

BEFORE THE  
OFFICE OF ADMINISTRATIVE HEARINGS  
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT,

v.

ALTA CALIFORNIA REGIONAL  
CENTER,

Service Agency.

OAH No. 2015050143

**DECISION**

The fair hearing in this matter was heard by Administrative Law Judge Marcie Larson (ALJ), Office of Administrative Hearings (OAH), State of California, on August 11, 2015, November 18, 2015, and January 28, 2016, in Sacramento, California.

Alta California Regional Center (ACRC) was represented by Robin Black, Legal Services Manager.

Claimant's mother represented claimant.

Evidence was received and the record remained open to allow submission of closing and reply briefs. ACRC's closing brief was marked as Exhibit 18. Claimant's closing brief was marked as Exhibit E. No reply briefs were filed. The record was closed and the matter was submitted for decision on February 29, 2016.

**ISSUES**

Does claimant qualify for services from ACRC under the Lanterman Developmental Disabilities Services Act (Lanterman Act), Welfare and Institutions Code section 4500 et seq., because he is an individual with autism, or intellectual disability, or because he has a disabling condition that is closely related to intellectual disability or requires treatment similar to that required for individuals with an intellectual disability?

## FACTUAL FINDINGS

1. Claimant was born in 1990, in Sacramento, California. Both of his parents are Vietnamese. Claimant is currently 25 years old. He was diagnosed with Attention Deficit and Hyperactivity Disorder (ADHD) when he was six years old. Claimant graduated from high school and attended junior college for a short period of time. Since the age of 18, claimant has sporadically resided with his parents and his teenage sister, in his parents' home. He has also lived independently, resided with friends, and lived in his vehicle. Claimant has worked various jobs, including at an auto shop, a retirement home, and as a janitor at a gas station.

2. In 2015, claimant's mother, who works as a physician's assistant for Kaiser, sought services for claimant from ACRC under the Lanterman Act, for Autism Spectrum Disorder. On April 14, 2015, ACRC denied her request, asserting that claimant was excluded from receiving regional center services because he does not have autism, intellectual disability, or a disabling condition that is closely related to intellectual disability. ACRC also found that claimant does not require treatment similar to that required for individuals with an intellectual disability and there was no evidence that claimant had epilepsy or cerebral palsy. ACRC recommended that claimant would benefit from "support, counseling and advocacy in meeting his needs by continued psychological treatment through [his] current mental health provider."

3. Claimant appealed the denial. A fair hearing was held on his appeal. During the fair hearing, claimant's mother argued that claimant was eligible for ACRC services under the Lanterman Act because claimant is an individual with Autism Spectrum Disorder, and that he has been misdiagnosed with psychiatric disorders.

### *History of Prior Treatment, Assessments and Evaluations*

4. From approximately 2004, until June 2015, claimant was treated by Robert Diamond, M.D., a Board certified psychiatrist at Kaiser Hospital in Folsom, California. Dr. Diamond diagnosed claimant with ADHD, a diagnosis claimant first received in approximately 1997, when he was six years old. Dr. Diamond also diagnosed claimant with mood disorder, although he did not specify which mood disorder. Dr. Diamond's treatment of claimant was limited to medication management. He did not provide counseling or therapy.

5. In approximately 2010, Dr. Diamond referred claimant for a neuropsychological evaluation at Kaiser, to assess his cognitive functioning.

### NEUROPSYCHOLOGICAL EVALUATION

6. On January 4, 2010, a neuropsychological evaluation was performed on claimant by Catherine Broomand, Ph.D., a Clinical Neuropsychologist, and Nicholas Jasinski, Psy.D, a Post-Doctoral Resident, both with the Center for Neuropsychological

Services at Kaiser. Claimant was 19 years old at the time of the evaluation. During the evaluation, medical, psychiatric, academic and psychosocial histories were obtained, claimant's medical records were reviewed, claimant's mother was interviewed and numerous tests were administered, including the Behavior Rating Inventory of Executive Functions-Parent Rating Form (BRIEF), California Verbal Learning Test-Second Addition (CVLT-II), Conners' Continuous Performance Test-II (CPT-II), Dot Counting Test, Green's Word Memory Test, Neuropsychological Assessment Battery-Screening Module (NAB), Nelson-Denny Reading Test, Rey Complex Figure Test Copy Trial, Stroop Color Word Test, Test of Memory Malingering, Trail Making Test, Verbal Fluency (FAS, Animals), Wechsler Adult Intelligence Scale-Fourth Edition (WAIS-IV), Wechsler Memory Scale-Fourth Edition Adult Battery (WMS-IV, selected subtests), Wisconsin Card Sorting Test (WCST) and the Woodcock-Johnston Tests of Achievement-Third Edition (WCJ-III). Claimant was also interviewed.

7. Dr. Broomand reviewed claimant's medical records and found that he was initially seen for psychiatric services in 1997, at which time he was diagnosed with ADHD. He was treated by developmental pediatrician Dr. Broadhurst from 1997 through 2000. He was treated with Ritalin and later with Concerta. In approximately 2005, he returned to Kaiser for medication management for his ADHD. Dr. Broomand also reviewed the medical records prepared by Dr. Diamond, who documented that claimant exhibited "chronic inattention, speech problems, and social awkwardness." He also described claimant as "oppositional and uncooperative with his parent." Claimant displayed "rigid and concrete thinking as well as oppositional behavior in sessions with Dr. Diamond."

8. Claimant's mother reported that claimant was verbally aggressive towards her and claimant's father, and that he had exhibited "physically aggressive behavior throughout his youth." She reported that claimant's ADHD manifested "mainly as particular difficulty with changes in routine, difficulty with future planning, hyperactivity, and significant difficulty focusing for any significant amount of time, particularly when uninterested in the topic or material." She also noted that he could be "impulsive with poor judgment." Claimant's mother cited an example of when claimant moved out of their home for a few weeks after he had a fight with his father. She also stated that claimant's behavior problems became more prominent after claimant turned 18 years old and that he "frequently" cited his age as "a reason why he does not have to comply with their demands." She also reported that claimant refused to take his ADHD medication.

