# BEFORE THE
# OFFICE OF ADMINISTRATIVE HEARINGS
# STATE OF CALIFORNIA

## In the Matter of:

## CLAIMANT

**vs.**

## REDWOOD COAST REGIONAL CENTER, Service Agency.

## OAH No. 2020040232

## DECISION

Administrative Law Judge Holly M. Baldwin, State of California, Office of Administrative Hearings, heard this matter on May 20, 2021, by telephone.

Kathleen Kasmire represented service agency Redwood Coast Regional Center.

Claimant represented herself.

The matter was submitted for decision on May 20, 2021.

## ISSUE

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

# FACTUAL FINDINGS

## Introduction

1. Claimant is 27 years old. She lives with her parents in Upper Lake.

2. In 2019, claimant self-referred to the Redwood Coast Regional Center (RCRC), seeking eligibility for regional center services based on a claim of autism spectrum disorder (ASD).

3. After conducting an intake assessment and psychological evaluation, and reviewing claimant's records, RCRC determined that claimant is not eligible for regional center services under the Lanterman Developmental Disabilities Services Act, Welfare and Institutions Code section 4500 et seq. (Lanterman Act). (All statutory references are to the Welfare and Institutions Code.) RCRC notified claimant of this decision on March 12, 2020. She submitted a fair hearing request on March 26, 2020.

4. Claimant contends she is eligible for regional center services due to ASD. RCRC acknowledges that claimant faces many challenges, but contends that she does not have an eligible developmental disability under the Lanterman Act, and contends that claimant's impairments are due to non-eligible mental health conditions, primarily borderline personality disorder.

## Applicable Eligibility and Diagnostic Criteria

5. The Lanterman Act provides assistance to individuals with five specified developmental disabilities: intellectual disability, cerebral palsy, epilepsy, autism, and what is commonly referred to as the "fifth category" of disabling conditions that are

closely related to an intellectual disability or that require treatment similar to that required for an individual with an intellectual disability. (§ 4512, subd. (a).)

6. For each of the above, the condition must begin before the age of 18, must be permanent, and must be a substantial disability for the person. "Substantial disability" means significant functional limitations, as appropriate to a person's age, in three or more areas of major life activity: receptive and expressive language, learning, self-care, mobility, self-direction, capacity for independent living, and economic self-sufficiency. (§ 4512, subd. (l)(1); Cal. Code Regs., tit. 17, § 54001, subd. (a).)

7. Eligible developmental disabilities do not include disabling conditions that are solely psychiatric disorders, solely learning disabilities, or solely physical in nature. (Cal. Code Regs., tit. 17, § 54000, subd. (c).)

8. Regional centers refer to the diagnostic criteria in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), in determining eligibility under the Lanterman Act based on autism. The DSM-5 was published in 2013 and currently serves as the principal authority for diagnosis of mental disorders in the United States.

9. 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 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 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 pp. 50-51.) The DSM-5 diagnosis of autism spectrum disorder encompasses a variety of disorders that were separately categorized in the DSM's Fourth Edition. (DSM-5 at p. 53.) The DSM-5 diagnostic criteria for ASD include a note stating: "Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder." (DSM-5 at p. 51.)

## Claimant's Developmental, Social, Educational, and Medical History

10. Claimant was born in June 1993.

11. For the first four years of her life, claimant lived on a crabbing boat with her family. Her mother did not have any concerns about claimant's development in early childhood, reporting that claimant was walking by her first birthday, said her first word ("fish on") around the time of her first birthday, and was reading by age five.

12. Claimant attended school through the eighth grade. She was enrolled in a GATE (Gifted and Talented Education) program at some point. She did not receive special education services. Claimant had good grades until the end of eighth grade, when her grades dropped. Claimant reported that she experienced social challenges starting in fourth or fifth grade, and that she was bullied in school.

13. Claimant stopped attending school in the first week of high school. She has offered varying explanations for leaving school. At hearing and in her 2020 psychological evaluation, claimant stated that she missed the high school orientation and quit school due to being overwhelmed and panicky. At a psychological evaluation

in January 2013 with Dr. O'Toole (see Factual Finding 19), claimant reported that she left school due to bullying and an unsafe school environment. At an evaluation in April 2013 with Dr. Danzig (see Factual Finding 20), claimant reported that she left school "for a boyfriend." When she was asked at hearing about these differing statements, claimant explained she was embarrassed to say she left school because she was overwhelmed, and that she told "half truths" to Dr. O'Toole and lied to Dr. Danzig.

