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

## In the Matter of:

## CLAIMANT

## and

## WESTSIDE REGIONAL CENTER, Service Agency

## DDS No. CS0020140

## OAH No. 2024080790

## DECISION

Irina Tentser, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter on November 14, 2024, at Westside Regional Center, located at 5901 Green Valley Circle, Suite 320, Culver City, California 90230.

Sonia Tostado, Westside Regional's Director's Designee, represented Westside Regional Center (WRC). (WRC staff psychologist, Dr. Karesha Gils, observed the fair hearing.)

Claimant, an adult, was represented by her authorized representative, Claimant's Mother. Claimant was not present at the fair hearing. (Claimant and Mother are not identified by name to protect their privacy.)

## ISSUE

Whether Claimant is eligible for regional center services under the Lanterman Developmental Disabilities Services Act (Lanterman Act)?

## EVIDENCE RELIED ON

WRC: Exhibits 1-12; Testimony of Thompson Kelly, Ph.D., WRC Intake Manager and licensed psychologist.

Claimant: Exhibits A-M; Testimony of Mother, Marie Johnson, Psy.D., and Brenda Osorio, Psy.D., both licensed psychologists at Providence St. John's Child and Family Development Center.

## FACTUAL FINDINGS

### Jurisdictional Matters

1. Claimant is 18 years old. She seeks regional center services based on claims of autism spectrum disorder (ASD).

2. Claimant's application for eligibility for regional center supports and services was processed at WRC in April 2024, when Claimant was a minor. (Claimant turned 18 years old in October 2024.) As part of the application process, Claimant was

fully assessed and evaluated by the multidisciplinary assessment team at WRC (WRC team). The WRC team was composed of a neurologist, psychologist and several counselors. WRC conducted a psychosocial assessment and a psychological assessment of Claimant as part of the intake process.

3. The psychologist who evaluated Claimant on behalf of WRC in May 2024 diagnosed her with Major Depressive Disorder, Generalized Anxiety Disorder (with panic disorder), Separation Anxiety Disorder and Obsessive-Compulsive Disorder (requiring further assessment). WRC also reviewed documents provided by Claimant, including a private psychological evaluation dated August 16, 2023, submitted by Mother, which included diagnoses of Obsessive-Compulsive Disorder (OCD) (with fair insight) and ASD without accompanying intellectual and communication impairment, level 1. (There are three levels of ASD. ASD level 1 describes individual with autism who require support but have low support needs. ASD level 2 describes individuals with autism who require substantial support. ASD level 3 describes individual with autism who require very substantial support.)

4. On July 31, 2024, the WRC team met and reviewed the information gathered about Claimant during WRC's evaluation process. The team determined Claimant was not eligible to receive services under the Lanterman Act (Welf. & Inst. Code, § 4500 et seq.) because she does not have a qualifying developmental disability. WRC notified Mother of its decision by letter dated August 13, 2024 (Notice of Action (NOA). (Exhibit 4, p. A18.)

5. The NOA explained that "[Claimant] is not substantially handicapped by intellectual disability, cerebral palsy, epilepsy, [ASD] or other conditions similar to intellectual disability as referenced in the California Welfare and Institutions Code Section 4512 and Title 17 of the California Administration Code Section 54000."

(Exhibit 4, p. A18.) Rather, WRC determined Claimant's challenges and concerns were better explained by Claimant's mental health diagnoses. WRC's follow-up recommendations included referring Claimant to Family Resource Center for community supports and services, the Department of Mental Health for ongoing mental health support, and to consider a referral to the Department of Vocational Rehabilitation for job training and support. (Exhibit 9.)

6. On August 19, 2024, Mother filed a Fair Hearing Request appealing WRC's decision denying Claimant eligibility for regional center services. (Exhibit 4.) The basis for the appeal was stated as, "[Mother] refute[s] [WRC's] finding that [Claimant] does not meet the requirements for eligibility, including [WRC's] assessment denying the diagnosis of [ASD]." (*Ibid.*)

7. After the appeal was filed, in early October 2024, WRC conducted a multidisciplinary observation and determined Claimant did not present with socialization and communication deficits. WRC further determined Claimant did not display repetitive behaviors and Claimant's scores on assessments conducted during the observation "indicated clinically insignificant scores for ASD diagnostic criteria." (Exhibits 2 and 7.) The WRC thereafter maintained its original determination Claimant is not eligible for regional center services and supports.

## Background

8. Claimant lives with her Mother, father, and an older sister, who is twenty-four years old. She was healthy at birth and met all developmental milestones at the age-appropriate times. Mother was diagnosed with extreme anxiety and agoraphobia during the third trimester of her pregnancy with Claimant. (Exhibit D, p. Z41.) Mother reported to WRC that there is a family history of schizophrenia; Claimant's maternal

uncle was diagnosed with schizophrenia. (Exhibits 5, p. A23; 6, p. A27.) Despite Claimant's unremarkable developmental history, Mother reported concerns with Claimant's affect and behavior from a young age. However, there is no record of Claimant being diagnosed with any developmental disability prior to August 2023.

9. No school records were submitted into evidence by Claimant. Based on Mother's report and information contained in evaluations and assessments submitted by the parties, Claimant attended general education classes throughout her Kindergarten through 12th grade public school education and graduated from Venice High School with a high school degree in June 2024. She was achievement oriented and has a history of performing well academically. (Exhibit 8, p. A54.)

10. Claimant's school attendance became irregular around the third grade, when she began to experience panic attacks and her school attendance became irregular, missing many days and classes, as Claimant did not feel well in a classroom setting. Despite Claimant's severe psychiatric issues, Claimant never had an IEP based on emotional or mental health challenges, or for other reasons. There was no evidence presented that Claimant experienced academic delays during her primarily education. (Exhibit 6, p. A27.) Further, there was no IEP was requested by Mother after Claimant, then a 16-year-old minor attending high school, was diagnosed with ASD in August 2023. (Exhibit 8.)

11. There is a history of diagnosed mental health diagnoses for Claimant since childhood. Despite Claimant's challenges, with strong Mother support, and mental health treatment, Claimant maintained friendships and was involved in the Girl Scouts for ten years growing up. However, Claimant's functioning began to deteriorate further in early adolescence. From 2021 to approximately 2023, Claimant attended weekly therapy sessions with a psychologist, with a treatment plan that included

medication. At the time she was diagnosed with Generalized Anxiety Disorder and Specific Phobia, Other. Based on Claimant not making as much progress in treatment as would be expected after two years, she was referred for a psychological evaluation. After the evaluation, in August 2023, the evaluator diagnosed Claimant with Obsessive-Compulsive Disorder (OCD), with fair insight and ASD, without accompanying intellectual and communication impairment, level 1. Claimant has not undergone treatment for OCD. (Mother's Testimony.)

12. In the fall of 2023, Claimant was accepted to Montana State University during her senior year at Venice High School and was awarded a scholarship with an intended major of Paleontology. She was also accepted to University of California, Davis, and University of California, Riverside. However, during the second semester of twelfth grade, in February 2024, Claimant refused to continue to attend high school and her Montana State University college acceptance and scholarship were revoked. Mother stated she requested that Claimant's high school place her on a 504 plan after Claimant began to miss school. (A 504 plan is formal agreement between the family and the school ensuring that proper accommodations are made for children with medical or psychiatric conditions, allowing the children to receive education.) Claimant was not placed on a 504 plan by the school but, the school informally provided accommodations to Claimant could graduate and receive her high school degree. (Mother's Testimony.)

13. Claimant graduated with a high school degree in June 2024 with informal accommodation by her school's teachers and administrators. She is currently a community college student, attending Santa Monica Community College (SMC) and is enrolled in online classes only. Claimant attended one in person class at SMC for the first four weeks of the fall 2024 SMC semester but was dropped from the class because

she stopped attending the course in person, reporting to Mother she felt like she was going to die when she was required to attend in person. As of the date of hearing, Claimant is increasingly isolated, rarely leaves her home, spending most of her time in her bedroom with her service cat. She does not have a driver's license and has not been able to maintain employment because of her inability to adhere to a working schedule. (Mother's Testimony.) Claimant is independent in all dressing, personal hygiene, and grooming tasks, but resists the tasks and requires prompting. Mother attributes Claimant's challenges primarily to the developmental disability ASD and seeks supports and services from WRC to assist Claimant and her family.