9. Academically, claimant's mother reported that claimant was a "straight A student from 1<sup>st</sup> through 6<sup>th</sup> grades," but that he needed significant help with organization of his materials to help him excel academically. She also reported in the sixth grade, claimant took the California Standardized Testing and Reporting (STAR) test and he performed in the "advanced range for English-language arts and mathematics." His scores on subtests were "all at or above the 75<sup>th</sup> percentile with most scores above the 90<sup>th</sup> percentile." Claimant had difficulty transitioning to middle school. Claimant had "extreme difficulty adjusting to the demands of having multiple classes with multiple instructors." Claimant's mother reported that because of these difficulties he "stopped caring" about school and quit applying himself.

His grades slipped and standardized test scores slipped. In 2003, claimant received a “504 plan” for school. He was given accommodations such as preferential seating in front of the class, extra time on tests, and the ability to turn in homework late. As a result, he was able to complete middle school. He received the same accommodations in high school. He graduated from high school, and his STAR testing from 2005 through 2007 indicated that he was performing in the proficient to advanced level in all areas. After graduation, claimant enrolled junior college. He failed all of his classes and was dismissed from the college. Claimant was not interested in returning to school. He would rather receive vocational training. He was interested in becoming an electrician or an “HVAC specialist.”

10. Claimant’s mother denied that claimant had any developmental delays as a child. He learned to walk and talk without difficulty. Claimant learned to speak English and Vietnamese concurrently as a child. English was his primary language and the language spoken at home. Claimant’s mother also reported that he had no history of “repetitive behaviors, rituals, stereotyped movements/behaviors, or obsessions and compulsions.” He was a “somewhat socially isolated child with few friends.” He had “always made poor eye contact and been socially awkward.” Claimant’s mother reported that claimant had one friend, whom she believed was a good influence on him.

11. Claimant’s medical history was significant for congenital nystagmus, an eye condition that causes uncontrollable eye movement. He was also diagnosed with high frequency sensorineural hearing loss and hyperopic stigmatism. In 1996, claimant underwent surgery on both eyes to address the nystagmus. The surgery did not correct the condition. Claimant’s mother reported that claimant had poor vision.

12. During claimant’s interview, his speech was “normal in volume, rate, and prosody though some mild articulation problems were noted.” Claimant made little eye contact and often looked at the floor. He gave “short answers to questions and did not imitate discussion.” Claimant “appeared to be able to read and perceive visual stimuli without difficulty.” He also did not display any “obvious evidence of hearing difficulties.” He also did not exhibit “significant signs of inattention, impulsivity or disinhibition.”

13. Claimant reported to Dr. Broomand that his ADHD was “characterized by difficulties maintaining attention, particularly on boring or uninteresting task.” He also reported “long standing difficulties with mental organization as well as future planning.” He reported further being “easily irritated by his parents.” His daily routine consisted of “playing video games, browsing the internet, and listening to music.” He reported that he enjoyed exercising and had “a few friends at the gym.”

14. Concerning the assessment testing and results, Dr. Broomand noted that claimant “exhibited variability in his effort.” Claimant “gave up often on tests” and refused to expand on answers. Due to the significant variability in effort, she determined that his “current results may not accurately represent his current cognitive functioning.” Claimant “exhibited significant variability” on the WAIS-IV, which “rendered his Full Scale IQ score uninterpretable.”

15. His academic skills measured by the WCJ-III showed an average range of proficiency in reading, mathematical, and written language abilities, which was “commensurate with his intellectual abilities.” Claimant’s performance on testing of his attention, concentration and working memory was also “variable.” Dr. Broomand noted that he “showed impairment on simple, rote attention span tasks with notably better (average range) performance on measures of auditory working memory.” On visual attention and visual scanning he performed in the “average range without error.” He “exhibited significant impairments on a test of sustained attention.”

16. In the area of executive functioning, claimant’s performance ranged from low average to average. He performed average on a measure requiring him to generate problem solving strategies in response to feedback and a measure requiring the inhibition of an automatic response. His mental flexibility and processing speed was in the low average range. Claimant’s mother was asked to complete a questionnaire asking her to assess claimant “across a number of behaviors associated with executive functioning.” Dr. Broomand noted that:

Validity indices indicated that she may have responded in an overly-negative manner making clear interpretation of her results difficult. In general, her responses indicated that she perceives [claimant] as having severe problems with emotional regulation and meta-cognitive abilities.”

17. In the report, Dr. Broomand opined that:

Claimant’s current performance may be consistent with his diagnosis of ADHD. More specifically, his possible difficulties with attention and executive functioning are often seen in children and adults with ADHD. Additionally, the clinical report given by [claimant’s mother] of poor judgment, impulsive decision making, reduced attention/concentration, irritability, and difficulty with changes in routine are also consistent with the diagnosis of ADHD. It should be noted that [claimant’s] current performance reflects his abilities in an unmedicated state as he has been non-compliant with ADHD medication. However, given his variable effort definitive statements about his current cognitive functioning are difficult to make. While he is somewhat socially disengaged, there does not seem to be any evidence of a Pervasive Developmental Disorder. Also, as mentioned before, there is no evidence of learning disability in his cognitive profile.

18. Pervasive Developmental Disorder was a disorder listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV).<sup>1</sup> Autism was condition included in a diagnosis of Pervasive Developmental Disorder. Because Dr. Broomand found that there was no evidence that claimant had a Pervasive Developmental Disorder, she ruled out the possibility that claimant had autism.

