BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: ANDREW S., Claimant, vs. NORTH LOS ANGELES REGIONAL CENTER, Service Agency.	OAH No. 2012080253

DECISION

This matter was heard by Julie Cabos-Owen, Administrative Law Judge with the Office of Administrative Hearings, on January 8, 2013, in Santa Clarita, California. Andrew S. (Claimant) was represented by his parents and authorized representatives, Jennifer S. and Justin S.[1] North Los Angeles County Regional Center (NLACRC or Service Agency) was represented by Stella Dorian.

Oral and documentary evidence was received, and argument was heard. The record was closed, and the matter was submitted for decision on January 8, 2013.

ISSUE

Does Claimant have Autistic Disorder, thus entitling him to receive regional center

[1] Claimant's and his parents' initials are used in lieu of their last names to protect their privacy.

services?

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FACTUAL FINDINGS

1. Claimant is an 10-year-old male (born September 25, 2002). He seeks eligibility for regional center services based on a diagnosis of autism.

2. On May 21, 2012, NLACRC sent a letter and a Notice of Proposed Action to Claimant's mother, informing her that NLACRC had determined Claimant is not eligible for regional center services. Claimant's father requested a fair hearing. (Exhibit 1.)

3(a). On May 7, 2008, when Claimant was five years, eight months old, he underwent a psychological evaluation by Kim B. Barrus, Ph.D. His parents had requested an evaluation because he was having great difficulty in school. Dr. Barrus noted that Claimant was taking Risperdal prescribed by his psychiatrist, Dr. John Beck.

3(b). Dr. Barrus noted that Claimant had no abnormal history and that "[t]here was no problem with motor development or language development; no problems with social development. No behavior, discipline or temperament problems noted." He also noted that "[h]e does not have any social problems at school or negative comments from teachers." (Exhibit 3.)

3(c). In his Mental Status/Behavioral Observations, he stated that Claimant "seemed hyperactive and fidgety and hard to stay on task. No depression was noted. There was considerable anxiety noted and moodiness noted. He was very impulsive. No psychosis, suicidal or homicidal ideation was noted." Dr. Barrus preliminarily noted that

"Classic Attention Deficit Hyperactivity Disorder [(ADHD)]" was "probable" and that "Mood Disorder" was "possible." (Exhibit 3.)

3(d). To assess Claimant's cognitive functioning, Dr. Barrus administered the Wechsler Preschool and Primary Scall of Intelligence – Third Edition (WPPSI-III). The measure of his overall intellectual abilities was in the average range (Full Scale IQ of 91). His verbal and performance abilities were also in the average range (VIQ – 93; PIA – 96). (Exhibit 3.)

3(e). Following testing for variables of attention, Dr. Barrus' impression was that Claimant had "severe problems with attention and impulse control." (Exhibit 3.)

3(f). Dr. Barrus administered the Gilliam Asperger's Disorder Scale and found a"Borderline probability of Asperger's Disorder." He also administered the Gilliam Autism Rating Scale and found "Low probability of Autistic Disorder." (Exhibit 3.)

3(g). After administration of a Young Mania Rating Scale, Dr. Barrus noted that Claimant's scores "indicate a very high probability of bipolar disorder or cyclical mood disorder." He further noted that, as reported by Claimant's parents, "It is noted that on a daily basis, he hits the kids at school, no one can get a word in edgewise, he talks so fast and his thoughts are going so fast that no one ca seem to make any sense of what he is saying. He switches mood like "night and day". His brain doesn't let him be nice, the patient states. He lies incessantly." (Exhibit 3.) In administering a Bi-polar Spectrum Disorder Questionnaire and a Mood Disorder Questionnaire, Dr. Barrus noted that Claimant reported possible mood swings and that most of the 15 bipolar symptoms were noted in Claimant.

3(h). In his summary, Dr. Barrus stated:

> [Claimant] is having serious behavior problems at school and with the family, and he is being treated with Risperdal by his

psychiatrist, which helps mitigate some of his impulsivity and moodiness.

The patient has a positive family history for mood disorder. In addition, his cognitive functioning is in the low average range; his mental stamina is probably compromised by his slow cognitive processing, making following directions or absorbing new information or ideas difficulty [sic] or strenuous.

Cognitive testing indicated average IQ, his processing speed is compromised somewhat, suggesting that he does not process information quickly or easily and this may be a factor; his verbal IQ is lower than his performance IQ, but both are in the low average range indicating he may have trouble catching on easily to items being taught or instructions being given.

[¶] . . . [¶]

There was some mild to moderate indication of Asperger's Disorder or High Functioning Autism Disorder and finally, there is significant indication of a severe mood disorder. He also has severe problems with sustained attention and impulse control.