## Claimant's Psychological Evaluations and Treatment History

### JUNE 24, 2016 PSYCHIATRIC EVALUATION FOR MEDICATION SUPPORT

14. On June 24, 2016, Claimant, then nine-years-old was referred for a psychiatric medical evaluation. (Exhibit D.) Claimant had been seeing a therapist for 18 months at the time of the psychiatric evaluation. The evaluation was performed by Brandy Cohen Brown, M.D. at Vista Del Mar Child & Family Services. Dr. Brown described Claimant's primary symptoms as follows:

> 9yo [Claimant] for initial eval with both parents and therapist. [Claimant] with peculiarities since birth. [Mother] reports unusual affect and sensory imtegration [*sic*] challenges since birth. Has struggles with variations of anxiety for several years with a recent exacerbation of symptoms that prompted psychiatric eval. [Claimant] is paralyzed by change and needs excessive preparation for anything new. [Claimant] resists going to school every day

> reporting that she is both anxious and does not feel well. [Claimant's] limitation have profoundly affected family with regard to opportunities and plan restrictions. Of note, [Mother] suffers from extreme agoraphobia so is uniquely well-suited to manages [*sic*] [Claimant] struggles-that siad [*sic*] admits that [Mother] is struggling with caregiver burnout herself. Per parents [Claimant] is limited in her activities due to her symptoms. Parents also report that [Claimant] lies routinely in order to avoid getting in trouble. Of note, parents are gently disciplinarians at the strongest.

(Exhibit D, p. Z40.)

15. During evaluation, Claimant's developmental milestones were described as "flat affect" during infancy (0-3 years old); "sensory integration challenges" during early years (4-6 years old); and "sensory integration challenges" and "regular dishonesty" during latency (6-11 years old). (Exhibit D, p. Z42.) The environmental stressor identified throughout the developmental milestones was "mom with agoraphobia." (*Id.*)

16. Dr. Brown diagnosed Claimant with panic disorder with agoraphobia with a recommended treatment plan of continuing weekly therapy and starting on the medication Zoloft. (Exhibit D, p. Z42.) Dr. Brown observed Claimant's mood to be anxious, with a "flat" affect, slowed speech, alert cognitive functioning. (*Ibid.*) Dr. Brown further commented, in evaluating Claimant's comprehensive mental status, "unusual affect, calculated, incomplete inaccurate responses. Focused on providing the most favorable response. No thoughts of self harm." (*Ibid.*)

## NOVEMBER 12, 2018 VISTA DEL MAR CHILD AND FAMILY SERVICES – OUTPATIENT SERVICES - TRANSFER SUMMARY

17. On November 12, 2018, Claimant, then 12-years-old, refused to continue therapy with the therapist she had been seeing weekly since approximately 2015, Joan Habschmidt, MA, LMFT. (Exhibit B.) As a result, Claimant and Mother requested a transfer to a new therapist. In the transfer summary, Ms. Habschmidt, described Claimant's presenting problems at the time she began treatment in February 2015 as including: intense anxiety, especially separation anxiety; nausea, crying and disorientation when family would embark on outings; pleading to stay home from school saying she was sick; refusing to eat because of stomach pains; and a panic attack at Disneyland which prompted the family to leave the park and precipitated the referral to therapy treatment. (*Ibid.*) Ms. Habschmidt further wrote that the parents described Claimant with "peculiarities since birth," such as "unusual affect and sensory integration challenges." (*Ibid.*) Claimant was also described as "paralyzed by changed" and needing "excessive preparation for anything new." (*Ibid.*)

18. Claimant's relevant history was described as anxiety with symptoms including headaches, stomach aches, fear of vomiting, fidgeting, and fear of leaving the home. (Exhibit B, p. Z4.) Ms. Habschmidt also described Claimant as "very shut down when it comes to expressing feelings" and recently starting to cut with Mother discovering four scratch marks on Claimant's arm. (*Id.*)

19. Claimant's course and response to treatment was described as consisting of weekly therapy for three years as of 2018. Ms. Habschmidt described Claimant as an anxious 12-year-old with "minimal reflective capacity" and often being "out of touch with emotions." (Exhibit B, p. Z4.) Claimant was described as trusting herself more in each session and being able to eliminate separation anxiety and fear of leaving the

house for family outings until she started cutting herself and refusing to come back to treatment with Ms. Habshmidt and requested transfer to another therapist.

20. Ms. Habschmidt described the parent-child relationship as "one of insecure attachment," with Claimant identifying with Mother by sharing Mother's problem of anxiety. (Exhibit B, Z5.) A reduction of Claimant's dependency on Mother was a treatment goal as Claimant slept with Mother 70 percent of the time, but "parents never enforced it and [Claimant] remains quite dependent on her [Mother]." (*Id.*)

21. At the time of the treatment transfer to a new therapist, Ms. Habschmidt assessed Claimant's prognosis as "good/guarded," with the self-assessment by Claimant or parents as "somewhat improved," and recommended for Claimant to continue her present medication regimen. (Exhibit B, p. Z5.) Claimant was subsequently transferred to another therapist at Vista Del Mar Child and Family Services for outpatient services.

## AUGUST 6, 2019 VISTA DEL MAR CHILD AND FAMILY SERVICES – OUTPATIENT SERVICES - TERMINATION SUMMARY AND TREATMENT PLAN QUARTERLY REVIEW

22. On August 6, 2019, when Claimant was 13 years old, Claimant's individual therapy treatment with her therapist, Theodore Lopez, MSW, was terminated because she met her treatment plan goals. (Exhibits A and C.) The stated reason for the termination was that "[Claimant] no longer requires individual therapy services as symptoms can be managed with coping skills and medication only services. [Claimant] and Mother reported [Claimant] has an increased ability to self-regulate when taking prescribed medication and utilizing her coping skills (breathing, counting)." (Exhibit A.)

23. Claimant's prognosis at the time of the treatment termination was assessed as "fair," as "[Claimant] has increased ability to self-regulate anxiety without mother's help." (Exhibit A, p. Z2.) Ms. Lopez recommended Claimant continue to take her discharged medication, Prozac, and utilize coping skills to manage symptoms.

## CLAIMANT'S TREATMENT AT THE CHILD AND FAMILY DEVELOPMENT CENTER – SAINT JOHN'S HEALTH CENTER – 2021 TO JULY 2024

24. Claimant's anxiety symptoms began to increase about a year after termination of treatment in August 2019 during the COVID-19 pandemic. (Exhibit 8, p. A53.) In 2021, at age 14, Claimant began treatment at Providence St. John's Child and Family Developmental Center (PSJ CFDC). She met with three therapists over the course of the next few years. From 2022 through February 2024, Claimant was in treatment with Brenda Osorio, Psy.D., attending weekly therapy sessions at PSJ CFDC or remotely via Zoom after Claimant to refused to attend the sessions in person. During her treatment with Dr. Osorio, in August 2023, Claimant was referred for a psychological evaluation at PDS CFDC. (Exhibit 8.)

### Hearing Testimony of Brenda Osorio, Psy.D. – 2022 to 2024 Treatment of Claimant

25. Dr. Osorio, Claimant's former therapist at PSJ CFDC, credibly testified regarding her treatment of Claimant from February 2022 through July 2024. At the time Claimant began treatment with Dr. Osorio, she was diagnosed with Generalized Anxiety Disorder and Specific Phobia, other. Dr. Osorio testified that her treatment of Claimant was exposure based and consisted of dialectical behavior therapy to address Claimant's anxiety. The focus was to provide Claimant with tools to cope with her anxiety. Because Claimant was not progressing in treatment as much as would be

expected, Dr. Osorio and Mother referred Claimant for a psychological evaluation at PSJ CFDC. As previously described above, after the psychological evaluation, in August 2013, Claimant was diagnosed with OCD, with fair insight, and ASD, without accompanying intellectual and communication impairment, level 1. (Exhibit 8.)

26. During Dr. Osorio's treatment, Claimant became depressed and stopped attending high school in person in February 2024. Dr. Osorio stopped treating Claimant in July 2024. Dr. Osorio shared her observations of Claimant at hearing, including, that Claimant struggled to read social cues, was disconnected from her emotions, and looked at Mother in joint sessions when providing responses. Dr. Osorio stated that there was a disconnection between Claimant's emotions and her behavior. As an example, Dr. Osorio described that in their termination session Claimant stated she was feeling sad but was smiling the whole time. Dr. Osorio stated Claimant felt overwhelmed by anxiety in social situations despite using her coping skills and needed an extended amount of time, several weeks, to recharge after exposure to social environments.