19. Dr. Broomand recommended that claimant comply with his ADHD medications. She also recommended “further clinical exploration of his behavioral disturbances,” as claimant’s mother had reported “increasing oppositional and confrontational behavior” in claimant. She also recommended a vocational evaluation to assist claimant in finding an occupation and to develop a plan to obtain employment.

*October 15, 2014 Letter from Fawzia Ashar, M.D., FAACAP*

20. Fawzia Ashar, M.D., FAACAP, is a Diplomate of the American Board of Psychiatry and Neurology, and the Director of the Kaiser Autism Spectrum Disorders Center. She works in the same office building at Kaiser as claimant’s mother. Dr. Diamond referred claimant to Dr. Ashar for an evaluation. Dr. Ashar wrote claimant a letter dated October 15, 2014, which stated:

This is to state that I met with you on [sic] for a diagnostic interview. This evaluation did not include psychological testing of any kind and I did not review your outside records. I did get a chance to review al [sic] the KPHC electronic record.

Based on my psychiatric interview with you I confirm the diagnosis of Autism Spectrum Disorder as it applies to your case.

21. At hearing, Dr. Ashar testified that she prepared the October 15, 2014 letter so that claimant could obtain educational and regional center services. She was the first doctor to diagnosis claimant with Autism Spectrum Disorder. After claimant received the October 15, 2014 letter from Dr. Ashar, his mother sought services from ACRC.

*Social Assessment Performed by ACRC*

22. On February 2, 2015, David Webb, Intake Counselor for ACRC, performed a social assessment of claimant. Mr. Webb met with claimant and his mother. Thereafter, Mr. Webb prepared a report. Mr. Webb testified at the hearing in this matter. Mr. Webb noted that claimant was to be assessed due to “social communication concerns and behavioral difficulties.” Claimant was interested in obtaining “general case management services, independent living, job training and educational support.”

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<sup>1</sup> The Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition (DSM-V) was released in May 2013.

23. The purpose of the social assessment was to obtain information about claimant's family, his medical and psychiatric history, to document behavior concerns and social functioning, and to obtain information about claimant's adaptive skills such as self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living and economic self-sufficiency.

24. Claimant's mother reported to Mr. Webb that claimant had a "short temper" and that he "tantrums" on a regular basis." Claimant yelled and hit walls during his tantrums and made "suicidal and para suicidal statements such as threatening to hurt or kill himself." She also reported that claimant had been placed on a "5150 hold" two times for making suicidal statements. The first time was in May 2014. Claimant was held at Kaiser in San Jose after he told a friend that he would harm himself if he was not allowed to stay with the friend. The second time occurred on July 31, 2014. Claimant was held at Sierra Vista Hospital (Sierra) after he stated if he had a motorcycle, he would "drive it fast" and kill himself. The medical records from Sierra indicated that claimant was diagnosed with bipolar disorder.

25. Claimant reported that he did not have any friends and that he did not like to talk. He also never had a girlfriend, but did have a sexual relationship with a female partner whom he "hung out and smoked marijuana with" in the past. Claimant informed Mr. Webb that he "races cars and motorcycles," that he plays video games, likes to play with "toy guns" and likes to listen to "R&B music." Claimant also reported that he used marijuana on a "regular basis" when he could "get it for free." Claimant reported further that he drank alcohol in the past and had "passed out," but that it was not a habit.

26. Claimant worked at a retirement home 32 to 40 hours per week. He served food, washed dishes, and cleaned. Claimant managed his money through the use of "smartphone apps." Claimant had incurred credit card debt, which he described as "free money." Claimant's mother reported that claimant had "never lived on his own" and when he moved out of their house he was "homeless." Claimant reported that he had no desire to move out of his parents' home. Claimant stated that he did not need a "house or car" and that he could live with his parents "forever." He further stated that his parents' home was in a "good area."

27. After Mr. Webb prepared his report, ACRC referred claimant to Jeffrey E. Miller, Ph.D., Clinical Psychologist, for a psychological evaluation and testing.

*Psychological Evaluation and Testing Performed by Jeffrey E. Miller, Ph.D.*

28. Dr. Miller has been a licensed psychologist since 1976. Dr. Miller was employed as a psychologist for ACRC from 1975 until 1988. Since approximately 1988, he has completed thousands of assessment as a vendored psychologist for ACRC.

29. On March 16, 2015, Dr. Miller completed an evaluation of claimant. Dr. Miller prepared a Psychological Evaluation and Testing Report. Dr. Miller testified at the

hearing in this matter. Dr. Miller's report included the following as the reason for the referral:

[Claimant] is a 25-year-old man, who has previously been identified as having Attention-Deficit/Hyperactivity Disorder, Bipolar Disorder and possible Autism Spectrum Disorder. This evaluation was performed at the request of his Intake Counselor at the Alta California Regional Center, David Webb, M.A., for the purpose of assessing his intellectual and emotional function, and adaptive behavior skills, in order to clarify his diagnosis, assist the Regional Center in the determination of his eligibility for their services, and make recommendations concerning treatment.

30. Dr. Miller administered standardized testing, interviewed claimant, his father and mother, and reviewed available records, including the following:

- Social Assessment Report by David Webb, M.A., dated 2/02/2015;
- Letter to [claimant] from Fawzia Ashar, M.D., FAACP, dated 10/15/2014;
- Transcript of courses taken-Folsom Cordova USD, dated 1/06/2015;
- Discharge summary, dated 5/15/2014;
- Medical Services Progress Notes, dated 5/15/2014;
- PAH Discharge Summary, by Jason Bynum, M.D., dated 8/01/2014;
- History and Physical Exam by Jose Ramirez, M.D., dated 8/1/2014;
- Clinical Discharge Summary, dated 5/15/2014;
- Medical Treatment Records-Kaiser, dated 1995 to 2014;
- Psychiatric Treatment Records by Robert Diamond, M.D., dated 2009 to 2014;
- Neuropsychological Evaluation by Catherine Broomand, Ph.D., and Nicholas Jasinski, Psy.D., dated 1/04/2010.

