomes very upset if his mother refuses or fails to echo his words verbatim. His related tantrums have progressed to

the point where he kicks his mother, breaks furniture and dishes, damages walls, hits himself on the head, bites himself, and/or calls 911 repeatedly.

37. Claimant has been detained for a mental health evaluation pursuant to Welfare and Institutions Code section 5150 numerous times since 2016.

38. In approximately March 2017, claimant was detained pursuant to section 5150 for a mental health evaluation. The details were not clearly established in the record, but it appears that claimant repeatedly called 911 regarding homeless people or his mother even after he was warned not to do that unless there was an emergency.

39. On April 3, 2017, at approximately 1:05 a.m. claimant was again detained for a mental health evaluation pursuant to section 5150 and admitted to Santa Clara Valley Medical Center, after hitting and punching his mother. A registered nurse reported that he "presented as disorganized, hallucinating, delusional" and endorsed an auditory hallucination of "the voice of this white guy" and a visual hallucination of "this white guy." Claimant stated "I hit my mom because this homeless man attacked me with a knife and my mother did nothing."

40. In a note entered at 2:18 a.m., a registered nurse reported that claimant's mother stated that he:

> has been increasingly delusional and violent at home, pushing her and throwing objects at windows, and walls, breaking some windows. He is extremely focused on the homeless population and difficult to redirect and manage at home. She says that she fears for the safety of her family, the community and her son and would like him to be treated and stabilized for longer than a couple of days.

41. At 11:43 p.m. on April 3, 2017, Heather A. Colbert, M.D., examined claimant and diagnosed Adjustment Disorder with Mixed Disturbance of Emotions and Conduct, and a secondary diagnosis of ASD. Dr. Colbert reported that she doubted a diagnosis of schizophrenia because claimant was not "internally preoccupied." She observed perseverative thought processes, poor reality testing, anxiety, poor frustration tolerance, which she found characteristic of Pervasive Developmental Disorder "with behavioral disturbance." [2] Dr. Colbert reported that claimant had received 234 mg of paliperidone (an anti-psychotic) earlier that day to "symptomatically treat his behavioral disturbance" and would need another dose a week later.

42. Claimant insists on wearing essentially the same clothes each day, regardless of season or weather. He wears a white cotton tank top, a navy sweatshirt, dark exercise tights or shorts, and slip-on sandals or "flip flops." He owns many of each item and stores them together. He also has collections of many yellow toy cars, bags

[2] The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) defines PDD – Not Otherwise Specified (PDD/NOS) as a "severe and pervasive impairment in the development of reciprocal social interaction associated with impairment in either verbal or nonverbal communication skills or with the presence of stereotyped behavior, interests, and activities . . . ." (DSM-IV-TR, at p. 84.) That diagnosis does not exist in the DSM-5 and has essentially been subsumed into ASD. The DSM-5 diagnostic criteria section for ASD provides that individuals with a well-established diagnosis of PDD/NOS should be given the diagnosis of ASD. (DSM-5, at p. 51.)

of "Cheetos" brand snacks, navy or black coffee mugs, and identical "Rotten Robbie" travel mugs.

43. Claimant's diet is extremely restricted and mostly consists of fried chicken, macaroni and cheese, and Cheetos. He refuses to eat vegetables, despite urging from his mother that vegetables would help him with constipation, which he experiences often.

44. Claimant's mother has to remind him many times to shower and when he does shower, he often fails to wash himself thoroughly, even after a doctor instructed him to be more diligent in that regard. Claimant's mother regularly trims his nails, flosses his teeth, and ties his shoelaces on the occasions that he wears shoes instead of sandals.

45. Claimant cannot safely be outside unattended. The last time his mother let him walk away from her at a park, he stood too close to a woman and the woman's husband became very agitated and threatened to call the police.