(Exhibit 3.)

3(i). Dr. Barrus diagnosed Claimant as follows:

AXIS I: 299.00 - High Functioning Autism

R/O 299.80 - Bipolar Disorder NOS

314.01 - Attention Deficit Disorder with Hyperactivity

315.9 – Learning Disorder NOS[2]

AXIS II: 799.9 Defer

AXIS III: 799.9 Defer

(Exhibit 3.)

3(j). Although Dr. Barrus diagnosed Claimant with "High Functioning Autism," this is not a diagnosis under the DSM-IV-TR. (DSM-IV-TR, pp. 69-84;Testimony of Sandi Fischer, Ph.D.) Code 299.00 refers to Autistic Disorder (DSM-IV-TR, p. 70), but in his report Dr. Barrus indicated a likelihood of only Asperger's Disorder, not Autistic Disorder. Furthermore, although Dr. Barrus diagnosed Claimant with a learning disorder, his report does not substantiate this diagnosis since no tests of academic functioning were administered. (Testimony of Sandi Fischer, Ph.D.) Consequently, Dr. Barrus' report was given less weight than other evaluations of Claimant, set forth below.

4(a). On March 12, 2010, Claimant was voluntarily admitted to BHC Alhambra Hospital after becoming assaultive towards his two-year-old sister and punching himself in the head several times. His parents reported that, at two years old, Claimant began a

[2] The diagnoses and their codes were derived from the Diagnostic and Statistical Manual of Mental Disorders, 4th ed., Text Revised (DSM-IV-TR), published by the American Psychiatric Association. The Administrative Law Judge takes official notice of the DSM-IV-TR as a generally accepted tool for diagnosing mental and developmental disorders.

history of numerous unsuccessful medication trials, including Zyprexa, Depakote, Concerta, Abilify, Tofranil, Ritalin, Risperdal, Strattera, Vyvanse and Focalin. At the time of his admission he had been taking Seroquel, but it was ineffective. (Exhibit 18.)

4(b). On admission, a mental status examination was conducted. The physician conducting the evaluation noted that Claimant was "quite inattentive and is not able to sit still. The patient has no focus whatsoever. The patient is inattentive throughout the interview. . . . Mood and Affect: Dysphoric and anxious. Thought Process: Concrete. . . . Insight and Judgment: Impaired. Impulse Control: Impaired." (Exhibit 18.)

4(c). Claimant's admission diagnoses were: Mood Disorder, not otherwise specified; rule out Major Depression; Rule out Bipolar Disorder; rule out Schizoaffective Disorder; rule out ADHD. (Exhibit 18.)

4(d). On admission, Claimant was started on Adderall XR and his Seroquel was discontinued. (Exhibit 18.)

4(e). On March 14, Claimant was noted to be inappropriately grabbing other patients' private parts. On March 15, Claimant "was agitated and has been hitting himself. [He] demonstrated extremely poor insight, judgment, and impulse control. The patient was also noted to report visual hallucination and auditory hallucination of leprechauns with gold. [His] Adderall XR [was increased]. Abilify . . . for psychosis and mood swings was initiated." On March 18, Claimant "continued to be somewhat bizarre and easily agitated. [He] continued to experience auditory and visual hallucination. [His] Adderall XR was increased [again]." (Exhibit 18.)

4(f). On March 21, 2010, Claimant was discharged with a guarded prognosis after nine days "in stable condition." His discharge medications were Adderall XR and Abilify. His discharge diagnoses were Psychosis, not otherwise specified, and ADHD. (Exhibit 18.)

5(a). On April 14, 2010, when Claimant was seven years, six months old and in second grade, he underwent a School Nurse Health Assessment to evaluate his eligibility

for special education. The nurse noted that he had been diagnosed with ADHD, and that he had been hospitalized from March 8, 2010, through March 21, 2010, after demonstrating "severe physically acting-out behavior towards others (aggressive towards younger sister) an self-harmful behavior." His hospital discharge diagnosis was "ADHD and Psychosis." (Exhibit 4.)

5(b). Claimant's prior medications included: "Risperdal (2007); Focalin (2008); Vyvanse (2009); Strattera (5/2009); . . . Concerta (2010); Depakote (2010); Zyprexa (3/2010); [and] Seroquel (3/2010). Claimant began taking Clonidine twice a day "for behavior control after acting-out behaviors continued to be exhibited on playground, in class (hands-off violations), and home." (Exhibit 4.)

5(c). Claimant's school disciplinary records from October 2008 through August 2010 list his numerous aggressive actions, including hitting other students on numerous occasions, punching students in the stomach and in the face, poking a student in the eye, hitting a student in the face, kicking a student in the groin, throwing sand in a student's face, throwing items (paper, eraser, scissors), and refusing to cooperate with the teacher.

