BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT

v.

GOLDEN GATE REGIONAL CENTER, Service Agency

OAH No. 2021040413

PROPOSED DECISION

Administrative Law Judge Regina Brown, State of California, Office of Administrative Hearings, heard this matter remotely on August 9 and 17, 2021.

Claimant was represented by his father. Claimant was not present at the hearing.

Dominique Gallagher, Manager of Intake and Assessment, represented Golden Gate Regional Center (GGRC).

The matter was submitted for decision on August 17, 2021.

ISSUE

Is claimant eligible for regional center services?

FACTUAL FINDINGS

1. Claimant is an adult African-American male in his 60's. Claimant's father is a strong advocate, very involved and supportive, and serves as conservator for claimant. Claimant's younger sister resides in San Francisco. His mother resides in Southern California.

2. Claimant has resided at Canyon Manor Residential Treatment Center in Novato since 1995. Prior to that, claimant lived at Napa State Hospital (NSH) for approximately 15 years. He has never worked or lived independently. He seeks regional center eligibility based on autism/Autism Spectrum Disorder (autism or ASD).

3. On March 16, 2021, GGRC issued a Notice of Proposed Action to claimant notifying him that he is not eligible for regional center services. On April 1, 2021, claimant timely submitted a Fair Hearing Request.

4. On April 15, 2021, an informal meeting was held. After a discussion about claimant's needs, abilities and challenges, the parties agreed that claimant did not have an intellectual disability. Claimant's father contended that claimant has autism; but he was not diagnosed before the age of 18 because autism was not well known at that time. The informal team explained that GGRC has been in existence since 1966. The informal team also explained that if claimant had displayed any symptoms of autism in his developmental period, it would have been documented in his medical and school records. Instead, the informal team believed that claimant's symptoms could be accounted for by his diagnosis of schizophrenia. The informal team had reviewed the available records and, after considering claimant's father contentions, concurred with the decision to deny claimant's eligibility for regional center services.

5. This hearing followed.

Claimant's Developmental Period

6. Claimant weighed 10 pounds at birth. His parents were concerned about his development until the age of three when he began to speak two-word phrases and full sentences. He was a happy baby and laughed a lot. It is unknown if he met his early developmental milestones. His father was not concerned about his coordination and claimant learned how to ride a bike.

7. Claimant's first psychiatric hospitalization at McAuley Neuropsychiatric Hospital in San Francisco occurred at the age of nine after his parents divorced. He lived primarily with his mother after the divorce.

8. Claimant attended a private elementary school. His teachers and school personnel observed that claimant was distant, withdrawn and had difficulty with social relationships. Claimant was considered difficult to reach and teach, and there were questions as to whether he had a thought disorder or was responding to internal voices and other cues known only to claimant. Claimant attended a private high school. He did not receive special education services.

9. Claimant's Kaiser Permanente (Kaiser) medical records, including extensive ophthalmology records related to his strabismus, spanned from infancy to 1975, when he was 17 years old. A Pediatric Multiphasic Health Checkup form, dated February 6, 1971, when claimant was 12 years old, was primarily left blank. This form would have documented his parents' concerns with claimant's development, including his learning or school performance, emotional or behavior problems and mental retardation.

On September 13, 1972, when claimant was 14 years old, his doctor released him to play football after a sports-checkup. On November 29, 1972, claimant sought treatment for an injury to his arm while skiing. On December 19, 1972, claimant sought treatment for an injury to his finger after playing football.

10. Claimant was independent with his self-care needs and able to take public transportation on his own. He was able to drive and had a car. He was bright, affectionate, friendly, funny, easily made jokes, and had friends.

11. According to claimant's father, claimant had "paranoid thinking" and inappropriate behaviors and was diagnosed with paranoid schizophrenia in the 12th grade. He graduated from high school.

Post-Developmental Period

12. Claimant attended San Francisco State University (SFSU). In 1976, when claimant was 19 years old, he attempted suicide by jumping off a seven story dormitory at SFSU. He sustained extensive injuries and multiple fractures. He was hospitalized for several months and underwent several surgeries, including a splenectomy. Since the incident, he has had orthopedic issues and wore special shoes to stabilize his ankle.