27. Claimant also had difficulty with routine changes and a connection to objects. For example, Dr. Osorio described that after the family car was changed due to a car accident, Claimant was so distraught by the change that she refused to go to school and therapy sessions. Dr. Osorio also described Claimant's sensory sensitivities, including a refusal to wear clothes that did not feel right because of her texture sensitivities and inability to function in noisy environments, such as when attending baseball games, due to overstimulation.

28. Dr. Osorio observed Claimant had difficulty conducting small talk in social situations, was blunt in her communications without realizing how Claimant's statements affected others, and had a disconnect with literal thinking. For example,

Claimant struggled to understand idioms. Dr. Osorio opined Claimant engaged in "masking" to hide her issues by imitating and copying her friends. (Masking, also known as camouflaging, is a learned strategy that autistic people use to appear neurotypical and blend in with society and may involve hiding or suppressing autistic behaviors, mimicking the behaviors of others, and developing social scripts.) Dr. Osorio opined that based on Claimant's unsuccessful treatment to address her issues since she was eight years old, including medication and therapy, further assessment was necessary to explain Claimant's behavior other than anxiety.

29. Dr. Osorio testified Claimant's issues were not initially substantially disabling when she began treating Claimant, but increased over time, culminating in Claimant refusing to attend her in person therapy sessions and high school classes. Claimant reported to Dr. Osorio at that time she was overwhelmed by everything. Based on Claimant's lack of progress in therapy, treatment with Dr. Osorio was terminated in July 2024 for Claimant to pursue a higher level of care at St. John's.

## August 16, 2023 Psychological Evaluation of Assessor Marie Johnson, Psy.D.

30. Over the course of four in-person, approximately two-hour sessions, on June 19, 22, 27, 30, and August 1, 2023, Marie Johnson Psy.D., a clinical psychologist at PSJ CFDC, conducted a psychological evaluation of Claimant when she was 14 years old. Dr. Johnson then issued an August 16, 2023 report of her evaluation. (Exhibit 8.) Dr. Johnson credibly testified at hearing regarding her evaluation and opined that based on her observations and her report's findings, Claimant should be found eligible based on the developmental disability of ASD for regional center services under the Lanterman Act.

31. As part of the psychological evaluation, Dr. Johnson administered several psychological assessment procedures (i.e. tests), including the Autism Diagnostic Interview – Revised (ADI-R); Autism Diagnostic Observation Schedule-2, Module 4; Behavior Assessment System for Children, Third Edition (BASC-3); Children's Yale-Brown Obsessive-Compulsive Scale (CY-BOCS); House-Tree Person; Millian Adolescent Clinical Inventory-II (MACI-II); Multidimensional Anxiety Scale for Children, Second Edition (MASC 2), Sentence Completion, Thematic Apperception Test (TAT); and Wechsler Intelligence Scale for Children, Fifth Edition (WICS-V). (Exhibit 8.) Dr. Johnson also reviewed Claimant's birth and developmental history; past medical history; past psychiatric and intervention history; educational history; and strengths. Claimant and Mother were both interviewed by Dr. Johnson.

32. At the time of the assessment, Claimant reported to Dr. Johnson she had one friend since sixth grade, and that this friend had introduced her to five others who were in Claimant's friend group, were supportive, understood Claimant's anxieties, and had shared interests. (Exhibit 8, p. A53.) Claimant also reported she was in a romantic relationship, sometimes spent time at friends' houses, but was anxious about contamination, which she coped with by washing her hands and "trying not to touch anything." (*Id.*) At the time of the evaluation, Dr. Johnson assessed Claimant's strengths as having a significant number of interests Claimant felt passionate about and took joy in, including camping, spending time outdoors, drawing, painting, baking, dinosaurs and animals. (*Id.* at p. A54.) Claimant's goals included being a paleontologist and working in a natural history museum. Additionally, Claimant had a group of friends who she enjoyed spending time with and whom she felt were supportive and understanding as well as a strong family support system. (*Id.* at p. A55.)

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33. Claimant's mother reported to Dr. Johnson that Claimant had a history of making rude or socially inappropriate comments to others, appeared to be unaware of the impact her comments had on others, and became upset when Claimant did not understand why her comments were considered offensive. (Exhibit 8, p. A53.) Mother also reported to Dr. Jonson that she had spent significant time teaching Claimant social skills, such as being polite, not interrupting, greeting people when she sees them, and explaining why some comments are considered rude. (*Id.* at p. A54.) Mother also reported that despite Claimant's healthy growth and development in all areas, Mother felt concerned about Claimant, describing Claimant as "lethargic" in her early years, not crying often but not seeming happy, and generally showing little expression. (*Id.* at p. A52.) At the time of the assessment, Claimant slept with Mother each night, consistent with Claimant's history of difficulty separating from her Mother.

34. Claimant reported to Dr. Johnson that she tries to act like other people to try to fit in. Mother also reported Claimant engages in mimicking social behavior. (Exhibit 8, p. A54.) Claimant reported that emotionally, she feels irritated and stressed when others don't do things efficiently, at loud noises, and when she doesn't understand jokes. (*Ibid.*) She stated to Dr. Johnson that the things that make Claimant feel happy include playing board games, video games, dinosaurs, eating certain foods, and getting things she wants. (*Ibid.*) Claimant further reported she feels sad when a pet dies or when she has lost something she has grown attached to such as the family car, a character in a video game, or other inanimate objects. (*Ibid.*) Based on Claimant and Mother's report, Dr. Jonson stated Claimant is sensitive to textures (i.e., mushy versus crunchy foods, clothing materials) and loud noises (i.e., yelling, loud talking, scraping noises from brakes, and items banging). (Exhibit 8, p. A53.)

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35. Claimant's past medical history, as reported by Dr. Johnson, included Claimant taking both Zoloft and Prozac since the approximate age of nine. Dr. Johnson's assessment took place during a time Claimant transitioned from taking Zoloft, 100 mg, to Prozac, 20 mg, and back again because Claimant did not feel Prozac was effective. The evaluation did not discuss whether the transition between the medications during the assessment dates had any impact on Claimant's observed demeanor and behaviors.

36. Claimant's anxiety symptoms began when she was eight years old. At the time of her evaluation, Claimant reported worries to Dr. Johnson that included many areas, including change, crowds, something happening to a family member, school performance, contamination, vomiting, and being able to work in the future because of her anxieties. (Exhibit 8, p. A54.) Claimant described avoiding speaking to peers at school because she does not know what questions they may ask her. (*Id.*)

37. Claimant stated to Dr. Johnson that she has panic symptoms that occur once or twice a month and can last up to two hours. (Exhibit 8, p. A54.) During her panic episodes, Claimant reported to Dr. Johnson she sweats, starts shaking, has difficulty breathing, feels nauseous, and her heart races. (*Id.*) Additional situations which cause Claimant to experience panic symptoms included times before school when she is stressed or nervous, being in a crowd of people, loud music, high temperatures, high humidity, being around someone who is intoxicated, when someone is ill, and when things "aren't just right." (*Id.*) Claimant does not like to sweat or exert herself physically because she is fearful it will lead to a panic attack.

38. During her evaluation, Dr. Johnson observed Claimant was appropriately dressed and well-groomed, denied suicidal or homicidal ideation, and had clear and goal directed through processes. (Exhibit 8, p. A55.) Dr. Johnson noted Claimant's

demeanor was "reserved, and [Claimant] presented as polite and cooperative." (*Id.*) She also described Claimant as demonstrating appropriate use of a social smile when, for example, greeting or responding to Dr. Johnson's smile. Otherwise, Claimant's expression was described as "generally neutral." (*Id.*) While Dr. Jonson noted that Claimant responded to all questions asked of her, Claimant did not engage in back-and-forth conversation with Dr. Johnson. Claimant reported being highly anxious about Dr. Jonson's testing, bouncing her leg up and down and frequently moving her rings back and forth. Dr. Johnson noted Claimant understood the purpose of the assessment, appeared motivated to participate, and demonstrated "very good focus, attention, and effort; persisting as tasks became more difficult." (*Ibid.*) Dr. Jonson therefore opined, based on Claimant's behaviors and level of effort throughout the assessment that "the current assessment results appear to be an accurate representation of [Claimant's] current functioning." (*Ibid.*)

