BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT

v.

INLAND REGIONAL CENTER, Service Agency

OAH No. 2021020084

DECISION

Kimberly J. Belvedere, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter remotely on August 25, September 14, and September 15, 2021, using the Microsoft Teams application due to the ongoing COVID-19 pandemic.

Keri Neal, Fair Hearings Representative, Fair Hearings and Legal Affairs, represented Inland Regional Center (IRC).

Kathleen Barrett, Attorney at Law, represented claimant's mother, who is claimant's conservator and authorized representative. Claimant was not present.

Oral and documentary evidence was received. The record was closed, and the matter submitted for decision on September 15, 2021.

ISSUE

Is claimant eligible for regional center services under the Lanterman Developmental Disabilities Services Act of 1969 (Lanterman Act) under the categories of autism spectrum disorder (autism); intellectual disability; or a disabling condition closely related to, or that requires treatment similar to, a person with an intellectual disability (fifth category)?

FACTUAL FINDINGS

Background

1. Claimant is a 22-year old man. Claimant has had various diagnosed mental health challenges since a young age, and had been living in residential facilities since approximately the age of 14, which were paid for (in whole or in part) by his school district. A person who qualifies for special education services may continue receiving those services until age 22 if they are an individual with "exceptional needs." (Ed. Code, § 56026.) When claimant turned 22, he was no longer eligible for the school district to provide residential services. Further, claimant experienced aggressive behaviors at his most recent residential facility, and his services were terminated. Claimant briefly lived with his uncle, and records indicated he lived with a female friend for a few months. Now, he lives at home (it was a bit unclear what his current living situation was, but based on claimant's mother's testimony regarding some of his behaviors, it seems he may be living at home). Claimant's mother is concerned, as claimant is not independent. Accordingly, claimant's mother provided records to, and sought services from, IRC under the category of autism.

2. On July 1, 2020, a multi-disciplinary team from IRC comprised of a doctor, psychologist, and program manager, conducted an intake assessment as required by Welfare and Institutions Code section 4642, which constituted review and discussion of claimant's records. One of those records included a psychological assessment that had been completed by an IRC psychologist on June 11, 2020. They concluded claimant did not qualify for regional center services under autism, intellectual disability, or the fifth category. No evidence was submitted, and eligibility was not requested based on, any other qualifying category.

3. Following the first denial, claimant's mother submitted additional records to IRC.

4. On December 29, 2020, a second multi-disciplinary team from IRC comprised of a different doctor from the first eligibility determination, two psychologists who differed from the psychologist in the first eligibility determination, and a program manager, met to discuss and review claimant's newly submitted records and the prior eligibility determination. They concluded claimant did not qualify for regional center services under any qualifying category, and that the new records provided did not show he needed to be evaluated a second time by IRC.

5. On December 30, 2020, IRC sent claimant's mother a Notice of Proposed Action stating that claimant did not qualify for regional center services under the Lanterman Act because the intake evaluations completed by IRC did not show claimant had a substantial disability as a result of autism, intellectual disability, cerebral palsy, epilepsy, or a condition that is closely related to an intellectual disability or requires treatment similar to a person with an intellectual disability.

6. On January 28, 2021, claimant's mother filed a fair hearing request challenging IRC's eligibility determinations. In the fair hearing request, she specified that she believes claimant qualifies for regional center services based on autism.

7. On February 18, 2021, an informal telephonic meeting was held between claimant's mother and IRC's fair hearings representative. The parties discussed claimant's records, why claimant's mother believed claimant qualified for regional center services, and why IRC believed claimant did not qualify. Following the meeting, IRC memorialized the terms of the meeting in a letter dated February 23, 2021. The letter stated, in part:

> The issue at hand is whether [claimant] is eligible for regional center services due to a substantially handicapping condition of Autism Spectrum Disorder and the 5th Category. [Claimant] has a history of seizures, however you explained that you are not pursuing IRC eligibility under the category of Epilepsy because his seizures are controlled. For your information, the law about who is eligible for regional center services, and what "substantial disability" means, is included in Attachment 1.
>
> During the informal meeting, introductions were made, and the purpose of the informal meeting was discussed. Persons present included you and I. You are [claimant's] mother and conservator. You presented your concerns regarding [claimant] and reasons why you feel he is eligible for services. You are concerned about [claimant's] future and

would like for [claimant] to have additional services to assist him.

[Claimant] is 21 years old. He currently resides with a friend/acquaintance and her family that he met on Facebook. He is currently not attending school nor is he employed. [Claimant] receives monthly social security benefits in the amount of approximately $940 per month and you are currently serving as his representative payee. [Claimant] does not receive In Home Supportive Services.

While in school [claimant] received special education services. He was initially found eligible for special education services due to speech or language impairment. During his educational years, his eligibility for services was reclassified to include other health impaired, emotional disturbance, and autism. Additionally, [claimant] participated in the general education setting, special day class, non-public school, and residential placement. [Claimant] resided in residential placement until he was provided a 30-day notice on March 27, 2020 due to behavioral challenges. You explained that [claimant] was involved in a fighting incident with peers and that the school district wanted to find an alternate placement to meet his needs because he was not progressing in the current placement.

[Claimant] has been diagnosed with the following conditions: Attention Deficit/ Hyperactivity Disorder, Bipolar

Disorder, Obsessive Compulsive Disorder, Dissociative Disorder, Oppositional Defiant Disorder, Schizoaffective Disorder, and Autism. Psychiatric needs are currently being met by Orange Psychiatric in Murrieta. He is scheduled to be seen every 3 months for medication management. [Claimant] is currently on a waiting list to be seen by a therapist affiliated with Orange Psychiatric. He is taking the following medications: Thorazine, 50 mg three times a day for behaviors, Cogentin 1 mg twice a day for side effects of Thorazine, and Gabapentin 300mg twice a day for behaviors/headache.

[Claimant] has Inland Empire Health Plan (IEHP) Medi-Cal insurance. He currently receives Full Service Provider (FSP) services through the insurance. The FSP provides him with Wrap Around services through Oak Grove and housing/living assistance.

When [claimant] was younger, he was diagnosed with Grand Mal and Petit Mal seizures. Neurology needs are currently being met by Progressive Neurology and Sleep Medicine Associates located in Riverside. His last appointment was October 7, 2020. His last seizure was observed 3-4 years ago. His last Electroencephalogram (EEG) was completed in September 2020 and was reported to be normal. It was recommended that [claimant] continue taking his current medications since his seizures are

> controlled with the current medication regiment. He is currently taking the following medications to control his seizures: Depakote ER, 1250mg at bedtime and Trileptal, 900mg in the morning and 900mg at bedtime.
>
> During the meeting we discussed obtaining additional records from [claimant's] providers. Currently I have only been provided with his Neurology provider's information. If you would like to move forward with the submission of additional records, please contact me with the providers information so that I may send you the release for review and signature. . . .

Following the informal meeting, IRC adhered to its two prior eligibility determinations that claimant was not eligible for regional center services under any category.

8. On May 3, 2021, a third multi-disciplinary team from IRC comprised of a doctor, psychologist, and program manager met to discuss and review claimant's medical records and the two prior eligibility determinations. They concluded that claimant was not eligible for regional center services based on cerebral palsy or epilepsy, and did not consider the other categories, as those had already been determined and no new evidence had been submitted regarding those conditions.

9. On July 19, 2021, a fourth multi-disciplinary team from IRC comprised of a doctor, psychologist, program manager, and senior counselor met to discuss and review claimant's records, three prior eligibility determinations, and a new medical evaluation that had been completed. They concluded claimant did not qualify for

regional center services under any qualifying category. Specifically with respect to epilepsy and/or seizures, they found that although claimant did have seizures, they were well controlled by his medication.

10. This hearing followed.

Diagnostic Criteria for Autism

11. The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) identifies criteria for the diagnosis of autism. The diagnostic criteria include persistent deficits in social communication and social interaction across multiple contexts; restricted repetitive and stereotyped patterns of behavior, interests, or activities; symptoms that are present in the early developmental period; symptoms that cause clinically significant impairment in social, occupational, or other important areas of function; and disturbances that are not better explained by intellectual disability or global developmental delay.

Core diagnostic features are evident in the developmental period, but intervention, compensation, and current supports may mask difficulties in at least some contexts. Manifestations of the disorder also vary greatly depending on the severity of the autistic condition, developmental level, and chronological age. The impairments in communication and social interaction are pervasive and sustained. Deficits in social-emotional reciprocity (i.e., the ability to engage with others and share thoughts and feelings) are clearly evident in young children with the disorder, who may show little or no initiation of social interaction and no sharing of emotions, along with reduced or absent imitation of others' behavior. What language exists is often one-sided, lacking in social reciprocity, and used to request or label rather than to comment.

Deficits in nonverbal communicative behaviors used for social interaction are manifested by absent, reduced, or atypical use of eye contact (relative to cultural norms), gestures, facial expressions, body orientation, or speech intonation. An early feature of autism spectrum disorder is impaired joint attention as manifested by a lack of pointing, showing, or bringing objects to share interest with others, or failure to follow someone's pointing or eye gaze. Deficits in developing, maintaining, and understanding relationships should be judged against norms for age, gender, and culture. There may be absent, reduced, or atypical social interest, manifested by rejection of others, passivity, or inappropriate approaches that seem aggressive or disruptive. These difficulties are particularly evident in young children, in whom there is often a lack of shared social play and imagination (e.g., age-appropriate flexible pretend play) and, later, insistence on playing by very fixed rules.

Stereotyped or repetitive behaviors include simple motor stereotypes (e.g., hand flapping, finger flicking), repetitive use of objects (e.g., spinning coins, lining up toys), and repetitive speech (e.g., echolalia, the delayed or immediate parroting of heard words; use of "you" when referring to self; stereotyped use of words, phrases, or prosodic patterns). Excessive adherence to routines and restricted patterns of behavior may be manifest in resistance to change (e.g., distress at apparently small changes, such as in packaging of a favorite food; insistence on adherence to rules; rigidity of thinking) or ritualized patterns of verbal or nonverbal behavior (e.g., repetitive questioning, pacing a perimeter). Highly restricted, fixated interests in autism spectrum disorder tend to be abnormal in intensity or focus (e.g., a toddler strongly attached to a pan; a child preoccupied with vacuum cleaners; an adult spending hours writing out timetables). Some fascinations and routines may relate to apparent hyper-or hyporeactivity to sensory input, manifested through extreme responses to specific sounds or textures, excessive smelling or touching of objects, fascination with lights or

spinning objects, and sometimes apparent indifference to pain, heat, or cold. Extreme reaction to or rituals involving taste, smell, texture, or appearance of food or excessive food restrictions are common and may be a presenting feature of autism spectrum disorder.

The age and pattern of onset also should be noted for autism spectrum disorder. The behavioral features of autism spectrum disorder first become evident in early childhood, with some cases presenting a lack of interest in social interaction in the first year of life. Symptoms are typically recognized, however, during the second year of life (12-24 months of age) or noted later than 24 months if symptoms are more subtle. When criteria for both ADHD and autism spectrum disorder are met, both diagnoses should be given. This same principle applies to concurrent diagnoses of autism spectrum disorder and developmental coordination disorder, anxiety disorders, and depressive disorders.

An individual must have a DSM-5 diagnosis of autism spectrum disorder to qualify for regional center services based on autism.