SARC Evaluation

46. On September 9, 2016, SARC staff psychologist Joshua Heitzmann, Ph.D., and Nancy Lee, Intake Services Coordinator, interviewed claimant and his parents. Dr. Heitzmann earned a Ph.D. in clinical psychology in 2010, from Palo Alto University, which is APA accredited. Dr. Heitzmann is a licensed clinical psychologist. He has been a staff psychologist for SARC since 2015. Before that he was a clinical manager/director for the Easter Seals Bay Area Autism Program for approximately one and one-half years and was a supervisor/manager for ACES, Inc. approximately one and one-half years before that, treating children with pervasive developmental disorders, which is his specialty. As a staff psychologist for SARC, Dr. Heitzmann

screens or assesses approximately 250 claimants per year, of whom approximately 160 claim eligibility based upon ASD.

47. On January 4, 2017, Dr. Heitzmann issued the Determination of Eligibility for Services report, finding that claimant was not eligible. Dr. Heitzmann's conclusion was based upon his: interview with claimant and his parents; observation of claimant; review of an intake and social assessment report prepared by Lee, Dr. Cheyette's January 20, 2016 Progress Note, and the November 6, 2015 Educationally Related Mental Health Services Assessment report; and consultation with the school psychologist who co-authored that report. Dr. Heitzmann also testified at hearing.

48. Dr. Heitzmann observed that claimant typically utilized short, choppy phrasing and had somewhat flat verbal output and flat affect. Dr. Heitzmann did not observe echolalic speech. Claimant "engaged in appropriate eye-contact at times, but utilized inconsistent, fleeting, and unusual eye-contact at times." Dr. Heitzmann reported that claimant did not exhibit significant interest in others and appeared to care more about an individual's ethnicity "than the actual person." Dr. Heitzmann further observed that claimant had:

> poor integration of non-verbal behaviors (such as delayed pointing of his finger when he stated "I have an idea"). Again, there were several instances of atypical, fleeting, and unusual (left-right) movements of his eyes. [Claimant] utilized his hands to speak frequently, but his timing and appropriateness of his gestures appeared to be choppy, dysrhythmic, and not congruent with his verbal content. Also, [claimant's] non-verbal gesturing appeared to be over-emphatic and repetitive with little appropriate

integration with communication. [Claimant] frequently made "shooshing" gestures in which he placed his index finger in front of his mouth and breathed out (typically used to quiet others), but the intention of his gesture was difficult to interpret how to respond. [Claimant] oftentimes repeated the exact phrase "sure, ya, uh hum" on several occasions (perseverative) and was observed to talk to himself about "past friendships" without being able to give specific information about these friends. [Claimant] also frequently stated "you know _____ ?" as a statement for his questions in the same, perseverative manner. At times, [claimant] appeared to be internally preoccupied by something that was not in response to external stimuli (talking to self, making unusual eye-movements, etc.). There was a repetitive, perseverative series of movements in which [claimant] had a delayed finger point (2 seconds) following a verbal response of "yes." [Claimant] was reported to be routine-based (needs to have same foods such as macaroni and cheese, etc.) and was observed to need to finish the names of his previous teacher prior to moving on with another topic. When the psychologist attempted to break the stating of his list of teachers, he appeared upset and continued naming until he was completed.

49. Dr. Heitzmann set forth the DSM-5 diagnostic criteria for ASD and opined that claimant met Criteria A(1) (deficits in social-emotional reciprocity) and A(3) (deficits in developing, maintaining and understanding relationships), B(2) (insistence

on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior), B(3) (highly restricted, fixated interests that are abnormal in intensity or focus), C (symptoms present in early developmental period), D (symptoms cause clinically significant impairment) and E (disturbances not better explained by intellectual disability (ID) or global developmental delay). Dr. Heitzmann opined that claimant did not meet ASD Criteria A(2) (deficits in nonverbal communicative behaviors), B(1) (stereotyped or repetitive motor movements, use of objects or speech), or B(4) (hyper- or hyporeactivity to sensory input or unusual interests in sensory aspects of the environment). Dr. Heitzmann further opined that, although claimant had a long history of restrictive and/or repetitive behaviors, "these appear to be resultant of the combination of a history of Tourette's Disorder and symptoms associated to a psychotic spectrum disorder."