39. Dr. Johnson administered the WAIS-IV to assess Claimant's intellectual as well as specific cognitive abilities. Claimant's intellectual level of functioning based on the WAIS-IV fell in the above average range and the 81st percentile compared to others her age. (Exhibit 8, p. A55.) Claimant's verbal comprehension abilities were in the high average, indicating a "well-developed ability to reason, problem-solve, and communicate using words." (*Ibid.*) Claimant's visual spatial reasoning and fluid reasoning were both assessed in the high average range and the 84th percentile. Claimant demonstrated a significant strength in the area of processing speed, the ability to focus attention and quickly scan, discriminate between, and respond to visual information, with a processing speed index in the 96th percentile. (Exhibit 8, p. A56.) Claimant's working memory was relatively weak compared to her other abilities, with a working memory index in the 50th percentile; her ability to hold onto and manipulate information in her head was relatively less developed than her other processing and

thinking abilities but was still within the average range and comparable to Claimant's same age peers. (*Ibid.*)

40. To assess social and emotional functioning, Dr. Jonson administered the BASC-3, CY-BOCS, MACI-II, MASC-2, HTP, and TAT, to Claimant. Based on the results, Dr. Johnson opined that while Claimant may attempt to appear calm on the surface, she seemed to be experiencing a "great deal of underlying tension." (Exhibit 8, p. A56.) Dr. Johnson cited Claimant's "number of intrusive, recurrent, and distressing thoughts that occur repeatedly throughout the day and are difficult for her to control." (*Id.*) Dr. Jonson further noted that the assessments' results indicate Claimant feels particularly vulnerable to physical illness, including thoughts of being contaminated, getting ill, and vomiting. In addition, Claimant was assessed as having difficulty adapting to changes and feeling particularly stressed by change and uncertainty; frequently apprehensive over small matters and engaging in rumination, getting "stuck" on "angry feelings." (*Ibid.*)

41. Dr. Jonson opined based on the assessments' results that Claimant's difficulty controlling her worries and making sense of her experience caused her to feel overwhelmed and to rely heavily on others to help her cope and manage stress. (Exhibit 8, p. A57.) Claimant needed assurance and direction from others based on her confusion at her inner experiences and felt anxious separating from her support system, primarily Mother. As an example, Dr. Johnson cited to the fact Claimant calls and texts her Mother repeatedly when Mother left the home and insisted on sleeping in Mother's bed at night. Claimant's separation difficulties were noted to be exacerbated by Claimant's persistent fear that something bad will happen to a family member, such as death or serious injury. (*Ibid.*)

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42. Dr. Johnson observed Claimant to be interpersonally cooperative and agreeable. Based on the results of the MACI assessment, Dr. Johnson concluded Claimant is generally trusting, desires enduring friendship, seems to want to please others, may tend to take a more passive role in relationships, leans heavily on others for guidance, protection, and security, at times "may be clingy," and "may feel particularly vulnerable and become overwhelmed when separated from those who provide support." (Exhibit 8, p. A57.) Dr. Jonson concluded, based on the results of the HTP and TAT assessments, that "[d]espite high levels of anxiety, [Claimant] generally seems to have a hopeful and positive outlook on life and views herself as working hard to overcome adversity." (*Ibid.*)

43. To assess Claimant's communication and reciprocal social interaction, Dr. Johnson administered the ADOS-2, Module 4. The purpose of the assessment was to evaluate Claimant for symptoms and behaviors consistent with possible ASD. (Exhibit 8.) Results of the ADOS-2 and ADI-R were not specifically reported in scores, but, rather, Dr. Johnson described the content in the evaluation. For example, Dr. Johnson described Claimant's observed facial expressions during the ADOS-2 administration, describing them as "limited." (Exhibit 8, p. A57.) Claimant's eye contact, intonation, volume, rate of speech, was noted as "appropriate." (*Id.*) Dr. Johnson noted Claimant did not "echo" any of her speech and did not use "any stereotyped speech or idiosyncratic use of words or phrases." (*Id.*) Claimant could gesture when prompted but demonstrated "only one instance of spontaneous gesture." (*Id.*)

44. Dr. Johnson noted that most of Claimant's communication was in response to direct questions. (Exhibit 8, p. A57.) She described Claimant as tending to provide lists of information when responding to questions without discussing Claimant's emotional reactions or personal thoughts. Dr. Johnson opined that

Claimant did not demonstrate "any shared enjoyment in the interaction with [Dr. Johnson] and appeared to prefer noninteractive portions," "did not express interest in [Dr. Johnson's] ideas, experiences, or reactions," and "did not respond to the use of humor." (*Ibid.*)

45. Dr. Johnson opined Claimant "seems to have limited understanding of the concept of social relationships," tending "to describe relationships in terms of the function [the relationships serve] for [Claimant] and had little insight into [Claimant's] role in the relationships." (Exhibit 8, p. A58.) Dr. Johnson observed Claimant did not display any stereotyped behavior and, though the intensity of Claimant's interests was described as "unusually high," noted that Claimant's interests did not seem to interfere with Claimant's other areas of functioning or family life. (*Ibid.*)

46. Dr. Johnson collected additional information regarding Claimant's socioeconomical and developmental functioning from Mother using the ADI-R. Mother reported Claimant "has a history of difficulties using nonverbal communicative behaviors, lack of socioeconomical reciprocity, and difficulty sustaining conversational exchange." (Exhibit 8, p. A58.)

47. Based on Claimant's test results and Dr. Johnson's observations, Dr. Johnson diagnosed Claimant with ASD, without accompanying intellectual and communication impairment, level 1. (Exhibit 8, p. A59.) In reaching her ASD diagnosis, Dr. Johnson stated diagnostic impressions included that Claimant "has deficits in social-emotional reciprocity and nonverbal communication, as well as difficulties understanding relationships;" "has an adverse response to sensory aspects in the environment including sounds and textures;" "is easily distressed by small changes;" and "[t]hese symptoms have been present since early development and cause clinically significant impairment in social, family, and school functioning." (*Id.*)

48. Dr. Johnson also diagnosed Claimant with OCD, with fair insight. (Exhibit 8, p. A59.) Dr. Johnson's stated OCD diagnostic impressions included that Claimant "has a number of intrusive, recurrent, and distressing thoughts that occur repeatedly throughout the day, are difficult for her to control, and cause her significant anxiety (obsessions);" "these thoughts center around excessive worry related to contamination, illness, and vomiting; worry that something bad will happen to family members; and getting things to feel 'just right'." (*Id.*) Dr. Johnson observed Claimant "typically attempts to suppress or neutralize these thoughts by engaging in avoidance strategies and relying on her mother for reassurance and support." (*Id.*) Dr. Johnson further opined Claimant "spends a significant amount of time thinking about and seeking relief from her obsessions, and the obsessions cause clinically significant distress and impairments in social and school functioning." (*Id.*) It was noted that Claimant recognizes that her beliefs may or may not be true.

49. Dr. Johnson recommended that Claimant should continue to engage in individual psychotherapy; engage in Cognitive Behavior Therapy (CBT) for OCD; continue medication management of symptoms; and that Claimant's Mother and family also participate in therapy to "identify and implement additional strategies to support" Claimant. (Exhibit 8, p. A59.) Dr. Johnson noted that "[a]n important aspect of collateral therapy will be to decrease accommodations (offering reassurance, modifying routine) at home." (*Id.* at p. A60.) Dr. Johnson recommended Claimant to share the results of her evaluation with Claimant's school.

## Hearing Testimony of Marie Johnson, Psy.D.

50. Dr. Johnson credibly testified at hearing regarding her August 2023 psychological evaluation of Claimant. Her testimony was consistent with her evaluation of Claimant. (Exhibit 8.) Dr. Johnson stated at hearing that she did not initially consider

ASD as a diagnosis for Claimant during her first two-hour assessment session with Claimant but concluded over the course of the subsequent three-days of assessment that Claimant was "masking" her "high functioning" ASD.

51. Dr. Johnson opined Claimant's anxiety stemmed from her ASD related difficulties in understanding social environments. She further opined that Claimant's challenges, including Claimant's current lack of capacity for independent living and economic self-sufficiency and impaired self-direction was caused primarily by Claimant's ASD, not her other mental health diagnoses. The effect of Claimant's OCD on Claimant's behavior and symptoms was not specifically addressed during Dr. Johnson's testimony.

52. Dr. Johnson further opined Claimant's ASD manifested in Claimant's early development. For example, Dr. Johnson cited Claimant's low affect, no expression, dislike at being touched, hugged, or kissed, and preference for being patted and not rubbed.