Diagnostic Criteria for Intellectual Disability

12. The DSM-5 contains the diagnostic criteria used for intellectual disability. The essential features of intellectual disability are deficits in general mental abilities and impairment in everyday adaptive functioning, as compared to an individual's age, gender, and socio-culturally matched peers. Intellectual functioning is typically measured using intelligence tests. Individuals with intellectual disability typically have IQ scores in the 65-75 range (unless an individual is African American, in which case IQ results are not considered). In order to have a DSM-5 diagnosis of intellectual

disability, three diagnostic criteria must be met. The DSM-5 states in pertinent part as follows:

> Intellectual disability (intellectual developmental disorder) is a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains. The following three criteria must be met:
>
> A. Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing.
>
> B. Deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.
>
> C. Onset of intellectual and adaptive deficits during the developmental period.
>
> [¶] . . . [¶]

Intellectual functioning is typically measured with individually administered and psychometrically valid, comprehensive, culturally appropriate, psychometrically sound tests of intelligence. Individuals with intellectual disability have scores of approximately two standard deviations or more below the population mean, including a margin for measurement error (generally +5 points). On tests with a standard deviation of 15 and a mean of 100, this involves a score of 65-75 (70 ± 5). Clinical training and judgment are required to interpret test results and assess intellectual performance.

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.

Deficits in adaptive functioning (Criterion B) refer to how well a person meets community standards of personal independence and social responsibility, in comparison to others of similar age and socio-cultural background. Adaptive functioning involves adaptive reasoning in three

domains: conceptual, social, and practical. The conceptual (academic) domain involves competence in memory, language, reading, writing, math reasoning, acquisition of practical knowledge, problem solving, and judgment in novel situations, among others. The social domain involves awareness of others' thoughts, feelings, and experiences; empathy; interpersonal communication skills; friendship abilities; and social judgment, among others. The practical domain involves learning and self-management across life settings, including personal care, job responsibilities, money management, recreation, self-management of behavior and school and work tasks organization, among others. Intellectual capacity, education, motivation, socialization, personality features, vocational opportunity, cultural experience, and coexisting general medical conditions or mental disorders influence adaptive functioning. . . .

[¶] . . . [¶]

Criterion B is met when at least one domain of adaptive functioning – conceptual, social, or practical – is sufficiently impaired that ongoing support is needed in order for the person to perform adequately in one or more life settings at school, at work, at home, or in the community. To meet the diagnostic criteria for intellectual disability, the deficits in adaptive functioning must be directly related to the intellectual impairments described in Criterion A.

Diagnostic Criteria for Fifth Category

13. Under the Under the fifth category, the Lanterman Act provides assistance to individuals with a disabling condition closely related to an intellectual disability or that requires similar treatment as an individual with an intellectual disability but does not include other handicapping conditions that are "solely physical in nature." (Welf. & Inst. Code, § 4512, subd. (a).) A disability involving the fifth category must also have originated before an individual attained 18 years of age, must continue or be expected to continue indefinitely, and must constitute a substantial disability.

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 intellectual disability, with many of the same, or close to the same, factors required in classifying a person as intellectually disabled. Another appellate decision has also suggested, when considering whether an individual is eligible for regional center services under the fifth category, that eligibility may be based largely on the established need for treatment similar to that provided for individuals with an intellectual disability, notwithstanding an individual's relatively high level of intellectual functioning. (*Samantha C. v. State Department of Developmental Services* (2010) 185 Cal.App.4th 1462.) In *Samantha C.*, the individual applying for regional center services did not meet the criteria for intellectual disability. The court understood and noted that the Association of Regional Center Agencies had guidelines (ARCA Guidelines) which recommended consideration of the fifth category for those individuals whose "general intellectual functioning is in the low borderline range of intelligence (I.Q. scores ranging from 70-74)." (*Id.* at p. 1477.) However, the court confirmed that individuals may qualify for regional center services under the fifth category on either

of two independent bases, with one basis requiring only that an individual require treatment similar to that required for individuals with intellectual disability.

The ARCA Guidelines provide criteria to assist regional centers in determining whether a person qualifies for services under the fifth category. The ARCA Guidelines provide that the person must function in a manner similar to a person with an intellectual disability or who requires treatment similar to a person with an intellectual disability.

FUNCTIONING SIMILAR TO A PERSON WITH AN INTELLECTUAL DISABILITY

14. A person functions in a manner similar to a person with an intellectual disability if the person has significant sub-average general intellectual functioning that is accompanied by significant functional limitations in adaptive functioning. Intellectual functioning is determined by standardized tests. A person has significant sub-average intellectual functioning if the person has an IQ of 70 or below. Factors a regional center should consider include: the ability of an individual to solve problems with insight, to adapt to new situations, and to think abstractly and profit from experience. If a person's IQ is above 70, it becomes increasingly essential that the person demonstrate significant and substantial adaptive deficits and that the substantial deficits are related to the cognitive limitations, as opposed to a medical or some other problem. It is also important that, whatever deficits in intelligence are exhibited, the deficits show stability over time.

Significant deficits in adaptive functioning are established based on the clinical judgements supplemented by formal adaptive behavioral assessments administered by qualified personnel. Adaptive skill deficits are deficits related to intellectual limitations that are expressed by an inability to perform essential tasks within adaptive domains

or by an inability to perform those tasks with adequate judgement. Adaptive skill deficits are not performance deficits due to factors such as physical limitations, psychiatric conditions, socio-cultural deprivation, poor motivation, substance abuse, or limited experience.

TREATMENT SIMILAR TO A PERSON WITH AN INTELLECTUAL DISABILITY

15. In determining whether a person requires treatment similar to a person with an intellectual disability, a regional center should consider the nature of training and intervention that is most appropriate for the individual who has global cognitive deficits. This includes consideration of the following: individuals demonstrating performance based deficits often need treatment to increase motivation rather than training to develop skills; individuals with skill deficits secondary to socio-cultural deprivation but not secondary to intellectual limitations need short-term, remedial training, which is not similar to that required by persons with an intellectual disability; persons requiring habilitation may be eligible, but persons primarily requiring rehabilitation are not typically eligible as the term rehabilitation implies recovery; individuals who require long-term training with steps broken down into small, discrete units taught through repetition may be eligible; and the type of educational supports needed to assist children with learning (generally, children with an intellectual disability need more supports, with modifications across many skill areas).

Diagnostic Criteria for ADHD

16. ADHD is not a qualifying diagnosis for regional center services. However, since many of claimant's records, and the experts in this case, referenced ADHD, the diagnostic criteria are mentioned here.

17. Sometimes, ADHD may be comorbid with a diagnosis of intellectual disability; or, it may exist separately. ADHD is a neurodevelopmental disorder defined by impairing levels of inattention, disorganization, and/or hyperactivity-impulsivity. Inattention and disorganization entail inability to stay on task, seeming not to listen, and losing materials, at levels that are inconsistent with age or developmental level. Hyperactivity-impulsivity entails overactivity, fidgeting, inability to stay seated, intruding into other people's activities, and the inability to wait. ADHD often persists into adulthood, with resultant impairments of social, academic, and occupational functioning.

The DSM-5 diagnostic criteria for ADHD includes: persistent pattern of inattention and/or hyperactivity that interferes with functioning or development, as characterized inattention, hyperactivity, or both.

In order to meet the diagnostic criteria under inattention, a person must have six or more of the following symptoms that persist for at least six months in a manner that impacts social and academic/occupational activities: often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or with other activities; often has trouble holding attention on tasks or play activities; often does not seem to listen when spoken to directly; often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., loses focus, side-tracked); often has trouble organizing tasks and activities; often avoids, dislikes, or is reluctant to do tasks that require mental effort over a long period of time (such as schoolwork or homework); often loses things necessary for tasks and activities (e.g. school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones); is often easily distracted; and is often forgetful in daily activities.

In order to meet the diagnostic criteria under hyperactivity and/or impulsivity, a person must have six or more of the following symptoms that persist for at least six months in a manner that is inconsistent with his or her developmental level and negatively impacts social and academic/occupational activities: often fidgets with or taps hands or feet, or squirms in seat; often leaves seat in situations when remaining seated is expected; often runs about or climbs in situations where it is not appropriate (adolescents or adults may be limited to feeling restless); often unable to play or take part in leisure activities quietly; is often "on the go" acting as if "driven by a motor"; often talks excessively; often blurts out an answer before a question has been completed; often has trouble waiting his/her turn; and often interrupts or intrudes on others (e.g., butts into conversations or games).

In addition, the following conditions must be met: several inattentive or hyperactive-impulsive symptoms were present before age 12 years; several symptoms are present in two or more settings (home, school or work; with friends or relatives; in other activities); there is clear evidence that the symptoms interfere with, or reduce the quality of, social, school, or work functioning; the symptoms do not happen only during the course of schizophrenia or another psychotic disorder; and the symptoms are not better explained by another mental disorder (e.g. Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

A diagnosis of ADHD Combined Presentation is appropriate if a person meets the criteria for both inattention and hyperactivity/impulsivity.

Diagnostic Criteria for Bipolar Disorder

18. Bipolar disorder is not a qualifying diagnosis for regional center services. However, since claimant's records and the experts in this case referenced bipolar disorder, this diagnostic criteria is mentioned here.

BIPOLAR I DISORDER

19. The bipolar I disorder criteria represent the modern understanding of the classic manic-depressive disorder or affective psychosis described in the nineteenth century, differing from that classic description only to the extent that neither psychosis nor the lifetime experience of a major depressive episode is a requirement. However, the vast majority of individuals whose symptoms meet the criteria for a fully syndromal manic episode also experience major depressive episodes during the course of their lives.

For a diagnosis of bipolar I disorder, it is necessary to meet the criteria for a manic episode. The manic episode may have been preceded by and may be followed by hypomanic or major depressive episodes. A manic episode includes, but is not limited to, a distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalization is necessary). During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior: inflated self-esteem or grandiosity; decreased need for sleep (e.g., feels rested after only 3 hours of sleep); more talkative than usual or pressure to keep talking; flight of ideas or subjective experience that thoughts are

racing; distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed; increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation; excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments). Co-occurring mental disorders with a bipolar I diagnosis are common, with the most frequent disorders being any anxiety disorder (e.g., panic attacks, social anxiety disorder [social phobia], specific phobia), occurring in approximately three-fourths of individuals; ADHD, any disruptive, impulse-control, or conduct disorder (e.g., intermittent explosive disorder, oppositional defiant disorder, conduct disorder), and any substance use disorder (e.g., alcohol use disorder) occur in over half of individuals with bipolar I disorder.

BIPOLAR II DISORDER

20. Bipolar II disorder requires a lifetime experience of at least one episode of hypomanic episode and one major depressive episode. The amount of time individuals with this condition spend in depression and the instability of mood experienced by individuals with bipolar II disorder is typically accompanied by serious impairment in work and social functioning.

A hypomanic episode includes, but is not limited to, a distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least four consecutive days and present most of the day, nearly every day. During the period of mood disturbance and increased energy and activity, three (or more) of the following symptoms have persisted (four if the mood is only irritable), represent a noticeable change from usual behavior, and have been present to a significant degree: inflated self-esteem or

grandiosity; decreased need for sleep (e.g., feels rested after only 3 hours of sleep); more talkative than usual or pressure to keep talking; flight of ideas or subjective experience that thoughts are racing; distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed; increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation; excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

A major depressive episode includes five (or more) of the following symptoms have been present during the same 2-week period that represent a change from previous functioning, and at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure: depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, or hopeless) or observation made by others (in children and adolescents, can be irritable mood); markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation); significant weight loss when not dieting or weight gain (e.g., a change of more than five percent of body weight in a month), or decrease or increase in appetite nearly every day (in children, consider failure to make expected weight gain); insomnia or hypersomnia nearly every day; psychomotor agitation or retardation nearly every day (observable by others; not merely subjective feelings of restlessness or being slowed down); fatigue or loss of energy nearly every day; feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick); diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others); recurrent thoughts

of death (not just fear of dying), recurrent suicidal ideation without a specific plan, a suicide attempt, or a specific plan for committing suicide.