14. Claimant obtained her GED at age 19.

15. Claimant's only work experience was as an intern for a few months with the California Conservation Corps when she was 19 years old.

16. Claimant does not currently have any peer or romantic relationships. She has had such relationships in the past, but reports that "they tend to leave." Claimant's mother reports that claimant had friends when she was younger.

17. Claimant lives with her parents, although their relationship is strained.

18. As an adult, claimant has a significant history of mental health concerns, discussed in more detail below. She has received treatment for multiple psychiatric diagnoses, including hospitalizations due to suicidal ideation and suicide attempts.

## PRIOR PSYCHOLOGICAL EVALUATIONS: DR. O'TOOLE AND DR. DANZIG

19. On two dates in December 2012 and January 2013, when claimant was 19 years old, she was evaluated by licensed clinical neuropsychologist Peggy O'Toole, Ph.D., who wrote a neuropsychological evaluation report dated January 7, 2013. Dr. O'Toole evaluated claimant at the referral of claimant's doctor (Richard Mendius, M.D.), for an assessment of current cognitive functioning, due to the recent onset of transient episodes of amnesia. Dr. O'Toole interviewed claimant and administered

cognitive and neuropsychological testing instruments. She reviewed two neuroimaging reports, but did not specify whether she reviewed any other medical records.

Claimant reported that her amnesia episodes coincided with visual auras, dizziness, and sometimes frontal headaches. She also reported a history of migraine headaches since age 17. Claimant reported having two head injuries in childhood, but did not report any lingering cognitive or physical effects. Claimant reported a history of trauma, depression, and ongoing suicidal thoughts. She also described herself as having chronically high anxiety related to social situations.

Dr. O'Toole reviewed an MRI taken in November 2012, which showed multifocal sinus disease but no other central nervous system pathology; and an EEG taken in October 2012, which had results within normal limits.

Dr. O'Toole administered a variety of cognitive and achievement tests, and found a decline in claimant's cognitive functioning. She found claimant's estimated premorbid verbal intelligence was in the high average range, but current verbal intelligence was in the average range, as was visualspatial intelligence. Tasks relying on verbal or auditory routes showed poorer outcomes than those relying on visualspatial analysis. Claimant's verbal learning and memory were borderline impaired to impaired, but her visual learning and memory were in the average to high average range.

Information from claimant's interview, testing, and observation showed significant levels of depression, social anxiety, trauma response, and suicidal thoughts. Mild degrees of dissociative processes were present, consistent with a trauma history. A personality inventory showed hypervigilance, social isolation, affective intensity, and a negative view of social interactions.

Dr. O'Toole used the Gilliam Asperger's Disorder Scale (GADS), "to query about neurodevelopmental atypical traits." Dr. O'Toole wrote:

> The patient endorsed, reported, and exhibited high levels of traits associated with Asperger's Disorder, including: explicit learning of social scripts, lack of intuitive understanding of others (versus logical understanding), frustration and impulsive anger in some social situations (punching walls at parents' house), difficulty relating to others, difficulty reading nonverbal cues, lowered emotional expressiveness, some restricted/focal interests and superior knowledge or skill in focal areas (computers and technology; she indicated that she can pick up a new smart phone or other gadget and figure it out far more quickly than anyone else she knows), some difficulty understanding humor, difficulty understanding subtle social communication, lack of pretend play when younger, and reliance on/need for familiar routine. Developmental information was only available via the patient (no parent report), but she has enough of the traits to meet criteria for Asperger's Disorder.

Dr. O'Toole did not provide any further details on scoring of the GADS or the criteria for Asperger's Disorder. Dr. O'Toole did not specify which of the above traits were observed by her, and which were self-reported by claimant.

Dr. O'Toole opined that the "overall pattern here is of likely cognitive decline" and found the pattern seen in testing was not consistent with effects of depression, anxiety, or dissociation. The results suggested left temporal lobe involvement.

Dr. O'Toole made the following diagnoses: Memory Loss, Cognitive Disorder Not Otherwise Specified, Asperger's Disorder, and Social Anxiety.

Dr. O'Toole recommended further neurological investigation regarding the cause of claimant's amnesia episodes, referral to the Department of Rehabilitation for vocational assistance, accommodations in classes or training programs, weekly contact with mental health professionals, neurocognitive treatment, and re-evaluation in 12 months.

