BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT

v.

GOLDEN GATE REGIONAL CENTER, Service Agency.

OAH No. 2023010312

DECISION

Administrative Law Judge Karen Reichmann, State of California, Office of Administrative Hearings, who served as the hearing officer, heard this matter on September 13, 2023, by videoconference.

Claimant was represented by his mother, with assistance from Vanessa Simmons, P.M.H.N.P., of the Felton Institute. Claimant was not present.

Dominique Gallagher represented Golden Gate Regional Center (GGRC).

The record closed and the matter was submitted for decision on September 13, 2023.

ISSUES

Is claimant eligible for regional center services?

Should GGRC perform additional assessments of claimant?

FACTUAL FINDINGS

Jurisdictional Matters

1. Claimant first contacted GGRC regarding regional center eligibility in November 2021, and submitted an application for eligibility in May 2022. The criteria for regional center eligibility are set forth in the Lanterman Developmental Disabilities Services Act (Lanterman Act) (Welf. & Inst. Code, §4500 et seq.), and related regulations.

2. On November 21, 2022, GGRC issued a Notice of Proposed Action to claimant notifying him that his request for eligibility was denied. GGRC does not believe that claimant has a developmental disability within the meaning of the Lanterman Act.

3. On December 19, 2022, claimant timely submitted a Fair Hearing Request. He requested that GGRC "Review Dr. Ozanick's progress notes and early BHRS records and any early GGRC recs. A meeting w/Dr. Ozanick and GGRC psychiatrist + consider going over results w/family + Felton team together."

Claimant's Background

4. Claimant is the fifth of seven children born to parents from Guatemala. He lives in Marin County. He speaks both Spanish and English. He will turn 18 in December 2023.

5. Limited medical and school records were offered into evidence.

6. Claimant was assessed in Spanish at age 3 and found to be speech and language delayed. He received speech and language therapy at a public special education preschool. Claimant was reassessed in English when he began kindergarten in 2011 and was found to have adequate language skills, with the evaluator writing that he "has good language skills that he displays when he is comfortable." Claimant was offered additional speech and language special education services, but his family revoked consent and no further services were provided at that time.

7. One of claimant's older brothers died in an automobile accident when claimant was 11 years old. This tragic event was extremely traumatizing for claimant.

8. Claimant's academic performance declined during middle school and he was placed in English and math workshop classes that were co-taught by general and special education teachers. Claimant's middle school teachers became concerned about changes in his behavior when he was in the eighth grade and referred him for a psychoeducational evaluation. The evaluation was delayed due to the pandemic and took place in the fall of 2020, when claimant was a high school freshman. Claimant's mother reported to the evaluators that claimant met all developmental milestones on time and that there were no concerns during his early development.

9. As a result of the October 2020 assessment, claimant was found eligible for special education services for other health impairment and emotional disturbance. In finding claimant eligible under the category other health impairment, the special education assessment team wrote that claimant "showed limited vitality and alertness which does adversely affect his educational performance." The team identified concerns in the areas of depression, withdrawal, hyperactivity, and attention problems as warranting services under emotional disturbance. The team recommended counseling in addition to other special education services.

10. In July 2021, claimant's parents took him to the emergency room and reported that he was suicidal, not sleeping, and hearing voices. Claimant was hospitalized and diagnosed with schizophrenia. He was hospitalized for psychotic symptoms twice more in 2021.

11. Claimant has been attending the Compass Academy instead of public high school since September 2021. He continues to receive special education services under the categories of other health impairment and emotional disturbance. He was also assessed in March 2022, and found eligible for speech and language services due to impairment in expressive, receptive, and pragmatic language.

12. As part of his special education individualized education program, claimant has been receiving services from the Felton Institute since September 2021. The Felton Institute provides therapy, medication management, case management, and peer counseling to claimant through its outpatient early psychosis program.

13. The Felton Institute assisted claimant's family in applying for GGRC services.

Diagnostic Criteria for Autism Spectrum Disorder

14. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR), sets forth the diagnostic criteria for Autism Spectrum Disorder (ASD) as follows:

> A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by all of 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 or preoccupation with unusual objects, excessively circumscribed or perseverative interests).

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

C. Symptoms must be present in the early developmental period (but may not become fully manifest

until social demands exceed limited 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 comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

Diagnostic Criteria for Intellectual Developmental Disorder

15. The DSM-5-TR sets forth the following criteria for Intellectual Developmental Disorder (formerly Intellectual Disability):

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 socio-cultural standards for personal independence. 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, work, school, and community.