13. From 1975 to 1979, claimant was hospitalized once at a neuropsychiatric institute and five times at San Francisco General Hospital for psychiatric-related concerns. In 1977, claimant attempted suicide again by cutting his throat. He was a resident of Cordilleras Mental Health Center in 1978. He was first admitted to NSH in November 1979, at the age of 22, because he was unmanageable in the other facilities due to symptoms of a thought disorder, assaultive behavior, suicide attempts, social withdrawal, and unauthorized absences.

14. According to his NSH records, claimant was re-admitted to NSH on March 30, 1983 with a diagnosis of schizophrenia, paranoid type, chronic. By 1994, he continued to experience delusional thinking, conceptional disorganization, blunted affect, lack of spontaneity, poor attention, lack of judgment, preoccupation, and active social withdrawal.

15. Claimant was discharged from NSH on January 31, 1995. A staff psychiatrist noted in the release summary that it was difficult for claimant to engage in conversation, he had poor articulation and it was difficult to understand him. Claimant was unable to respond to questions about calculations, memory, abstractions or thought content. Claimant transferred to Canyon Manor and continues to reside there.

Claimant's Canyon Manor Assessments

16. In July 2019, Claimant had reconstructive orthopedic surgery to correct damage from his first suicide attempt. He was sent to recover at Pine Ridge Skilled Nursing Facility (Pine Ridge) in San Rafael.

17. Upon his release from Pine Ridge, claimant returned to Canyon Manor on December 3, 2019. Robert S. Hausner, M.D., performed a psychiatric admission evaluation of claimant. In the history of present illness section, Dr. Hausner wrote that claimant has an extensive psychiatric history, with a prior history of autism, apparently diagnosed at age 6, with his first psychotic break occurring when he was 18 years old, and several suicide attempts. During the interview, claimant was unable to provide a coherent history. He was alert and oriented to person, place, year and month, but he did not know the exact day or date. His affect remained markedly flat with minimal ability to express a range of emotion and his thought process was slow with intermittent subvocalizing. His operational judgment was profoundly impaired with

minimal insight into his illness. Dr. Hausner diagnosed claimant with schizophrenia, paranoid, chronic, and status post-surgery, leg. Dr. Hausner noted that claimant is on psychiatric medications including Depakote, Clozapine, Risperidone, and Zofran. Dr. Hausner also noted that claimant is a smoker and listed the symptoms impacting his functioning as hallucinations, delusions, depression, social isolation/withdrawn, and history of suicide.

18. According to Dr. Hausner's December 2019 progress notes, claimant was inaudible in his speech and needed to be redirected as part of reality testing. He exhibited psychotic behavior, walked around with his eyes closed which required redirection by staff, and engaged in "touching behavior" that also required redirection.

19. According to the initial assessment conducted by Canyon Manor social worker, James Quigley, Jr., on December 6, 2019, claimant was "diagnosed with autism at age six. Other significant psychiatric symptoms emerged at age nine." Quigley, Jr., noted that claimant has good short term and long term memory, socially inappropriate behaviors, poor eye contact or keeps his eyes closed, garbled speech, and requires some assistance with dressing.

Claimant's GGRC Social Assessment

20. In July 2019, during claimant's rehabilitation from reconstructive orthopedic surgery, staff at Pine Ridge submitted a request to the Department of Developmental Services, Federal Programs Operations Section (DDS), for claimant to be evaluated for regional center eligibility. On September 10, 2019, DDS sent a Pre-Admission Screening and Resident Review (PASARR) referral to GGRC. GGRC opened the case for intake and assessment on September 12, 2019.

21. Katie Schloesser, LCSW, has been a social worker for GGRC for 14 years. On October 10, 2019, Schloesser met with claimant and his father at Pine Ridge. Claimant's father completed an application and consent for assessment and signed releases to obtain information from Pine Ridge and Canyon Manor. On the application, claimant's father did not disclose any of claimant's current or previous doctors, medical records, or hospitalizations.