53. Dr. Johnson's August 2023 evaluation predated the February 2024 time period when Claimant's functioning declined and she stopped attending school. Accordingly, after Mother's hearing testimony regarding Claimant's current behaviors, Dr. Johnson was asked if she would have diagnosed Claimant at a higher level of ASD, such as level 2 or 3, rather than level 1, if Claimant had presented to her for evaluation with the same behaviors she was now exhibiting. In response, Dr. Jonson stated that it was likely that she would have diagnosed Claimant at a higher level of ASD if Claimant exhibited the same behaviors, such as refusing to attend high school and rarely leaving home, at the time she performed her August 2023 evaluation.

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## WRC Psychological and Multidisciplinary Assessments of Claimant

### MAY 2024 PSYCHOLOGICAL EVALUATION OF ASSESSOR GABRIELLE DU VERGLAS, PH.D.

54. Claimant was referred to WRC by Mother because she suspected ASD and/or ID. On April 10, 2024, WRC performed a psychosocial assessment of Claimant, then 17 years old. (Exhibit 5.) No evidence of ID was found by WRC based on the assessment. Claimant's WRC intake counselor referred Claimant for a WRC psychological evaluation to rule out ASD.

55. On May 8, 13, 14, and 31, 2024, Gabrielle Du Verglas, Ph.D., a clinical psychologist, conducted a psychological evaluation of Claimant, then 17 years old. As part of the psychological evaluation, Dr. Du Verglas administered several psychological tests, reviewed Dr. Johnson's evaluation of Claimant, consulted with Claimant's then therapist Dr. Osorio, and interviewed Mother and Claimant.

56. Dr. Du Verglas's testing of Claimant included: a record review; behavioral observation; the Wechsler Abbreviation Scale of Intelligence-Second Edition (WASI-II); Wide Range Achievement Test, Fifth Edition (WRAT-5); Adaptive Behavior Assessment System-Third Edition (ABAS-3); Vineland Adaptive Behavior Scales-3 (completed with both Mother and Claimant interview); ADOS-2; ADI-R; Beck Depression Inventory; Beck Anxiety Inventory; Children's Yale-Brown Obsessive Compulsive Scale; and collateral interview with Claimant's then therapist Dr. Osorio. (Exhibit 6, p. A29.)

57. During her assessment, Dr. Du Verglas observed Claimant during a two-hour session on May 13, 2024, and a second session on May 31, 2024, when the VABS-3 was administered. A May 12, 2024 session was cancelled because Mother reported Claimant would not leave the house.

58. On May 13, 2024, Dr. Du Verglas observed Claimant was appropriately groomed, entered the assessment room without difficulties, was able to tolerate the lengthy session and consistently participated without difficulties. (Exhibit 6, pp. A29-A30.) Claimant was noted to speak in full, coherent sentences, with no pronunciation errors, no difficulties with verbal expression, normal voice pitch, tone of language, and rhythm, and no difficulties with pronunciation. Claimant had "appropriate eye contact," responded to questions consistently without difficulties, was oriented to time, place, and person and was able to provide personal information about herself. (*Ibid.*)

59. During the second in-person session on May 31, 2024, Dr. Du Verglas noted that Claimant was again in good hygiene and appropriately groomed and dressed. However, Dr. Du Verglas observed Claimant's affect and demeanor looked "different" than how she presented during the first May 13, 2024 session, with a "more solemn" and "less talkative" demeanor. (Exhibit 6, p. A30.) In response to Dr. Du Verglas asking Claimant about her emotions and the observed difference in Claimant's emotional state, Claimant acknowledged to Dr. Du Verglas that she was "more depressed and felt worse than when initially seen." (*Ibid.*) Dr. Du Verglas observed that during the VABS-3 administration, with both Claimant and Mother present, Claimant "frequently looked at her mother before answering and appeared very dependent on her mother's presence." (*Ibid.*)

60. On May 14, 2024, Dr. Du Verglas interviewed Dr. Osorio, who had been Claimant's therapist for two years at the time of the interview. Dr. Osorio described Claimant's recent irregular attendance at sessions because Claimant did not leave the house, requiring some sessions to be held via Zoom. Dr. Osorio stated that even though Claimant had made some progress learning and being able to address her symptoms of anxiety, Claimant was "not willing to participate in more intense therapy,

for example, using exposure to address her fears." (Exhibit 6, p. A30.) Dr. Osorio described that Claimant's description of her significant depression and anxiety does not always match her visual presentation, which was noted to be consistent with Claimant's past psychiatrist observation. Dr. Du Verglas noted the same observation, describing that Claimant was frequently smiling, fully participating in conversation, while describing significant symptoms of anxiety and depression. Dr. Osorio also described Claimant's phobias and fearful reactions about vomiting, contamination, and germs, but stated to Dr. Du Verglas that Claimant showed no interest in addressing those fears through exposure therapy. Dr. Osorio did not identify any difficulties with verbal expression and repetitive behaviors during the sessions or over-focusing on specific themes or subjects.

61. Claimant's cognitive abilities, assessed by the WASI-II, were in the very superior range, with a full-scale intelligent quotient (IQ) of 140. (Exhibit 6, p. A31.) Similarly, Claimant's academic abilities, assessed by the WRAT-5, showed scores in the above average range and about 12.9 grade level. (*Id.* at p. A32.)

62. Dr. Du Verglas administered the ABAS-3 to measure Claimant's adaptive functioning, with Mother serving as informant. Claimant's results on the ABAS-3 indicated extremely low adaptive skills based on General Adaptive Composite (GAC) score of 60, at the 0.4th percentile, with Conceptual standard score of 64, at the 1st percentile, and Practical skills of 56, at the 0.2nd percentile, all in the extremely low range of abilities. Claimant's Social score of 75, at the 1st percentile, fell in the low range of abilities. (Exhibit 6, p. A33.)

63. Upon further review of Mother's responses on the ABAS-3, Dr. Du Verglas concluded that many items endorsed as skills Claimant cannot do are not related to Claimant having difficulties understanding or knowing how to do the skills,

but rather, "it is not performing the skill because of [Claimant's] anxiety or other mental health issues, such as fear of germs." (Exhibit 8, p. A33.) As an example, Dr. Du Verglas cited that while it was endorsed on the ABAS-3 that Claimant never orders meals in a restaurant, it was not because Claimant cannot read the menu, as her reading composite score was above the 12.9 grade level, but rather due to Claimant's anxiety. (*Id.* at p. A33-A34.) Similarly, there were several items endorsed in the Leisure domain that Claimant was able to do in the past, such as attending community events that her anxiety prevents her from doing. Even allowing for the fact Claimant had not left the house since February 2024 except for a few times, Dr. Du Verglas noted Claimant was able to attend her prom, although she had stopped attending school, because she wanted to attend the prom, and she had no difficulty getting dressed, putting on her makeup and looking festive, but was anxious while attending. This was consistent for the Social domain, where Claimant had a group of friends with whom she would socialize, and continued to keep in contact with friends, mainly through social media, though she no longer attended social and group events because she does not leave the house. (*Ibid.*)

64. Because of the discrepancy of not performing tasks due to mental issues rather than difficulties knowing how to do the task identified by Dr. Du Verglas on the ABAS-3, the VABS-3 was completed via interview with both Claimant and Mother to "ensure accuracy of responses." (Exhibit 6, p. A34.) It was noted Claimant frequently looked at Mother prior to answering. The VABS-3 did not identify delays in adaptive functioning. Based on the results, Claimant can attend to all skills of daily living such as taking a shower, getting dressed, and choosing her own clothes. In the Domestic domain, "when motivated", Claimant can prepare food, can follow a recipe individually and independently and shop for ingredients with Mother accompanying her to the store. (*Ibid.*)

65. Dr. Du Verglas described that prior to refusing to go to school in February 2024, Claimant was able to ride a bike close to her home and walk to school. At the time of the evaluation, Claimant did not attend school and stayed home; she had no school assignments and spent her free time watching videos, playing with her cat, and baking or attending to her hobbies. There was no expectation of any chores or tasks expected of her on a routine basis. (Exhibit 8, p. A34.) Dr. Du Verglas concluded that given interfering difficulties with anxiety, Claimant does not leave the home and stays home almost all the time except for a few isolative instances where Claimant would go on an outing, accompanied by her Mother.

66. Dr. Du Verglas administered the ADOS-2, Module 4 to evaluate Claimant for symptoms and behaviors consistent with possible ASD, as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). (Exhibit 6.) Dr. De Vargas's ADOS-2 testing included observation and analysis of Claimant's reciprocal social interaction, communication, and stereotyped behaviors and restrictive interests. (*Id.* at pp. A35-A36.) Dr. Du Verglas did not score the results of the ADOS-2 "due to [Claimant's] symptoms occurring during acute psychiatric illness." (*Id.* at p. A45.) The results of the ADOS-2 were determined by Dr. Du Verglas to be inconsistent with ASD symptoms, as described in Factual Findings 73 through 77.