In addition to a diagnosis of bipolar II disorder, an evaluator should specify the severity of the disorder (i.e. mild, moderate, or severe) and whether the condition presents with anxiety, rapid cycling, mood-congruent psychotic features, mood-incongruent psychotic features, catatonia, peripartum onset, seasonal patterns, or other mixed features.

Co-occurring mental disorders with a bipolar II diagnosis include, but are not limited to, any anxiety disorder (e.g., panic attacks, social anxiety disorder [social phobia], specific phobia), ADHD, schizophrenia, substance use disorders, personality disorders, cyclothymic disorder, and major depressive disorder.

Substantial Disability

21. In addition to having a qualifying diagnosis (i.e. autism, intellectual disability, epilepsy, cerebral palsy, or the fifth category), a person must also be substantially disabled as a result of that diagnosis in three or more areas of a major life activity, pursuant to California Code of Regulations, title 17, section 54000. These areas are: communication (must have significant deficits in both expressive and receptive language), learning, self-care, mobility, self-direction, capacity for independent living, and economic self-sufficiency. The ARCA Guidelines also refer to California Code of Regulations, title 17, sections 54000 and 54001, regarding whether a person has a substantial disability.

Claimant's Records and IRC Expert's Assessment/Testimony of Those Records

22. Ruth Stacy, Psy.D., testified on behalf of IRC. Dr. Stacy is a staff psychologist at IRC and has devoted virtually her entire career, even prior to obtaining her degree, to individuals who are seeking or already receiving IRC services. She has held multiple positions at IRC, including senior intake counselor, psychological assistant, and consumer services coordinator. Her career at IRC began in 1990, as such, she has been providing services to IRC almost exclusively for over three decades. In addition to her doctorate degree in psychology that she obtained in 2008, she also holds a Master of Arts in Counseling Psychology (2004), a Master of Arts in Sociology (1980), and a Bachelor of Arts in Psychology and Sociology (1978). Dr. Stacy has received training in the administration of the Autism Diagnostic Observation Schedule, Second Edition (ADOS-2), the administration of the Autism Diagnostic Observation Schedule (ADOS), Mental Health Strategies for Individuals with Co-occurring Developmental Disabilities from the Los Angeles County Department of Mental Health, Psychological Tele-Assessments during COVID-19: Ethical and Practical Considerations, and at least 36 qualifying continuing education hours every year since becoming licensed in 2013, as required by the California Board of Psychology. Dr. Stacy qualifies as an expert in the diagnosis of autism and in the assessment of individuals for IRC services.

23. On June 11, 2020, Dr. Stacy conducted a psychological assessment of claimant. That assessment included a review of records provided by claimant. Records were also submitted following Dr. Stacy's assessment, which were also reviewed by her prior to providing testimony in his matter. The following is a summary of relevant

portions of the supplied records with pertinent points from Dr. Stacy's testimony highlighted.

INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP) DATED JANUARY 8, 2001, AND REGIONAL CENTER OF ORANGE COUNTY CONSUMER ID NOTES DATED MARCH 26, 2003, THROUGH JULY 2, 2003

24. Claimant qualified for services under the Early Start program (Early Start) prior to the age of three years old. He received those services from the Regional Center of Orange County. In order to qualify for services under Early Start, a child under the age of three years old must have a 33 1/3 percent delay in specified categories, speech being one of them. Claimant qualified, according to his Individualized Family Service Plan (IFSP) in the category of speech. According to the IFSP dated January 8, 2001, when claimant was approximately two years old, claimant's mother stated claimant did speak but did not speak as much as his older brother. What few words he did speak were not intelligible to others. Claimant's mother noted to the IFSP author that claimant lined things up and would spit out food and choke on saliva, so she was concerned about autism.

According to Dr. Stacy, nothing in the IFSP shows any concern regarding autism, intellectual disability, or fifth category. The things expressed by claimant's mother (lining things up, sensory issues with food) are sometimes typical for children who have no developmental challenges. Moreover, the IFSP noted that claimant was social, interactive, eager to participate in testing, and liked being around people. He was also able to imitate play on a doll. None of these behaviors are consistent with autism.

When a child receiving Early Start services turns three years old, a determination has to be made if they will continue to receive services under the Lanterman Act.

According to the consumer ID notes from the Regional Center of Orange County, there was no concern expressed regarding any qualifying condition under the Lanterman Act. They mention claimant's seizures, but that the seizures were controlled and therefore not substantially handicapping. Accordingly, claimant's Early Start case was closed and he was not transitioned to services under the Lanterman Act.

WEST ORANGE COUNTY CONSORTIUM FOR SPECIAL EDUCATION WESTMINSTER SCHOOL DISTRICT PSYCHOEDUCATIONAL ASSESSMENT DATED FEBRUARY 4, 2002

25. On February 4, 2002, when claimant was three years old, claimant's school district conducted a psychoeducational assessment to determine claimant's eligibility for special education services. During the assessment, claimant was friendly, alert, and cooperative. Regarding the Bayley Scales of Infant Development, used to determine cognitive ability, claimant scored above average. On the adaptive portion of the test, claimant's adaptive skills showed average for his age. Claimant's expressive and receptive language were shown to be age appropriate. Claimant only qualified for special education services because of an articulation disorder.

WEST ORANGE COUNTY CONSORTIUM FOR SPECIAL EDUCATION FOUNTAIN VALLEY SCHOOL DISTRICT PSYCHOEDUCATIONAL ASSESSMENT DATED OCTOBER 17, 2005

26. On October 17, 2005, when claimant was just shy of seven years old, his school district conducted a psychological assessment to determine claimant's ongoing eligibility for special education services. The report noted multiple diagnoses, including ADHD and bilateral hearing loss, among others. On the Wechsler Intelligence Scale for Children, Fourth Edition (WISC-4), designed to test cognitive functioning in

children aged 6 to 16 years, claimant had various strengths, such as his verbal and perceptual skills which were in the average range, and overall was determined to be able to cognitively function in the low-average to average range. Claimant's academic skills (reading, writing, and mathematics) were assessed using the Wechsler Individual Achievement Test and the Woodcock-Johnson III. He struggled in the areas of verbalizing language and math, but not with writing. The report noted that his academic progress was being impacted by his medical conditions, which were causing him to miss a lot of school. Nonetheless, his full-scale IQ score was still 88, which is in the low average range.

As Dr. Stacy explained, claimant was found eligible for special education services based on his continued speech and language impairment, and the category "other health impairment" due to claimant's ongoing medical problems. Nowhere in the report does it mention autism, intellectual disability, or the fifth category, nor is there any documentation of restricted/repetitive patterns of behavior, sensory problems, or any of the characteristic features of autism. No autism testing was completed because there was no reason to do so. Dr. Stacy explained that claimant "clearly" did not have intellectual disability due to his cognitive functioning being at the level it was, and there was nothing to indicate his adaptive scores were so low that he had a condition similar to a person with an intellectual disability or required treatment similar to a person with an intellectual disability.

MENIFEE UNION SCHOOL DISTRICT TRIENNIAL EVALUATION REPORT DATED OCTOBER 24, 2008

27. On October 24, 2008, when claimant was just shy of 10 years old, his school district conducted a triennial evaluation report to determine claimant's ongoing needs for special education services. On the WISC-4, claimant scored virtually the

same as he did in 2005, and had a full-scale IQ of 87, placing him still in the low-average range of functioning. His verbal and perceptual reasoning remained in the average range. The evaluator noted claimant was cooperative during the testing and did not require an excessive amount of reinforcement or praise. He demonstrated adequate concentration. While claimant did not initiate conversation, he responded appropriately to the evaluator during casual conversation. On the assessments relating to academics, claimant again scored in the low average to average range as well, with writing being below average, the only change from the prior assessment.

The Behavioral Assessment System for Children, Second Edition (BASC-2), is a rating scale that was filled out by claimant's teacher, designed to assess claimant's emotional and behavioral state. Claimant's scores varied widely between average, at risk, borderline, or clinically significant. Claimant's teacher reported claimant is easily distracted from his school work and his behaviors were aggressive at times. Claimant often picked at his skin and seemed disconnected from others. Claimant also bullied others, called other children names, and could be argumentative.

Notwithstanding the emotional and behavioral concerns expressed by claimant's teacher, Dr. Stacy's testimony showed there was nothing remarkable about this report, as claimant's cognitive level was similar to the previous psychoeducational assessment conducted three years prior, and there were no concerns in the report regarding autism. This report also noted prior diagnoses of ADHD, bipolar disorder, and obsessive compulsive disorder (OCD), among others.

MENIFEE UNION SCHOOL DISTRICT INTERDISCIPLINARY EVALUATION REPORT DATED DECEMBER 14, 2011

28. On December 14, 2011, when claimant was almost 13 years old, his school district conducted an interdisciplinary evaluation to assist claimant's Individualized Education Plan (IEP) team in discerning claimant's educational needs. At that time, the team saw only the need to assess for eligibility under other health impairment and emotional disturbance.

During the interview with claimant, the evaluator noted he had articulation problems. Claimant did not have any problems understanding or communicating with the evaluator. The evaluator was able to keep claimant engaged during the evaluation. Claimant reported he likes school and had a favorite class. Claimant reported having trouble sleeping and gaining weight because of his medications. He reported he enjoys relationships with other people and has friends, but desired to have more friends. Claimant preferred to be with other people rather than by himself. He also reported a quick temper and that he would get angered by loud noises.

Claimant's mother reported claimant had "hallucinated in the past during a manic episode" and that she suspected he "hurt himself in the past" because he had cut marks on his wrists. Claimant would display frustration, tantrums, and intolerance when confronted with demands. He exhibited impulsivity, insomnia, and hypersomnia during a "depressed phase." She indicated that when claimant was having a "depressed phase" he could be in a "depressed mood for days."

Claimant's teacher reported claimant was difficult to communicate with when he was in a "manic" phase and that other students annoying claimant would "set him off." On one occasion claimant hit a peer with his fist "in what appeared to be a manic

phase." When claimant was in a "manic phase," he would climb on tables. During a classroom observation, the evaluator noted claimant interacted with the teacher and did what he was told but laughed and giggled, climbed under the table, and had poor attention. When at lunch, claimant moved from group to group, chatting with peers. He smiled.

The assessments administered were the BASC-2, the Connors Behavior Rating Scale – Third Edition (Conners-3), and the Reynolds Adolescent Depression Scale – Second Edition (RADS-2). On the BASC-2, claimant, his teacher, and his mother rated claimant. While the ratings differed somewhat, generally, claimant's scores were elevated in the areas of hyperactivity and aggression. On the Conners-3, it involves a rating system filled out by parents, teachers, and anyone familiar with claimant. Claimant's scores were generally elevated in all areas. As Dr. Stacy explained, this is a test designed to test for ADHD. On the RADS-2, claimant's self-rated score indicated he did not have depressive symptomology.

The evaluator concluded that claimant qualified for special education services under emotional disturbance, he was already being served under the category of other health impairment, and that his emotional disturbance was likely causing problems in his academic abilities.