50. Dr. Heitzmann opined that claimant's "history of auditory hallucinations (e.g. auditory hallucinations and hearing voices), visual hallucinations (sees multiple forms of the devil), and olfactory hallucinations (smells the devil)" were more indicative of psychiatric diagnosis, "specifically in the psychotic/mood disorders spectrum." Dr. Heitzmann concluded that claimant did not meet the DSM-5 criteria for ASD or ID and instead met the diagnostic criteria for schizophreniform disorder, with poor prognostic features, as well as for Tourette's Disorder, which are not eligible conditions under the Lanterman Act.

51. Dr. Heitzmann was critical of Dr. Cheyette's diagnosis of ASD because she did not administer formal testing, relied on reports of claimant's parents instead of a record review, because evidence of symptoms of ASD early in claimant's life was minimal, and because claimant's function appeared to decline steeply in his senior year

of high school, which Dr. Heitzmann finds most likely attributable to emotional disturbance.

52. The Autism Diagnostic Observation Schedule – Second Edition (ADOS-2) is widely regarded as the most reliable tool for assessment of ASD. However, Dr. Heitzmann explained that the ADOS has a high incidence of false positive results. Dr. Heitzmann testified that he did not administer formal testing to claimant because he was exhibiting symptoms of schizophrenia and it would be unethical to test claimant before he was stabilized with medications.

53. At hearing, Dr. Heitzmann also pointed to the April 3, 2017 reports from a registered nurse at the Santa Clara Valley Medical Center that claimant "presented as disorganized, hallucinating, delusional" and endorsed auditory hallucinations. However, Dr. Heitzmann appeared unfamiliar with Dr. Colbert's report later that day, contained in the same medical record, in which she gave a secondary diagnosis of ASD to claimant; explained that she "doubted" a diagnosis of schizophrenia because claimant was not "internally preoccupied"; and further observed perseverative thought processes, poor reality testing, anxiety, and poor frustration tolerance, which she found characteristic of PDD, which is now considered a basis to diagnose ASD.

54. Dr. Heitzmann also pointed to claimant's deficits in self-care, which he attributes to avolition as opposed to inability and reports is atypical for ASD. Dr. Heitzmann also opined that claimant's exposing of himself purportedly to make other students "go away" is less common in ASD because it requires a theory of mind.[3]

[3] Theory of mind is the ability to understand the mental states of others and to recognize that those mental states may differ from one's own.

55. Dr. Heitzmann testified that the letters and report from claimant's two experts (discussed below) did not change his opinion that claimant does not meet the diagnostic criteria for ASD. Dr. Heitzmann believes that claimant's experts failed to address claimant's hallucinations and delusions.

Claimant's Experts

DR. KLINDT

56. William Creffield Klindt, M.D., has been claimant's treating psychiatrist since May 2017. Dr. Klindt earned his medical degree from Oral Roberts University School of Medicine in Tulsa, Oklahoma in 1989. Dr. Klindt also holds a bachelor of arts degree in psychology from the University of California, Berkeley. Dr. Klindt is a Board Certified Diplomate of the National Board of Psychiatry and Neurology. From 1994 through 2002, Dr. Klindt served on the clinical faculty of Stanford University School of Medicine's Department of Psychiatry and Behavioral Services, Division of Child Psychiatry and Child Development. From 1990 through 1994, Dr. Klindt worked as a psychiatric consultant for various medical centers in California. From 1994 through 1997, Dr. Klindt worked for Kaiser Permanente and served as the Acting Chief of the Child and Adolescent Psychiatry Department. Since then, he has worked in private practice. He has treated more than 100 patients with ASD.

57. Dr. Klindt initially conducted an evaluation of claimant, including a multi-hour examination of claimant, administration of several psychiatric assessment instruments, a multi-hour interview of claimant's parents, and review of claimant's school and medical records. Since then, Dr. Klindt has treated claimant once per month for approximately 45 minutes. Dr. Klindt wrote letters to SARC, dated April 2, May 14, and June 6, 2018, and testified at hearing.