67. Mother was interviewed about relevant history with the ADI-R based on concerns related to possible diagnosis of ASD. (Exhibit 6, p. A36.) Based on Mother's responses, Dr. Du Verglas did not find Claimant had qualitative abnormalities in reciprocal social interaction, qualitative abnormalities in communication, or restrictive, repetitive and stereotyped patterns of behavior. (*Id.* at pp. A36-A37.) During the ADI-R, Mother reported to Dr. Du Verglas the family skinned a raccoon after it had been killed in response to Claimant's request so that Claimant could then clean the racoon and

keep it in her room. According to Dr. Du Verglas, the incident was not symptomatic of ASD but was consistent with Claimant's OCD symptoms of preoccupation with contamination and germs. (*Ibid.*)

68. Claimant was the informant on the Beck Depression Inventory-II, resulting in a score of 26, which Dr. Du Verglas stated was consistent with moderate symptoms of depression. (Exhibit 6, pp. A37-A38.) On the Beck Anxiety Inventory, Claimant's score of 35 fell in the severe range of anxiety, according to Dr. Du Verglas.

69. On the Children's Yale-Brown Obsessive Compulsive Scale administered by Dr. Du Verglas, Claimant endorsed difficulties with concerns about contamination and germs; in the past self-harm (around age 13 cutting herself); fear that harm would come to others; having violent and horrific images; fear of doing something that would be embarrassing; somatic concerns such as excessive concerns about illness and disease; fear of not saying something correctly; excessive hand washing; taking many precautions to avoid contact with contaminants; significant worry; checking on things; and generally feeling uneasy. (Exhibit 6, p. A38.)

70. Dr. Du Verglas's impressions of Claimant's cognitive function from the assessment was that, consistent with previous results, there were no deficits in Claimant's cognitive abilities. (Exhibit 8, pp. A38-A39.)

71. Dr. Du Verglas's impressions of Claimant's adaptive function from the assessment was that Claimant's current adaptive limitations "are due to motivation and effects of anxiety and motivation rather than [Claimant's] ability to execute the tasks." (Exhibit 8, p. A39.)

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72. Dr. Du Verglas's psychiatric diagnosis impressions of Claimant based on the assessment was that there was support for diagnoses of general anxiety, separation anxiety, social anxiety, and OCD. (Exhibit 8, p. A39.)

73. Regarding ASD, Dr. Du Verglas diagnostic impressions based on the assessment was that the "review of [Claimant's] history, current behaviors, and collateral information does not clearly support diagnosis of [ASD]." (Exhibit 8, p. A39.) The reasons cited for her impressions were as follows: no indications of any delays in attainment of developmental milestones; no difficulties with language development, or social interactions prior to age eight; Claimant's symptoms occurring around age eight (which Mother believes are symptomatic of ASD because they depict social-emotional challenges) were precipitated by panic attacks, which then resulted in difficulties attending school and restricted social participation; and Claimant's communication and ability to describe her own emptions and communicate did not evidence any deficits. (*Ibid.*)

74. In ruling out the ASD diagnosis, Dr. Du Verglas further stated:

> Currently, the primary areas of concern are [Claimant's] psychiatric diagnoses of general anxiety disorder, separation anxiety disorder, depression, and some symptoms of OCD behaviors. It should be further cautioned that the ADOS or some of the other ASD instruments have not been validated on individuals who have significant psychiatric issues, and the scores therefore cannot be interpreted with validity. There was significant difference, for example, in [Claimant's] presentation during the first to second session, where she herself endorsed more

> symptoms of anxiety and depression which affected her social presentation.

(Exhibit 6, p. A39.)

75. Dr. Du Verglas's additional important reason for ruling out ASD included the fact that Claimant's affect did not match her verbal descriptions of her anxiety symptoms, as observed during their first session and "endorsed by previous providers prior to age 5." (Exhibit 6, p. A39.) Additionally, Dr. Du Verglas noted that Claimant does not present with restrictive and repetitive patterns of behavior typically seen in an ASD diagnosis (i.e., stereotyped movements, idiosyncratic language, insistence on sameness, or ritualized patterns of behavior.). (*Ibid.*) Dr. Du Verglas opined Claimant's difficulties with noise and sound as described cannot be attributed to an ASD diagnosis and, similarly, Claimant's reported inability to tolerate guests past 8:00 p.m. started later in her life. (*Id.* at p. A40.)

76. Dr. Du Verglas opined, based on the assessment results, that Claimant's primary diagnosis of anxiety disorder and depression currently prevented Claimant from functioning socially because the symptoms of those diagnoses restrict Claimant's social participation in school and engagement in social activities. Dr. Du Verglas explained that diagnoses of depression and anxiety are psychiatric conditions distinct to developmentally based diagnosis of ASD. (Exhibit 8, p. A40.)

77. In her assessment, Dr. Du Verglas, described and applied the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) criteria for ASD to Claimant. (Exhibit 8, pp. A40-A41.) As explained by Dr. Du Verglas, the diagnosis of ASD based on the DSM-5 requires persistent impairment in social communication and social interaction (criteria A) and restricted, repetitive patterns of behavior, interests in

activities (criteria B). The symptoms need to present from early childhood (criteria C) and impair functioning (criteria D). The diagnosis of ASD for Claimant was "not confirmed" by Dr. Du Verglas "due to acute phase of depression, anxiety, psychiatric symptoms that cannot be attributed to diagnosis of ASD and inability to confirm symptoms occurring during early developmental period." (*Id.* at p. A40.)

78. Based on Claimant's test results and Dr. Du Verglas's observations and analysis of Claimant's history, Dr. Du Verglas diagnosed Claimant with Major Depressive Disorder, General Anxiety Disorder, with panic disorder, Separation Anxiety Disorder, and OCD, requiring further assessment. (Exhibit 6, p. A41.) Dr. Du Verglas recommended Claimant continue Claimant's psychiatric treatment for her primary diagnoses of depression and anxiety and opined that, based on Claimant's current acute symptoms of psychiatric illness, it may be more realistic for Claimant to attend a community college or a college close to home as Claimant may not have the resilience to live on her own or with other students out of state.

## WRC OCTOBER 3, 2024 MULTIDISCIPLINARY ASSESSMENT

79. As part of its evaluation of Claimant's eligibility for regional center services and supports, WRC referred Claimant, then 17 years old, 11 months, for a multidisciplinary psychological assessment to evaluate her symptoms related to her condition. The evaluation was limited to assessing developmental disabilities, specifically ASD. (Exhibit 7.)

80. On October 3, 2024, three psychologists, including Rebecca R. Dubner, Psy.D., and Thomas R. Kelly, Psy.D., conducted the multidisciplinary assessment of Claimant. Dr. Dubner's administered tests as part of the assessment including observation of Claimant; and interviews with Mother and Claimant, using the Adaptive

Behavior Assessment Scales, 3rd Edition (ABAS-3); and the Childhood Autism Rating Scale, 2nd Edition, High Functioning (CARS-2-HF). (Exhibit 7, p. A46.)

81. Dr. Dubner's assessment results indicated Claimant's adaptive functioning fell within the below average range based on the results of the ABAS-III. Claimant's scores in the conceptual, social and practical domains fell in the low and below average range. Dr. Dubner concluded that Claimant "requires assistance to meet her daily needs [for example, grocery shopping], yet her profile does have strengths that appear to be assisting her in her daily routine." (Exhibit 7, p. A49.) As examples of strengths, Dr. Dubner noted Claimant "appears to be able to meet her daily care needs, including feeding, bathing and clothing herself." (*Ibid.*)

82. Based on Dr. Dubner's evaluation, including Claimant's scores on the CARS and ADI-R, Dr. Dubner concluded Claimant does not present with deficits in communication and socialization and does not display repetitive behaviors, required showing for a DSM-5 diagnosis of ASD. (Exhibit 7, p. A49.) Dr. Dubner stated that both the CARS-2 and ADI-R "indicated clinically insignificant scores for diagnostic criteria of [ASD]." (*Id.*) Dr. Dubner therefore ruled out an ASD diagnosis for Claimant, stating she "does not display behaviors that align with a diagnosis of [ASD]." (*Ibid.*)

## Mother's Testimony

83. Mother credibly testified at hearing in support of her opinion Claimant is eligible for regional center services under the Lanterman Act. She has observed Claimant exhibit symptoms she asserts are consistent with an ASD diagnosis since Claimant was a baby, including displaying a flat affect in her expression, and what Mothers believes to be behaviors which successful masked Claimant's ASD symptoms behavior throughout her life. As one example, Mother submitted pictures of Claimant

imitating poses of other individuals, like her sister and Disneyland dress-up characters, in family pictures. Mother has researched the phenomenon of masking and believes Claimant's masking, like many girls, delayed Claimant's ASD diagnosis and caused misdiagnosis of Claimant in the past and by WRC. She argued, consistent with the articles she had read and analyzed, that Claimant, like many girls diagnosed with ASD, exhibited less repetitive and restricted behaviors than boys do and was also more likely to control her behavior in public, so others, like teachers, psychologists, and psychiatrists, did not catch the differences in Claimant's behavior. (Exhibit I.) (Mother submitted pictures of Claimant since early childhood and various articles about masking ASD to corroborate her testimony, which were considered in rending this decision. (Exhibits F-K, M.))