31. Dr. Miller obtained a family, developmental, social, and medical history for claimant. Claimant's parents indicated that they first became concerned about claimant's development when he was six or seven months old. He was overly active and he was delayed in his language. He spoke his first words in Vietnamese at two years of age. Vietnamese was the main language spoken at home. Claimant did not learn English until he was four or five years old. As an infant, claimant did not want to be held. He preferred to crawl and was hyperactive. At six years old, claimant began to dress in his mother's clothes and "rejected traditional male games and dress." At some point, he was diagnosed with

Gender Dysphoria. Dr. Miller noted that claimant had stated in the past that when he was four years old his father began to physically abuse him and he witnessed domestic violence between his parents.

32. Dr. Miller was provided information concerning claimant's educational history, which was consistent with the information provided during the January 4, 2010 neuropsychological evaluation, performed by Dr. Broomand.

33. Claimant lived at home until he was 18 years old. He got into a physical fight with his parents and left home. During claimant's angry and physical outburst, claimant's parents called law enforcement and ordered him to move out of their house. Claimant lived with a friend for a period of time, was homeless, and lived in his car. For a time, claimant had a homosexual orientation and lived with his boyfriend. He considered having transgender surgery and received hormone therapy in order to become a female. In approximately 2013, he changed his mind and stopped pursuing the treatment. Claimant returned home when he was approximately 24 years old.

34. Concerning claimant's medical history, Dr. Miller noted that he was treated for ADHD starting in 1997. Beginning in 2006, claimant was treated with psychiatric medications, including Wellbutrin, Metadate, Prozac, Depakote, Ritalin, Strattera, Concerta, Zolfot, Adderall, fluoxetine, Zyprexa, Benadryl, Ambien and Focalin. Dr. Diamond managed claimant's psychiatric medications. Claimant reported that he did not benefit from the psychotropic medications and stopped taking them. Claimant also reported to Dr. Miller that he had a prescription for medicinal use of marijuana, which he used as a sleep aid and for recreational purposes.

35. Dr. Miller noted that claimant had been hospitalized twice for psychiatric treatment. In May 2014, he was hospitalized at Kaiser, "following a conflict with his boyfriend, with whom he was living with at the time." Following his discharge from Kaiser, he was placed in "Momentum," which is a "transitional treatment facility." The records from Momentum indicated that while he was at the facility he was able to "socialize appropriately with the other residents." In August 2014, claimant was hospitalized at Sierra for "suicidal thoughts and threats, following a conflict with his parents." The Sierra records indicated that claimant was evaluated during his stay. During claimant's evaluation, it was noted that he had "good eye contact," made "lighthearted jokes" and smiled "appropriately."

36. Dr. Miller reviewed the records prepared by Dr. Diamond regarding his treatment of claimant. On July 7, 2014, Dr. Diamond wrote that claimant had some Pervasive Developmental Disorder "features," but that he was "not clearly Autism Spectrum Disorder." In another report dated August 4, 2014, Dr. Diamond wrote that claimant was "not clearly Autism Spectrum Disorder, but his relatedness and rigid thinking and behavior are challenging." Dr. Miller noted that Dr. Diamond referred claimant to Dr. Ashar. On October 15, 2014, Dr. Ashar "diagnosed him at that time as having Autism Spectrum Disorder, but did not administer to him any psychological tests, in support of this diagnosis."

37. Dr. Miller administered the following tests: Wechsler Adult Intelligence Scale-Fourth Edition (WAIS-IV), Behavior Rating Inventory of Executive Function-Adult Version Informant Report (BRIEF-A), Adaptive Behavior Assessment System-3 (ABAS-3), Millon Clinical Multiaxial Inventory-III (MCMI-III), Rorschach Inkblot Test, EPS: Behavior Rating Scales, Social Responsiveness Scale-Second Edition Parent Report (SRS-2), and Autism Diagnostic Observation Schedule-2-Module 4 (ADOS-2). Dr. Miller described claimant’s behavior during the test as “cooperative and well motivated.” Claimant had “adequate frustration tolerance, and would usually persevere at more difficult tasks, but occasionally he would give up easily if he was uncertain of the correct answer.” Claimant had “significant problems with completion of paper-and-pencil-type tasks due to his nystagmus.” Claimant worked “very slowly,” which resulted in lower scores on timed tasks on the WAIS-IV.

38. On the WAIS-IV, claimant received the following scores:

<u>SCALE</u>	<u>COMPOSITE SCORE</u>
Verbal Comprehension	108
Perceptual Reasoning	92
Working Memory	89
Processing Speed	59
Full Scale	87

Dr. Miller found that claimant’s scores on the WAIS-IV indicated that claimant demonstrated that he is “currently functioning in the low-average-to-average range of intelligence, with a Full Scale IQ score of 87, which places him at the lower 19<sup>th</sup> percentile for his age.” There was a “16 point difference between his Verbal Comprehension and Perceptual Reasoning scores,” which indicated that he performed “significantly better on tasks involving verbal reasoning and expressive language skills, than he does on tasks involving nonverbal reasoning and visual motor skills.” Dr. Miller opined that claimant’s visual processing and eye-hand coordination were significantly below average due to his nystagmus.

Dr. Miller found that claimant’s “overall profile of scores on this test indicates that he is of average intelligence, but he has significant deficits in his ability to perform visual-motor tasks, due to his nystagmus, that causes his eyes to be unable to stay focused on visual materials.” He further stated that claimant has “basic cognitive skills necessary to live independently and to work at a regular job, but his emotional and behavioral problems prevent him from functioning more independently.”