58. Dr. Klindt reports that he did not administer a specific formal assessment tool for ASD (such as the ADOS-2) because such tools cover the same information that can be obtained from a "skillfully administered clinical interview by a competent, experienced Child and Adolescent Psychiatrist" such as himself.

59. Dr. Klindt believes that claimant clearly meets the DSM-5 criteria for ASD and that his deficits cannot be explained by Tourette's Disorder or a psychotic disorder such as schizophrenia.

60. Dr. Klindt believes that claimant meets ASD Criteria A(2) (deficits in nonverbal communicative behaviors). He has observed that claimant lacks awareness of personal space and boundaries. For example, claimant stands very close to Dr. Klindt and will remain standing even after Dr. Klindt sits.

61. Dr. Klindt believes that claimant meets ASD Criteria B(1) (stereotyped or repetitive motor movements, use of objects or speech). Dr. Klindt has observed claimant repeatedly touching his head, smelling his fingers and smelling his armpits. Dr. Klindt also points to claimant's repetitive language in their sessions, such as prefacing nearly every question with "Can I ask you" and often repeating "not good" before and after words and phrases.

62. Dr. Klindt believes that claimant meets ASD Criteria B(4) (hyper- or hyporeactivity to sensory input or unusual interests in sensory aspects of the environment) and cites claimant's insistence on wearing the same cotton and loose-fitting clothes.

63. Dr. Klindt also finds Dr. Cheyette's opinion that claimant suffers from ASD persuasive. He observes that she is a Board Certified pediatric neurologist, which requires five or six years of post-medical school training and continuing education.

64. Dr. Klindt has not observed signs of Tourette's Disorder in claimant and believes that reports that claimant suffered from Tourette's likely derived from behaviors and vocalizations associated with ASD. Dr. Klindt explained that the vocal tics of Tourette's typically include grunts, which claimant does not exhibit, and the motor movements of Tourette's are typically more "spastic" than claimant's eye-blinking.

65. Dr. Klindt appeared to believe that claimant had received special education services for ASD much earlier than 2014. When told that he had exited special education in 2004 and not returned until 2014, Dr. Klindt stated that did not change his conclusions.

66. Dr. Klindt reported that claimant is currently being treated with Olanzapine—an atypical second generation mood stabilizer indicated for ASD behavioral disturbances and also for schizophrenia—and Gabapentin—an anti-convulsive mood stabilizer prescribed to help claimant's impulse control.

67. Dr. Klindt has not observed any symptoms of auditory hallucinations, delusions, disorganized speech, grossly disorganized or catatonic behavior, or negative symptoms in claimant. Dr. Klindt believes that claimant's "odd use of idiosyncratic language and way of describing things is consistent with ASD and not an indication of an underlying psychosis." Dr. Klindt believes that Dr. Colbert's April 3, 2017 assessment doubting a diagnosis of schizophrenia is more reliable than the registered nurse's reports concerning hallucinations and delusions earlier on that date.

68. Dr. Klindt acknowledges that claimant's statements have raised questions about schizophrenia. However, Dr. Klindt explained that claimant's references to the "devil" should be viewed in the context of his bible study and do not evidence a false

belief outside of the purview of societal norms in that context. Dr. Klindt also did not find evidence that the "belief" was persistent over time. Moreover, claimant's beliefs about race, ethnicity and homelessness are not delusions because they are informational and to the extent they are personal, they are based upon actual interactions of claimant.

69. Dr. Klindt acknowledges that the prodromal phase of schizophrenia can include social withdrawal and decreased academic performance, and that the symptoms can wax and wane. However, he points out that if claimant was suffering from the beginnings of schizophrenia in late 2015 or March of 2017, one would expect the "full blown" condition within six months and that has not occurred.

70. Dr. Klindt reports that in his practice of clinical psychology he has witnessed many young adults with schizophrenia, and he believes that claimant is "not close" to that diagnosis.