20. On April 30, 2013, clinical psychologist Jay L. Danzig, Ph.D., wrote an assessment of claimant for the Department of Rehabilitation, focused on vocational issues. Dr. Danzig administered a subtest of the Wechsler Adult Intelligence Scale, Third Edition, and found claimant's fluid intelligence and ability to think clearly were within the bright normal range. Responses to specific test items suggested that test results were somewhat below her problem solving potential, "primarily as a result of underlying psychological issues, which occasionally create gaps in her focus and concentration." Dr. Danzig noted that claimant had good vocabulary and reading comprehension, but that her expressive vocabulary was in the first percentile, "which indicates that she becomes tongue-tied when placed in time pressure situations." In discussing claimant's vocational style, Dr. Danzig found that claimant was experiencing "an ongoing and significant clinical depression wherein she is filled with apprehension, insecurity, and worry about her present life situation as well as her vocational future." "With respect to interpersonal relationships, she is a shy, threat sensitive, and tough-minded individual who is extremely uncomfortable when even a modicum of interpersonal demands impinges on her." He noted claimant's ego functioning was fragile and her frustration tolerance was significantly impaired.

## PSYCHIATRIC TREATMENT

21. Claimant has been placed on numerous psychiatric evaluation holds under section 5150. Some of these inpatient stays are discussed below.

22. Claimant was evaluated at the Adventist Health Clear Lake emergency department on March 29, 2016, at age 22. She went to the emergency room on the advice of her counselor, due to suicidal ideation. Claimant was placed on a 5150 hold and admitted, with a plan for transfer to Napa State Hospital.

23. Claimant has attended weekly individual therapy sessions with psychologist Emily Garner, Psy.D., since August 2017. Dr. Garner wrote a letter on March 18, 2019, summarizing her treatment of claimant. Dr. Garner noted that this letter did not represent a full clinical picture of claimant's symptoms and behavioral presentation, because claimant requested that some information be withheld.

At intake, Dr. Garner diagnosed claimant with Major Depressive Disorder, Severe, Recurrent, with anxious distress and mixed mood features. Claimant reported she had previous diagnoses of Bipolar Disorder and Borderline Personality Disorder. Over the course of treatment, Dr. Garner corroborated claimant's diagnosis of Borderline Personality Disorder, and also diagnosed her with unspecified "features of Autism Spectrum Disorder."

Dr. Garner noted a pervasive pattern of family dysfunction involving claimant and her parents engaging in emotionally heightened and verbally aggressive conflict on a regular basis.

Dr. Garner wrote that claimant had explored a number of treatment options for her symptoms, including medication, electroconvulsive therapy, and individual therapy,

but had been dissatisfied with most of those providers. Dr. Garner also noted that claimant "acknowledged that she often benefits more from the ritual of treatment visits and related medical attention than from the treatments themselves." Dr. Garner wrote: "While interpersonal relationships have often been a source of conflict and disappointment, [claimant's] most significant gains during her course of treatment thus far have been in initiating meaningful and enjoyable connections with others, some through structured activities and others more spontaneously by connecting with individuals in her extended community as well as with previously distanced family members."

24. Claimant was hospitalized at Aurora Santa Rosa Hospital in April 2019, after going to the emergency room due to suicidal ideation.[1] Self-abuse was also noted. A section 5250 hold was placed (an additional 14-day psychiatric hold that may be authorized following an initial 72-hour hold under section 5150). Claimant also self-reported she had factitious disorder (a condition in which a person intentionally falsifies medical or psychiatric symptoms; formerly called Munchausen syndrome).

Brian Sparks, M.D., completed a psychiatric evaluation of claimant. Dr. Sparks noted in his mental status examination: "The patient is calm, cooperative and has good interpersonal relations. Her psychomotorical activity is negative for agitation or retardation. No tics, tremors, or stereotype movements noted. Her speech is normal rate, rhythm, volume, quantity, and prosody." Dr. Sparks diagnosed Unspecified

[1] The records from Aurora Santa Rosa Hospital were not submitted at hearing, but they were reviewed by Dr. Michael Wright as part of his psychological evaluation of claimant for RCRC, and he discussed them in his report and testimony at hearing.

Anxiety Disorder and Borderline Personality Disorder. The discharge summary also noted: "the patient [is] oppositional, consistent with borderline, attempting to transgress boundaries, provoke confrontation so she can enjoy both the pleasure of being angry and the righteousness of having moral superiority of the victim."