84. Mother is Claimant's primary caretaker. Claimant insists Mother sleep with her nightly and is dependent on Mother. Mother described that when she was recently separated for 12 hours from Claimant to travel to the Bay Area, she received multiple texts from Claimant including one asking Mother if Claimant was going to die because Claimant had eaten food with a spot of mold on it.

85. Mother disputed WRC's assessments of Claimant. For example, Mother cited the WRC team's reliance on the fact that Claimant wore make-up during an assessment session to rule out an ASD diagnosis as immaterial to an assessment of whether Claimant has ASD. In addition, Mother disputed Dr. Du Verglas's description that Claimant goes shopping for cooking ingredients for recipes, testifying that Claimant does not go to stores because she doesn't like how aisles are lined up at the store.

86. Claimant, herself, also reviewed the WRC's multidisciplinary assessment and, on her own copy, highlighted and emphasized certain portions, writing

handwritten comments disputing come of the assessors' conclusions. (Exhibit L.) Claimant's written comments included that Claimant: "needed more support;" hated change, disputing that she demonstrated significant adaptive skills; learned to apply makeup and smile for pictures from her older sister; medications only somewhat alleviate her panic attacks; nothing is working to deal with her issues, such as anxiety; "didn't go to school for a whole semester because of my anxiety;" and was not meeting her daily care needs, including feeding, bathing and clothing herself. (*Ibid.*) In response to the recommendations portion of the assessment suggesting Claimant continue with weekly therapy sessions to manage her anxiety, engage in Dialectical Behavior Therapy (DBT), and CBT, take medications with guidance from her psychiatrist, and consider leisure activities and meditation to minimize her anxiety and attempt to integrate with her peers in social and academic settings, Claimant wrote, "WHAT HAVE I BEEN DOING FOR OVER THE LAST DECADE." (*Id.*)

87. Mother described Claimant's behaviors, stemming from early childhood until the current time, which she argued were symptoms of ASD and supported a substantially disabling ASD diagnosis for Claimant. Some of Claimant's early development behaviors described by Mother included mimicking people on when and how to smile; eating heads of lettuce; refusing to wear clothes up until the age of 5 (i.e., taking off her clothes in the car as soon as Claimant was not in public); and insisting on getting dinosaur bones and bugs at her second birthday.

88. Mother described Claimant's current interests as including dead things; collecting photos of white people; skinning and cleaning and keeping the skeleton of a racoon; a lizard skull necklace; wanting to keep the skull of the family dog after the dog dies; geology (i.e., shells); keeping a collection of animal feet, including chicken, rabbit, raccoon, muskrat, and beaver feet; insisting on keeping a dead horse shoe crab;

and cutting out and posting picture of human teeth. Mother reported that Claimant insisted on wearing her father's clothes and loose clothing. As an example of Claimant's ASD symptoms, Mother cited the fact that Claimant's smile was not genuine in family pictures, lack of engagement during a family camping trip to King's Canyon because Claimant was fixated on staring at rocks on the ground; engagement in recent age inappropriate behavior at her paternal aunt's funeral by laying on the ground in her dress; and emotional dysregulation because Claimant's father was in mourning for his deceased sister and was not responding to Claimant at breakfast time.

89. Mother attributed Claimant's past ability to have a friend group and engage in social relationships to Claimant's primary friend, who acted in a maternal role to Claimant, and facilitated Claimant's acceptance into the friend group. Mother described Claimant's social anxiety and mimicking behavior as causing shallow friendships because Claimant did not really understand social relationships and how to act, but only imitated her friends to maintain the relationships. For example, Claimant repeated what her friends said during conversation instead of engaging in back-and-forth meaningful conversation. In addition, Mother reported Claimant does not understand sarcasm or jokes.

90. Mother reported Claimant's frequent meltdowns which Mother denied were consistent with panic attacks due to anxiety, but argued were consistent with autistic meltdowns, submitting an article on the topic of panic attacks versus autistic meltdowns to support her testimony. (Exhibit J.) She described Claimant as verbally combative, inappropriate, and lacking understanding on how her offensive remarks affect others. As examples, Mother described Claimant calls her "fat," has called babies "ugly," and escalated an argument over politics during last Thanksgiving dinner with a family friend by refusing to calm down and calling the friend "stupid."

91. Mother described that Claimant does not engage in self-care and must be reminded to shower, change her clothes, and brush her teeth. Mother reported Claimant resists brushing her teeth because she associates it with vomiting. Claimant is currently prescribed Zoloft, Seroquel, Buspirone, Hydroxyzine, and Famotidine. Mother stated Claimant is not responsible in taking her medications. Mother described that Claimant does not know how to regulate her emotions and cannot be alone for extended periods of time.

92. Mother has become increasingly concerned that none of the past and ongoing psychiatric and therapeutic treatment accessed by family since Claimant was a young child have helped Claimant function effectively. Mother maintains ASD is the primary cause of Claimant's substantial disability. Mother did not address Claimant's other mental health diagnosis, specifically, OCD, during her testimony or why Claimant was not currently receiving treatment to address her OCD symptoms.

93. Mother convincingly described the challenges Claimant and family faced in living with Claimant's ongoing issues. Mother could not describe what specific services and supports WRC should provide Claimant if Claimant was found eligible for regional center services, but asserted the family needs professional assistance to help Claimant function. Mother hopes Claimant can be helped by becoming a WRC consumer so that Claimant can achieve her goals of attending college to study paleontology and eventually working in a natural history museum.

## WRC Testimony

94. Thompson Kelly, Ph.D., licensed psychologist, WRC's Intake Manager, credibly testified on behalf of WRC at hearing. Dr. Kelly was part of the WRC multidisciplinary team which determined Claimant was not eligible to receive services

from the regional center because Claimant was not assessed as being substantially disabled due to a developmental disability, attributing her challenges to mental health diagnoses. (Welf. & Inst. Code, § 4512.) Dr. Kelly explained the basis of WRC's position and explained that having reviewed all the relevant records and after listening to all the evidence presented at hearing, he maintains his and WRC's conclusion that Claimant does not qualify for regional center services because she does not have a developmental disability which is substantially disabling.

95. "Substantial disability" is a condition resulting in significant functional limitations, as appropriate to the age of the person, in three or more of the following areas of major life activity: receptive and expressive language; self-care; learning; mobility; self-direction; capacity for independent living; and economic self-sufficiency. (Legal Conclusion 8.)

96. Dr. Kelly acknowledged that some of Claimant's symptoms, such as sensory issues and Mother's reported flat affect since early childhood, were consistent with ASD. However, Dr. Kelly disagreed with Claimant's ASD, mild presentation (level 1) diagnosis by Dr. Johnson. Dr. Kelly explained that Claimant's developmental history, Dr. Du Verglas's assessment, the multidisciplinary assessment, as well as the evidence presented at hearing by Claimant, did not present sufficient evidence to support an ASD diagnosis for Claimant, but indicated Claimant's mental health diagnoses were the more likely source of Claimant's significant symptoms. In rejecting Claimant's argument that her interest in skulls and bones was symptomatic of a fixed interest associated with ASD, for example, Dr. Kelly noted that Claimant's reported interest in skulls and bones did not constitute the type of fixated interest consistent with an ASD symptom but presented as more of an educational and professional real interest associated with Claimant's desire to become a paleontologist. Further, Dr. Kelly

explained that unlike a developmental disability, like ASD, which typically presented with stable symptoms, Claimant's symptoms were not consistent across settings, had fluctuated over time, increasing in adolescence, and were, therefore, more consistent with Claimant's mental health diagnoses. Specifically, if Claimant had ASD, a developmental disability, her level of ASD would not fluctuate depending on the time in her life an assessor's assessment took place, resulting in varying levels of ASD diagnosis between levels 1, 2, or 3, as Dr. Johnson's testimony indicated.