DR. JONES

71. Michael B. Jones, Ph.D., evaluated claimant and issued a report dated January 22, 2019. Dr. Jones is a licensed clinical psychologist. Dr. Jones earned a Ph.D. in clinical psychology in 1982, from the California School of Professional Psychology in Los Angeles. Dr. Jones is an expert in ASD and schizophrenia. He completed a post-doctoral internship at Stanford University Medical Center (Division of Child Psychiatry and Development), where he researched autism, Tourette's Syndrome, and other disorders. Dr. Jones has been in private practice since 1984. Approximately 90 percent of Dr. Jones' practice involves evaluations. Ten percent involves treatment. He regularly consults with regional centers, including SARC, to evaluate eligibility for services. He conducts approximately 15 such evaluations per month. From 2001 to the present, Dr.

Jones served as the consulting lead clinician of the multi-disciplinary Early Autism Diagnostic Clinic for Valley Mountain Regional Center.

72. Dr. Jones reviewed claimant's medical records and psychoeducational reports, Dr. Klindt's letters to SARC, and videos and pictures depicting claimant's repetitive and destructive behaviors. Dr. Jones also met with claimant on four occasions, including a visit to claimant's home, interviewed him, observed him, and administered the ADOS-2 and other instruments. Dr. Jones interviewed claimant's parents and administered multiple instruments to his mother, and consulted with Dr. Klindt telephonically.

73. Dr. Jones reports that claimant cooperated with him but "his clinical presentation was remarkable for his profound repetitive/stereotyped speech and atypical ideation/interests . . . he ALWAYS brought the conversation back to the same restricted/idiosyncratic topics in a very 'driven,' perseverative manner." Dr. Jones observed that many of claimant's questions and comments were repeated two to three times. Claimant expressed antipathy toward Mexicans, but it "appeared more like a deep-seated prejudice based on harsh personal judgments and over-generalizations than reflective of feeling of personal persecution or other more gross manifestations of a psychotic process, such as visual or auditory hallucinations and inappropriate affect." Dr. Jones observed that the quality of claimant's eye contact was inconsistent; but he did use some appropriate informational, conventional and descriptive gestures, which were coordinated with his verbalizations and gaze. Claimant blinked his eyes regularly while speaking. His facial expressions were largely ones of dissatisfaction.

74. Dr. Jones observed claimant "once self-distracted in a clearly unusual self-stimulating way. While using small red/white blocks to make a pattern, he stopped putting the blocks together and, instead, took one off the desk, placed it up close to

his eyes and moved it around so that he could inspect it from different angles for about 15 seconds." Claimant "presented as very 'driven' and often in need of confirmation of simple factual information."

75. Dr. Jones administered the Wechsler Intelligence Scale for Adults-Fourth Edition (WASC-IV). Claimant's Full Scale IQ score was 62 (first percentile, within the deficient range). Dr. Jones reports:

> The test results are a good estimate of [claimant's] current level of general intellectual functioning given the fact he attempted to attend and concentrate and was never unmotivated or uncooperative. His functioning was clearly impaired by his many off-task restricted/repetitive behaviors due to his autism, such as his prolonged visual inspection of a small block during the Block Design subtest and his many entirely tangential verbalizations.
>
> Lastly, the test results represent a substantial drop in [claimant's] cognitive functioning when compared to results from his psychoeducational assessment by the school dated 12-16-14. His WAIS-IV Full Scale IQ at that time was 96 (Average range). This drop may be related to the fact that he is no longer exposed to a structured environment, such as school or a day treatment program, and thus is more inclined to pursue his idiosyncratic interests. Possible medication side effects may also be blunting his skills. However, his cognitive slippage is so significant that more malicious causes cannot be ruled cut.

76. Dr. Jones administered the ADOS-2, Module 4 (Adolescent/Adult) to claimant and reports that claimant achieved scores of three in communication (at the cutoff for autism); and 10 in social interaction (above the cutoff for autism); and his combined score of 13 was above the cutoff for autism. Dr. Jones did not observe immediate echolalia, but reports that claimant's "verbalizations were noteworthy for the presence of stereotyped/ idiosyncratic use of words and phrases" and his verbalizations were "very much out of context." Claimant "regularly spontaneously offered up his thoughts," but not his feelings and experiences. Claimant was only able to talk about his feelings when specifically asked about them, and "struggled even more when it came to reporting on his experiences."