25. On May 30, 2019, claimant was admitted to Aurora Las Encinas Hospital in Pasadena on a 5150 hold at the request of her therapist at a residential treatment program, due to suicidal ideation. The discharge summary by Jory F. Goodman, M.D., dated June 1, 2019, noted claimant had a long history of Borderline Personality Disorder and self-mutilation. She had attempted suicide more than once in the past and harmed herself repeatedly. Her discharge diagnoses included a primary diagnosis of Dissociative Anxiety Disorder and a secondary diagnosis of Borderline Personality Disorder, severe, with frequent fragmentation, affective storms, and rages. In a psychiatric evaluation on May 31, 2019, Dr. Goodman recommended medication and dialectical behavioral therapy, noting: "Ultimately, the treatment of her borderline character is the key . . . ."

## RCRC Eligibility Assessment

### INTAKE SOCIAL ASSESSMENT: KNIGHT

26. On November 15, 2019, claimant participated in an intake social assessment interview with RCRC intake specialist Morgan Knight, at the Lakeport office. Knight interviewed claimant, and then collected claimant's records, referred her for evaluation by a psychologist, and participated in the RCRC eligibility team meeting. Knight wrote a social assessment report and testified at hearing.

Claimant's intake interview with Knight lasted about two and one-half hours. Knight also met claimant briefly a few months earlier in the lobby of the Ukiah office, when claimant came to submit her referral.

During the intake interview, Knight obtained information from claimant about her developmental, educational, medical, and mental health history, and about her current adaptive functioning in the areas of communication skills; self-care and independent living; mobility, sensory issues, and community access; self-direction; emotional issues; social issues; and learning and cognition. Knight did not obtain information from claimant's parents, noting that although claimant lived with her parents, she had a strained relationship with them and did not authorize them to release information to RCRC. Knight was not able to obtain school records.

*Communication:* Claimant exhibited appropriately developed vocabulary and expressive language skills, and engaged in reciprocal dialogue. Her receptive communication skills presented as appropriate. Knight noted that during their first interaction in the lobby, claimant demonstrated appropriate eye contact, shook her hand, and engaged in appropriate reciprocal dialogue. Knight stated that claimant presented differently during the intake interview with respect to eye contact and hand movements, but did not provide any more specific description of the differences. Knight observed no imitative or repetitive speech by claimant. When asked about her ability to manage multi-step verbal directions for routines, claimant stated that she prefers receiving written directions.

At hearing, Knight was asked whether claimant's "masking" skills may have affected her assessment of client's behavior at their initial meeting. Knight opined that masking typically does not modify a person's ability to engage in reciprocal

communications, and she would still expect to see a difference in reciprocal dialogue for a person with ASD, regardless of masking.

*Self-care and independent living:* Knight stated that claimant was independent in dressing, managing laundry routines, remembering to shower, take medication, and managing her dental hygiene. Claimant could cook with an air fryer and follow other simple recipes. Claimant independently schedules and attends her medical and other appointments. She described herself as messy and disorganized, and lacking motivation to complete household chores. She does her own shopping and runs errands for her parents. Claimant receives monthly disability benefits, and reported being very impulsive with money.

*Sensory issues:* Claimant reported that she avoids loud noises such as music, and is sensitive to the smell of perfumes and lotions. She did not report tactile issues. Claimant reported frequently fasting for weight loss and primarily consuming meats. She reported regular problems falling asleep.

*Motor skills and community access:* Claimant reported no problems with fine and gross motor skills, balance, or spatial awareness. Claimant reported engaging in finger flexing behaviors. Claimant has a driver's license and owns a vehicle, and transports herself to community activities.

*Self-direction:* Claimant reported lacking impulse control regarding money management and emotional self-regulation. She reported that she lacked consistency in her routines, rather than having rigid routines.

Claimant reported, and her medical records reflect, engaging in self-harming behavior and multiple suicide attempts. Claimant reported that her suicidal ideation began between the ages of 13 and 14. During her teen years, she engaged in tantrums

and defiant behavior toward her parents. Claimant reported periods of manic behavior. Claimant and her therapist's records reported concerns with excessive attention-seeking behavior with medical professionals and possible factitious disorder.

*Emotional:* Claimant reported her moods fluctuating between very low periods and manic states. She reported her emotional responses to be either excessive in intensity or lacking in responsiveness. Claimant reported eight to nine prior psychiatric inpatient admissions, and her records showed multiple psychiatric diagnoses, including anxiety, depression, and borderline personality disorder. Claimant reported that she frequently experiences excessive anger, and regularly considers suicide.

With respect to interpersonal relationships, claimant reported inappropriately intense attachment to preferred peers or romantic partners, resulting in others feeling overwhelmed by her attention and ending the relationship. Her longest romantic relationship lasted three to six months. Knight noted that claimant's relationships with peers and family may be lacking in quality of attachment.

