BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT,

vs.

SAN GABRIEL/POMONA REGIONAL CENTER,

Service Agency.

OAH No. 2019120632

DECISION

Thomas Y. Lucero, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on February 7, 2020, in Pomona, California.

Daniel Ibarra appeared for the service agency, San Gabriel/Pomona Regional Center. Claimant represented himself with the assistance of his mother and grandmother, whose names are confidential.

Oral and documentary evidence was received. The record was closed and the matter was submitted for decision on February 7, 2020.

ISSUE PRESENTED

Whether claimant is eligible for services.

Jurisdiction

1. In a Notice of Proposed Action (NOPA) effective November 12, 2019, the service agency advised claimant:

> The review of your Regional Center case, with psychological evaluations completed prior to your 18th birthday (in 2014 & 2018) and recent records submitted, Kaiser Permanente Report dated March 2019 and Desert/Mountain Charter Special Educations Local Plan Area Individualized Education Program dated April 2018 do not indicate evidence of substantially handicapping Intellectual Disability, Autism Spectrum Disorder, Cerebral Palsy, Epilepsy, or conditions similar to Intellectual Disability prior to the age of eighteen.

(Ex. 1.) The NOPA was enclosed with a letter to claimant of the same date, November 12, 2019, advising that because "review of your case record [does] not indicate evidence of a possible developmental disability as defined in the Lanterman Act [i.e., the Lanterman Developmental Disabilities Services Act, Welfare and Institutions Code section 4500 through 4885], the request for Intake re-evaluation is denied." (*Ibid.*)

2. On November 20, 2019, mother as authorized representative appealed and timely requested a fair hearing, stating that "[t]he results do not reflect the current state of [claimant's] development and current skill level." (Ex. 2.)

3. Claimant, born in January 2002, lives with mother and stepfather. He attends public school special education classes. Extensive evaluations over the years have noted delays and deficits.

Testing Results

4. In late 2013, the Pasadena Unified School District (Pasadena USD) authorized an Education Related Mental Health Services (ERMHS) assessment.

A. Natasha G. Stebbins, Licensed Clinical Social Worker (LCSW), signed the assessment summary on December 10, 2013. She found that claimant met eligibility requirements for ERMHS and recommended that claimant "participate in outpatient mental health services under ERMHS." (Ex. 3.)

B. The assessment was based on Ms. Stebbins's review of, among other things, Individualized Education Plans (IEP's) performed at Pasadena USD on March 12, 2013 and September 10, 2013, Pasadena USD transcripts, including claimant's sixth grade attendance records and grades, and a March 25, 2011 Triennial Psycho-Educational Evaluation from Bethany Christian School, where claimant had been a student.

C. Ms. Stebbins conducted five interviews: two sixth grade teachers, the school psychologist, Ingrid Alvarez MS (Master of Science), mother, and claimant. She also observed claimant in class. Ms. Alvarez however, had not personally evaluated or provided services to claimant.

D. Under "Developmental History," Ms. Stebbins noted that claimant "has presented with inattention, hyperactivity and behavioral acting out at school since

approximately Kindergarten; despite medication, behaviors have persisted. In addition, [claimant] continues to demonstrate delays in the areas of language and speech." (*Id.*)

E. Under "Medical History," Ms. Stebbins noted claimant's "ADHD [Attention Deficit Hyperactive Disorder], which was diagnosed in 2006 [and] for which he takes medication. [Claimant] also has incontinence that started around the age of seven[,] . . . a combined result of medication side effects, cognitive delays and behavioral issues." (*Id.*)

F. Under "Family History," Ms. Stebbins noted "a history of clinical depression (grandmother and mother). Mother also reports that [claimant's] father was diagnosed with ADHD and took medication to treat it as a child." (*Id.*)

G. Under Educational History, Ms. Stebbins noted that claimant "currently qualifies for Special Education as a student with Special Education Services under Specific Learning Disability (SLD) and Speech and Language Impairment (SLI). He first qualified for Special Education Services on an IEP dated 05/06/2006 while attending a non-public, religious school . . . . He was first approved for special education in the . . . public school system on 04/08/2011. He has been noted as being impulsive, aggressive and having difficulty making and keeping friends. [Claimant] has been identified as having speech and language delays, and he has been provided speech and language services throughout his academic career that continue to date. . . . Psycho-Educational Evaluation dated 03/25/2011 identified physically aggressive behavior that appeared to be non-purposeful in nature, deficits in the areas of attention and self-control and distractibility. [Claimant's] disruptive classroom behaviors include: tantrums, yelling and task refusal." (*Id.*)

H. Under "Mental Health History," Ms. Stebbins notes that claimant had eight weeks of group counseling services in the past and six months of mental health therapy at Kaiser Permanente (Kaiser) in 2011. Mother noted at the hearing that the therapy at Kaiser was discontinued because clinicians there believed it was ineffective. Also in 2011, claimant "was weaned from his medication under his psychiatrist's supervision." (*Id.*) But then claimant attempted to hurt himself. He had threatened his sister with a knife in approximately 2007.