22. Schloesser interviewed claimant's father to conduct a social assessment of claimant. His father described claimant's developmental history as indicated above in Factual Findings 6-7 and 10-11. His father also described claimant's current level of functioning as follows:

a. Motor/Mobility: Prior to his surgery, claimant was wheelchair bound. He now uses a walker. Although claimant's father stated that claimant was not athletic and did not play on any sports teams, his Kaiser records indicated that he played football and did ski.

b. Self-help/Life Skills: Claimant depends on staff to help him with his dressing and bathing needs. He can use utensils to eat, but cannot prepare his own food. He can use the urinal, but needs assistance with bowel movements. He smokes.

c. Cognitive Ability: Claimant loves books and was a "good enough student" to get into college. Claimant has a "narrow memory," but what he does remember is "sharp acuity." Stress and pressure effect his memory.

d. Communication Skills: Claimant's communication is very unclear and 90 percent of his expressive language is unintelligible. He usually mutters.

e. Emotional/Behavioral: Claimant does not display intentional verbal or physical aggression. He inappropriately touches others because he has no sense of boundaries. He exhibits "asocial" behaviors. He has not had access to drugs or alcohol for the past several years.

f. Social Relationships: Claimant is not a social person. He does not initiate friendships. He enjoys painting and drawing and plays the piano and banjo. He watches television and plays bingo. He reads National Geographic magazines and talks about wanting to travel. He goes on outings with his father. He likes to shop at Goodwill, eat at restaurants, and attend fairs and street events to listen to music.

23. On January 21, 2020, Schloesser and GGRC staff psychologist Telford Moore, Ph.D., interviewed claimant, his father and Canyon Manor staff. Claimant was quiet, but his verbal responses were garbled and incomprehensible. With a nod, he deferred to his father to provide information. Claimant's father stated that he moved to New York when claimant was a child and that claimant's younger sister had witnessed claimant's childhood and adolescence. Claimant's father stated that claimant's mother, a school psychologist, had made vague references about claimant having autism, but claimant's father had very little knowledge about her endeavors or resolution regarding any diagnosis during his childhood. GGRC obtained signed releases of information for San Francisco County Mental Health,[1] claimant's sister and his mother.

[1] There was no indication in the record that these records were obtained.

24. On January 21, 2020, for an unspecified reason, GGRC closed the case without a determination. Claimant was not notified of the case closure. On September 30, 2020, the case was reopened for assessment of claimant.

25. On October 19, 2020, Dr. Moore contacted claimant's sister. She indicated that she knew very little about claimant's childhood and adolescence. However, she recalled that: (a) claimant was fairly bright, but became easily frustrated in communicating his ideas which were odd or strange; (b) claimant preferred to be alone most of the time, but he regularly attended school; (c) his self-help skills were normal; (d) their mother did most things for him; (e) he had no repetitive behaviors or ideations, but he was resistant to following social rules, his good communication skills were marred by his way of thinking, and he had no friends or lovers; (f) their mother suffered from an unspecified mental illness; (g) he was diagnosed with schizophrenia at age 16, not 17 or 18; (h) he became suicidal during his first year of college; (i) he was never in special education classes, in part because he attended independent schools associated with SFSU; and (j) he started using drugs at age 14 or 15.

26. Schloesser issued the social assessment report on October 23, 2020. She recommended that GGRC secure and review available pertinent records or documentation and conduct further evaluation by GGRC's Interdisciplinary Assessment Team to determine eligibility.

27. On October 27, 2020, Schloesser and Dr. Moore spoke with claimant's father regarding the Interdisciplinary Assessment Team's observations that there was no evidence in the developmental period to indicate a diagnosis of autism. Claimant's father was displeased and asked that medical records be obtained from NSH. GGRC obtained claimant's NSH medical records as described above in Factual Findings 13-15 above.

28. On January 7, 2021, the Interdisciplinary Assessment Team comprised of staff physician Theresa Keyes Osantowski, Dr. Moore, and Schloesser met remotely with claimant's father and his friend, a licensed psychologist. The Interdisciplinary Assessment Team reiterated that there was no evidence of a diagnosis of autism in claimant's developmental period. Claimant's father was displeased. He requested that GGRC obtain claimant's records from Kaiser. GGRC obtained claimant's Kaiser medical records as described above in Factual Finding 9.