Knight described claimant as appearing to appropriately describe and interpret her own and others' emotions. Claimant admitted exhibiting empathy only for the purpose of garnering attention for herself.

*Social:* Claimant reported having no current peer relationships, but had past peer and romantic relationships. Knight noted that many of claimant's interactions with others centered around attention-seeking behavior or getting her personal needs or desires met. Knight noted that social anxiety appeared to be the primary challenge for claimant's community access. Claimant reported having limited awareness of social cues, and limited capacity for demonstrating empathy. Knight noted that her perspective of various situations may be considered egocentric in nature.

*Learning/cognitive:* Claimant left school after eighth grade, and obtained a GED. She did not receive special education, and was enrolled in GATE classes.

### PSYCHOLOGICAL EVALUATION: DR. WRIGHT

27. Claimant was evaluated by licensed psychologist Michael Wright, Ph.D., who is contracted to perform eligibility assessments for RCRC. He is also the regional director of an organization that provides applied behavior analysis to people with ASD. Dr. Wright has 27 years of experience related to ASD.

28. Dr. Wright evaluated claimant on two dates in February 2020, wrote a psychological evaluation report dated February 27, 2020, and testified at hearing.

Dr. Wright reviewed claimant's records, conducted clinical interviews of claimant and her mother (including obtaining developmental information from claimant's mother), performed a cognitive assessment, and administered three assessment instruments which he described as the "gold standard" tools for diagnosis of autism. After evaluating all of this information, Dr. Wright concluded that claimant does not have ASD or another developmental disability under the Lanterman Act.

Dr. Wright reviewed claimant's history of mental health treatment, including multiple psychiatric hospitalizations (most recently in June 2019), and four reported prior suicide attempts. Dr. Wright wrote that claimant had previous diagnoses of Major Depressive Disorder, Borderline Personality Disorder, Autism Spectrum Disorder, Panic

Disorder, and Post-Traumatic Stress Disorder (PTSD).[2] Dr. Wright also reviewed Dr. Garner's March 2019 letter discussing her treatment of claimant.

During the evaluation, Dr. Wright observed that claimant appeared nervous at the beginning of the initial interview, rocking back and forth and tapping her fingers on the table. As the assessment progressed, these behaviors dissipated.

Dr. Wright administered the Wechsler Adult Intelligence Scale-IV (WAIS-IV) to assess claimant's cognitive abilities. Claimant's performance placed her full-scale IQ in the average range, with a score of 102. Her performance was not even across the sub-tests, with a verbal comprehension index in the high average range, but a working memory index in the borderline range.

The Adaptive Behavior Assessment System, Third Edition (ABAS-3) is a rating scale for assessing skills of daily living in people with ASD, developmental delays, intellectual disability, and other conditions. Claimant and her mother completed the ABAS-3. Claimant's self-ratings resulted in her General Adaptive Composite (GAC) score falling in the extremely low range. Dr. Wright found that claimant may have been overly critical of her own abilities, based on his observations and claimant's other statements regarding her activities. The ratings of claimant's mother also resulted in a GAC score in the extremely low range. Dr. Wright also found that this appeared to be a low estimate based on statements made by claimant's mother during her interview.

Dr. Wright administered the Autism Diagnostic Interview-Revised (ADI-R), a standardized, semi-structured clinical interview for caregivers of children and adults, to

[2] At hearing, claimant disputed this statement, reporting that she has never had a formal diagnosis of ASD, panic disorder, or PTSD.

claimant's mother. The ADI-R scores for claimant were at the cutoff in the areas of communication and reciprocal social interactions, and below the cutoff in the area of restrictive patterns of behavior.

For reciprocal social interactions, claimant's mother reported that claimant had no difficulty with eye contact when she was younger, but as an adult she often looks at the ground when talking to others. As a child, claimant had the same range of facial expressions as other children, but did not smile when approaching others. As a child, claimant tended to play next to other children without joining them. Claimant had neighborhood friends as a child, and enjoyed playing group sports. Claimant's current peer interactions are limited to online video games; her mother hears her laughing and engaging with those peers online.

Regarding communication, claimant pointed to things to express interest when she was younger, but did not use other common gestures. Claimant conversed with others and engaged in social verbalizations from an early age. Claimant used some idiosyncratic language, such as calling her parents by their first names as a young child, but otherwise had no problems with reversing pronouns, stereotyped language, echolalia, or asking inappropriate questions.