I. In her interview, mother told Ms. Stebbins that claimant could be quite playful with others but very aggressive at times. Mother estimated that claimant, who was 12 years old at the time, had the maturity level of an eight-year old.

J. Based on her interview with claimant, Ms. Stebbins concluded that he "presented as a kind and thoughtful young man with a fair amount of insight with regard to his behavioral issues and a desire to change." (*Id.*) The conclusion was based on observations: "[Claimant's] mannerisms and ways of expressing himself made him appear much younger than his age. He was respectful, polite, friendly and cooperative. [Claimant] was easy to engage and readily answered questions . . . . [Claimant's] eye contact was normal. He presented as comfortable with assessor. His speech was normal though impaired. [Claimant] was oriented to person, place and time ,. . . ." (*Id.*)

K. His teachers told Ms. Stebbins that claimant had trouble getting along with peers. They thought claimant's angry outbursts and tantrums occurred when claimant was asked to do work he found challenging. He did best with one-on-one instruction. About half his days at school were good, half bad. "While he often fails to complete classwork on paper, he often participates by answering questions out loud and contributing thoughtful insight to lessons." (*Id.*)

L. Ms. Stebbins summarized: [Claimant] was diagnosed with . . . ADHD and . . . demonstrates an inability to learn that cannot be better explained by sensory or other health factors. . . . [Claimant's] . . . history of attention problems, verbal and physical aggression, atypical activities of daily living and difficulty with functional communication, place him at risk for school failure without additional school supports. (*Id.*)

5. On August 27, 2014, Juliet Warner, Ph.D., a pediatric neuropsychologist at Southern California Permanente Medical Group, Pediatric Department Neuropathology Service, Los Angeles Medical Center, evaluated claimant, assisted by an examiner, Katrina Rydzewski, M.A. Dr. Warner's report, Exhibit 4, was based on neuropsychological test data, parent behavior ratings, and clinical observation.

A. Regarding behavioral observations, Dr. Warner found claimant "notably immature." (*Id.*) But his speech was coherent, his thought processes linear, his range of affect normal. He was talkative and fully cooperative, exerting "adequate effort on all tasks administered." (*Id.*)

B. Dr. Warner summarized the testing and test results: claimant was "administered measures of general intellectual functions, global processing abilities including attention, working memory, and executive function; and more specific abilities including fine motor skills and adaptive functions. Overall, the results render a profile of well-developed intellectual and cognitive functions based on expressions given his age. However, examples of variable success across a diversity of tasks appear consistent with a profile of generally moderate cognitive dysregulation." (*Id.*)

C. Dr. Warner set out recommendations to improve claimant's learning and performance at school. She also recommended a comprehensive

occupational therapy assessment because of "moderate to severe delays in bilateral fine motor skill development." (*Id.*)

D. Based on variability in test scores, Dr. Warner stated that his profile "lends evidence to support the previous diagnoses of ADHD and depression, while also exemplifying his multiple areas of strength. No less, the current profile of extremely elevated symptoms including hyperactivity, impulsivity, depression, and emotional lability is suggestive of an early-onset bipolar disorder with co-morbid ADHD. Of great concern clinically, his apparent lack of response to the present regimen of Prozac lends further evidence of diagnostic complexity above and beyond a singular depressive disorder." (*Id.*)

E. Using the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, fifth edition) and its system of numbered diagnoses, Dr. Warner's diagnosed claimant with

314.01	ADHD, Combined Presentation, by history
296.20	Major Depressive Disorder, Unspecified, by history; Rule-out 296.6 Bipolar I Disorder, Most recent episode mixed.

6. On October 24, 2014, mother contacted the service agency, as set out in an interdisciplinary (I.D.) note in Exhibit 19: "Mother has mentioned that [claimant] has low comprehension, has speech delay, struggles with socializing, is extremely dependent, struggles with self-care, watches 'baby cartoons,' struggles with self-direction, was [only] recently able to tie his shoe, acts as a seven year old [being 12 years old at the time], and would have difficulty being independent." (*Id.*) The service agency scheduled a psychological evaluation and Social Assessment.

7. Edward G. Frey, Ph.D., issued a Psychological Evaluation, Exhibit 6, based on two assessment sessions with claimant, December 16, 2014 and January 14, 2015. Dr. Frey's purpose was to assist in determining eligibility for services from the service agency. Dr. Frey focused on two possible conditions that, under the Lanterman Act, section 4512, subdivision (a), are grounds for eligibility: Intellectual Disability and ASD.