GGRC's PASARR Response

29. On March 10, 2021, GGRC sent a letter to DDS indicating that claimant was found ineligible for regional center services under State and Federal guidelines. Attached to the letter was the PASARR report completed by Schloesser. The PASARR report indicated that assessments had been completed on claimant in the areas of self-help development, speech and language development, independent living development, sensor-motor development, social development, vocational development, emotional development, and academic/educational development. Regarding the question of whether claimant was in need of specialized services, the box was checked "No," but no explanation was provided on the report as required.

30. On March 16, 2021, GGRC issued a Notice of Proposed Action to claimant denying his eligibility for regional center services.

GGRC Eligibility Determination

31. The Lanterman Mental Retardation Services Act was signed into law in 1969. In 1973, the Lanterman Act expanded regional center services to include other developmental disabilities, including autism, epilepsy, and cerebral palsy, and was

amended as the Lanterman Developmental Disabilities Act, Welfare and Institutions Code section 4500 et seq. (Lanterman Act).

DIAGNOSTIC CRITERIA FOR AUTISM SPECTRUM DISORDER

32. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5), section 299.00, sets forth the diagnostic criteria for ASD as follows:

> A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative not exhaustive):
>
> (1) Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back–and–forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
>
> (2) Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
>
> (3) Deficits in developing, maintaining, and understanding relationships, ranging for example, from difficulties adjusting behavior to suit various social contexts;

to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive):

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

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

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

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

C. Symptoms must be present in the early development. (They may not become fully manifested until social demands exceed limited capabilities, or may be masked by learned strategies in later life).

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

E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co–occur; to make co-morbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

DR. MOORE'S PSYCHOLOGICAL REPORT

33. Dr. Moore has been the staff psychologist at GGRC for over 18 years. He is board-certified in behavioral and clinical neuropsychology. Dr. Moore testified at hearing. His expert opinion testimony was persuasive.

34. Dr. Moore prepared a Psychological Review for Eligibility report. Dr. Moore met with claimant, but he could not administer the usual psychological assessments or diagnostic tools to claimant because of claimant's delusional symptoms of schizophrenia and his unintelligibility. Dr. Moore reviewed the following reports: Kaiser medical records which contained no reference to reported symptoms of autism; NSH medical records which contained no reference to reported symptoms of

autism; conservatorship documents; GGRC application for services; GGRC social assessment; history and psychiatric evaluations by Dr. Hausner; Canyon Manor initial assessment; and social services assessment prepared by Quigley, Jr.

Dr. Moore interviewed claimant's father and sister; his mother was unavailable. In his discussion with claimant's sister, Dr. Moore found that many of the activities that claimant engaged in during his developmental period were not the types of activities in which individuals with ASD engage. For example, unlike claimant, individuals with autism do not usually play team sports, they need assistance with activities of daily living, they have difficulty with communication, they exhibit repetitive behaviors, they rarely have suicidal ideation and they rarely use recreational drugs or smoke. In addition, claimant received no special education services, which is rare for an individual with ASD. However, some behaviors that claimant engaged in, such as being distant and withdrawn, and having difficulty in social relationships are associated with individuals with ASD.

Dr. Moore noted that neither claimant's father nor his sister provided contact information for claimant's mother and her history of mental illness could have provided vital information about claimant's history.

In his report, Dr. Moore noted that according to the DSM-5, ASD manifests prior to the age of three and symptoms must be present in the early developmental period. Dr. Moore noted that claimant had a well-documented history of symptomatic schizophrenia and psychiatric hospitalizations starting at age nine. Dr. Moore found that there was "evidence of emerging mental disorder in childhood; and there is evidence of manifest schizophrenia starting in adolescence and continuing to the present day."