C. Onset of intellectual and adaptive deficits during the developmental period.

GGRC Eligibility Determination

16. Social Worker Mariana Perry (formerly Cardenas) interviewed claimant's mother by telephone (in Spanish) and interviewed claimant over videoconference (in English) in June 2022. She reviewed documents provided by the family and compiled her observations into a social assessment report. Claimant's mother reported that she became concerned about him when he was 11 years old, when his brother died. Claimant started being aggressive and not sleeping during this time. During her interviews, Perry learned that claimant has no motor or mobility impairments and enjoys bicycling and skateboarding; is able to shower and dress independently; can prepare simple meals for himself, wash dishes, and do laundry; and is teaching himself to play guitar, drums, and piano. During his interview, claimant was drawing words in different font styles and frequently showed his work to Perry. Perry was able to hold a back and forth conversation with claimant, who spoke clearly. Perry did not observe any ASD-type repetitive behaviors, and claimant's mother did not describe restricted or repetitive behaviors to Perry. Perry did not believe that claimant fit the eligibility criteria for GGRC services.

Prior to the pandemic, an applicant for regional center services was typically observed at school or elsewhere in the community as part of the intake assessment.

This practice had not yet been reimplemented at the time of claimant's assessment and he was not observed at school.

17. GGRC psychologist Telford Moore, Ph.D., performed a psychological assessment of claimant on October 4, 2022. Dr. Moore has performed eligibility assessments for GGRC for more than 20 years. Dr. Moore wrote a report with his findings and testified at the hearing. Dr. Moore spent approximately three hours with claimant and his mother.

18. With the assistance of a Spanish-language interpreter, claimant's mother completed the Adaptive Behavior Assessment System—Third Edition (ABAS-3), an assessment of adaptive skills. Based on her ratings, claimant was scored as Average and received no scores indicating substantial impairment in any of the skill areas assessed, including "social."

19. Dr. Moore did not observe claimant to display characteristic traits of either autism (such as significant social communication impairment, repetitive patterns of behavior, or restricted interests) or schizophrenia (such as pressured speech, delusions, alogia, incoherence, or hallucinations) during the assessment. Claimant was cooperative and made good eye contact.

20. Dr. Moore administered six tests to claimant: the Bender Visual-Motor Gestalt Test-Second Edition (Bender-Gestalt-II); the Childhood Autism Rating Scale-Second Edition-High Functioning (CARS2-HF); the Dot Counting Test (DCT); the Grooved Pegboard Test (GPT); the Trail Making Test (TMT); and the Wechsler Adult Intelligence Scale, Fourth Edition (WAIS-IV).

a. Claimant's scores on the Bender-Gestalt-II were classified as Average and were not suggestive of a developmental disability.

b. On the CARS2-HF, a rating scale of categories indicative of ASD, claimant's overall classification was Minimal-to-No Symptoms. Dr. Moore testified that claimant's score indicates that even if he does have ASD, it is not significantly impairing him.

c. Claimant completed the GPT with his non-dominant hand substantially slower than with his dominant hand, and completed the task using both hands at a similar time as he did with his dominant hand. Dr. Moore noted that this pattern of scores is sometimes seen in individuals with severe mental illness.

d. Claimant's score on the DCT indicated that he was applying good effort during the assessment, but that he might have attentional difficulties consistent with schizophrenia.

e. Claimant was scored at low average on both components of the TMT, indicating both poor processing speed and poor executive functioning. Dr. Moore concluded that claimant's errors may reflect attentional difficulties consistent with schizophrenia.

f. Claimant's full scale IQ was measured at 74, which is classified as Very Low. Dr. Moore compared claimant's scores with the score he received on the Wechsler Intelligence Scale for Children, Fifth Edition (WISC-V), that was administered by the school psychologist in October 2020, two years earlier. Dr. Moore observed a notable decline in all areas assessed except for processing speed. He noted that this decline is very common among adolescents who suffer the onset of schizophrenia, and not typical of individuals with ASD.

21. Dr. Moore noted that there is an overlap of symptoms between ASD and schizophrenia and that there can be disputes between practitioners regarding the

appropriate diagnosis of an individual. Dr. Moore views information regarding the individual's early developmental period to be critical in rendering a diagnosis.