Regarding restricted and repetitive patterns of behavior, claimant's mother reported claimant did not make unusual hand or body motions when younger. Her mother observed claimant's current rocking behavior primarily during medical appointments, and only a few times at home. Claimant's mother did not report that claimant had any unusual sensory issues now or as a child. Claimant reads many medical books and told her mother she likes the medical attention, believing she may have Munchausen syndrome. Claimant is ritualistic in her eating, needing to have the lights on so she can see her food, and not liking to eat in front of others as a child.

Dr. Wright administered the Autism Diagnostic Observation Scale-Second Edition (ADOS-2) to claimant, using Module 4, which is for adults or adolescents with fluent speech. The ADOS-2 revealed classifications of "non-spectrum" for the areas of "communication" and "communication and social interactions," and "autism spectrum" for the area of social interaction. Dr. Wright observed that claimant's language and communication were appropriate throughout the ADOS-2. She used appropriate gestures while conversing, although they sometimes lacked integration with her statements. No stereotyped or idiosyncratic use of words or phrases were observed. Claimant used very little eye contact during the ADOS-2, often looking to the side when conversing, but looking directly at the examiner to make a point. She used an appropriate range of facial expressions when conversing. She easily labeled others' emotions and demonstrated an understanding of her own emotions. She reported having prior peer and romantic relationships. Claimant also reported on her own characteristics that annoy others. During the ADOS-2, claimant did not demonstrate any unusual hand mannerisms or repetitive behaviors, unusual sensory behaviors, compulsions and rituals, or interest in highly specific topics.

Dr. Wright opined in his report that: "Given the evidence gained in this assessment, [claimant] does not exhibit enough behaviors consistent with autism spectrum disorder to warrant that diagnosis at this time. . . . Within social communication she did not have difficulties responding to or initiating social interactions. Within restrictive behaviors she has rituals with eating but no other symptoms. Furthermore her difficulty did not appear to occur during the early developmental period." Dr. Wright reviewed the DSM-5 criteria for ASD, and concluded that claimant did not meet enough of the criteria for a diagnosis.

Dr. Wright diagnosed claimant with Borderline Personality Disorder (by history), Obsessive-Compulsive Disorder, and Major Depressive Disorder in partial remission (by history).

Dr. Wright concluded that claimant's primary disability is borderline personality disorder. The essential feature of borderline personality disorder is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, that begins by early adulthood and is present in a variety of contexts, as indicated by five or more of the following: (1) frantic efforts to avoid real or imagined abandonment; (2) a pattern of unstable and intense interpersonal relationships alternating between extremes of idealization and devaluation; (3) identity disturbance: markedly and persistently unstable self-image or sense of self; (4) impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating); (5) recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior; (6) affective instability due to marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days); (7) chronic feelings of emptiness; (8) inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights); (9) transient, stress-related paranoid ideation or severe dissociative symptoms. (DSM-5 at p. 663.)

Dr. Wright opined that:

> The diagnosis of borderline personality disorder captures her primary difficulties with relationships, self-identity, and suicidal ideation. Her outburst[s] in home appear related to her difficulties with interpersonal relationship with her

> mother and not due to rigidity or difficulties with sensory inputs.
>
> While her ABAS-3 rating indicated substantial impairment there is information indicating that these are a low estimate of her abilities. She takes care of her own health needs, has lived in different states, owns her own car, reported that she budgets her own money, and completed her G.E.D. within three weeks. Her verbal self-report and intelligence testing indicate much higher functioning. It is the examiner's opinion that her difficulties with borderline personality disorder is the reason she has not obtained independent living commensurate with her intelligence and not some other mental health disorder.

29. At hearing, Dr. Wright discussed the DSM-5 diagnostic criteria for ASD and explained his opinion that claimant does not meet these criteria. He also discussed the Lanterman Act eligibility criteria, which require both a diagnosis of autism or another eligible developmental disability, and substantial impairments in at least three areas of major life activity. Dr. Wright concluded claimant had not met these criteria.

30. Dr. Wright stated that treatment for borderline personality disorder is not similar to treatment for ASD. Dialectical behavioral therapy is designed specifically to treat borderline personality disorder, including teaching boundaries and cognitive skills. Dr. Wright recommends that claimant pursue this type of therapy.

31. Regarding Dr. Garner's letter, in which she stated that she diagnosed claimant with "features of" ASD, Dr. Wright found this wording suggested claimant had

some symptoms consistent with ASD, but not enough symptoms to meet full criteria for a diagnosis.

32. At the time of writing his report, Dr. Wright had not received a copy of Dr. O'Toole's January 2013 evaluation report, in which she diagnosed claimant with Asperger's Disorder. Dr. Wright subsequently reviewed Dr. O'Toole's report and discussed it at hearing; it confirmed his opinion that claimant does not have ASD.