A. Dr. Frey reviewed testing performed at Kaiser, described above. He had information on claimant's difficulties in school and his eligibility for special education services "due to autism as well as specific learning disabilities." (*Id.*)

B. Dr. Frey administered the Wechsler Intelligence Scale for Children, fifth edition (WISC-V), the Vineland Adaptive Behavior Scales, second edition (VABS-II), the Autism Diagnostic Interview, Revised (ADI-R), and the Autism Diagnostic Observation Schedule-2 (ADOS-2). Dr. Frey found claimant cooperative and he "generally followed directions appropriately." (*Id.*)

C. Dr. Frey noted that common descriptive ranges based on standard scores fall between 110 to 119, above average or above expected level, to 35 to 49, moderate delay, very much below expected level. In the following categories claimant's composite scores on the WISC-V were:

i. Visual Comprehension: 100, that is, within the range of 90 to 110, average, at expected level;

ii. Visual Spatial: 105;

iii. Flu id Reasoning: 103;

iv. Working Memory: 88, that is, in the range of 80 to 89, high borderline to low average, slightly below expected level;

v. Processing Speed: 72, that is, in the range of 71 to 79, low borderline, below expected level; and

vi. Full Scale IQ: 92

(*Id.*) Dr. Frey summarized: "Based upon the above test results, it appears clear that [claimant] is not an adolescent with an Intellectual Disability. There may be some slight visual perceptual and visual motor difficulties. Reasoning skills, however, both verbally and non-verbally, appear to be in the average range. Testing does not support viewing this young man as an individual with an Intellectual Disability." (*Id.*)

D. Mother provided information for the VABS-II. Dr. Frey noted various difficulties claimant experienced as described by mother, and summarized: "it appears there are some mild deficiencies present in overall adaptive functioning." (*Id.*)

E. Dr. Frey's social and emotional assessment was based on the ADI-R. He summarized: "this developmental interview would tend not to support the presence of an [ASD] with this adolescent. [Claimant] did not appear to show abnormalities in the area of social interaction or communication. There were some slight oddities noted in the area of restricted repetitive and stereotyped behaviors." (*Id.*)

F. Regarding results of the ADOS-2, Dr. Frey noted "some slight autistic-like features" in the area of social interaction. Claimant's language, however, Dr. Frey described as "not autistic like." (*Id.*) He considered claimant's "fair level of fidgety behavior consistent with his existing diagnosis of ADHD." (*Id.*) He concluded that the ADOS-2 "does not support a diagnosis" of ASD [Autism Spectrum Disorder]. (*Id.*)

8. On January 14, 2016, claimant underwent several tests at the Outpatient Child Development Consultation, Kaiser, Fontana, California.

A. Edward Curry, M.D., tested claimant for ASD.

B. Dr. Curry spoke to mother and reviewed records, such as an IEP and Triennial School Assessment, regarding which he noted "Autistic like feature." (Ex. 5.)

C. Dr. Curry administered the ADOS-2. His conclusion: "Classification: non-spectrum." (*Id.*)

D. As Dr. Curry wrote, the ADOS-2 assesses communication, social interaction, and imaginative play skills in adolescents and adults with fluent speech. Dr. Curry found that the overall quality of claimant's language was "largely correct. His volume was loud at times but rhythm and intonation were appropriate. . . . His eye contact was appropriate . . ." (*Id.*) Dr. Curry observed no compulsions or rituals. On a parent report screening measure, the Social Communication Questionnaire (SCO), mother gave claimant a score of 14, below the cutoff score of 15.

E. Dr. Curry reviewed the assessments by other Kaiser professionals to give his overall assessment: "[Claimant] does NOT fulfill DSM-5 criteria for [ASD] based on the psychological, speech and language, and occupational therapy assessment. [Claimant] does not have significant speech and language deficits. [Claimant] does not have sensory processing issues or deficits in activities of daily living." (*Id.*)

9. Examiner Kelly Jung's Academic Assessment Report, Exhibit 9, discussed claimant's academic testing in mid-February 2017. The report was used as part of a triennial evaluation, as described below.

10. On March 2, 2017, Aveson Charter Schools issued an ERMHS Assessment Report, Exhibit 7, and a Psychoeducational Assessment Report, Triennial Evaluation, Exhibit 8. The IEP related to these assessments is Exhibit 10, providing details on accommodations and assistance to be provided claimant in support of instruction and special education services. Exhibit 15 is a later IEP, from April 2018, with similar details and findings.