Dr. Moore found that there was no documented evidence of ASD during claimant's developmental period. Dr. Moore opined that as defined in the Lanterman Act, claimant does not meet the eligibility criteria for ASD, cerebral palsy, intellectual disability, or seizure disorder. Dr. Moore also opined that claimant does not have a condition similar to intellectual disability, does not have treatment needs similar to individuals with intellectual disability, and does not have a developmental disability as defined in Welfare and Institutions Code section 4512. Dr. Moore concluded that claimant is not eligible for GGRC services.

Testimony of GGRC Witnesses

DR. MOORE

35. Dr. Moore provided an overview of the Lanterman Act and the DSM. In 1966, the first two regional centers were established in California. The Lanterman Act was enacted in 1969. In 1973, it expanded regional center services to include autism. The DSM-I and DSM-II did not include autism as a diagnosis. However, the DSM-II, which went into effect in 1967, interchangeably used the terms infantile autism and childhood schizophrenia. The behavioral descriptors of an autistic disorder were first described in the DSM-III in 1980.

36. The DSM-5 was enacted in 2013, and it contains the criteria to evaluate individuals for eligibility under autism, no matter the individual's age. The DSM-5 does not have a checklist for the criteria of autism and it does not require a clinician to use a checklist to determine eligibility for regional center services. Clinicians must know the criteria for ASD under the DSM-5. GGRC does not use a checklist. Claimant was evaluated under the DSM-5 as required.

37. Dr. Moore agreed that in 1957, when claimant was born, the DSM-I did not have a diagnosis of autism. Also, in 1975, when claimant was 18 years old, the DSM-II which would have applied, also did not have a diagnosis of autism. Dr. Moore agreed that claimant's medical records during the developmental period would not have recorded a diagnosis of autism because they pre-date the DSM-III.

38. Dr. Moore explained that schizophrenia is a thought disorder which has positive symptoms (hallucinations, delusions, false beliefs, severely disorganized) and negative symptoms (withdrawal, poor hygiene, poor motivation to interact). The negative symptoms of schizophrenia can be confused with ASD which is a relational disorder. State mental hospitals are where individuals with conditions, like schizophrenia, are treated through medication and therapy which is different than developmental centers where individuals with developmental disorders, like ASD, are managed and not treated.

39. Dr. Moore explained that claimant's admittance into a neurological psychiatric institute at nine years old was insufficient to establish a diagnosis of ASD. He acknowledged that, in 1967, this type of facility would have treated patients with symptoms of autism and schizophrenia. Dr. Moore further explained that when a child exhibits certain symptoms it is difficult for a clinician to distinguish between autism and schizophrenia. The younger the child, the harder it is to distinguish. However, when a child exhibits clear evidence of schizophrenia, then a clinician is better able to make the distinction and looks at the trajectory of schizophrenia especially as schizophrenia usually is symptomatic in the teenage years.

40. Dr. Moore also explained that the December 2019 records of Dr. Hausner and Quigley, Jr., which noted that claimant was diagnosed with autism at age six, was insufficient to establish a diagnosis of ASD. Dr. Moore found that there were no

underlying medical records to support their notations. However, Dr. Moore stated that if such records are located, GGRC could change its determination.

41. Dr. Moore described this as a sad case. He recognized that claimant's father has attempted over the years to obtain resources and support for his son and he is deeply committed to his son and his quality of life.

42. Dr. Moore has a master's degree in public health with a focus in health systems related to Native Americans. He is aware of the health care discrepancies in the United States between Caucasian and rich people as opposed to poor people and people of color. He is aware that historically, children of color were typically diagnosed with autism later in life. He is aware of the bias in the delivery of health care services to people of color.

43. Dr. Moore confirmed that GGRC has had several cases of determining eligibility for individuals over the age of 18 with autism. Dr. Moore insists that GGRC did its due diligence and obtained records looking for any evidence of autism in claimant's developmental period. GGRC's assessment of claimant was not influenced by racial or socioeconomic bias.

DR. KEYES OSANTOWSKI

44. Dr. Keyes Osantowski has been a staff physician at GGRC for 31 years. She is familiar with the DSM-5 criteria for ASD and confirmed that GGRC does not need a checklist of the criteria to make a determination of eligibility for regional center services. She did not meet with claimant in person because of the pandemic.