Dr. Stacy explained that in reviewing the behavior discussed in this interdisciplinary evaluation report, claimant's assessment results and behaviors were consistent with ADHD. Claimant's behaviors, such as interacting with peers, having friends, wanting to be with friends, and being both manipulative and exploitative, were all inconsistent with autism. Nothing in this report showed any concerns with autism, intellectual disability, or the fifth category.

MENIFEE UNION SCHOOL DISTRICT INTERDISCIPLINARY EVALUATION REPORT DATED FEBRUARY 27, 2014

29. This interdisciplinary evaluation was completed on February 27, 2014, when claimant was 14 years old. The report noted claimant received special education services under the categories of emotional disturbance and other health impairment. According to Dr. Stacy, all of the cognitive scores in this evaluation exceeded the range for intellectual disability. Claimant's behaviors were consistent with bipolar disorder and ADHD, not with autism.

AUTISM CENTER PSYCHODIAGNOSTIC EVALUATION DATED OCTOBER 23, 2015

30. On October 23, 2015, when claimant was just shy of 17 years old, he underwent an assessment specifically to test for autism. Claimant's mother, in the report, noted claimant exhibited many explosive behaviors and frustrations, as well as "self-injurious" behaviors (tried to strangle himself with seatbelts and cords in 2015). Because claimant posed a danger to others, he lived in a facility for a brief time until October 2015. He was placed in that facility because he had multiple psychiatric hospitalizations since 2014. His issues did not resolve, and he was released from those facilities with the recommendation of long-term residential therapy.

The evaluators, according to their report, only reviewed claimant's interdisciplinary evaluation report and his IEP from 2015. They did not review any of the other records dating back to claimant's toddler years documented in this decision. They administered only rating tests, such as the Adaptive Behavior Assessment System – third Edition (ABAS-3), the Childhood Autism Rating Scale – Second Edition (CARS-2), and the Social Responsive Scale – Second Edition (SRS-2). They did not administer the

Autism Diagnostic Observation Scale – Second Edition (ADOS-2), which Dr. Stacy testified is the "gold standard" of autism testing. On the CARS-2, claimant showed "severe level of autism-related symptoms." Dr. Stacy explained that claimant's entire history showed no concerns regarding autism and behaviors inconsistent with autism, so, to all of a sudden see that he screened as having "severe" symptoms of autism does not fit with his developmental history. She noted that the other two assessments administered showed low adaptive skills, however, claimant had been living in residential facilities and not at home – and normally these rating scales would be filled out by someone who lived with him. Thus, she questions the validity of the low ratings by claimant's mother. Dr. Stacy also noted that the report referred to bipolar disorder having been diagnosed in the past, and claimant's mother had indicated he had been diagnosed with bipolar disorder, but no records were provided showing how that diagnosis was achieved.

PERRIS UNION HIGH SCHOOL DISTRICT TRIENNIAL PSYCHOEDUCATIONAL REPORT DATED FEBRUARY 20, 2017

31. Claimant's school district conducted a triennial psychoeducational assessment on February 20, 2017, when claimant was 17 years old. They administered multiple tests geared towards assessing claimant's cognitive and adaptive skills. At this time, claimant was living in a residential facility in Colorado due to the need for social-emotional stabilization. They were told the facility was geared towards individuals with autism. They also were provided with the recent report from the Autism Center.

While speaking with claimant, claimant told them he would like to be a rapper or guitar player. When asked what he would do if he could not be a rapper or guitar player, he said he would like to be a nurse. Claimant expressed excitement about turning 18 because he would be able to "make more decisions for himself." Claimant

expressed that he likes his current placement, but the subjects he studied were his strong points and were too easy. Academically, he tested in the very low and low average range, showing claimant's beliefs were not consistent with his actual performance.

Overall, the evaluator concluded that while claimant should continue to be eligible for special education services under his current categories, that claimant should be considered for special education for autism. Dr. Stacy pointed out, however, that the criteria for autism for special education services fall under Title 17 of the California Code of Regulations and not the DSM-5 – and there is no DSM-5 diagnosis in this assessment, which is required for regional center eligibility. This was the last report completed during claimant's developmental period.

PERRIS UNION HIGH SCHOOL DISTRICT PSYCHOEDUCATIONAL ASSESSMENT DATED JANUARY 17, 2019, AND INDIVIDUALIZED EDUCATION PROGRAM DATED APRIL 30, 2019

32. On January 17, 2019, when claimant was 20 years old, his school conducted a psychoeducational assessment. The evaluation included the categories (for special education) of autism, other health impairment, emotional disturbance, and speech and language impairment. As with all the previous records, there was no concern noted about intellectual disability. At this time, claimant was living in a residential treatment facility in Nevada.

Dr. Stacy pointed out many behaviors inconsistent with autism. Specifically, it noted claimant had "correct social norms." He expressed a willingness to engage with the examiner. According to Dr. Stacy, that means a lot. A person with autism will not have correct social norms and will not be engaging with people. Further, under parent

input, claimant's mother reported that he has adapted well to his placement and keeps in contact with her. Other areas of the report indicate he greets peers with handshakes and has good interactions. Under testing observations, it indicated good social emotional reciprocity and good speech and eye contact. Claimant's mother reported sometimes claimant cheats or is deceptive. Again, none of these behaviors are consistent with autism and are also not indicative of being substantially disabled under applicable law.

Multiple tests were administered, including cognitive testing and the Gilliam Autism Rating Scale, Third Edition (GARS-3). There were no concerns with intellectual disability (he was still in the low average range) or anything that would meet the criteria for the fifth category. Claimant showed "at risk" in being able to maintain his attention. Claimant's language skills were in the low average. The GARS-3 was the only test specifically designed for autism, and the form was filled out by claimant's mother. The evaluator noted that it is only to screen "autistic-like" behaviors for purposes of special education. It does not consider DSM-5 criteria. On this test, claimant's reported behaviors showed he was "very likely" on the autism spectrum. The report indicated that claimant's history of special education had been emotional disturbance and other health impairment, but after the 2016 Autism Center assessment, the IEP Team agreed to change his eligibility from emotional disturbance to autism. It also noted all of claimant's other diagnoses, but added bipolar disorder. Ultimately the evaluator recommended claimant continue to be eligible for special education under autism and other health impairment.

33. Claimant's IEP following the assessment reflected "other health impairment" and "autism." It also, however, states that his "bipolar disorder" affects

him in a general education setting. It also notes claimant knows how to "push" people's buttons, which Dr. Stacy said is wholly inconsistent with autism.

LETTERS FROM TELOS U DATED JULY 30, 2020; OAK GROVE DATED OCTOBER 15, 2020; AND CLAIMANT'S SCHOOL DISTRICT DATED OCTOBER 28, 2020

34. The letter from Telos U, dated July 30, 2020, was completed by Kyle Barth, LMFT, who also testified at the hearing. Mr. Barth is not a clinical psychologist. The letter was one page and merely recounted terms that are stated in the DSM-5 diagnostic criteria for autism and said claimant had behaviors that fit those patterns. It did not contain any assessments. It did not indicate if there was any meaningful review of claimant's past history.

35. The letter from claimant's school district dated October 28, 2020, was completed by Rebecca Gehlke, Psy.D., LMFT, was also a one page letter that recounted some behaviors Dr. Gehlke believed were consistent with autism and explained that claimant needs regional center services. The letter noted claimant's previous diagnosis of autism and indicated claimant may have developmental delay. Dr. Gehlke testified at the hearing. The letter did not indicate that any assessments were completed to come to the conclusion that claimant had autism and did not mention anything about the DSM-5 and whether claimant met the diagnostic criteria for autism. It also did not indicate if there was any meaningful review of claimant's history.

36. The letter from Oak Grove dated October 15, 2020, was written by Tamara Trejos, the Wrap Around Program Coordinator. As with the other letters, it was only one page, recounted some behaviors claimant had, asserted he struggled with good judgment and navigating social situations, but did not contain any independent

assessment or diagnoses of any mental health condition such as autism or intellectual disability. Ms. Trejos also did not testify at the hearing.

37. Dr. Stacy pointed out that claimant's developmental history and assessments were inconsistent with autism and nothing in the letters changed her mind on that issue.

PROGRESSIVE NEUROLOGY AND SLEEP MEDICINE ASSOCIATES MEDICAL RECORDS DATED NOVEMBER 3, 2020, AND OCTOBER 7, 2020, AND JUNE 30, 2021, MEDICAL ASSESSMENT CONDUCTED BY REGIONAL CENTER

38. Records from the Progressive Neurology and Sleep Medicine Associates was provided. They were very short and did not include any new assessments. They listed claimant's prior diagnosis of autism. It indicated claimant's seizures were under control.

39. On June 30, 2021, Linh A. Tieu, D.O., conducted a medical assessment of claimant and found his seizures were under control and were not substantially handicapping.

NEUROPSYCHOLOGICAL EVALUATION BY DR. MARK MCDONOUGH, PH.D. DATED DECEMBER 11, 2020

40. On December 11, 2020, Mark McDonough, Ph.D., conducted a neuropsychological evaluation of claimant. Claimant had been referred to Dr. McDonough by his school district, which specifically indicated that claimant needed regional center services because he had an autism diagnosis, among other things, and the purpose of the evaluation was for "diagnostic clarity."

41. Dr. McDonough spoke with claimant and his mother. He also reviewed prior records. Notably, in reviewing a record from January 20, 2020, from claimant's school district (which was not included in exhibits provided to IRC), Dr. McDonough found the following information:

> Claimant attended kindergarten in the Fountain Valley School District. He was retained in kindergarten due to health issues and frequent absences. He transferred to the Menifee District in first grade and attended Oak Meadows Elementary for third grade. He attended Somerset and Oak Grove nonpublic schools. He was placed at New Haven RTC on 07/20/2017 from Devereaux, Colorado. Subsequently placed from New Haven to Mountain Valley RTC in Nevada City, CA. On 06/01/2018, Perris Union District received notification from Mountain Valley that they were providing a 30-day notice to terminate services for claimant based on aggression towards peers and staff, noncompliance with policies and expectations, bullying, intimidating, sabotaging peers programs, and refusal to take accountability for his behaviors. Claimant was subsequently placed at Telos RTC in Utah.
>
> Claimant had a history of behaviors which consisted of frequent hospitalizations and multiple 5150's . . . on 02/05/2018, law enforcement report was filed . . . he was cited for assault. Since placement at Telos – incidence buying AK-47 bullets, leaving campus in a car, property

damage, vape pen, physical and verbal altercations with peers and staff.

According to Dr. Stacy, all of the above behaviors are not consistent with autism but instead of mental health disorders.

During his interview with claimant, Dr. McDonough noted claimant made limited eye contact and was often "contradictory or challenging" to his mother. He had a mild articulation deficit, especially with the letter "R." He blamed his past struggles on teachers, peers, organizations, and other patients.

Dr. McDonough noted claimant had prior diagnoses of ADHD and bipolar disorder at age five. Subsequent diagnoses include, but were not limited to, ADHD, OCD, Sensory Integration Disorder, seizure disorder, PTSD, and OCD. Claimant's mother told Dr. McDonough that IRC had recently completed an assessment and determined claimant did not qualify under autism and felt claimant's behaviors were better explained by his other mental health conditions. Claimant's mother also told Dr. McDonough that claimant's diagnosis of autism was "long established." She stated there was no history of autism in the family.

Claimant's mother told Dr. McDonough that claimant liked to line things up as a child, and had sensory preferences (i.e. needed a certain shampoo). He had behavioral problems all throughout his educational years leading to him having to be placed in residential facilities. He was in an altercation at one facility that resulted in a rather severe injury to his eye, and he left the facility. In his most recent facility he was also terminated for noncompliance issues, and sent home in March 2020. Claimant began receiving wrap around services at that time, as he continued to bounce around from various residential programs.