A. The ERMHS Assessment Report was performed "to determine if [claimant] experiences significant socio-emotional or socio-behavioral needs that impede his ability to benefit from special education services." (Ex. 7.) The report stated in part: "[Claimant] struggles controlling his body and maintaining concentration . . . . [Claimant] enjoys being social and interacting with both peers and staff." (*Id.*) The report concluded: "For the new IEP service year, it is recommended that [claimant] continue to develop self-control skills and appropriate touch." (*Id.*)

B. The Psychoeducational Assessment Report, Exhibit 8, like other such reports, required triennially, was to determine, in aid of claimant's IEP team, whether claimant "continues to meet the qualifying criteria for special education services, and to develop appropriate education recommendations."

i. The special education disabilities that the report examined were: (i) ASD, (ii) Specific Learning Disability (SLD), (iii) Other Health Impairments (OHI), and (iv) Emotional Disturbances (ED). The reported noted that claimant's eligibility for special education services was based primarily on ASD and secondarily on SLD.

ii. The report included results from 12 tests, including, most pertinently: (i) WISC-V, (ii) Autism Spectrum Rating Scale (ASRS), (iii) Adaptive Behavior Assessment System, third edition (ABAS-3), and (iv) Behavior Assessment System for Children, third edition (BASC-3). The summary of test results and review of records stated that claimant "presents with Low Average cognitive ability. Processing deficits were found in the area of cognitive association, specifically when time was a factor, auditory processing (phonological processing and auditory memory), and sensorimotor processing. Attention functioning was also an area of concern. Other areas of processing, including cognitive conceptualization, visual processing, and cognitive expression, are not areas of concern at this time." (*Id.*)

iii. Regarding evaluation for ASD, the report stated: "Per the parent and teacher ASRS rating scales, [claimant] continues to present with behaviors associated with autism. [Claimant] himself also reported difficulty with social interactions and interpersonal relations, per his BASC-3 self-report results. Additionally, review of speech and language report indicates that pragmatics, or the social use of language, is an area of concern. This aligns with information . . . that [claimant] struggles with reading social cues. Finally, review of the ERMHS assessment indicated difficulty related to social interactions and communication as well as reading social cues and social norms. . . . Per ASRS rating scales, he also presents with concerns in the areas of behavioral rigidity and sensory sensitivity per both raters." (*Id.*) This part of the report had this conclusion in bold: "[Claimant] continues to qualify as a student with the special education eligibility of Autism." (*Id.*,)

iv. The report stated, again in bold: "[Claimant] meets special education eligibility as a student with an . . . OHI . . . related to attention difficulties. He

does not meet special education eligibility as a student with an . . . OHI related to anxiety or depression-related behaviors.**"** (*Id.*)

11. Two I.D. notes reflect the service agency's activity respecting claimant in late 2017. One note, in Exhibit 19, is dated November 21, 2017, and records directions from Deborah Langenbacher, Ph.D., a licensed psychologist among the service agency's professional advisors. In Dr. Langenbacher's November 15, 2017 I.D. note, Exhibit 11, she wrote of "mixed results" from several of claimant's tests. Dr. Langenbacher wrote that claimant had been assessed at the service agency in 2015, when "cognition was in the low average range (WISC-V FSIQ 92). Scores on ADOS-2 and ADI-R did not suggest ASD." (*Id.*) Dr. Langenbacher wrote that re-evaluation of claimant was appropriate to rule out "ID [Intellectual Disability] or 5th category, including IQ testing . . . and eval[uation] of adaptive skills." (*Id.*) The "5th category" is shorthand for the fifth of five conditions that may be grounds for eligibility under the Lanterman Act, Welfare and Institutions Code section 4512, subdivision (a), referenced in the Legal Conclusions below.

12. In a March 7, 2018 Statement of Eligibility, Exhibit 12, the service agency's team, including Dr. Langenbacher, determined that claimant "to be ineligible for further assessment or case management services based on no developmental disability." The service agency's NOPA, also dated March 7, 2018, elaborated: "Based on the testing data . . ., [claimant] does not meet criteria for a diagnosis of ASD. In addition, based upon his level of cognitive and adaptive functioning, a diagnosis of Intellectual Disability is not indicated." The NOPA acknowledged that claimant had a history of Speech Sound Disorder, Learning Disability, ADHD, and Depressive Disorder. In a March 13, 2018 Notice of Resolution, Exhibit 14, claimant withdrew a fair hearing request without prejudice.

13. In a March 8, 2019 Monitoring Report, Exhibit 16, Mary-Katherine McGovern, M.D., a psychiatrist at Kaiser, found no change in claimant's various mental health symptoms since his October 18, 2017 intake assessment, except that he was doing worse at "getting along emotionally."

A. Dr. McGovern's progress notes, included in Exhibit 16, state that the source of her information was claimant's chart, claimant himself, and mother. Dr. McGovern noted claimant's IEP, and its findings of ASD and learning disability.