45. Pediatric medical records are useful because autism usually manifests itself early in the developmental period, around age three. In her review of claimant's

Kaiser records, Dr. Keyes Osantowski found that his mother was unable to get claimant to wear a patch for his strabismus and he was characterized as being "wiggly." However, there were no Kaiser doctor referrals to a regional center and no indication that his parents reported any symptoms related to autism.

SCHLOESSER

46. Schloesser testified that a PASARR is used for residents in a skilled nursing facility. A PASARR referral does not mean that an individual is deemed eligible for regional center services. The regional center must perform an assessment for eligibility after receiving a PASARR. If a person is determined to be eligible for regional center services while residing at a skilled nursing facility, then the skilled nursing facility receives additional funding.

47. Schloesser credibly testified that when she signed the PASARR for claimant, she was confirming that the areas of assessment described in the PASARR had been addressed during the social assessment interviews and through claimant's medical records. The social assessment interviews covered claimant's self-help development, speech and language development, independent living development, sensor-motor development, social development, vocational development, emotional development, and academic/educational development, as required on the PASARR. Schloesser acknowledged that she checked the boxes, but she did not provide a written explanation on the PASARR. She completed the form to the best of her ability.

48. Schloesser confirmed that GGRC has received referrals for individuals over the age of 18 and has made positive determinations of eligibility. Even if an individual is over the age of 18 without a specific diagnosis of ASD before the age of 18, GGRC looks for sufficient evidence of symptoms present before the age of 18 to

determine eligibility. The social assessment report assists with gathering information to review under the DSM-5 criteria.

49. Schloesser stated that she gathered all the information and records that she was made aware of to determine claimant's eligibility for services. Schloesser agreed that claimant has deficits and is in need of assistance, but opines that his deficits are not due to a developmental disability.

Claimant's Additional Evidence

50. At hearing, claimant's father provided a letter written by Price M. Cobbs, M.D., dated February 5, 1991, which was addressed to a physician at NSH. Dr. Cobbs was a board-certified psychiatrist and a friend of claimant's parents. Dr. Cobbs wrote the letter at the request of claimant's father to support the contention that claimant's condition existed before the age of 15. Dr. Cobbs never formally examined claimant or saw him as a patient.

In his letter, Dr. Cobbs explained that because he was on the board of directors of the private elementary school that claimant attended, teachers and school personnel sought Dr. Cobbs for advice regarding claimant. They observed that claimant was distant, withdrawn and had difficulty with social relationships, he was considered difficult to reach and teach, and there were questions as to whether he had a thought disorder or was responding to internal voices and other cues known only to claimant. Dr. Cobbs advised them to share their concerns with his mother and recommended a psychiatric evaluation and treatment if indicated.

51. At hearing, Dr. Moore found Dr. Cobb's letter to be unpersuasive because Dr. Cobbs did not formally assess claimant and there was no mention of autism in the

letter. The letter did not change his opinion regarding claimant's ineligibility for regional center services.

52. Dr. Hausner is a board-certified psychiatrist who oversees claimant's treatment at Canyon Manor. Dr. Hausner wrote a letter, dated April 23, 2021, in support of providing GGRC services to claimant. Dr. Hausner diagnosed claimant with schizophrenia with autistic features. Dr. Hausner opined that claimant is profoundly disabled and requires assistance with activities of daily living. Dr. Hausner wrote that claimant exhibits difficulty expressing himself and he has difficulty learning new behaviors. Dr. Hausner wrote that claimant cannot manage his own finances due to disorganized thoughts and defective operational judgment as an integral part of his developmental disability (the onset of which occurred in his early teens). Dr. Hausner concluded that as of result of his impairment, claimant is incapable of independent living and GGRC could provide needed guidance and assistance in helping him progress further and mitigate some of his disabilities.

53. At hearing, Dr. Moore found Dr. Hausner's letter to be unpersuasive and it did not change his opinion that claimant is ineligible for regional center services. Dr. Moore confirmed that the DSM-5 does not have a diagnosis of "schizophrenia with autistic features." Dr. Moore noted that there was no evidence that Dr. Hausner has any training in determining eligibility on the basis of ASD. Dr. Moore agreed that claimant is severely disabled, but opined that he does not have a developmental disability under the Lanterman Act.