Dr. Moore observed that there is no evidence that claimant displayed symptoms of ASD during the early developmental period. He concluded that claimant does not meet the diagnostic criteria for ASD. He also concluded that claimant did not meet the diagnostic criteria for intellectual disability because his intellectual decline is the result of his schizophrenia, and because his score on the ABAS-3 did not indicate deficits in adaptive functioning. Dr. Moore also concluded that claimant did not qualify for eligibility under the "fifth category" because he does not have a condition similar to intellectual disability or have treatment needs similar to individuals with intellectual disability. Dr. Moore concluded that claimant does not have a developmental disability within the meaning of the Lanterman Act.

22. Staff Physician Theresa Keyes, M.D., has worked for GGRC for more than 30 years. She reviewed all documents provided by claimant, but did not examine or interview claimant or his mother. Dr. Keyes testified that she saw no indication that claimant exhibited behaviors indicative of ASD in the early developmental period, and no indication that anyone in either the school or healthcare setting ever suspected that he had ASD. Claimant's referral for speech and language services at age three appears to have reflected issues with articulation and not the type of communication deficits associated with ASD. GGRC found no record of claimant having been referred for services prior to 2021. If claimant had been referred to GGRC at age 3 and only exhibited speech and language deficits, it is unlikely that he would have been found eligible at that time. Dr. Keyes believes that if anyone who provided speech and language therapy to claimant had suspected ASD, he would have been assessed at that time. Dr. Keyes believes that claimant is not eligible for regional center services.

Claimant's Evidence

23. Claimant's mother reported that claimant was different than her other children, mainly played with his brothers, and did not play with friends outside of school. She stated that around age 6, he became distant, and around age 6 to 8, claimant became frequently angry. He would sometimes throw things and refuse to eat. After his brother died, his symptoms became worse. She did not describe claimant demonstrating restricted, repetitive patterns of behavior, interests, or activities during early childhood.

24. Three individuals from the Felton Institute wrote letters in support of claimant's appeal; one also testified at the hearing.

a. Logan Moody took over as claimant's clinical case manager in July 2023. Moody has a master's degree in clinical psychology. Moody holds both an associate professional clinical counselor license and an associate marriage and family therapist license, and is working towards full licensure as both a licensed marriage and family therapist and licensed professional clinical counselor. Prior to working at the Felton Institute, Moody worked for three years with special education students, including many with ASD. Moody has worked on teams which assessed children for ASD.

Moody has met with claimant's family, teacher, and social worker, and has observed him at school. Claimant has a paraeducator with him for support throughout the school day and there are only two other students in his class.

Moody reported that claimant followed instructions well, but did not interact with peers during school recess and did not make eye contact. Moody spoke with claimant's teacher and social worker, who reported that claimant will only talk about

and engage with his particular interests (skateboarding, cars, guitar, and the "Magic the Gathering" card game) and becomes upset if a peer does not share his interests.

Moody reported that it took Felton staff multiple interviews with claimant's mother in order to build trust and provide more comprehensive information regarding claimant's early development. Moody believes that claimant's family revoked consent for special education services due to fear, because some family members were undocumented immigrants.

Moody believes that an ASD diagnosis is fitting in light of claimant's deficits in social skills and restricted interests. Moody noted that claimant's psychotic symptoms have stabilized on his medication, and believes that the social deficits and restrictive interests claimant continues to exhibit therefore reflect ASD.

b. Vanessa Simmons, P.M.H.N.P., took over claimant's psychiatric care about six months ago. She believes that claimant meets the diagnostic criteria for ASD and that his primary diagnosis is ASD rather than schizophrenia. She cited a study that found that psychosis symptoms are present in up to 34.8 percent of patients with ASD. She believes claimant's mother has repeatedly reported that claimant is "fine" and met early developmental milestones because of cultural norms, stigma, and fear of diagnosis. Simmons wrote that in her interactions with claimant, he demonstrates deficits in social-emotional reciprocity, including a flat affect. She noted that he struggles to maintain peer relationships and that his mother reported this has been consistent since early childhood. She added that he forces conversation to his niche interests and plays with a small toy in consistent patterns during his appointments with her.

c. Natalie Gougeon, LCSW, has been providing weekly therapeutic services to claimant for more than eight months. She wrote that claimant's aggressive behavior has improved, but that social deficits persist, including isolation, overly serious mood, abnormal eye contact, limited peer relationships, restricted interests, requiring prompting, restricted focus in interactions, and difficulty with receptive communication. She wrote that is functioning has not improved at the Compass Academy sufficiently to enable him to return to a public school, which he desires.