B. Dr. McGovern noted:

i. "Persistent deficits in social communication and social interaction across multiple contexts . . . ." (*Id.*)

ii. "Restricted, repetitive patterns of behavior, interests, or activities . . . ." (*Id.*)

iii. "[S]ymptoms have been present since age 4-5 years old." (*Id.*)

iv. "Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning . . . ." (*Id.*)

v. "These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay, Intellectual disability and [ASD] frequently co-occur; to make comorbid diagnoses of [ASD] and intellectual disability, social communication should be below that expected for general developmental level. Although patient is developmentally delayed by about 4-5 years per pediatrician, his symptoms are not as expected from the average

13-14 year old. He does not have intellectual disability as his IQ is 95 per [mother]." (*Id.*)

C. Dr. McGovern's diagnosis was: "ASD, Severity Level 1, without accompanying language impairment." (*Id.*)

14. Mother advised during the hearing that Kaiser ceased claimant's treatment in the belief it was ineffective. Easterseals Southern California issued a November 8, 2019 six-month report, Exhibit 17, indicating that it was collaborating with Kaiser to provide claimant therapy in Applied Behavioral Analysis (ABA) with respect to a single diagnosis, namely ASD. The recommendation in the report was for 10 hours per week of direct intervention and 60 hours of supervision or enhanced supervision over a six-month period. The report describes various behavioral goals, including improving claimant's receptive and expressive communication, pragmatic communication, such as gaining a person's attention before engaging in communication, self-help skills, particularly relating to hygiene, and behavior reduction goals, such as to decrease tantrums.

15. On January 15, 2020, Edward G. Frey, Ph.D., issued a second Psychological Evaluation, Exhibit 18, regarding claimant. Dr. Frey's task was to assess specifically for ASD. Dr. Frey had information from mother and he reviewed records, noting that claimant had been assessed twice previously for services at the service agency. Dr. Frey also attempted new testing, the ADOS, but claimant quickly resisted and argued that the service agency had all the information about him it needed. Dr. Frey summarized that he could "offer no new information based on the current assessment as [claimant] was non-compliant. Based on a review of records and history, however, examiner does not believe there is sufficient clinical evidence to substantiate a diagnosis of Autism, particularly prior to age 18." (*Id.*)

16. Jennie M. Mathess, Psy.D., evaluated claimant on January 30, 2020. Her Psychological Assessment is Exhibit 20. Dr. Mathess interviewed claimant and mother and administered four tests: (i) ADI-R, (ii) ADOS-2, (iii) the Vineland Adaptive Behavior Scales, third edition (VABS-3), and (iv) Wechsler Adult Intelligence Scale, fourth edition (WAIS-IV).

A. Under "Cognitive/Intellectual Functioning," Dr. Mathess discussed the results of the WAIS-IV. She wrote that claimant's "Full Scale IQ [standard score 78, as set out on the last page of her report] is in the borderline range, but should be interpreted with caution due to variability between index scores. More specifically, his performance on the Processing Speed Index is notably lower than his performance in all other areas. Due to the aforementioned variability, it is this examiner's opinion that [claimant's] General Ability Index (GAI) is considered the best estimate of his overall cognitive functioning. His GAI score falls in the low average range." (*Id.*)

B. Regarding ASD, Dr. Mathess commented on results of the ADI-R, for which mother supplied responses. "Her responses resulted in scores below the necessary cutoff scores in all areas . . . . Such a response pattern indicates that a diagnosis of [ASD] is not likely." (*Id.*) Dr. Mathess wrote that claimant's "scores on the ADOS-2 fell within the non-spectrum range, below the cutoff score for autism and autism spectrum. His eye contact was appropriate and [claimant] directed a range of appropriate facial expressions toward the examiner. . . . [Claimant] provided at least one clear indication of being responsible for his actions, but this was not consistent across contexts. . . . [Claimant] showed responsiveness to most social contexts, but his responses were slightly awkward at times." (*Id.*)

C. Using DSM-5, Dr. Mathess diagnosed:

315.39 (F80.0)	Speech Sound Disorder
314.01 (F90.2)	[ADHD] Combined presentation (by history)
311 (F32.9)	Unspecified Depressive Disorder (by history)

17. Dr. Langenbacher prepared a January 31, 2020 Record Review Note, Exhibit 21. She comments on claimant's extensive records, including those described above. Dr. Langenbacher concludes:

> We have carefully reviewed all records available to us, including school reports, IEPs, records from Kaiser, and [claimant] has been assessed on three separate occasions at [the service agency] for regional center eligibility. Clearly, he has many challenges, and has had numerous diagnoses over his lifetime. Based on this review there is no indication for an Intellectual Disability or "Fifth Category" for persons who are functioning like someone with an intellectual disability and require similar services. There has been mention of [ASD], however, with three evaluations through regional center and two assessments with Kaiser in 2014 and 2016, that diagnosis has not been substantiated. The psycho-educational report from 2017 reports Autism as his eligible condition for special education, however, the results (in the average range) from their own testing do not support Autism.