77. Dr. Jones reports that claimant "exhibited substantial impairment in the reciprocal social interaction section of the ADOS-2." His eye contact was generally good and appropriately coordinated with his gaze and his vocalizations. However, his affect was flat except in "brief bursts of animation surrounding topics of interest to him." He was unable to show any understanding of the emotions of others, or insight into social relationships. "The overall quality of [claimant's] social overtures was clearly odd by virtue of being stereotyped, repetitive and idiosyncratic, while the overall quality of his social response was also unusual by virtue of being socially awkward and his persistent struggles finding words to express his thoughts." Dr. Jones added:

> In regards to restricted and repetitive behaviors, [claimant] exhibited clearly excessive and repetitive interests in unusual topics, such as about animals, and ethnic issues. In addition, [claimant] occasionally clasped his hands and twisted his fingers. He also very quickly and briefly touched his shoulders and face a couple of times in a seemingly

ritualistic way. In addition, [claimant] briefly placed an open hand close to his face while looking at his fingers (hand regard). He also blinked eyes a lot, though this is not a scoreable behavior on the ADOS-2. Lastly, he was observed to move his lips without vocalizing.

78. Dr. Jones reports that in claimant's third office visit:

[Claimant] was never observed responding to inappropriate internal stimuli. He denied any verbal or auditory hallucinations or delusions when asked questions about these symptoms from different angles, including subtle questions [ranging from whether claimant] had ever had any peculiar experiences [that] others have not had, to direct questions about [whether claimant] had ever heard voices or seen people, animals or things others people could not see or hear. [Claimant] denied any such psychotic behaviors and did so while sustaining his gaze with a flattened facial expression up until his thought processes were violently intruded upon by his idiosyncratic thoughts, and interests, such as: "Do you study the Bible? Are you a Christian?" "Do you like bull fighting?"

[Claimant] was also stumped by very simple questions meant to assess his comprehension and practical judgment skills and ability to grasp and respond to incongruent situations. For example, I asked him what he thought if I told him I knew a man who "kept a donkey in his

> bedroom?" [claimant] paused and finally said after a prompt or two: "I'm not sure sir." His problems answering these sorts of questions is consistent with his low score on the comprehension subtest of the WAIS-IV, wherein he was unable to answer simple questions, such as what money is used for and why certain foods need to be cooked.
>
> His struggles are clearly related to severe auditory comprehension and word retrieval problems rather than to any psychiatric process. Other evidences of intact reality testing involved knowing that The Lord of the Rings was fictional. "I wish Lord of the Rings existed." Such comments reflected a more immature, childlike inner world.

79. Dr. Jones administered a Social Communication Questionnaire (SCQ) (Lifetime Version) to claimant's mother and reports that 32 of the 40 test items were marked in the "positive/clinically significant direction," well above the "cutoff of 15 for ASD and as well as above the more conservative cutoff of 24, which is the mean for autism."

80. Dr. Jones opines that claimant meets all of the DSM-5 diagnostic criteria for ASD. Regarding ASD Criteria A(2) (deficits in nonverbal communicative behaviors), Dr. Jones cites claimant's reported history of poor eye contact through 2018 (although observed as adequate during Dr. Jones' evaluation); typically flat or angry facial expressions; repetitive vocalizations when happy, but often without looking at others to share enjoyment; and reported history of inability to use or understand basic gestures as a child (although currently uses appropriate number of gestures). Dr. Jones points to Dr. Heitzmann's observation in 2016 that claimant had "poor integration of

non-verbal behaviors" and opines that observation alone shows a non-verbal deficit sufficient to satisfy Criteria A(2).