5(d). The Nursing Diagnosis and Health Accommodations were stated as follows: "Risk for self-directed and other-directed physical violence; requires close monitoring on campus. Impaired social interaction; positive reinforcement when appropriate peer interactions occur." (Exhibit 4.)

5(e). Although Claimant was hospitalized for 13 days, he did not have a discharge diagnosis related to Autistic Disorder or any Pervasive Developmental Disability. Additionally, nothing in the School Nurse Health Assessment report suggested that Claimant suffered from Autistic Disorder. (Testimony of Dr. Fischer.)

6(a). On May 6, 2010, as part of an initial Individualized Education Plan (IEP), Claimant underwent a psycho-educational evaluation. He was administered the Wechsler Intelligence Scale for Children – Fourth Edition (WISC-IV), and obtained a Full Scale IQ

score of 103 (average range). His Verbal Comprehension and Working Memory scores were in the average range (93 and 97 respectively), and his Perceptual Reasoning and Processing Speed scores were in the high average range (110 and 112 respectively). (Exhibit 5.)

6(b). Claimant's mother was concerned about Claimant's reading skills and his behavior. She stated that they were having great difficulty finding the correct medication to address is medical issues, and that he was on multiple medications. Claimant's teacher reported that Claimant was "very outgoing and social," but that his work completion was very poor and that he was often off-task. She noted that he required constant reminders and assistance to complete work. Claimant's teacher was concerned about the "anger episodes [he] sometimes demonstrates at school." She also noted that, "when he gets frustrated and upset, he completely shuts down. He requires a lot of repetition and praise to succeed." Neither Claimant's parents nor his teachers noted any concerns with his adaptive capabilities. (Exhibit 5.)

6(c). His teacher's description of him as "outgoing and social" is not consistent with a child suffering from Autistic Disorder. (Testimony of Dr. Fischer.)

6(d). Claimant did appear to suffer from deficits in his auditory processing skills. He was administered the Test of Auditory Processing Skills (TAPS-3), and scored in the delayed range on several subtests, including Number Memory Forward, word Memory, Sentence Memory, Auditory Comprehension and Auditory Reasoning. (Exhibit 5.)

6(e). Despite these auditory processing delays and his diagnosis of ADHD, Claimant's school district found that he "did not meet eligibility criteria for Special Education services as a student with a Specific Learning Disability. (Exhibit 5.)

7. Nevertheless, Claimant was found eligible for Special Education services under the category of Other Health Impairment (OHI), based on the determination that his "medical issues of Psychosis and ADHD are impacting his ability to be successful in general

education." (Exhibit 6.)

8(a). On September 15, 2010, another psycho-educational evaluation was conducted, when Claimant was seven years, eleven months old and attending third grade.

8(b). Claimant's teacher from the prior year stated that Claimant was "very outgoing and social. He is very good at math. [She was] concerned that [Claimant's] work completion is very poor." (Exhibit 7.) Claimant's third grade teacher reported that Claimant's behaviors varied daily. Some days he would arrive half asleep, lower his head and sleep. Most days, he would arrive and start running around from student to student and could not sit down to complete his work. She reported that Claimant "interacts very well with her, constantly talking to her even when she is trying to give instructions to the class." Although she observed that he was "pretty happy," she also noted that he demonstrated inappropriate behaviors including taking items off students' desks, running around the classroom, hitting peers, and making noises and arm movements "that draw a lot of attention to him." (Exhibit 7.)

8(c). In October 2010, when an examiner arrived at Claimant's classroom, "the moment he saw the examiner, he recognized the examiner and said, 'Hi' and proceeded to explain to the examiner what the class was doing." (Exhibit 7.) Also in October 2010, Claimant was observed "constantly attempting to hold [another] student's attention, trying to make him talk and laugh with him." (Exhibit 7.)

8(d). The evaluator noted that there was evidence that Claimant suffered from an emotional disturbance, that there was evidence of a processing problem, and that Claimant showed signs of an attentional deficit which had a noticeable impact on his educational achievement. (Exhibit 7.)

9. Claimant's behaviors noted in the September 2010 psycho-educational evaluation were not suggestive of a diagnosis of Autistic Disorder, since children suffering from Autistic Disorder do no initiate interactions with others. (Testimony of Dr. Fischer.)

10. A May 10, 2011 IEP documented that Claimant's primary qualifying disability for special education services had changed to "Emotional Disturbance (ED)" and that OHI became his secondary disability for special education eligibility. He was moved to a special day class. It was noted that Claimant was "able to communicate his needs at an age appropriate level" and that his "adaptive skills are not an area of concern." (Exhibit 8.)