School reports, as well as evaluations completed with Kaiser, support other diagnoses which are not eligible for regional center (e.g., ADHD, Disruptive Mood Dysregulation Disorder, Depression). [Claimant] could benefit from continued mental health services to address his concerns.

Claimant's Evidence at the Hearing

18. Claimant testified at the hearing. At first he was at a loss. He said that it takes him a while to think of things. He was concerned, however, because, as he said, he has felt more stressed recently, both at home and at school. He has had problems with focus and memory, saying he could not remember the last few days, amending that testimony, however, to say that it takes him time to remember things, but at times, after a delay of a few days, he may remember "incidents."

19. Claimant's testimony was supported and supplemented by both mother and grandmother. As mother stated, claimant's focus is improved by medications he takes. Mother recognized that professionals who have evaluated claimant in the past have considered his symptoms ASD-like. But claimant struggles in many ways that, as mother believes, support a diagnosis of ASD:

A. Claimant has had episodes over the past few years when he becomes extremely irate, screaming and yelling. Claimant broke his foot in two spots on one occasion, has punched holes in walls, and sometimes bangs his head against objects in frustration.

B. Claimant has been hospitalized twice because he was believed to be a threat to himself. He has spoken to mother about ending his life, because of his intolerable situation.

C. Mother is afraid that claimant may hurt someone else. He has no friends and does not know how to act in social situations. He is unable to read social cues.

D. Claimant soils himself daily. For this and other problems, mother has tried many things over the past 10 years, but in her opinion, no measures have been effective. Professionals have likewise tried and failed to find effective remedies.

E. Psychotherapy that claimant received at Kaiser was discontinued because, as they advised mother, claimant is beyond their help. Kaiser then outsourced another service, at the Five Acres organization, where claimant had nearly a year of care. Again, the care was discontinued as ineffective.

F. Currently claimant receives ABA services from Easterseals Southern California, as described in Finding 14 above. The services, adapted specifically for claimant, are described in an "ABA Snapshot," Exhibit A. In mother's view, however, there has been little progress. At times mother perceives that there is progress for a week or somewhat longer, only to see claimant regress.

20. Grandmother agreed with mother's testimony. Grandmother has helped claimant and his family by caring for claimant at her home, but she believes that claimant's problems have continued to the point that she will no longer be able to help.

LEGAL CONCLUSIONS

Burden of Proof

1. The burden of proof is on claimant, the party seeking to change the status quo. The evidentiary standard is proof by a preponderance of the evidence. (Evid. Code, §§ 115 and 500.) Claimant did not meet his burden in this case.

2. "Burden of proof" means the obligation of a party to establish by evidence a requisite degree of belief concerning a fact in the mind of the trier of fact or the court. Except as otherwise provided by law, the burden of proof requires proof by a preponderance of the evidence. (Evid. Code, § 115.) "'Preponderance of the evidence means evidence that has more convincing force than that opposed to it.' [citations omitted] . . . . The sole focus of the legal definition of 'preponderance' in the phrase 'preponderance of the evidence' is on the *quality* of the evidence. The *quantity* of evidence presented by each side is irrelevant." (*Glage v. Hawes Firearms Company* (1990) 226 Cal.App.3d 314, 324-325, italics in orig.) In meeting the burden of proof by a preponderance of the evidence, claimant "must produce substantial evidence, contradicted or uncontradicted, which supports the finding." (*In re Shelley J.* (1998) 68 Cal.App.4th 322 at p. 329.) Except as otherwise provided by law, a party has the burden of proof as to each fact, the existence or nonexistence of which is essential to the claim for relief or defense that the party is asserting. (Evid. Code, § 500.) Where a petitioner seeks to obtain government benefits or services, the petitioner bears the burden of proof. (See, e.g., *Lindsay v. San Diego Retirement Bd.* (1964) 231 Cal.App.2d 156, 161-162 [disability benefits]; *Greatorex v. Board of Admin.* (1979) 91 Cal.App.3d 54, 56-58 [retirement benefits].)

The Five Disability Categories Making One Eligible for Services

3. "Developmental disabilities" under the Lanterman Act have three characteristics. An individual is eligible for services whose disability: (i) "originates before an individual attains 18 years of age"; (ii) "continues, or can be expected to continue, indefinitely"; and (iii) "constitutes a substantial disability for that individual." (Welf. & Inst. Code, § 4512, subd. (a).)