54. No one testified in support of claimant's case and claimant provided no expert witness testimony.

Claimant's Contentions

55. Claimant's father has raised several arguments that he believes should result in claimant's eligibility for GGRC services.

56. Claimant's father contends that GGRC improperly closed his case. This contention is not persuasive. Schloesser described the procedure to close a case. A case may be closed for administrative reasons while Schloesser waits to receive records or more testing is performed. Once received, a case can be reopened. An applicant is not informed that a case had been administratively closed.

Schloesser credibly testified that claimant's case was closed for administrative purposes. It appears that there may have been some confusion when claimant left the skilled nursing facility and returned to Canyon Manor about whether the PASARR needed to be completed given that additional funding would not be needed at the skilled nursing facility after his discharge. Furthermore, the onset of the COVID-19 pandemic impacted GGRC's ability to obtain documents and complete the social assessment. Schloesser also testified that although claimant's case was administratively closed, she was actively obtaining records. In any event, his case was reopened and he was determined to be ineligible for services.

57. Claimant's father contends that GGRC did not conduct the social assessment within 15 days as required, and improperly delayed claimant's eligibility determination. This contention is not persuasive. Again, with the onset of the COVID-19 pandemic, the delay was not unreasonable. It is unfortunate that it took a year to complete the social assessment; but it was completed. There is insufficient evidence that GGRC unduly prejudiced claimant by the delay as he was ultimately determined to be ineligible for services. Also, claimant's father did not disclose in the application or

otherwise inform GGRC staff that medical records were available from NSH and Kaiser, which contributed to the delay in obtaining records.

58. Claimant's father contends that the PASARR screening and summary report were not accurately completed, and that GGRC made a false representation that constitutes a denial of claimant's civil rights. This contention is not persuasive. Schloesser credibly testified about her actions regarding completion of the PASARR, as stated in Factual Findings 29 and 46-49. The evidence did not establish that there was a denial of claimant's civil rights related to the PASARR.

59. Claimant's father contends that GGRC misapplied the DSM-5 criteria because the evaluators did not utilize a checklist as other treaters use to diagnose ASD. This contention is not persuasive. The evidence established that the DSM-5 does not include a checklist of criteria to diagnose ASD. Nor is GGRC required to create a checklist of criteria. The Interdisciplinary Assessment Team was well aware of the criteria for ASD under the DSM-5 in determining that claimant was ineligible for services.

60. Overall, claimant's father contends that claimant has been discriminated against based on his race, age, and disability. He states that it is difficult to find evidence of claimant's autism because treaters and clinicians were not recording this type of information for African-American children during claimant's developmental period. Furthermore, there are no records available because this is the type of situation which led to the creation of the Lanterman Act. He believes that claimant was misdiagnosed and placed in psychiatric institutions because at that time clinicians were equating autism to childhood schizophrenia. He contends that it is impossible to expect claimant to satisfy criteria that were not in existence before he became 18. Also,

he believes there is bias because claimant does not fit into the normal age group that GGRC serves.

According to claimant's father, claimant was never psychotic until he started on the medications, and he was "purely autistic" before that. He believes that claimant is not a psychiatric patient and GGRC can place him anywhere they want. He wants to have claimant released from a locked facility because claimant "needs a better life than that."

61. It is plausible that claimant may have been misdiagnosed during his childhood. It is also plausible that he may have had indicators of criteria that today could be diagnosed as ASD under the DSM-V. Unfortunately, claimant has not provided the required evidence to establish this. It is believed that at some point his treaters were told that claimant was diagnosed with autism at the age of six. However, it is claimant's burden to provide evidence to support this as well. The medical records from Kaiser and NSH did not indicate such a diagnosis at the age of six. If this evidence exists, it is claimant's burden to obtain these records. Until such time, claimant has failed to meet his burden.

Fifth Category

62. Although the parties agreed at the informal meeting that claimant was seeking eligibility under ASD, it appears that claimant's father has raised the issue in his closing argument of whether claimant is eligible under the fifth category.