39. Claimant also completed the MCMI-III, which is a “self-administered, objective personality test that is computer-scored and interpreted using a program.” Dr. Miller noted that on this test, claimant:

...had significant elevations on the Schizoid, Avoidant, Antisocial, Schizotypal, Paranoid, Interpersonally Unengaged,

Expressively Impassive, Interpersonally Aversive, Vexatious Representations, Cognitively Mistrustful, and Expressively Defensive Scales.

40. Dr. Miller elaborated on the MCMI-III findings. He stated in part, that:

More specifically, the results of this test indicated that he is an anxious individual who is low in self-esteem and has few outlets for venting his underlying anger, frustrations, and resentment. He is currently experiencing an intense conflict between wanting to withdraw from all contacts with others, and a strong fear of having to become more independent and self-reliant. He may have periods of depersonalization, bizarre behavior and an anxious distrust of others. At one time, he may have wanted to have close relationships with others, but now he avoids interacting with others because he believes that they will disappoint and reject him. He is low in self-esteem and he expects to fail and be humiliated by others. He typically relates to others in a depressive and passively-aggressive manner. He often feels that others do not give him the support he needs. He is prone towards mood and erratic angry outburst. He may withdraw into his fantasy and dream world, to avoid the unpleasant tasks of daily living and to avoid conflicts with others. He is unable to function more independently due to his self-doubts.

41. Dr. Miller further stated that claimant's "overall profile of scores on this test is similar to that of individuals who have been diagnosed as having Schizoid Personality Disorder, Avoidant Personality Disorder, and Paranoid and Antisocial Personality Traits."

42. Claimant's mother completed the ABAS-3, which is an "adaptive-behavior scale that is designed for, and normed on, adults [claimant's] age; and is usually completed by a parent or caretaker." The "responses to the statements provide an overall understanding of a person's ability to function in nine different areas of daily living." Based on those responses, claimant obtained a General Adaptive Composite standard score of 59, which is in the severely impaired range (.03 percentile).

43. Dr. Miller spent approximately three hours with claimant. He noted some of the following behavior observation during the interview portion of the session:

[W]hen the examiner first introduced himself to [claimant] in the waiting room, [claimant] established eye contact and responded appropriately. He related to the examiner in a friendly and cooperative manner, and a good rapport was established with him. He responded readily and appropriately to

questions posed to him. His voice had normal intonation and prosody, but his speech was rapid at times. He spoke in mostly simple, but at times, more complex, sentences. He was able to maintain eye contact, and had appropriate facial expressions. He would sometimes use descriptive hand gestures while talking. His thought processes were linear and goal-directed. There was no evidence of echolalic speech, or idiosyncratic use of words. He did not show any evidence of a hyper- or hypo-reactivity to sounds, sights, odors, or tactile sensations. His affect was somewhat flat, and his mood was euthymic. He rarely smiled. There was no evidence of delusional thoughts, but he is clearly distrustful and suspicious of others, and angry at times, in response to perceived mistreatment by others. He did not appear to be experiencing any auditory or visual hallucinations. He did not express any suicidal or homicidal thoughts. Judgment and reasoning were impaired. His intellectual functioning was determined to be in the average range.

During the interview part of the session, most of the conversation with him [was] one-sided, and focused upon various areas of interest to him. He did not appear to have any fixed areas of interest that he was compelled to talk about. The examiner gave him several opportunities to respond to the examiner's thoughts and feelings, which he did not do. He would, however, offer information about himself, and provide leads for the examiner to follow. He responded appropriately to questions posed to him, but did not initiate conversations. He enjoyed talking about his interests in his cats, cars and motorcycles. When asked what his long-term goals and plans are for his life, he said that he would like to live by himself in an apartment in Folsom, and work as a pharmacist assistant.

44. Dr. Miller also administered the ADOS-2, a "standardized, semi-structured observation assessment tool that allows examiners to observe and gather information regarding an individual's social behavior and communication in a variety of different situations." Dr. Miller noted that "[s]ignificant scores do not automatically mean that an individual has Autism Spectrum Disorder, but only that its presence is a reasonable possibility." Dr. Miller further noted that "the two areas in which individuals with Autism experience the greatest difficulty: Communication and Reciprocal Social Interactions." Claimant scored a "3" for communication and "5" for social interaction, for a total score of "8." Dr. Miller opined that the "overall results of [the]test indicate that [claimant] exhibits the symptoms of Autism Spectrum, but not Autism, to a significant degree."

45. Claimant's mother completed the SRS-2, which "assessed symptoms associated with Autism Spectrum Disorders and Social Communication Disorders." Dr. Miller noted that "results of this scale indicate that his mother sees him as having symptoms of these disorders to a significant degree." Based upon the answers provided by claimant's mother, claimant's score on the SRS-2 was "83." Dr. Miller noted that this was "in the severe range" of Autism Spectrum Disorder. He further stated that "[i]ndividuals in this range have significant deficiencies in reciprocal social behavior, and severe problems with daily social interactions."

46. Dr. Miller utilized the DSM-5 to determine if claimant met the diagnostic criteria of Autism Spectrum Disorder. DSM-5 section 299.00, Autism Spectrum Disorder, states:

The essential features of Autism Spectrum Disorder are persistent impairment in reciprocal social communication and social interaction (Criterion A), and restricted, repetitive patterns of behavior, interests or activities (Criterion B). These symptoms must be present in early childhood and limit or impair everyday functioning. (Criterion C and D). . . . The impairments in communication and social interaction specified in Criterion A are pervasive and sustained. . . . Manifestations of the disorder also vary greatly depending on the severity of the autistic condition, developmental level, and chronological age; hence, the term spectrum. Autism spectrum disorder encompasses disorders previously referred to as early infantile autism, childhood autism, Kanner's autism, high-functioning autism, atypical autism, pervasive developmental disorder not otherwise specified, childhood disintegrative disorder, and Asperger's disorder.