4. Welfare and Institutions Code section 4512, subdivision (l)(1), provides guidance on a disability's third characteristic. Under this statute, a disability is "substantial" when it causes "significant functional limitations, as determined by a regional center, in three or more of the following areas of major life activity, as appropriate to the person's age: (A) Self-care. (B) Receptive and expressive language. (C) Learning. (D) Mobility. (E) Self-direction. (F) Capacity for independent living. (G) Economic self-sufficiency."

5. Further guidance is provided in California Code of Regulations, title 17, section 54001, subdivision (a)(1): a substantial disability "results in major impairment of cognitive and/or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential . . . ."

6. The Lanterman Act puts developmental disabilities into five categories.

A. The first four categories have brief labels: (i) "intellectual disability"; (ii) "cerebral palsy"; (iii) "epilepsy"; and (iv) "autism" [now called ASD under the DSM-5]. (Welf. & Inst. Code, § 4512, subd. (a).)

B. Developmental disabilities in the fifth category have a more extended description: "disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability, but [the category] shall not include other handicapping conditions that are solely physical in nature." (*Ibid.*)

7. A claimant's substantial disability must not be caused solely by an excluded condition. The statutory and regulatory definitions of "developmental disability" (Welf. & Inst. Code, § 4512 and Cal. Code. Regs., tit. 17, § 54000) exclude conditions that are solely physical in nature. California Code of Regulations, title 17, section 54000, also excludes conditions that are solely psychiatric disorders or solely learning disabilities. A claimant with a dual diagnosis, a developmental disability coupled with a psychiatric disorder, a physical disorder, or a learning disability, could still be eligible for services. But the claimant whose conditions originate only from excluded categories (psychiatric disorder, physical disorder, or learning disability, alone or in some combination) and who does not have a developmental disability, would be ineligible.

8. Despite its more expansive description, the fifth category does not confer eligibility on every person with a learning or behavioral disability. Many with such disabilities are ineligible.

9. Claimant did not assert and there was no evidence that claimant is eligible for services based on cerebral palsy or epilepsy.

ASD-Related Eligibility

10. Claimant's main contention was eligibility based on ASD. The testimony by claimant, his mother, and grandmother was detailed and credible. It is appropriate

to consider such evidence regarding the possibility of ASD. Mother and grandmother are both long experienced caregivers for claimant. As stated on page 53 of the DSM-5, diagnoses of ASD are "most valid and reliable when based on multiple sources of information, including clinician's observations . . . [and] caregiver history." While the testimony corroborated many findings by physicians, psychologists, and others, however, it did not counter the extensive record prepared by the health care professionals who, having observed, evaluated, and tested claimant over the years, have opined repeatedly that claimant's challenges, while significant, are not ASD.

11. The DSM-5, in Categories A through E, pages 50 to 51, lays out these diagnostic criteria for ASD:

> A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive; see text):
>
> 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 (examples are illustrative, not exhaustive; see text):

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

2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).

3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or

preoccupation with unusual objects, excessively circumscribed or perseverative interests).

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

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

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

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

12. In claimant's school-related records, there is evidence of professional opinion, notably in the 2017 psycho-educational report described in Finding 10, in

support of autism or ASD. But Dr. Langenbacher's observation, as described in Finding 17, is, on this record, more persuasive. The description of claimant and his symptoms may be considered sufficiently like ASD for special education purposes, but testing results do not lead to the same conclusion. Given especially the evidence available from experts, on balance the evidence currently available does not support ASD under the DSM-5 criteria.

A. On the one hand, claimant struggles daily with social interaction. He conducts himself awkwardly at times. His speech is delayed or impaired. He has emotional and aggressive outbursts, strong enough at times that mother has proper concern for his own and others' safety. This evidence suggests that claimant meets, or nearly meets, the DSM-5 criteria for persistent deficits in social communication and in particular deficits in emotional reciprocity as described in paragraph A.1 of the criteria.

B. But the evidence is not clear in this regard. Claimant is able to communicate in many contexts, verbally and with appropriate gestures and manner. His manner includes good eye contact with interlocutors, though he can express himself somewhat awkwardly at times. In testing, claimant has been mostly cooperative, the one exception in the record being his last evaluation by Dr. Frey, as indicated in Finding 15.

C. Arguably claimant's strongest evidence in support of a finding of ASD is the evaluation by Dr. McGovern, whose unequivocal diagnosis was ASD, as set out in Finding 13. But Dr. McGovern's diagnosis lacks persuasiveness. It was based on no testing that she, or an examiner under her supervision, performed. Besides the interviews that she conducted, Dr. McGovern relied on past testing, IEP's, and claimant's chart. Her conclusions about claimant are clear, as set out, for instance, in

Finding 13.D. The conclusions track the DSM-5 criteria. But Dr. McGovern's report does not explain the conclusions and lacks persuasiveness as a result.