Dr. Wright noted that the GADS instrument used by Dr. O'Toole is a screening tool meant to be used by a rater who has had at least two weeks of contact with the person being assessed. Dr. O'Toole only met with claimant on two occasions. In addition, Dr. Wright noted that the developmental information was based wholly on claimant's self-reporting, which in his opinion made the entire assessment invalid. Dr. Wright also found that some items listed by Dr. O'Toole as indicative of Asperger's are not autistic behaviors, for example, punching walls, and that claimant's ease of using technology was not a specialized interest indicative of ASD. Dr. Wright concluded that the information gathered by Dr. O'Toole was insufficient to make a diagnosis of ASD.

### DR. SULLIVAN

33. John Sullivan, M.D., has been a medical consultant for RCRC since 1985. After medical school, he completed a three-year residency in pediatrics, including training in developmental and mental health problems of children and adolescents. He has also had ongoing continuing education and experience regarding developmental disabilities in children and adults. Dr. Sullivan reviewed claimant's records and evaluations, participated in the RCRC eligibility team meeting, and testified at hearing.

Dr. Sullivan discussed the challenges in making a determination whether an adult with little documentation from early childhood has met the diagnostic criteria for

ASD. He noted that many symptoms of ASD may be "in the eye of the beholder" and that parental assessments may vary. However, Dr. Sullivan also noted that while manifestations of ASD may vary based on a person's age, the symptoms of ASD are pervasive and persistent, so the eligibility team considers a person's history over time. They also consider the "big picture" of developmental disabilities and other comorbid conditions, to determine which symptoms are associated with which diagnosis, and consider the totality of a person's behaviors and symptoms.

Dr. Sullivan and the other members of the RCRC eligibility team considered all five possible conditions that would confer eligibility for regional center services, and concluded that claimant did not have an eligible condition.

## RCRC ELIGIBILITY TEAM DETERMINATION AND INFORMAL MEETING

34. On March 10, 2020, the RCRC eligibility team met to discuss whether claimant was eligible for regional center services. The eligibility team consisted of clinical psychologist Dr. Jerry Drucker, Dr. Sullivan, Knight, and client services manager Dwayne Nelson. The team reviewed claimant's records and evaluations, and concluded that she did not meet the eligibility criteria under the Lanterman Act.

35. RCRC sent claimant a letter on March 12, 2020, denying eligibility and issued a notice of proposed action that day. Claimant filed a fair hearing request.

36. On April 17, 2020, claimant participated in an informal meeting with Kathleen Kasmire, the RCRC executive director's designee. On April 20, 2020, Kasmire wrote a decision summarizing the informal meeting, and affirming RCRC's conclusion that claimant is not eligible for regional center services for a diagnosis of ASD.

## Claimant's Additional Evidence

37. Claimant testified at hearing.

38. Claimant explained that she had no childhood medical records because her family did not go to doctors when she was a child, due to lack of health insurance. Claimant reported that her mother did not know what early childhood behaviors were normal or abnormal, because they lived on a boat and her mother did not talk with other mothers. Claimant reported she had spoken with her mother, who said she was crying and confused during her interviews with Dr. Wright. Claimant believes her mother may not have provided accurate information, and stated her mother has memory loss from chemotherapy.

39. Claimant stated she has never been diagnosed with Munchausen syndrome, PTSD, or panic disorder, explaining that these were self-diagnoses. Claimant no longer believes she has Munchausen syndrome.

40. Claimant stated that Dr. Garner described her as having "features of" ASD because Dr. Garner has not tested claimant for ASD and does not specialize in autism.

41. Claimant discussed a number of points in the reports of Knight and Dr. Wright, highlighting items that she believes were inaccurately reported by them. Claimant concedes that none of these items bear directly upon a diagnosis of ASD, but contends that they are indicative of an overall failure to listen and observe her closely. Claimant wanted a new autism evaluation by another evaluator.

42. Claimant also testified that some of her self-reporting about adaptive functioning was inaccurate, and she overstated her abilities due to embarrassment. Claimant stated at hearing that she does not remember to shower, and that she only

brushes her teeth once or twice a year. Regarding her impulsivity in spending money, claimant stated that at the time of her RCRC evaluation she was $5,000 to $8,000 in debt, but now she is $25,000 in debt because she bought a new car when she did not really need it. Dr. Wright's report noted claimant previously lived in another state with a partner. Claimant explained at hearing that she impulsively flew to Minnesota to live with a partner, but she only lived there for three months and was dependent on her partner and parents for financial support. Claimant also reported needing supervision when cooking due to a tendency to burn herself with hot oil.