Dr. McDonough administered the Conners Continuous Performance Test – Third Edition (Conners-3); Millon Clinical Multiaxial Inventory – Fourth Edition (MCMI-4); Gilliam Asperger Disorder Scale (GADS); SRS Rating Scale; Vineland Adaptive Behavior Scales, Third Edition (Vineland-3); Wechsler Adult Intelligence Scale - Fourth Edition (WAIS-4); ACS Social Perception Subtests; and the Trauma Symptom Inventory – Second Edition (TSI-2).

The testing showed claimant had inattention and impulsivity. His cognitive functioning was generally within the low average range, although Dr. McDonough said it was approaching borderline. Claimant's overall intellectual functioning was in the low average range (consistent with how he tested throughout his entire academic history). Claimant's adaptive skills ranged from extremely low to below average. On the GADS and the SRS, which are both rating scales filled out by others regarding their perceptions of claimant's behaviors, claimant's behaviors were found to be within the possible range of spectrum-like behaviors. The ADOS was not administered.

Dr. McDonough concluded that although claimant's "behaviors" have "waxed and waned" over time and displayed an "overlap" with autism and other disorders, and autism was "more prominent throughout the history." He disagreed with any diagnosis of bipolar, which he indicated happened at the age of five which was not appropriate and he believed incorrectly diagnosed. He disagreed with Dr. Stacy's evaluation and said there was little evidence to show claimant could function in daily life.

DR. STACY'S PSYCHOLOGICAL ASSESSMENT DATED JUNE 11, 2020

42. On June 11, 2020, Dr. Stacy conducted a psychological assessment of claimant. She administered the Autism Diagnostic Observation Schedule, Second Edition (ADOS-2); the CARS-2 (high functioning version); and the Vineland-3.

43. Dr. Stacy reviewed all prior records recounted above. Her testimony concerning those records was indicated above, where appropriate. Dr. Stacy believed the historical records did not support a diagnosis of autism, intellectual disability, or the fifth category. She explained, the ADOS is a functional test – it is a standardized and validated assessment that is considered the gold standard in autism diagnosis. Though not required, it is the best indicator of autism since it does not rely on just parent reports or examiner observations. In order to administer the ADOS, a person must be specifically trained. The ADOS looks for specific traits of autism, it assesses communication, social nuances, social skills, patterns, it is built specifically around the DSM-5 criteria for autism.

44. During the assessment, claimant effectively used verbal and nonverbal communication. When she administered the CARS, it showed minimal or no symptoms of autism. When she administered the ADOS, it showed claimant fell outside the range for autism. His adaptive skills on the Vineland-3 were low, but that is likely because he has other mental health afflictions that cause low adaptive behavior. She is also not surprised he may have difficulty in independent life skills because he has lived in residential placements since he was 14. Dr. Stacy did not conduct cognitive testing because throughout the records claimant was in the low average range and had IQ scores in excess of 80, which is not indicative of intellectual disability.

45. Dr. Stacy respectfully disagreed with Dr. McDonough's conclusions about autism. She stated that many of the behaviors claimant had in the past are likely attributable to his other mental health conditions. He had multiple mental health hospitalizations over the years. The records are full of instances of mood swings, rapid cycling, anger, depressing, etc. – and claimant's mother indicated he had a prior diagnosis of bipolar disorder. The behaviors and features of bipolar disorder are "well

documented" in the documents provided. While claimant has many comorbidities, she diagnosed him with bipolar II disorder, with rapid cycling, with mood congruent psychotic features; OCD; and ADHD.

46. Dr. Stacy considered all the records in reaching her diagnosis. In that respect, her diagnosis of bipolar II disorder was not a "carry over" diagnosis. She explained that in addition to the DSM-5 features of bipolar II disorder evident throughout claimant's history (i.e. rapid cycling), claimant also had "hypersexualized behavior while at Telos U – he would sneak out to see girls. This is not indicative of autism. Sensory issues as well are commonly related to bipolar and ADHD.

47. Further, claimant's behaviors varied over the years. He had good social skills early on. He wanted to make friends and interact with his peers. He makes eye contact. He tells jokes, for example. With autism, you would see consistency over time; not behaviors changing back and forth. Claimant's social skills worsened over time as his mental health difficulties increased.

48. Dr. Stacy concluded claimant did not meet criteria for autism.

49. Overall, after concluding claimant did not meet the diagnostic criteria for autism, Dr. Stacy explained that claimant's IQ of 80 and cognitive skills, as evident throughout the records provided, shows his skills are in the low average range which is too high to qualify for services under intellectual disability. Also, his adaptive skills may have been lower at times, however, there is nothing that shows his adaptive skills were lower due to cognitive concerns. There are many reasons a person may have lower adaptive skills, such as psychiatric conditions, and given her diagnosis of bipolar II and review or the records, nothing showed claimant's lower adaptive scores were such that his functioning was "similar to" a person with an intellectual disability. Further,

regarding whether claimant requires "treatment" similar to a person with an intellectual disability, the records did not show he does. Treatment is distinct from services. For example, treatment is meant to treat a disability, while services are something that a person may merely benefit from. A "treatment," for example, would be an antibiotic for someone who is sick. A "service" for someone who is sick would be driving them to their appointment. The records show that while claimant may benefit from "services" that a person with an intellectual disability might benefit from – like many individuals might regardless of their cognitive abilities – he does not receive any treatment similar to a person with an intellectual disability. Thus, he is not eligible for regional center services under the fifth category.

50. Regarding claimant's ineligibility under the category of autism in addition to what was already discussed above, Dr. Stacy explained that the weight of claimant's records show many other diagnoses other than autism that better explain his behavior and that many of claimant's symptoms/behaviors over the years are inconsistent with autism. Claimant's social and emotional skills at a young age were inconsistent with autism, as he had friends and was social. Also, while claimant may have received special education services under autism, the criteria for receiving special education services for autism is different compared to the DSM-5, as those criteria are found in Title 17 of the California Code of Regulations, and just because a person meets the criteria for special education, does not mean they meet the criteria under the DSM-5, which is required to become eligible for regional center services. Also, for regional center services, the diagnosis alone is not enough; they must also be substantially disabled in three or more areas of a major life activity. Under Title 17, a person does not need to be substantially disabled.

51. On cross-examination, claimant's attorney went to great lengths to point out various behaviors over the years throughout the records and asked Dr. Stacy if that isolated behavior was consistent with a diagnosis of autism. Dr. Stacy explained many times that, while some of the behaviors might be consistent with autism, they are also consistent with many of the other mental health diagnoses claimant has held over the years. Moreover, if a person has autism, one would expect it to be evident in the early childhood years and continue consistently throughout a person's life. Claimant's records do not show that. Early on, claimant had good social skills. They worsened as his mental health problems increased.

Evidence Presented by Claimant

CLAIMANT'S EXPERT

52. Dr. McDonough's testimony is summarized as follows: Dr. McDonough has a Bachelor of Arts degree in sociology and psychology. He has a Master of Arts in clinical psychology. He obtained a Ph.D. in 1992. He completed a post-doctoral fellowship in pediatric neuropsychology in 1994. Dr. McDonough has been in private practice since 1999 in the field of psychotherapy, psychology, and forensic neuropsychology. A large part of his practice involves working with the developmentally disabled. Prior to being in private practice, Dr. McDonough worked in a variety of settings and held titles such as director of clinical services, associate clinical director, and neuropsychological coordinator. His positions involved conducting neuropsychological evaluations. Dr. McDonough has provided consultation services as an expert for various entities. He has held multiple teaching positions in the field of neuropsychology. He has received awards and has multiple publications in the field of psychology on a variety of subjects. Dr. McDonough is an expert in the field of neuropsychology.

Dr. McDonough said neuropsychology is "very different" from psychology. Usually a psychologist graduates and just starts practicing. With neuropsychology, a person must complete an additional two years of study. Specifically, his field looks at brain function and is somewhat of an "interface of neurology and psychiatry with psychology."

The assessment Dr. McDonough conducted is detailed above under its respective heading. Dr. McDonough's testimony pertaining to that report is as follows: While speaking with claimant during the assessment, claimant made limited eye contact. Claimant was "very fractious" with his mother and always disagreeing with her. Claimant had mild articulation difficulties. Claimant was very introspective, and his self-awareness was very compromised.

Claimant has a long history of being aggressive towards people. He is on a variety of medications. If he goes off of his medications, it will destabilize his behaviors.

Dr. McDonough reviewed all the records provided and believes claimant's behaviors are not bipolar disorder. He said bipolar "usually starts" at age 25. It does not mean it cannot be diagnosed in children, but a doctor should be careful giving that diagnosis at a young age. He believes Dr. Stacy did not conduct any "functional" testing of claimant. He also feels that "psychiatry" tends to "overrate bipolar." What also struck him in Dr. Stacy's evaluation was that it said claimant was self-aware, because that is not the case.

Dr. McDonough believes claimant's behaviors are indicative of autism. While some of the behaviors may suggest bipolar, autism is a more compelling explanation.

He believes the school district struggled with diagnosing claimant, so that is why they referred claimant to him for evaluation.

TESTIMONY OF KYLE BARTH

53. Kyle Barth's testimony is summarized as follows: Mr. Barth is a licensed marriage and family therapist who works at Telos U, a residential treatment center for young adults in Utah. He has worked there since 2016. Mr. Barth's duties include acting as a primary therapist and providing clinical care for residents. He has about eight students he is responsible for at any given time.

Claimant was a resident at Telos U from December 2018 to March 2020. Mr. Barth does not diagnose anyone. He said that the diagnosis of autism was provided to Telos U when claimant arrived and his "observations" were consistent with autism. His role in claimant's care was to provide one weekly therapy session, family or parent coaching session, and he had frequent contact with claimant. Claimant's living arrangements were eight separate apartments with a shared bathroom. Claimant's activities of daily living were very low-skilled. Regardless of whether support was provided, claimant had an inability to follow through on such tasks such as cleaning his room, having social relationships, and maintaining any kind of responsibility.

Claimant demonstrated a strong desire to connect with others but a weak understanding in how his behavior affected others. Claimant was prone to anxiety and depression especially when he would seek acceptance from peers and be rejected. He would be on an "escalation" and then "crash." Claimant had an inability to regulate his emotions which affected his relationships. For example, once claimant put a swastika underneath a Jewish student's door. On other occasions, he would engage in verbal and physical aggression and threatened to harm others. On yet another occasion,

claimant purchased AK-47 bullets for a peer whom he thought would appreciate it because that peer liked guns, without realizing the impropriety of it.

Claimant had an "obsessive interest" in Harry Potter. He liked wearing certain clothes all the time and his food had to be specific. Although he had fixations, they would change from time to time. In that respect claimant also exhibited rigid thinking patterns. Once his mind was set on something, claimant would refuse to see another perspective.

While claimant was at Telos U he was unable to hold a job. Claimant had a job at a fast food facility but his interactions were uncomfortable because he would act "sexual" and made people uncomfortable. He also had an inability to get prepared for work. They tried to set him up with a job working at Telos U but he would get aggressive with staff and peers, so ultimately, Telos U had no choice but to kick him out of the facility.