D. There is other evidence that claimant has characteristics indicative of ASD as described in paragraph A.3 of the DSM-5 criteria, deficits in developing, maintaining, and understanding relationships. Most notable perhaps is the difficulty he has making and keeping friends. (See, e.g., Finding 4.G.)

E. There was relatively little evidence concerning DSM-5 criteria under paragraph B. The evidence did not establish that claimant's behavior is confined to restricted or repetitive patterns.

F. Such symptoms as claimant demonstrated meet the criterion of paragraph C of the DSM-5. Claimant's symptoms were present in the early developmental stage. (Finding 4.D.)

G. Claimant showed that he has multiple developmental delays. More than one expert who has evaluated his behavior has found that claimant acts like a person years younger than he is. He struggles academically and lags his peers in this way as well. Claimant showed as well that he has deficits. He has trouble paying attention at school, for instance, and he misses social cues, leading to his observed awkwardness or oddity. In some sense, it is fair to describe claimant as significantly impaired in important areas of functioning. But the evidence did not establish that claimant has met the ASD criterion of paragraph D of the DSM-5. There was insufficient, or, in the case of Dr. McGovern, unpersuasive evidence upon which to conclude that, by reason of autistic traits, claimant has clinically significant impairment in social or other important areas of current functioning. There is lacking in the

evidence a clinician's opinion that persuasively sets out how claimant is impaired because of ASD and its symptoms.

Intellectual Disability

13. The Lanterman Act and its implementing regulations do not define Intellectual Disability (previously called Mental Retardation) but the condition may be analyzed using criteria set out on page 33 of the DSM-5: "a disorder . . . that includes both intellectual and adaptive functioning deficits in conceptual, social and practical domains . . . ."

14. The DSM-5, page 37, calls for assessing adaptive functioning, not just such cognitive capacity as may be assessed by an IQ score:

> IQ test scores are approximations of conceptual functioning but may be insufficient to assess reasoning in real-life situations and mastery of practical tasks. For example, a person with an IQ score above 70 may have such severe adaptive behavior problems in social judgment, social understanding, and other areas of adaptive functioning that the person's actual functioning is comparable to that of individuals with a lower IQ score. Thus, clinical judgment is needed in interpreting the results of IQ tests.

15. Claimant has trouble focusing and concentrating. He does poorly academically. But his mental faculties are in some ways normal, even if below average, as indicated by his FSIQ, which has been measured between 78 most recently and 92 in the past. There is legitimate concern that claimant's cognitive abilities will be adversely affected by his other challenges. But the evidence did not establish that his

cognition is so impaired or impeded or that his adaptive functioning is so deficient that he is properly diagnosed with Intellectual Disability.

Fifth Category

16. Because Intellectual Disability is characterized by significant cognitive and adaptive deficits, a closely related condition must be likewise characterized by significant deficits, cognitive or adaptive or both. The deficits must affect a claimant's ability to function so that it is at a level close to that of a person with Intellectual Disability. The quantity of deficits is not determinative. A condition in the fifth category need not strictly replicate the same deficits as Intellectual Disability. Otherwise the fifth category would be redundant. The question is the quality, and how low the quality, of a claimant's cognitive and adaptive functioning.

17. In *Mason v. Office of Administrative Hearings* (2001) 89 Cal.App.4th 1119, the appellate court held that "the fifth category condition must be very similar to mental retardation [now called Intellectual Disability], with many of the same, or close to the same, factors required in classifying a person as mentally retarded. Furthermore, the various additional factors required in designating an individual developmentally disabled and substantially handicapped must apply as well." (*Id.*, 89 Cal.App.4th at 1129.) Claimant has not been described or evaluated by a professional as a person whose condition should be considered closely related to Intellectual Disability.

18. Claimant documented that in certain ways his adaptive functioning is deficient. His hygiene is a significant problem, so much so that it affects his ability to socialize. His speech is somewhat impaired. When claimant is frustrated or angry, he has difficulty controlling himself, so much so that he has put holes in walls. Claimant has other troubles in adaptation, as described in Finding 19.

19. The weight of the evidence, however, does not support a finding that claimant's condition fits into the fifth category under the Lanterman Act. Dr. Mathess recently evaluated claimant. As set out in Finding 16, she did not find claimant's deficits in cognition or struggles to adapt to be closely related to those of persons with Intellectual Disability. Dr. Langenbacher is one of the few experts whose evaluation, as described in Finding 17, explicitly considers whether claimant might be covered by the fifth category, but she rejects the supposition. As the record stands, there is insufficient evidence to support a finding of fifth-category eligibility.

20. On this record, claimant is not eligible for services under the Lanterman Act.

ORDER

Claimant's appeal of the service agency's determination that he is not eligible is denied..

DATE:

THOMAS Y. LUCERO
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.