81. Regarding ASD Criteria B(1) (stereotyped or repetitive motor movements, use of objects or speech), Dr. Jones cites claimant's: history of lining up toys when young and current practice of lining up his cups/glasses, slippers and sun glasses; unusual repetitive hand/finger movements; odd repetitive vocalizations; odd word usage; repetitive comments and questions; and insistence on his mother's repetition of his words.

82. Regarding ASD Criteria B(4) (hyper- or hyporeactivity to sensory input or unusual interests in sensory aspects of the environment), Dr. Jones cites claimant's: hand regard; prolonged visual inspection of testing blocks; reported history of spinning wheels on small toy cars as a child for long periods of time; coverage of ears in response to noise, extreme sensitivity to sounds (demonstrated by covering his ears); lifelong habit of smelling his blanket; and preference for soft materials.

83. Dr. Jones diagnoses claimant with ASD, with secondary diagnoses of Persistent (Chronic) Motor Tic Disorder, mild; Insomnia Disorder, severe; and Other Specified Disruptive, Impulse-Control and Conduct Disorder, severe, which causes claimant substantial impairment. Dr. Jones explains:

> This almost 21-year-old never married Asian/American young man presents a complex (and interesting) clinical case. Perhaps [claimant's] most salient clinical characteristics are his profoundly intense and unrelenting odd stereotyped thoughts, speech, interests and behaviors.

He is a prisoner of them and makes his parents his cell mates.

[¶] . . . [¶]

[Claimant's] aforementioned symptoms are just the most dramatic facet of an Autism Spectrum Disorder. They, then, are accompanied by a history and current presentation of marked deficits in social-emotional reciprocity and nonverbal behaviors used for social communication. These behaviors have caused others to see him as "crazy." A diagnosis of ASD has also been complicated by his parents' unwillingness to have him fully assessed. This reluctance was probably a function of several factors, such as being eternally hopeful, first generation Chinese concerned about him being stigmatized, and a lack of knowledge about developmental disorders. Like many parents with a developmentally impaired child, they focused on his lack of language.

[Claimant's] ASD is clearly associated with severe clinical impairment in all important areas of development except mobility and thus constitutes a substantial developmental disability. While certainly not intellectually disabled, [claimant's] general cognitive functioning currently falls well within the Deficient range, with his overall adaptive functioning being even lower.

[Claimant's] ASD is associated with a persistent (Chronic) Motor Tic Disorder as evidenced by persistent eye blinking. While [claimant] makes various odd vocalizations, they do not appear to be typical of vocal tics as much as of repetitive sounds often associated with ASD. Hence, a diagnosis of Tourette's Disorder is ruled out.

An Other Specified Disruptive, Impulse-Control and Conduct Disorder is also given due to [claimant's] chronic history of assaultive behavior towards his parents and destruction of property in the family home. Fortunately, these aggressive acting-out behaviors have not generalized beyond the family home.

A diagnosis of Schizophrenia is not an unreasonable hypothesis but is ruled out for a number of reasons. First and foremost, [claimant] does not meet the necessary DSM-5 criteria. He does not present with first order criteria, such as experiencing hallucinations or delusions. Nor does he exhibit the extreme apathy and emotional flatness that can be associated with some types of Schizophrenia.

[Claimant] does exhibit many disordered behaviors that can be mistaken for the disorganized speech and disorganized behavior typical of that type of Schizophrenia formerly referred to as Disorganized Type. However, although [claimant's] thinking and speech can appear very disorganized, they are typically organized around his

restricted interests. [Claimant] also exhibits clear periods of lucidity and coherence between his odd vocalizations, periods in which he can be reasoned with and functions more adequately.

In addition, [claimant] does not exhibit as disturbed of thought processes on all levels as is typically the case with Schizophrenia where speech and behavioral disorganization are the central focuses. Put another way, as disturbed as [claimant's] thinking/speech may appear, he does not actually have a formal thought disorder.

Similarly, while [claimant's] behavior is clearly disorderly and even bizarre, it is not as disorganized as one might think. To the contrary, it is "hyperorganized" in so far as he is "driven" by needs for sameness, by various idiosyncratic routines and by other restricted and repetitive behaviors. The sheer number of these is well beyond what is typically seen in a person with Schizophrenia.