97. Dr. Kelly admitted he could not specifically identify which of Claimant's psychiatric disorders was responsible for her school refusal and other behaviors, but opined that Claimant's OCD, which was not being specifically currently treated, may be responsible and recommended Claimant undergo treatment specifically designed to address her OCD.

98. Dr. Kelly opined that even if the ASD diagnosis is conceded, which WRC did not agree with based on Claimant's presented evidence and WRC's assessments of Claimant indicating mental health diagnoses, Claimant is substantially disabled only in the area of self-direction. Dr. Kelly maintained, however, given the evidence, Claimant's self-direction issues are caused primarily by her mental health diagnoses and not the developmental disability of ASD.

## Analysis

99. The evidence was insufficient to establish an ASD diagnosis, per DSM-5 requirements, for Claimant. (Factual Findings 1-98.)

100. Specifically, there was insufficient evidence presented, based on the articles presented regarding the phenomenon, Dr. Johnson's and Dr. Osorio's testimony, and Mother's observations of Claimant's behaviors, that Claimant's masking

skills caused WRC and Claimant's past assessors to misdiagnose Claimant and miss Claimant's ASD diagnosis. Dr. Kelly convincingly addressed the masking argument at hearing and pointed to the fact that Claimant's symptoms and behaviors were not consistent with the type of stable symptoms over time associated with an ASD diagnosis. In addition, Dr. Kelly explained that WRC's trained clinicians, with extensive experience in behavioral intervention associated with ASD, made misdiagnosis unlikely due to masking in Claimant's case, especially considering Claimant's developmental history and past intensive psychiatric and psychological interventions.

101. Even if Claimant's ASD diagnosis was credited in this matter, the evidence did not establish Claimant was substantially disabled due to an ASD diagnosis, but rather, due to the more likely cause of her mental health diagnoses, some of which, like Claimant's OCD, remain untreated. For example, WRC conceded, that Claimant has substantial functional limitations in self-direction, given, as one example, her significant difficulty coping with her fears and anxieties. Claimant, in turn, did not establish through the evidence presented that a developmental disability (i.e., ASD), rather than her mental health diagnoses, was the cause of her limitations in self-direction. Further, the evidence did not establish Claimant has significant functional limitations in learning, mobility, self-care, or receptive and expressive language. Similarly, there is insufficient evidence Claimant's current significant functional limitations in the areas of capacity for independent living and economic self-sufficiency, are primarily caused by a developmental disability, but, instead, are more likely attributable to Claimant's mental health diagnoses.

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## LEGAL CONCLUSIONS

1. An administrative hearing to determine the rights and obligations of the parties, if any, is available under the Lanterman Act to appeal a contrary service agency decision. (Welf. & Inst. Code (Code), §§ 4700–4716.) Claimant requested a hearing to dispute WRC's denial of Claimant's eligibility for services and supports under the Lanterman Act. Jurisdiction for this appeal was therefore established.

2. Claimant has the burden of establishing her eligibility for Lanterman Act services and supports by a preponderance of the evidence. (*Lindsay v. San Diego Retirement Bd*. (1964) 231 Cal.App.2d 156, 161; Evid. Code, §§ 115, 500.) "Preponderance of the evidence means evidence that has more convincing force than that opposed to it. [Citations] . . . [T]he sole focus of the legal definition of 'preponderance' in the phrase 'preponderance of the evidence' is the quality of the evidence. The quantity of the evidence presented by each side is irrelevant." (*Glage v. Hawes Firearms Co*. (1990) 226 Cal.App.3d 314, 324–325 (emphasis in original).) Claimant has failed to meet her burden of proof in this matter.

### Determination of Claimant's Eligibility under Lanterman Act

3. To be eligible for Lanterman Act supports and services, Claimant must present with a qualifying developmental disability. Code section 4512, subdivision (a)(1), 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. . . . [T]his term shall include intellectual disability,

cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability, but shall not include other handicapping conditions that are solely physical in nature.

4. California Code of Regulations, title 17, section 54000 defines "developmental disability" as a disability attributable to intellectual disability, cerebral palsy, epilepsy, autism, or disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for intellectually disabled individuals. The disability must originate before age 18, be likely to continue indefinitely, and constitute a substantial disability.

5. The Lanterman Act and related regulations do not contain a definition of the qualifying developmental disability of "autism." As a result, when determining eligibility for services based on autism, it is defined as consistent to the definition of ASD stated in the DSM-5. (The ALJ takes official notice of the DSM-5 as a generally accepted tool for diagnosing mental and developmental disorders.)

6. The DSM-5, section 299.00 discusses the diagnostic criteria which must be met to provide a specific diagnosis of 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; see text):

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1. Deficits in social-emotional reciprocity, ranging, for example from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.

2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.

3. Deficits in developing, maintaining, and understanding relationships, ranging, for example from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers. [¶] . . . [¶]

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

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

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

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

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

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

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

E. These disturbances are not better explained by intellectual disability (intellectual development disorder) or

> global 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.

(DSM-5, at pp. 50-51.)

7. Claimant did not establish by a preponderance of the evidence that Claimant meets the criteria under the DSM-5 for a diagnosis of ASD. (Factual Findings 1-100.)

8. For an individual with a developmental disability to qualify for regional center services, the individual's developmental disability must also constitute a "substantial disability." "Substantial disability" is a condition that "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." (Cal. Code Regs, tit. 17, § 54001, subd. (a)(1).) Additionally, for an individual's developmental disability to constitute a "substantial disability,'' the developmental disability must result in significant functional limitations in three or more of the following areas of major life activity, as determined by a regional center, and as appropriate to the age of the person: [¶] (1) Self-care. [¶] (2) Receptive and expressive language. [¶] (3) Learning. [¶] (4) Mobility. [¶] (5) Self-direction. [¶] (6) Capacity for independent living. [¶] (7) Economic self-sufficiency." (Cal. Code Regs., tit. 17, § 54001, subd. (a)(2).)

9. California Code of Regulations, title 17, section 54000, excludes three conditions from the definition of "developmental disability." Psychiatric disorders

involving impaired intellectual or social functioning which originated because of the psychiatric disorders are not considered developmental disabilities under the Lanterman Act. "Such psychiatric disorders include psycho-social deprivation and/or psychosis, severe neurosis or personality disorders even where social and intellectual functioning have been seriously impaired as an integral manifestation of the disorder." (Cal. Code. Regs., tit. 17, § 54000, subd. (c)(1).)

10. To have a qualifying developmental disability under the Lanterman Act, an individual's substantial disability must not be solely caused by an excluded condition. (Welf. & Inst. Code, § 4512; Cal. Code. Regs., tit. 17, § 54000). Therefore, a person with a "dual diagnosis," that is, a developmental disability coupled either with a psychiatric disorder, a physical disorder, or a learning disability could still be eligible for services. However, someone whose conditions originate only from the excluded categories (psychiatric disorder, physical disorder, or learning disability, alone or in some combination) and who does not have a developmental disability would not be eligible.

11. Claimant presented insufficient evidence she suffers from a condition eligible for regional center services, including ASD. (Legal Conclusion 5-7.) However, even assuming Claimant has ASD, Claimant presented insufficient evidence that any proffered elements of Claimant's purported ASD constitute a substantial disability for Claimant. While the evidence established that, as of the date of the fair hearing, Claimant has significant challenges that limit her functioning in various areas, including self-direction, there is insufficient evidence to establish that Claimant's challenges are based on a developmental disability, including ASD. Rather, Claimant's significant challenges with life activities are attributable to her mental health conditions, such as Anxiety, Depression, and/or OCD. As a result, Claimant does not meet the Lanterman

Act requirements of eligibility as defined in Welfare Institutions Code section 4512, and California Code of Regulations, title 17, section 54001.

12. Based on the totality of the evidence, Claimant's failed to establish she has a developmental disability as defined by the Lanterman Act. WRC's denial of Claimant to receive regional center services was, accordingly, proper.

## ORDER

Claimant's appeal is denied. Claimant is not eligible to receive services under the Lanterman Act. Westside Regional Center's denial of Claimant's eligibility to receive regional center services is upheld.

DATE:

IRINA TENTSER
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 may appeal the decision to a court of competent jurisdiction within 180 days of receiving the final decision.