To diagnose Autism Spectrum Disorder, it must be determined that an individual has persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history: (1) deficits in social-emotional reciprocity, (2) deficits in nonverbal communication behaviors used for social interaction, and (3) deficits in developing, maintaining, and understanding relationships. The individual must also have restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history: (1) stereotyped or repetitive motor movement, use of objects or speech, (2) insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior, (3) highly restricted, fixated interests that are abnormal in intensity or focus, and/or (4) hyper- or hypo-

reactivity to sensory input or unusual interest in sensory aspects of the environment. In addition, symptoms must be present in the early developmental period and must cause clinically significant impairment in social, occupational, or other important areas of current functioning.

47. In his report, Dr. Miller included a chart containing the DSM-5 Diagnostic Criteria for Autism Spectrum Disorder. Dr. Miller provided specific examples in the chart concerning claimant's conduct, which supported his findings. At hearing, Dr. Miller testified that in order to meet the diagnostic criteria for Autism Spectrum Disorder, claimant must meet all three criteria under reciprocal social communication and social interaction (Criterion A). Claimant met two of three criteria. Under restricted, repetitive patterns of behavior, interests or activities (Criterion B), claimant must meet two of the four criteria. Claimant met one of the four criteria. Dr. Miller concluded that claimant met "some, but not all of the basic DSM-5 diagnostic criteria for Autism Spectrum Disorder, *and this disorder has been ruled out.*" (Italics in original.)

48. Dr. Miller also concluded that claimant did not meet the diagnostic criteria for intellectual disability. The DSM-5 sets forth the following criteria that must be met for a diagnosis of intellectual disability:

Intellectual Disability (intellectual developmental disorder) is a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains. The following three criteria must be met:

A. Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing.

B. Deficits in adaptive functioning that result in failure to meet developmental and socio-cultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.

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

49. Dr. Miller opined that claimant's evaluation demonstrated that he is functioning in the "low-average-to-average range of intelligence, with a Full Scale IQ of 87 on the WAIS-IV, which places him at the 19<sup>th</sup> percentile for his age." He further stated that his "adaptive behavior skills, as assessed by the ABAS-3, are in the extremely low range" with a General Adaptive Composite score of 59. Dr. Miller opined that claimant's "deficits in adaptive behavior are mostly due to emotional/behavior factors and lack of motivation, rather than a lack of knowledge or skill to be able to perform tasks of daily living more independently." As a result, Dr. Miller concluded that claimant does not meet the DSM-5 diagnostic criteria for Intellectual Disability.

50. Dr. Miller stated that, "[c]onsistent with is reported history, [claimant] has always had problems with hyperactivity, distractibility, poor impulse control, and a short attention span." Dr. Miller opined that claimant would meet the criteria for "**Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Presentation.**" (Bolding in original.)

51. Dr. Miller further opined that:

While the results of the ADOS-2 and SRS-2 indicate that he may have Autism Spectrum Disorder, the results of the MCMI-III, along with information about his personal history, indicate that he probably has a **Bipolar-Related Disorder**, along with **Schizoid, Avoidant, Paranoid**, and **Antisocial** personality traits. (Bolding in original.)

Dr. Miller further opined that claimant "does not appear to meet all of the diagnostic criteria for Bipolar Disorder, he has significant and, at times, abruptly changes in his mood, that are [an] over-reaction to the situation he is in at the moment." In addition, he explained that there are "symptom overlap amongst schizoid, avoidant, and paranoid personality traits, and Autism Spectrum Disorder, and all of them can cause problems and conflicts in social relationships."

52. Dr. Miller wrote that if claimant were motivated, he would "benefit from various services in the community," such as "instruction on daily living skills," and "cognitive/behavioral therapy," as well as "mood-stabilizing medication."

*July 7, 2015 Evaluation Prepared by Dr. Ashar and Vanessa Fontes, Psy.D*

53. After Dr. Miller issued his report and ACRC notified claimant's mother that her request for services for claimant from ACRC under the Lanterman Act was denied, Dr. Diamond again referred claimant to Dr. Ashar at the Autism Spectrum Disorder Center at Kaiser. At hearing, Dr. Diamond testified that he was aware that there was going to be an appeal of ACRC's denial of claimant's request for services. Dr. Diamond believed that an evaluation from the Autism Spectrum Disorder Center would be helpful to "confirm and elaborate on the diagnosis" that Dr. Ashar gave claimant on October 15, 2014.

54. On July 7, 2015, Dr. Ashar and Vanessa Fontes, Psy.D, a clinical psychologist conducted an “Autism Spectrum Disorder Evaluation” and issued a report, which was signed by Dr. Fontes. At hearing, Dr. Ashar testified that the July 7, 2015 evaluation was a “continuation” of the evaluation she performed on October 15, 2014. The purpose of the July 7, 2015 evaluation was to perform a “more comprehensive assessment” to determine if claimant had “IQ” issues or adaptive living skills issues, and to “further confirm the diagnoses of autism.” Dr. Ashar denied that the evaluation was performed for purposes of the fair hearing. Dr. Ashar served as a consultant to Dr. Fontes during the evaluation. Dr. Fontes administered tests, which included the ABAS-II, ADOS-2, and WAIS-IV. Dr. Fontes also interview claimant and his parents. Dr. Fontes did not list any medical records she reviewed as part of the assessment. However, Dr. Fontes provided a letter dated January 27, 2016, that stated she reviewed claimant’s Kaiser records.

55. The report indicated that claimant’s parents were first concerned about claimant when he was two years old. Specifically, they were concerned about his “rigidity and fixation with certain activities with no regard for the enormous amount of time he spends on them, his anger outbursts, inability to express his feelings, lack of interest/motivation, and poor communication skills.” It was further reported that he lacked empathy for others, did not have friends his age and was fixated on specific topics. Claimant’s mother reported that at one point claimant appeared to be “homophobic,” but then became fascinated with transgender individuals. He sought treatment to become transgender but then “lost interest.” There is no mention in the report that claimant had sexual relationships with both men and women.