On a less primary level, [claimant] appears to have exhibited many of his odd behaviors early in life. For example, his parents reported a lack of speech until three or four, and when he started talking, it was in a highly repetitive manner. However, even if onset of his current ASD behaviors emerged after the early developmental period, but before reaching majority, this would not necessarily constitute evidence for schizophrenia or another mental health

disorder. Rather, it would still represent some sort of neurodevelopmental disorder. There is no reason to suspect that his restricted and repetitive behaviors emerged later--due to an alternative etiology, such as some sort of unidentified insult to the nervous system or neurological disorder.

Other evidence that counter-indicates Schizophrenia are several severe and unexpected side effects to trials of multiple atypical antipsychotic medications.

Individuals with childhood-onset Schizophrenia also usually exhibit their symptoms after a normal period of development. [Claimant's] early developmental history was not normal.

Moreover, the deterioration in [claimant's] cognitive functioning is not consistent with the general onset of Schizophrenia, since disturbances in perceptual, social and emotional regulation typically occur first with deterioration in cognitive functioning typically occurring late in the course of the disease.

Lastly, while admittedly subjective, [claimant] does not have the "feel" of someone with Schizophrenia. At the same time, his presentation is clearly more unusual and complex than the vast majority of individuals with ASD and thus I consider it atypical.

> Diagnoses of Schizotypal Disorder and Schizoid Disorder are counter-indicated because they are not associated with the high levels of restricted and repetitive behaviors [claimant] presents with. Moreover, individuals with these sorts of disorders are not apt to be as social as [claimant] can be. To the contrary, while [claimant] clearly lacks social-emotional reciprocity, he can be very outgoing, regularly approaching strangers to share his idiosyncratic preoccupations.

Ultimate Conclusions

84. The opinions of Dr. Klindt and Dr. Jones that claimant suffers from ASD are more persuasive that the contrary opinion of Dr. Heitzmann. Dr. Heitzmann is a credible and qualified expert, but Dr. Klindt and Dr. Jones are more experienced. Dr. Klindt and Dr. Jones both spent considerably more time observing claimant than Dr. Heitzmann. The opinions of Dr. Klindt and Dr. Jones are consistent with the diagnoses of Dr. Cheyette and Dr. Colbert, whereas Dr. Heitzmann's opinion is the only opinion that claimant does not suffer from ASD or that claimant does suffer from a psychotic disorder. Dr. Heitzmann also appeared unfamiliar with and was unable to explain the April 3, 2017 opinion of Dr. Colbert, which undercuts Dr. Heitzmann's reliance on reports that claimant experienced hallucinations and delusions early that day. Dr. Jones administered the ADOS-2, which Dr. Heitzmann emphasized is the "gold standard" assessment instrument, while Dr. Heitzmann did not. Dr. Heitzmann's own observation that claimant had "poor integration of non-verbal behaviors" tends to show that claimant satisfies Criteria A(2), which is the critical criterion in dispute. Dr. Heitzmann did not explain why, if claimant suffers from SSD instead of ASD, his symptoms have

not progressed into the "full blown" disease, as would be expected. Claimant presented evidence sufficient to establish that he is substantially disabled by ASD. Claimant proved—and SARC does not dispute—that his disability originated before he reached age 18 and is expected to continue indefinitely.

LEGAL CONCLUSIONS

1. The State of California accepts responsibility for persons with developmental disabilities under the Lanterman 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 intellectual disability, cerebral palsy, epilepsy, and autism. This term

shall also include disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability . . . ." (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 met his burden of establishing that he is substantially disabled by autism, a developmental disability as that term is defined in the Act. (Factual Finding 84.) His disability originated before the age of 18 and is expected to continue indefinitely.

5. Claimant is eligible for regional center services.

ORDER

The appeal of claimant from the service agency's denial of regional center eligibility is granted. Claimant is eligible for regional center services.

DATE:

MICHAEL C. STARKEY
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.