25. Felton Institute staff believe that claimant's family did not seek services for him due to cultural stigma, and concerns over their immigration status. They believe that had the family not revoked consent for special education services when claimant was 6 years old, he would have been assessed and diagnosed with ASD. The Felton Institute staff request that GGRC perform a partial re-assessment of claimant, including re-interviewing his mother and observing him at school.

26. Felton Institute staff pointed to progress notes prepared by Felton's psychiatrist Krystal Ozanick, M.D. Dr. Ozanick reviewed claimant's medical records, including an assessment by a clinician named Sandra Ramirez in 2012, when claimant was 6 years old. Per Dr. Ozanick, Ramirez wrote that claimant was referred by his school for extreme introversion, minimal interaction with peers, no friends, and poor eye contact, and that he was selectively mute and only speaking with family. Ramirez wrote that claimant was referred to GGRC when he was younger "due to speech development" and that "pronunciation and articulation were an issue." Ramirez's assessment was not provided to GGRC and was not offered into evidence. GGRC has no record of claimant having been referred for services prior to 2021. Dr. Keyes was asked about Ramirez's note during her testimony, and it did not change her opinion that claimant does not have ASD. She believes Ramirez's note is more suggestive of

prodromal symptoms of schizophrenia, and reiterated that there was no evidence that anyone ever suspected claimant of ASD during the early developmental period.

27. An Informal Fair Hearing meeting was held on January 17, 2023. Dr. Moore was present as was a second GGRC psychologist. Claimant's former Felton Institute case manager also attended, and told the team that Dr. Ozanick had modified her diagnosis of claimant from Schizophrenia, unspecified, to Bi-Polar with psychotic features. Dr. Moore testified that no other new evidence was provided at the meeting, and that the team offered to speak with Dr. Ozanick. Dr. Moore and Dr. Keyes confirmed that GGRC has reviewed all evidence that has been provided by claimant. No BHRS records were provided.

Ultimate Findings

28. The evidence was insufficient to establish that claimant is substantially disabled by an eligible condition. Claimant has never been formally diagnosed with ASD or intellectual disability. There was no evidence that anyone in the healthcare or school environment suspected that claimant has ASD until the practitioners at the Felton Institute endorsed an ASD diagnosis within the last year. Dr. Moore assessed claimant and concluded that he does not meet the diagnostic criteria for either ASD or intellectual disability, and does not qualify for eligibility under the fifth category. Dr. Keyes concurred. Their opinions were persuasive and consistent with the evidence provided by claimant.

The opinions of the Felton Institute staff are based heavily on inferences and speculation, are not corroborated by the evidence, and do not establish that it is more likely than not that claimant has a developmental disability as defined in the Lanterman Act.

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" refers only to intellectual disability, autism, epilepsy, cerebral palsy, and what is commonly referred to as the "fifth category." (Welf. & Inst. Code, § 4512, subd. (a).) The fifth category refers to "disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability." (*Id.*)

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).)

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 Lanterman Act.

4. GGRC's eligibility team performed a thorough evaluation of claimant and reviewed all records provided by his family and the Felton Institute. GGRC determined that he does not have a developmental disability within the meaning of the Act. There was insufficient evidence to rebut this persuasive evidence. (Factual Finding 28.)

5. GGRC has performed all actions requested on the Fair Hearing Request. All evidence provided has been reviewed and considered and a meeting was held with the family and a representative from the Felton Institute to explain GGRC's eligibility determination. (Factual Findings 3 & 27.)

6. The suggestion by the Felton Institute staff that GGRC should re-assess claimant is rejected. Claimant has been given ample opportunity to provide evidence in support of his application for eligibility for well more than a year, including at the hearing. The evidence at the hearing, including the testimony of claimant's mother, did not suggest that GGRC's determination is likely to change following a reassessment.

7. Claimant has not met his burden of establishing that he is entitled to regional center eligibility due to autism spectrum disorder or intellectual developmental disability, or under the fifth category, or that a reassessment is warranted. Accordingly, his appeal is denied.

ORDER

Claimant's appeal is denied.

DATE:

KAREN REICHMANN

Administrative Law Judge

Office of Administrative Hearings

NOTICE

This is the final administrative decision. Each party is bound by this decision. Either party may request a reconsideration pursuant to subdivision (b) of Welfare and Institutions Code section 4713 within 15 days of receiving the decision, or appeal the decision to a court of competent jurisdiction within 180 days of receiving the final decision.