56. Dr. Fontes noted that for the interview portion of the evaluation, claimant arrived 45 minutes late. Claimant’s mother arrived on time and was present during the “feedback session” with claimant. Dr. Fontes documented the following behavior observations of claimant during the evaluation:

When the examiner greeted [claimant], he did not make eye contact. He appeared rather upset about the appointment and started talking about politics and bureaucracy. At times, his speech appeared rather scripted as he spoke about things he did not appear to comprehend and he spoke out of context. He appeared to initially refuse to comply with testing, however after a short while he complied and completed the necessary assessments. He appeared tired and he nodded off during some of the test administration, as which point the examiner attempted with success to wake him simply by talking. Once awake he continued to answer the administration questions. Throughout the evaluation, he continued to speak about politics, about his interest in listening to news broadcasting, and about being “homeless.” He rarely appeared interested in interacting with the examiner, despite her attempts to talk about her interests.

57. Dr. Fontes administered the WAIS-IV. Claimant received the following scores:

<u>SCALE</u>	<u>COMPOSITE SCORE</u>
Verbal Comprehension	107
Perceptual Reasoning	86
Working Memory	71
Processing Speed	81

A full scale score was not listed in the report. Dr. Fontes did not opine as to whether claimant had an intellectual disability, nor did she comment on the results of the WAIS-IV as it related to her assessment of claimant.

58. Dr. Fontes also administered the ADOS-2. Dr. Fontes concluded that claimant's "total scores (Communication + Social Interaction) fell within the classification of autism." Dr. Fontes did not list the ADOS-2 scores in the report. Dr. Fontes noted that claimant's speech was "rather rapid and jerky." She also noted that he "occasionally used stereotyped utterances and odd use of words," but she did not provide any examples. Claimant also "lacked back-and-forth conversation skills." He used "spontaneous conventional and instrumental gestures, with some limited descriptive gestures." In addition, his "eye contact was poorly linked with other forms of communication to initiate, regulate, or terminate social interaction with the examiner." Dr. Fontes noted that claimant would "smile to himself at his own comments, but did not appear to direct his smiles to the examiner."

59. Under the "Impressions" section of the report, Dr. Fontes wrote that the results of the evaluation were "suggestive of Autism Spectrum Disorder." Dr. Fontes concluded that claimant "[e]xhibits all DSM-5 criteria under A, as well as B2, B3, C, D, and E." Dr. Fontes included a chart containing the DSM-5 Diagnostic Criteria for Autism Spectrum Disorder. Dr. Fontes did not provide any examples in the chart concerning her observations of claimant's conduct, to support her findings.

60. Neither Dr. Ashar nor Dr. Fontes conducted testing to identify differential diagnoses to determine whether claimant met the criteria for any other disorders or conditions. Nor were there any diagnoses ruled out. Dr. Ashar testified that it is Kaiser's standard of practice to complete differential diagnoses when performing autism assessments. Dr. Ashar contended that Dr. Diamond completed the differential diagnosis. However, Dr. Diamond did not complete a differential diagnosis.

61. Dr. Ashar was also not aware of the January 4, 2010 neuropsychological evaluation performed on claimant by Catherine Broomand, Ph.D. As a result, she was not aware that Dr. Broomand had ruled out that claimant had a Pervasive Developmental Disorder. Dr. Ashar did not review claimant's medical records from Sierra. Dr. Ashar was not aware that claimant had been hospitalized two times for 5150 holds in 2014. She also was not aware that claimant smoked marijuana. Dr. Ashar acknowledged that marijuana use can have an effect on a person's mental status.

62. Dr. Ashar also did not review claimant's education records. She was not aware that he graduated from high school. She also was not aware of claimant's daily activities or that he held a job.

*Additional Testimony at Hearing*

CYNTHIA ROOT, PH.D.

63. Cynthia Root, Ph.D., is a Staff Psychologist employed by ACRC. She has been a licensed clinical psychologist since 2008. Dr. Root has over seven years of experience completing and reviewing assessments for intellectual disability and autism. She is also trained to administer and interpret ADOS-2 results. In addition to performing evaluations, Dr. Root is part of the ACRC eligibility review team. She reviewed assessments and evaluations performed by vendored psychologists. Dr. Root was part of the eligibility team that reviewed claimant's request for services under the Lanterman Act.

64. At the hearing, Dr. Root testified about whether the exhibits admitted into evidence indicated that claimant was eligible for services from ACRC. Dr. Root reviewed all of the information submitted concerning claimant, including all assessments performed, and claimant's medical and education records, to determine if he qualified for services under any of the five developmental disabilities delineated in the Lanterman Act: intellectual disability, cerebral palsy, epilepsy, autism, and/or a disabling condition found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability (fifth category).

65. Dr. Root reviewed the report issued by Dr. Miller. She found the report to be comprehensive and performed pursuant to the best practice standards for completing a psychological evaluation and testing report. Dr. Miller listed all of the records he reviewed, including educational and medical records. Dr. Miller provided specific examples of his observations to support his findings. He also listed differential diagnoses. Dr. Root opined that Dr. Miller appropriately ruled out Autism Spectrum Disorder and she agreed with the diagnosis of Bipolar Disorder, Unspecified Personality Disorder, and ADHD. She agreed that many of claimant's symptoms, such as difficulties with eye contact, social interactions, and rigidity can be symptoms of Autism Spectrum Disorder. However, based on the entirety of the information reviewed by Dr. Miller, claimant's symptoms could be better explained by the diagnoses Dr. Miller identified.