When asked why the "plethora" of diagnoses other than autism were ignored in writing the letter he wrote for this hearing, Mr. Barth said he did not ignore them, but he felt his observations were consistent with autism. Mr. Barth testified that a "psycho-social" assessment is conducted by the facility psychiatrist when someone arrives at Telos U, but from the testimony, it was unclear whether it was a formal assessment where tests were administered or merely a review of records or some other less involved "assessment." At any rate, no assessment was provided with the letter written by Telos U.

TESTIMONY OF EMILY BYERS

54. Emily Byers's testimony is summarized as follows: Ms. Byers has been a wrap around facilitator at Oak Grove since April 2015. Oak Grove is a center for

education and the arts, and includes a residential treatment facility as well as a non-public school and other community-based services and programs. Ms. Byers works in the community-based services section.

Wrap around services are a team-based intensive approach designed to meet the needs of students and their families. They consider what resources are needed and provide "linkages" to families that need help with short-term stabilization. A team is comprised of a Family Facilitator, Parent Partner, and Behavioral Specialist. Her duties as the facilitator include case management for wrap around teams and families, run once a week team meetings, and coordinating with school district. She helps administer the program known as ERMS – the educationally related mental health services.

Claimant received wrap around services from August 2020 to July 2021. Ms. Byers has never met claimant face to face. All of her interaction with him and his family have been via text message or video chat. They began helping claimant when he was kicked out of his last residential placement. Claimant told them during a meeting that he was expecting a baby with his girlfriend. Claimant supposedly has issues with medication compliance, per his mother. Claimant had problems following a bus schedule. Claimant had problems respecting boundaries. Claimant also had problems sustaining employment. Ms. Byers believed his inability to hold down a job was more than just lack of motivation because claimant talked about wanting a job. Claimant has a lot of dreams and plans (like being a singer or a rapper) but did not like when they tried to build a plan on how to achieve those things.

One of the services they provided was to work with claimant and his school district so a teacher could work with claimant online and help him sign up and finish

classes. He did not follow through with that and returned all materials provided to him around November or December 2020.

TESTIMONY OF REBECCA GEHLKE

55. Dr. Gehlke's testimony is summarized as follows: Dr. Gehlke holds a Psy.D. in marital and family therapy and she is a licensed marriage and family therapist. She specializes in marriage and family therapy. She is a coordinator of mental health services for the Perris Unified School District and has held that position since 2014. Her duties include overseeing a team of mental health professionals who provide services as directed by students' IEPs, coordinates services for non-public schools, and oversees wrap around for the school district.

Dr. Gehlke began working with claimant in 2014 while he was attending a non-public school. She observed him November 12 through 15, 2019, while he was attending Telos U. She explained that she did not do any testing of claimant because it is "not their job to label or diagnose." Rather, her job is to consider eligibility based on the testing done by the school psychologist and assess whether there are any mental health issues impairing him for purposes of his education.

Claimant is impulsive at times and unable to manage money. He is easily triggered if things are not routine, which has led to physical altercations in the past. He is, however, very creative and makes up his own rap music. He has difficulty following multi-step directions. He cannot hold down a job because he shows up late. Claimant's social functioning is impaired; he has been kicked out of multiple placements because of aggression and has a history of anger, depression, and being sleep deprived. Claimant cannot function independently.

CLAIMANT'S MOTHER'S TESTIMONY

56. Claimant's mother testified as follows: Claimant's mother is a pediatric nurse. She currently works in mental health but has only been doing that for three years because she sought additional training to help her son.

Claimant has had problems since he was a child. He had his tongue clipped to help with speech issues, but it did not help. They were referred to the regional center because he was delayed in speech and language. He received early start services. At that time, claimant also would bang his head on the crib, walk in circles, and would not answer to his name. When he aged out of early start services, regional center felt claimant was "too social" to qualify under autism, even though he had a lot of autistic-like tendencies.

After he was no longer receiving services, claimant started grouping objects. It would go in different phases. First he would pick red. Then he would switch to shiny objects. Claimant always had to have a specific routine. His clothes had to be put on in a certain order. His food could not touch other food and he could not eat anything brightly colored. Claimant had specific bath toys he would play with and would have frequent melt downs of things did not go his way.

When claimant was enrolled in preschool, he had some behaviors that were concerning, like always taking off his shoes. They eventually duct-taped the shoes to his feet. He would spend time at the water fountain just letting his hands run under the water.

After claimant finished preschool, they moved him to a public kindergarten. They had seen a child psychologist who put him on medication. They thought he had ADHD, and tried him on that medication, but it caused seizures and he missed a lot of

school. When she mentioned claimant would become irritable on the medication for his ADHD, the doctors changed his diagnosis to bipolar disorder.

Throughout claimant's childhood, claimant had behavioral problems. He had multiple hospitalizations for "5150." Claimant would have emotional outbursts if things were too loud, if textures were not right, or where his clothes did not fit right. His first hospitalization was in the second grade.

Claimant always struggled to fit in socially in middle school. Claimant would tell jokes to fit in with his peers, but the other kids would make fun of him. He could not communicate properly with his peers. Claimant struggled in high school even more because it was a much bigger setting. He does not do well if his routine is changed. He got in trouble in high school for "pantsing" a student. He thought it was appropriate and did it to fit in. Claimant's inability to function well led to him having to transfer to a non-public school. He did not do very well there either.

Claimant next started his placements in various residential facilities. He continued to have problems with fighting or aggression. Claimant had a fight at one of the facilities and ended up becoming blind in one eye. He had to leave that facility. From there, he went to a facility in Northern California, which was a locked facility. He did a little better there but still struggled. That facility terminated his residency. From there, claimant went to Telos U. Telos U was a pretty amazing place. Claimant did very well there, and she wishes he was still there. However, he still had altercations and they said they could not keep him.

After claimant was kicked out of Telos U, it was right at the start of the COVID-19 pandemic. Claimant initially went to his uncle's house, but claimant's rigid eating habits and behaviors were too much for claimant's uncle. Claimant returned home for

a while, but she cannot care for him. Claimant would turn on the stove and leave it, leave candles burning, and refuse to take his medications. His behaviors just continued to get worse. It was unclear if claimant still lived with his mother or is living elsewhere as of the time of the hearing.

Claimant struggles with purchases, finances, doing laundry (i.e. needs a specific detergent, specific dryer sheets), cannot take meds on his own, watches Harry Potter all the time, and "fixates" on motorcycles. Claimant likes rap music, does not like wearing shoes, is constantly switching light switches on and off, and drumming on things or nodding his head to "self-soothe."

Claimant's mother feels she rated claimant's behaviors fairly every time she rated claimant. Without services from the regional center she is "really stuck between a rock and a hard place" because claimant needs services.

LEGAL CONCLUSIONS

Applicable Law

1. The Legislature enacted a comprehensive statutory scheme known as the Lanterman Act (Welf. & Inst. Code, § 4500 et seq.) to provide a pattern of facilities and services sufficiently complete to meet the needs of each person with developmental disabilities, regardless of age or degree of handicap, and at each stage of life. The purpose of the statutory scheme is twofold: To prevent or minimize the institutionalization of developmentally disabled persons and their dislocation from family and community, and to enable them to approximate the pattern of everyday living of nondisabled persons of the same age and to lead more independent and

productive lives in the community. (*Assn. for Retarded Citizens v. Dept. of Developmental Services* (1985) 38 Cal.3d 384, 388.)

2. Welfare and Institutions Code section 4501 outlines the state's responsibility for persons with developmental disabilities and the state's duty to establish services for those individuals.

3. The Department of Developmental Services (department) is the public agency in California responsible for carrying out the laws related to the care, custody and treatment of individuals with developmental disabilities under the Lanterman Act. (Welf. & Inst. Code, § 4416.)

4. The Lanterman Act is set forth at Welfare and Institutions Code section 4500 et seq. Welfare and Institutions Code section 4501 provides:

> The State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge. Affecting hundreds of thousands of children and adults directly, and having an important impact on the lives of their families, neighbors and whole communities, developmental disabilities present social, medical, economic, and legal problems of extreme importance . . .
>
> An array of services and supports should be established which is sufficiently complete to meet the needs and choices of each person with developmental disabilities, regardless of age or degree of disability, and at each stage of life and to support their integration into the mainstream

> life of the community. To the maximum extent feasible, services and supports should be available throughout the state to prevent the dislocation of persons with developmental disabilities from their home communities.

5. Welfare and Institutions Code section 4512, subdivision (a), defines "developmental disability" as a disability that "originates before an individual attains 18 years of age; continues, or can be expected to continue, indefinitely; and constitutes a substantial disability for that individual." A developmental disability includes "disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability." (*Ibid.*) Handicapping conditions that are "solely physical in nature" do not qualify as developmental disabilities under the Lanterman Act. (*Ibid.*)

6. California Code of Regulations, title 17, section 54000, provides:

> (a) "Developmental Disability" means a disability that is attributable to [intellectual disability][1], cerebral palsy, epilepsy, autism, or disabling conditions found to be closely related to [intellectual disability] or to require treatment

[1] Although the Lanterman Act has been amended to eliminate the term "mental retardation" and replace it with "intellectual disability," the California Code of Regulations has not so been amended. Accordingly, the term "mental retardation" was replaced with "intellectual disability" to reflect the proper designation of the disability at issue.

similar to that required for individuals with [intellectual disability].

(b) The Developmental Disability shall:

(1) Originate before age eighteen;

(2) Be likely to continue indefinitely;

(3) Constitute a substantial disability for the individual as defined in the article.

(c) Developmental Disability shall not include handicapping conditions that are:

(1) Solely psychiatric disorders where there is impaired intellectual or social functioning which originated as a result of the psychiatric disorder or treatment given for such a disorder. Such psychiatric disorders include psycho-social deprivation and/or psychosis, severe neurosis or personality disorders even where social and intellectual functioning have become seriously impaired as an integral manifestation of the disorder.

(2) Solely learning disabilities. A learning disability is a condition which manifests as a significant discrepancy between estimated cognitive potential and actual level of educational performance and which is not a result of generalized mental retardation, educational or psycho-social deprivation, psychiatric disorder, or sensory loss.

(3) Solely physical in nature. These conditions include congenital anomalies or conditions acquired through disease, accident, or faulty development which are not associated with a neurological impairment that results in a need for treatment similar to that required for mental retardation.

7. California Code of Regulations, title 17, section 54001, provides:

(a) "Substantial disability" means:

(1) A condition which 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; and

(2) The existence of significant functional limitations, as determined by the regional center, in three or more of the following areas of major life activity, as appropriate to the person's age:

(A) Receptive and expressive language;

(B) Learning;

(C) Self-care;

(D) Mobility;

(E) Self-direction;

(F) Capacity for independent living;

(G) Economic self-sufficiency.

(b) The assessment of substantial disability shall be made by a group of Regional Center professionals of differing disciplines and shall include consideration of similar qualification appraisals performed by other interdisciplinary bodies of the Department serving the potential client. The group shall include as a minimum a program coordinator, a physician, and a psychologist.

(c) The Regional Center professional group shall consult the potential client, parents, guardians/conservators, educators, advocates, and other client representatives to the extent that they are willing and available to participate in its deliberations and to the extent that the appropriate consent is obtained.

(d) Any reassessment of substantial disability for purposes of continuing eligibility shall utilize the same criteria under which the individual was originally made eligible.

8. In a proceeding to determine whether an individual is eligible for regional center services, the burden of proof is on the claimant to establish by a preponderance of the evidence that he or she meets the diagnostic criteria for an eligible condition and that he or she is substantially disabled within the meaning of California Code of Regulations, title 22, section 54001. (Evid. Code, §§ 115; 500.)