63. To be considered an eligible developmental disability under the Lanterman Act, intellectual disability or a disability under the fifth category must originate before the age of 18, must continue or be expected to continue indefinitely,

and must constitute a substantial disability for the person. (Welf. & Inst. Code, § 4512, subd. (a).)

64. It is undisputed that claimant has substantial limitations in his adaptive functioning, but he has not shown that these are due to a developmental disability as defined by the Lanterman Act, as opposed to his psychiatric condition of schizophrenia, which is not an eligible condition. To the contrary, the evidence established that claimant suffered from a decline in cognitive function due to his psychiatric condition. Claimant also has not demonstrated by a preponderance of the evidence that he has a condition falling within the fifth category of regional center eligibility, that is, a disabling condition closely related to intellectual disability, or that requires treatment similar to that required by persons with intellectual disability, which arose before the age of 18.

Ultimate Findings

65. The opinion of Dr. Moore was well-reasoned and persuasive, and established that claimant does not meet the diagnostic criteria for ASD, and that his deficits and other behaviors are instead manifestations of his psychiatric diagnosis of schizophrenia. Claimant has no formal diagnosis of autism. No records during claimant's developmental period indicate that he meets the diagnostic criteria for ASD under the DSM-5 to be eligible for GGRC services. Also, claimant has not demonstrated by a preponderance of the evidence that he has an intellectual disability or a condition that falls under the fifth category.

66. All other arguments raised by GGRC and claimant were considered and were not persuasive.

LEGAL CONCLUSIONS

1. The State of California accepts responsibility for persons with developmental disabilities under the Lanterman Act. (Welf. & Inst. Code, § 4500 et seq.) The purpose of the Act is to rectify the problem of inadequate treatment and services for the developmentally disabled, and to enable developmentally disabled individuals to lead independent and productive lives in the least restrictive setting possible. (Welf. & Inst. Code, §§ 4501, 4502; *Association for Retarded Citizens v. Department of Developmental Services* (1985) 38 Cal.3d 384.) The Act is a remedial statute; as such it must be interpreted broadly. (*California State Restaurant Association v. Whitlow* (1976) 58 Cal.App.3d 340, 347.)

2. A developmental disability is a "disability which originates before an individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual." The term "developmental disability" includes autism. (Welf. & Inst. Code, § 4512, subd. (a).) A developmental disability is a disability that originates before an individual reaches age 18; continues, or can be expected to continue, indefinitely; and constitutes a substantial disability for that individual. (§ 4512, subd. (a); Cal. Code Regs., tit. 17, § 54000, subd. (b).) The term "developmental disability" includes intellectual disability,[2] cerebral palsy, epilepsy, autism, and the fifth category of disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals

[2] The term "intellectual disability" has replaced the formerly used term of "mental retardation."

with an intellectual disability. (§ 4512, subd. (a); Cal. Code Regs., tit. 17, § 54000, subd. (a).)

Handicapping conditions that consist solely of psychiatric disorders, learning disabilities, or physical conditions do not qualify as developmental disabilities under the Lanterman Act. (Cal. Code Regs., tit. 17, § 54000, subd. (c).) This is the case even when serious problems with social and intellectual functioning exist.

3. Regional center services are limited to individuals who meet the eligibility requirements established by law. It is claimant's burden to prove that he has a developmental disability, as that term is defined in the Act.

4. The GGRC Interdisciplinary Assessment Team did a thorough evaluation of the available records. There was insufficient evidence to establish that claimant suffered from ASD before the age of 18. Instead, the evidence established that his symptoms are caused by a psychiatric condition, namely schizophrenia, which is not an eligible condition for regional center services.

5. Claimant has not met his burden of establishing that he is entitled to regional center eligibility due to autism or under the fifth category. Claimant has not met his burden of establishing he has a developmental disability as that term is defined in the Lanterman Act. (Factual Findings 61 and 64.) Because there is insufficient evidence at this time that claimant has an eligible condition for regional center services, his appeal must be denied.

ORDER

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

DATE: August 30, 2021

REGINA BROWN
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.