66. In contrast, Dr. Root opined that Dr. Ashar and Dr. Fontes failed to complete a comprehensive evaluation. Dr. Fontes did not list any educational records or medical records that she reviewed. Dr. Ashar was not aware of the January 4, 2010 neuropsychological evaluation performed by Dr. Broomand. Dr. Ashar was also not aware that claimant was hospitalized on 5150 holds in 2014, or that he used his marijuana. There was also no information in the report that Dr. Ashar or Dr. Fontes considered any differential diagnoses.

67. In addition, Dr. Root opined that Dr. Fontes used “canned” language and generic information for the examples listed for the ADOS-2. The standard of practice required that Dr. Fontes include specific examples and less generic information in that section. Similarly, Dr. Fontes failed to provide any comments or examples to explain how claimant met the DSM-5 criteria for Autism Spectrum Disorder. Dr. Root disagreed with the diagnosis of Autism Spectrum Disorder rendered by Dr. Ashar and Dr. Fontes. Dr. Root opined that the July 7, 2015 evaluation contained significant flaws that adversely affected the conclusion and were not substantiated by the totality of the records related to claimant.

68. In sum, Dr. Root opined that based upon the totality of the record, claimant did not qualify for services from ACRC under the Lanterman Act.

#### CLAIMANT’S MOTHER

69. Claimant’s mother testified that after claimant was hospitalized at Sierra in July 2014, she and Dr. Diamond decided that they needed to “step back” and find another diagnosis for claimant. Shortly thereafter, Dr. Diamond referred claimant to Dr. Ashar. After Dr. Ashar diagnosed claimant with Autism Spectrum Disorder, Dr. Diamond told claimant’s mother to seek outside help for claimant in the form of regional center services. As a result, claimant’s mother sought services for claimant from ACRC.

70. Claimant’s mother testified that claimant’s conduct during the assessment performed by Dr. Miller was a result of his marijuana use, not psychiatric disorders as opined by Dr. Miller. Claimant’s mother contended that claimant had a medical marijuana card that allowed him to use marijuana to help him sleep. Since the evaluation performed by Dr. Miller, she has taken claimant’s medical marijuana card, and discouraged him from smoking marijuana.

71. Claimant continues to live at home sporadically and is working, but does not keep the same job for more than a few months. Claimant’s mother believes when he does not live at home, he lives on the streets and in homeless shelters. She would like ACRC to help claimant find work and live independently.

#### *Discussion*

72. When all the evidence is considered, claimant’s mother did not establish that claimant is eligible for services from ACRC under any of the categories of developmental disabilities covered under the Lanterman Act. Dr. Miller’s and Dr. Root’s opinions that claimant is not an individual with autism or an intellectual disability, and did not qualify for services under the fifth category, were persuasive. Although claimant has adaptive functioning deficits as a result of his ADHD, and mental disorders, the evidence did not establish that these deficits were due to any developmental disability recognized in the Lanterman Act. Dr. Miller’s evaluation is comprehensive, thorough, and well-reasoned. His conclusions are persuasive.

In contrast, the evaluation performed by Kaiser is lacking in many respects. The evaluation does not take into consideration claimant's educational history or the entirety of his medical history, including the assessment performed by Dr. Broomand in 2010. Dr. Fontes and Dr. Ashar also failed to consider differential diagnoses that may have better explained claimant's symptoms. As a result, the evaluation performed by Kaiser is not reliable.

73. The legislature made the determination that only individuals with one or more of the five specified types of disabling conditions identified in the Lanterman Act are eligible for services from regional centers. The legislature chose not to grant services to individuals who may have other types of disabling conditions, including mental health disorders, if they cannot show that they fall within one of the five categories delineated in the act. In addition, the legislature provided that, in order for an individual to qualify for services under the Lanterman Act, the individual's developmental disability must be substantially disabling and must be the cause of the adaptive deficits as to which the requested services relate. Although the result may seem harsh, particularly for individuals with mental health disorders, the legislature did not grant regional centers the authority to provide services to individuals whose disabilities fall outside the five specified categories. Because claimant's mother did not show that claimant is an individual with autism or an intellectual disability, or that he has a disabling condition that is closely related to intellectual disability or requires treatment similar to that required for individuals with intellectual disability, she did not establish that claimant is eligible for services under the Lanterman Act. Consequently, her request for services from ACRC must be denied.

## LEGAL CONCLUSIONS

1. Pursuant to the Lanterman Act, Welfare and Institutions Code section 4500 et seq., regional centers accept responsibility for persons with developmental disabilities. Welfare and Institutions Code section 4512 defines developmental disability as follows:

“Developmental disability” means a disability that originates before an individual attains age 18 years, 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 [commonly known as the “fifth category”], but shall not include other handicapping conditions that are solely physical in nature.

2. California Code of Regulations, title 17, section 54000, further defines the term “developmental disability” as follows:

(a) “Developmental Disability” means a disability that is attributable to mental retardation, cerebral palsy, epilepsy, autism, or disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation.

(b) The Development Disability shall:

(1) Originate before age eighteen;

(2) Be likely to continue indefinitely;

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

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

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

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

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

3. As set forth in the Factual Findings, claimant's mother did not establish that claimant qualifies for services under the Lanterman Act because he is an individual with autism or an intellectual disability, or because he has a disabling condition that is closely related to intellectual disability or requires treatment similar to that required for individuals with an intellectual disability. Consequently, she did not establish that claimant qualifies for services from ACRC under the Lanterman Act. Claimant's appeal must therefore be denied.

#### ORDER

Claimant's appeal is DENIED. Alta California Regional Center's denial of services to claimant under the Lanterman Act is SUSTAINED.

DATED: March 10, 2016

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MARCIE LARSON  
Administrative Law Judge  
Office of Administrative Hearings

#### NOTICE

**This is the final administrative decision in this matter. Each party is bound by this decision. An appeal from the decision must be made to a court of competent jurisdiction within 90 days of receipt of the decision. (Welf. & Inst. Code, § 4712.5, subd. (a).)**