43. Claimant stated she engages in "masking" of her symptoms such as trying to remember to look at people when talking to them, and hiding repetitive movements from the view of others.

44. Claimant reports that she receives SSI (Supplemental Security Income) benefits based on her 2013 diagnosis of Asperger's disorder. She contends that if she meets eligibility requirements for SSI, she should also meet eligibility requirements for regional center services.

## Ultimate Factual Findings

45. Claimant did not establish that she meets the criteria for an ASD diagnosis. Dr. Wright's recent psychological evaluation of claimant was thorough, utilizing the "gold standard" assessment tools for ASD, and included information obtained from claimant's mother and a review of claimant's records in addition to interviewing and testing claimant. Claimant pointed out a number of statements in Dr. Wright's report that she contends were inaccurate, but these items did not undermine the overall credibility of Dr. Wright's evaluation and opinion.

Claimant received a diagnosis of Asperger's Disorder in 2013 from Dr. O'Toole, but that evaluation was conducted for another purpose, and did not focus on the question of whether claimant has a developmental disability. Furthermore, the diagnosis was based on claimant's self-reporting with no other sources of developmental information. Under these circumstances, Dr. O'Toole's diagnosis does not constitute a "well-established" DSM-IV diagnosis of Asperger's disorder that should result in a DSM-5 diagnosis of ASD. Nor does claimant's receipt of SSI benefits based on Dr. O'Toole's diagnosis mean that she meets the eligibility criteria for regional center services. The Social Security Administration's determination of SSI eligibility is based on different criteria than the Lanterman Act's eligibility criteria.

The opinions of Dr. Wright and the RCRC eligibility team, that claimant does not have a diagnosis of ASD or another eligible developmental disability, and that her functional impairments are due primarily to borderline personality disorder, are persuasive.

Based on the evidence presented at hearing, claimant has not established that she has a developmental disability as defined by the Lanterman Act (cerebral palsy, epilepsy, autism, intellectual disability, or a condition closely related to intellectual disability or requiring treatment similar to that for intellectual disability).

## LEGAL CONCLUSIONS

1. In a proceeding to determine whether an individual is eligible for regional center services, the burden of proof is on claimant to establish that he or she has a qualifying developmental disability, by a preponderance of the evidence.

2. The State of California accepts responsibility for people with developmental disabilities under the Lanterman Act. (§ 4500, et seq.) The purpose of the Lanterman Act is to rectify the problem of inadequate treatment and services, and to enable people with developmental disabilities to lead independent and productive lives in the least restrictive setting possible. (§§ 4501, 4502; *Association for Retarded Citizens v. Department of Developmental Services* (1985) 38 Cal.3d 384.)

3. The term "developmental disability" includes intellectual disability, cerebral palsy, epilepsy, autism, and disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability (the "fifth category"). (§ 4512, subd. (a); Cal. Code Regs., tit. 17, § 54000, subd. (a).)

A developmental disability must originate before the individual reaches age 18; must continue, or be expected to continue, indefinitely; and must constitute a substantial disability for that individual. (§ 4512, subd. (a); Cal. Code Regs., tit. 17, § 54000, subd. (b).)

Under the Lanterman Act, handicapping conditions that are solely psychiatric in nature, solely learning disabilities, or solely physical in nature are not considered developmental disabilities. (Cal. Code Regs., tit. 17, § 54000, subd. (c).) However, services are not to be denied to a claimant with a learning disability or psychiatric disorder, so long as the claimant can also establish a qualifying condition under the Lanterman Act. (*Samantha C. v. Department of Developmental Services* (2010) 185 Cal.App.4th 1462.)

4. "Substantial disability" means major impairment of cognitive and/or social functioning, and the existence of significant functional limitations, as

appropriate to the person's age, in three or more of the following areas of major life activity: receptive and expressive language, learning, self-care, mobility, self-direction, capacity for independent living, and economic self-sufficiency. (§ 4512, subd. (l)(1); Cal. Code Regs., tit. 17, § 54001, subd. (a).)

5. Claimant has not met her burden of establishing that she has a developmental disability as defined in the Lanterman Act. (Factual Finding 45.) Because there is insufficient evidence that claimant has an eligible condition for regional center services, her appeal must be denied.

## ORDER

Claimant's appeal of the service agency's denial of regional center eligibility is denied. Claimant is not eligible for regional center services based on the evidence presented at hearing.

DATE:

HOLLY M. BALDWIN
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.