Evaluation

9. Based on the documents provided and testimony at hearing, a preponderance of the evidence did not establish that claimant is eligible for regional center services under the categories of autism, intellectual disability, or the fifth category.

10. When claimant's mother filed the fair hearing request, the sole issue was autism. Nowhere in the fair hearing request was intellectual disability or the fifth category claimed to be a qualifying diagnosis. In the informal meeting letter prior to the hearing, it was claimed that the issues were autism and the fifth category, but there was no mention of intellectual disability. At hearing, it was pointed out by the ALJ that the only issue in the fair hearing request was autism and therefore, that was the only issue to be addressed (as the informal meeting letter is not the pleading that controls the proceeding, rather the fair hearing request is). IRC did not dispute that. However, claimant's counsel indicated she would like intellectual disability and the fifth category considered. IRC did not object, and the three eligibility determinations they made included these conditions. Thus, the case proceeded on eligibility determinations based on autism, intellectual disability, and the fifth category.

11. Claimant's mother loves her son and her testimony was heartfelt. She was certainly credible with respect to her recounting of claimant's history, behaviors, and diagnoses. Claimant's mother believes claimant has autism and claimant's inability to function independently, as well as being able to care for claimant while he remains in the home, concerns her very much. However, even assuming claimant was misdiagnosed over the years, the weight of the evidence established that claimant's condition throughout his developmental years is better explained by the other many diagnoses he has had over the years, and not by autism. Moreover, Dr. Stacy's

evaluation and testimony of claimant was relied upon more heavily than Dr. McDonough's evaluation and testimony, as discussed below.

12. A person is qualified to testify as an expert if he/she has special knowledge, skill, experience, training, or education sufficient to qualify him as an expert on the subject to which his or her testimony relates. (*Chavez v. Glock, Inc.* (2012) 207 Cal.App.4th 1283, 1318-1319.) In resolving any conflict in the testimony of expert witnesses, the opinion of one expert must be weighed against that of another. In doing so, consideration should be given to the qualifications and believability of each witness, the reasons for each opinion, and the matter upon which it is based. California courts have repeatedly underscored that an expert's opinion is only as good as the facts and reason upon which that opinion is based. (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 924.) Relying on certain portions of an expert's opinion is entirely appropriate. A trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke Davis & Co.* (1973) 9 Cal. 3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected material." (*Id.* at pp. 67-68, quoting from *Neverov v. Caldwell* (1958) 161 Cal. App. 2d 762, 767.) The fact finder may also reject the testimony of a witness, even an expert, although it is not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal. 3d 875, 890.) Additionally, the testimony of "one credible witness may constitute substantial evidence," including a single expert witness. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.)

There were two experts who testified in this case. Dr. McDonough and Dr. Stacy. Both experts were well-qualified in their respective fields and their applicable credentials were impressive. Both were well-qualified to testify regarding whether claimant suffered from autism, intellectual disability, or the fifth category. However, more weight was given to Dr. Stacy's testimony as she is a clinical psychologist and an expert in the diagnosis of the developmental disabilities in this matter and specifically, in the determination of whether a person qualifies for regional center services. Dr. McDonough, whose evaluation was impressive and also thorough, did not administer the ADOS to claimant, which is the gold-standard in the diagnosis of autism. And although Dr. McDonough is certainly well-qualified to render an opinion regarding claimant's challenges, Dr. Stacy has spent in excess of three decades in a regional center working with, diagnosing, assessing, evaluating, and rendering diagnoses and conclusions specifically regarding eligibility for regional center services.

AUTISM

13. A preponderance of the evidence did not establish that claimant meets the criteria for regional center services under the category of autism.

Nothing in claimant's Early Start documents or consumer ID notes shows concerns regarding autism. Although claimant's mother expressed concern about autism because of claimant's speech delay, lining things up, and difficulty feeding him, Dr. Stacy noted that these things are not unusual of a young child who does not have a developmental disability.

In 2002, when claimant was assessed for special education services by his school district, his cognitive ability showed that he was above average for his age, there were no issues noted with his adaptive skills, and his expressive and receptive language

were age-appropriate. Claimant was friendly, alert, and cooperative. The only reason claimant was found eligible for special education services was because of an articulation disorder, not because of problems with expressive and receptive language. The IFSP also noted that claimant was social, interactive, eager to participate in testing, liked being around people, and was able to imitate play on a doll. As Dr. Stacy explained, none of these behaviors are consistent with autism, in fact, they are quite the opposite of what one would expect to see in a child with autism.

In 2005 when claimant's school district assessed him, claimant was found to be functioning cognitively in the low average to average range. Though he had some challenges in various academic areas, those were noted as attributable to his multiple medical (as opposed to psychological) conditions that were causing him to miss a lot of school. As Dr. Stacy explained, claimant was found eligible for special education services based only on speech and language impairment and other health impairment. There were no concerns regarding autism.

In 2008, when claimant was again assessed by his school district, claimant's cognitive levels remained virtually unchanged, and although claimant's teacher reported poor behaviors (bullying, aggression, name-calling), nothing consistent with autism (such as stereotyped interests or sensory problems) were reported. The evaluator showed no concern regarding autism.

In 2011, when claimant was 13 years old, he underwent an assessment by his school district that involved behavioral assessments. The evaluator concluded claimant qualified for special education under emotional disturbance. Dr. Stacy reviewed the description of the behaviors in the report, such as being friendly, manipulative, and exploitative, and said that claimant's evaluation results and behaviors were consistent with ADHD and nothing in the report indicated a concern with autism.

The interdisciplinary evaluation was completed on February 27, 2014, when claimant was 14 years old showed claimant continued to be eligible for special education services under the categories of emotional disturbance and other health impairment. According to Dr. Stacy, all of the cognitive scores in this evaluation exceeded the range for intellectual disability and were not indicative of the fifth category. Claimant's behaviors were consistent with bipolar disorder and ADHD, not with autism.

In 2015, claimant underwent an assessment for autism at the Autism Center. After the CARS-2, the evaluator found claimant's ratings scored him as having "severe" symptoms of autism. However, it is noted that this report should be viewed with caution because the evaluators did not review claimant's entire psychiatric or medical history; they only reviewed a recent IEP and his most recent interdisciplinary evaluation from his school district. Moreover, as Dr. Stacy explained, given that there were absolutely no concerns regarding autism from any previous professional who assessed claimant, it is inconsistent with his history to all of a sudden be in the "severe" range for autism. Moreover, the CARS-2 is just a rating scale, the ADOS-2 is the "gold standard" used to assess if a person falls within the autism spectrum. This test, however, was not administered. Thus, this report was afforded little weight.

Claimant's school district conducted a triennial psychoeducational assessment on February 20, 2017, when claimant was 17 years old. This assessment was conducted soon after the autism diagnosis that claimant received from the Autism Center. The discussions with claimant did not show behaviors consistent with autism. He showed career goals, the ability to reason, and the desire to make decisions for himself. The evaluator, however, concluded claimant should be considered for special education under the category of autism. This recommendation does not match claimant's history,

and is also suspect because of the fact that no ADOS was administered. Further, as Dr. Stacy pointed out, the criteria for autism for special education services fall under Title 17 of the California Code of Regulations and not the DSM-5 – and there is no DSM-5 diagnosis in this assessment, which is required for regional center eligibility. So, even though claimant may have had autistic-like behaviors, that is not the criteria for regional center services. This report was also given little weight.

On the 2019 psychoeducational assessment, the only test geared towards autism was the GARS-3 which was a rating scale filled out by claimant's mother. The GARS-3 is designed to merely test "autistic-like" behaviors and thus render a person eligible for special education, which is a different criteria than autism under the DSM-5. The ADOS-2 was not administered.

The letters from Telos U dated July 30, 2020; Oak Grove dated October 15, 2020; and claimant's school district dated October 28, 2020, were not helpful. They provided no new information regarding any clinical assessments or tests administered and merely recounted behaviors. Moreover, at this time, claimant was already over the age of 18 and thus outside of the developmental period. Finally, even assuming these letters contained enough information to show claimant likely had autism and was misdiagnosed over the years, the earlier reports dating back to when claimant was not even three years old consistently rejected autism and every professional that saw claimant over the years, with the exception of the Autism Center, did not have a concern regarding autism. Thus, the letters recounting some autistic-like behavior in claimant's adult years do not overshadow the wealth of records that show the contrary.

Dr. McDonough's evaluation shows claimant has significant behavioral and adaptive challenges, but does not support a DSM-5 diagnosis of autism. At best, the

evaluation shows claimant has some autistic-like behaviors. The detailed recount of a prior record that was not contained in exhibits speaks volumes: it showed claimant was aggressive, bullied others, sabotaged others, didn't follow rules, left his residential treatment facilities, and even purchased AK-47 bullets. None of these behaviors are consistent with autism, rather, they are consistent with a variety of other mental health disorders. Nothing in Dr. McDonough's report showed restricted/repetitive interests, stereotyped behaviors. It is unclear from his evaluation how he arrived at the conclusion that autism "better" explains claimant's behaviors when virtually all of the behaviors described in the report are more indicative of someone with severe mental or emotional problems. As Dr. Stacy explained, just because someone might have particular behaviors does not mean it is autism. It is the totality of the records and until he was a teenager, there were no concerns regarding autism. Moreover, the screening tests administered are filled out by others regarding their opinion of claimant's behaviors; to that end, they are subjective measures. The only objective measure for autism, the ADOS, was not administered. Dr. McDonough concluded that autism was "more prominent throughout the history," but the entirety of the records, as discussed above, do not support that assessment.

14. Dr. Stacy's assessment is more consistent with claimant's historical diagnoses and educational history. She provided a diagnosis of bipolar II disorder. The DSM-5 excerpt for bipolar II disorder sounds very much like many of the behaviors that claimant has had over the years. Dr. Stacy pointed out that many of the other afflictions that claimant has would better explain his extreme behaviors. She also noted many behaviors (such as wanting to have friends, wanting a job, etc.) are not consistent with autism. Finally, she administered the ADOS and it showed claimant does not have autism. This is a standardized objective test as opposed to the subjective GADS and SRS administered by other evaluators, and it is also noted, that

when Dr. Stacy administered the CARS-3 for high functioning adults, claimant also scored outside the range for autism.

15. The record as a whole simply does not support a finding that claimant meets the diagnostic criteria for autism. Autism does not just simply "appear" when someone becomes a teenager; as the DSM-5 indicates, autism should be more than evident at an early age. With claimant, neither the Orange County Regional Center nor the myriad of clinical professionals that assessed him up to about the age of 16 ever had a concern about autism. He was never referred for special education services because of autism. Any reference to autism did not surface until his was 16 years old when he underwent an assessment at the Autism Center, and at that, they never administered the ADOS-2. Rather, they administered the CARS-2, which is merely a screening test based on reporting of behaviors. When Dr. Stacy administered the ADOS-2 in 2020, claimant's results showed no concerns regarding autism, which would be consistent with this history.

16. Claimant has never displayed *persistent* deficits in social communication, *persistent* deficits in social interaction, or restricted/repetitive and stereotyped *patterns* of behavior, interests, or activities, which are characteristic of autism. Though claimant's mother testified about behaviors that might fit into those categories, the voluminous records submitted in this case do not contain such detailed descriptions of those behaviors. It is also noted that in prior evaluations, claimant's mother described behaviors that were much more consistent with bipolar II disorder or other mental health conditions.[2] This is not to say claimant's mother is not credible; she certainly is

[2] For example, in one of the triennial evaluations, claimant's mother told the evaluator that claimant "hallucinated in the past during a manic episode" and that she

credible and wants the best for her son. But, the records are devoid of such behaviors that would indicate claimant meets the criteria for autism as opposed to other mental health disorders.

17. Additionally, although the testimony of Mr. Barth, Dr. Gehlke, and Ms. Byers and the letters from Dr. Gehlke and Mr. Barth were considered, they were given little weight. None of these individuals conducted an assessment. Ms. Byers never met claimant in person. Mr. Barth is not a licensed psychologist. As such, while these individuals were helpful in describing the adaptive challenges claimant has, they provided no useful information to cast doubt on the wealth of records that show claimant has mental health conditions other than autism.

18. Claimant does not meet the DSM-5 criteria for autism.

INTELLECTUAL DISABILITY

19. Claimant does not qualify for services under intellectual disability. Nothing in claimant's Early Start documents or consumer ID notes shows concerns regarding intellectual disability. In 2002, when claimant was assessed for special education services by his school district, his cognitive ability showed that he was above average for his age. There were no concerns noted regarding intellectual disability.

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suspected he "hurt himself in the past" because he had cut marks on his wrists. She further stated claimant would display frustration, tantrums, impulsivity, insomnia, and hypersomnia during a "depressed phase." She also indicated that when claimant was having a "depressed phase" he could be in a "depressed mood for days."

20. In 2005, when claimant was already seven years old, there were still no issues with cognitive functioning. While he struggled in certain academic areas, claimant was found to be functioning cognitively in the low average to average range. Further, his academic challenges were directly attributable to his multiple medical (as opposed to psychological) conditions that were causing him to miss a lot of school. There were no concerns expressed regarding intellectual disability. As Dr. Stacy explained, claimant was found eligible for special education services based only on speech and language impairment and other health impairment. There were no concerns regarding intellectual disability as claimant's cognitive scores and full-scale IQ of 88 took him well outside the cutoff for that diagnosis.

21. Three years later, when claimant's school district assessed him in 2008, his cognitive levels remained virtually unchanged from 2005.

22. In 2011, when claimant was 13 years old, he underwent an assessment by his school district that involved behavioral assessments. No cognitive tests were done and nothing in the report indicated a concern with intellectual disability. Similar results were rendered in 2014 in another assessment. The triennial assessment conducted when claimant was 17 years old showed his cognitive abilities were in the very low to low average range. Again, taking him outside the scope of an intellectual disability diagnosis.

23. The 2019 psychoeducational assessment administered by claimant's school district did not show any concerns regarding intellectual disability and claimant was not found eligible for special education services under intellectual disability. His cognitive skills continued to be in the low average range.

24. Dr. McDonough's evaluation showed claimant functions in the low average range, and thus, does not meet the criteria for intellectual disability. Dr. Stacy did not do any intelligence testing because the entirety of claimant's educational history, coupled with Dr. McDonough's 2020 evaluation, all showed claimant was within the low average range which is not indicative of being intellectually disabled.

25. Cognitively, claimant has consistently functioned in the average/low average level over the years, and his IQ results have placed him outside the range for intellectual disability.

CLAIMANT DOES NOT HAVE A CONDITION CLOSELY RELATED TO INTELLECTUAL DISABILITY

26. Claimant does not qualify for services under the fifth category because a preponderance of the evidence did not establish that he suffers from a condition closely related to an intellectual disability.

27. In *Mason, supra,* 89 Cal.App.4th 1119, the appellate court held that "the fifth category condition must be very similar to [intellectual disability], with many of the same, or close to the same, factors required in classifying a person as [intellectually disabled]." (*Id.* at p. 1129 [emphasis added].) Further, the presence of adaptive deficits alone, absent cognitive impairment, is also not sufficient to establish that a person has a condition closely related to an intellectual disability. (*Samantha C., supra,* 185 Cal.App.4th at p. 1486 [intellectual disability "includes both a cognitive element and an adaptive functioning element"].)

28. Nothing in claimant's Early Start documents or consumer ID notes shows concerns regarding the fifth category. To the contrary, it shows the only concern the regional center had at the time claimant turned three was his seizures, and because

they were not substantially handicapping, he did not qualify for services under the Lanterman Act. In 2002, when claimant was assessed for special education services by his school district, his cognitive ability showed that he was above average for his age and his corresponding adaptive skills showed average for his age. There was nothing that showed he had any condition that was similar to an intellectual disability or that required treatment similar to a person with an intellectual disability.

29. In 2005, when claimant was already seven years old, there were still no issues with cognitive functioning. While he struggled in certain academic areas, claimant was found to be functioning cognitively in the low average to average range. Further, his academic challenges were directly attributable to his multiple medical (as opposed to psychological) conditions that were causing him to miss a lot of school. There were no concerns expressed regarding intellectual disability. As Dr. Stacy explained, claimant was found eligible for special education services based only on speech and language impairment and other health impairment. Because of his cognitive functioning and a complete lack of any substandard performance in adaptive functioning, claimant – as Dr. Stacy stated – "clearly" did not have a condition similar to a person with an intellectual disability or required treatment similar to a person with an intellectual disability.

30. Three years later, when claimant's school district assessed him in 2008, his cognitive levels remained virtually unchanged from 2005. Although claimant's adaptive abilities, as reported by the teacher showed things like aggression, bullying, name-calling, and poor attention, there was nothing to show the adaptive scores were so low as to overcome the cognitive ability such that it could be said claimant had a condition similar to a person with an intellectual disability or required treatment similar to a person with an intellectual disability.

31. In 2011, when claimant was 13 years old, he underwent an assessment by his school district that involved behavioral assessments. No cognitive tests were done and nothing in the report indicated a concern with intellectual disability, a condition similar to a person with an intellectual disability or required treatment similar to a person with an intellectual disability. The 2014 assessment, which was similar to the 2011 assessment, was similarly unremarkable. As was the 2017 triennial assessment, which did not show claimant had a condition similar to an intellectual disability or required treatment similar to a person with an intellectual disability. This was also the last report completed during claimant's developmental period. Nothing in any subsequent reports indicated claimant suffers from a condition closely related to an intellectual disability or that requires treatment similar to a person with an intellectual disability.

CLAIMANT DOES NOT HAVE A CONDITION THAT REQUIRES TREATMENT SIMILAR TO A PERSON WITH AN INTELLECTUAL DISABILITY

32. Claimant also does not qualify for services under the fifth category because a preponderance of the evidence did not establish that he suffers from a condition that requires treatment similar to an intellectual disability.

33. Determining whether claimant's condition "requires treatment similar to that required" for persons with an intellectual disability is not simply an exercise in reviewing the broad array of services provided by regional centers (*e.g.*, counseling, vocational training, living skills training, supervision) and finding merely that a person would benefit from those services. Indeed, the appellate court has been abundantly clear that "services" and "treatment" are two different things.

That the Legislature intended the term "treatment" to have a different and narrower meaning than "services" is evident in the statutory scheme as a whole. The term "services and supports for persons with developmental disabilities" is broadly defined in subdivision (b) of section 4512 to include those services cited by the court in Samantha C., e.g., cooking, public transportation, money management, and rehabilitative and vocational training, and many others as well. (§ 4512, subd. (b); *Samantha C., supra*, 185 Cal.App.4th at p. 1493, 112 Cal.Rptr.3d 415.) "Treatment" is listed as one of the services available under section 4512, subdivision (b), indicating that it is narrower in meaning and scope than "services and supports for persons with developmental disabilities."

The term "treatment," as distinct from "services" also appears in section 4502, which accords persons with developmental disabilities "[a] right to treatment and habilitation services and supports in the least restrictive environment. Treatment and habilitation services and supports should foster the developmental potential of the person and be directed toward the achievement of the most independent, productive, and normal lives possible. Such services shall protect the personal liberty of the individual and shall be provided with the least restrictive conditions necessary to achieve the purposes of the treatment, services, or supports." (§ 4502, subd. (b)(1).) The

> Lanterman Act thus distinguishes between "treatment" and "services" as two different types of benefits available under the statute. (*Ronald F. v. Dept. of Developmental Services* (2017) 8 Cal.App.5th 84, 98-99.)

34. Thus, claimant must show that he requires "treatment" similar to a person with an intellectual disability as opposed to just that he would benefit from "services" that might benefit a person with an intellectual disability.

35. There was no testimony or evidence presented that showed claimant "requires treatment" similar to a person with an intellectual disability, as opposed to merely "services" that assist him in his day to day life. Claimant's expert testified solely about autism, and claimant's cognitive functioning is too high. Though claimant does have some adaptive challenges, given his higher level of cognitive functioning, he cannot meet the criteria for the fifth category.

SUBSTANTIAL DISABILITY

36. The "substantial disability" standard is set forth in California Code of Regulations, title 22, section 54001. Eligibility for regional center services requires not only a qualifying condition but also a substantial disability. In order to meet this standard, it is not enough to show that claimant merely has general adaptive challenges, cannot live independently, or requires assistance to meet his full potential. California Code of Regulations, title 17, section 54001, subdivision (a)(1), requires that the qualifying condition result in "major impairment" of cognitive and/or social functioning so as to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential; and the

existence of "significant functional limitations" in three or more areas of specified life activities, as appropriate to the person's age. (*Ibid.*)

Because claimant did not meet the criteria for autism, intellectual disability, or the fifth category, he does not have a qualifying condition, rendering the issue of whether he is substantially disabled in three or more areas of a major life activity moot. Put another way, because claimant does not have a qualifying condition, it is unnecessary to address whether he is substantially disabled in three or more areas of a major life activity because he is not eligible for regional center services unless he has both.

CONCLUSION

37. Two different regional centers have determined claimant does not qualify for services under the Lanterman Act. Most recently, on four separate occasions, a multidisciplinary team of at least three regional center professionals who were psychologists, doctors, or program managers determined on each occasion that claimant did not qualify for regional center services. Claimant's records show that claimant has had many mental health challenges over the years (ADHD, OCD, bipolar disorder) and has always received special education services. However, as discussed above, the records do not support a finding that claimant has autism, intellectual disability, a condition closely related to an intellectual disability, or requires treatment similar to a person with an intellectual disability.

38. There is no doubt that claimant needs some sort of assistance or services to address the challenges he faces as a result of his various mental health conditions. Claimant cannot live independently. Based on his recent experiences in the residential

facilities, he may even present a danger to himself or others due to his aggression and outbursts. If that were the standard, finding claimant eligible would be an easy task.

However, the fact that someone cannot live independently and has behavioral problems is not the standard for regional center services. Many individuals with many different mental health conditions cannot live independently and have behaviors just like those exhibited by claimant. Unfortunately, regional center services are reserved for a very specific segment of the developmentally disabled population, not anyone with a developmental disability. A person must have a qualifying diagnosis and be substantially disabled. Though clearly claimant struggles in his life, the evidence established his challenges are likely attributable to his many other diagnosed conditions as opposed to autism, intellectual disability, or fifth category.[3] Accordingly, on this record and in light of applicable law, claimant's request for regional center services must be denied.

39. These conclusions are based on the Factual Findings and Legal Conclusions as a whole. Evidence and arguments presented by the parties, and not referenced in this decision, have been considered in reaching this decision. All arguments contrary to this decision have been considered and rejected.

[3] It is important to note that the purpose of this decision is not to decide which mental disorders claimant may have; rather, it is only to decide – based on the evidence – why he does not meet the diagnostic criteria for autism, intellectual disability, or the fifth category.

ORDER

Claimant's appeal is denied.

DATE: September 28, 2021

KIMBERLY J. BELVEDERE
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.