11. A January 2012 IEP noted that Claimant's communication development and adaptive/daily living skills were age appropriate. However, it was also noted that he "consistently talks over others and struggles to engage in reciprocal conversations." Claimant was described as an "intelligent, outgoing, caring student. He is friendly and is very imaginative." (Exhibit 10.)

12(a). On March 24, 2012, a Mental Health Assessment was conducted by a Licensed Clinical Social Worker (LCSW) with the Los Angeles County Department of Mental Health.

12(b). Claimant's parents reported that Claimant "makes up stories to get attention and is 'manipulative' on a daily basis. They stated that he tries to play his parents and school staff against each other in order to get privileges which he would not otherwise receive." (Exhibit 12.) This demonstrates a sophisticated social understanding, and it is unlikely for children with Autistic Disorder to figure out how to "play people against each other" because one would need to understand how social interactions work, an ability that a person with Autistic Disorder is unlikely to possess. (Testimony of Dr. Fischer.)

12(c). During the assessment, the LCSW noted that Claimant "wanted to learn how to behave better so that he could earn his parents' trust and have better peer relationships." (Exhibit 12.)

12(d). The assessor recommended that Claimant receive: individual therapy once per week, for 45 minutes each session; family therapy once every two weeks, for 50 minutes per session; a medication evaluation; and a follow-up with a psychiatrist if

medications are prescribed. (Exhibit 12.)

13(a). On April 11, 2012, on referral by NLACRC, licensed psychologist Anna Levi, Psy.D., conducted a psychological evaluation of Claimant to determine his current level of functioning and to assess him for possible autistic characteristics. The evaluation included a review of records, an interview with Claimant's parents, observations of Claimant, and administration of diagnostic tools for measuring cognitive functioning, adaptive skills and autistic characteristics. Claimant was nine years, six months old. (Exhibit 13.)

13(b). Dr. Levi noted:

> [Clamant] reportedly does not make eye contact, but has a range of facial expressions that he shares with others, including shared enjoyment. He shows things of interest and sometimes offers to share his things. He plays pretend with children, follows a child's lead and can play board games, but usually ends in a tantrum because he forces his rules and makes his own game to make it favorable for him to win as he has a very hard time losing. . . . He mentions friends, but his parents believe he does not have them. He played inappropriately with family friends, showing his private area and often puts hands in his private area. He tries to change the topic when someone is upset and, instead of offering comfort, he avoids emotional subjects. When he initiates contact, his eye contact is lacking, although he verbally initiates well and does not stop talking. He talks at wrong times and off topic. He gives lengthy explanations eventually getting his experience across. He repeats parts of sentences and repeats requests (what he wants) over and over.

> When he is interacting one-on-one, his is mostly appropriate. In a group, he is seeking negative attention a lot of the time. . . . There is no history of repetitive, idiosyncratic or stereotypic language. He is fascinated with weapons and makes anything into a weapon in any play activity, such as using a fanny pack's straps as a weapon. Certain characters and pictures catch his attention in games, such as Mario and [Luigi]. . . He has a collection of cars that he keeps in a special order, but they sometimes get mixed up. There are no nonfunctional routines or rituals reported. He kicks his legs, is always moving and fidgeting. There is no repetitive use of objects or preoccupations with parts of objects, but he gets attached to an object and carries it everywhere, using it for anything, such as a container that he can use to store something inside. He is a "hoarder" according to his parents as he picks up many different items, like a used fork or milk bottle, and keeps them.
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> (Exhibit 13.)

13(c). Dr. Levi administered the Wechsler Abbreviated Scale of Intelligence (WASI), and Claimant obtained a Full Scale IQ score of 94.

13(d). Dr. Levi administered the Vineland Adaptive Behavior Scales (VABS-II) to assess Claimant's adaptive functioning; his parents were the respondents. Based on his parents' reporting, Claimant's communication skills were in the low borderline range, his social skills were mildly deficient, and his daily living skills were in the low borderline range. (Exhibit 13.) These VABS-II scores were inconsistent with information from Claimant's IEPs

indicating that his adaptive skills were age appropriate. (Testimony of Dr. Fischer.)

13(e). The Autism Diagnostic Observation Schedule, Module 3 (ADOS-3) was administered. Claimant's overall scores and his score in communication were below the autism and autism spectrum range. His score in social interaction was in the autism-spectrum range, but not in the autism range. [3]

13(f). The Autism Diagnostic Interview – Revised (ADI-R) was administered with Claimant's parents as respondents. Based on their responses, Claimant's scores in reciprocal social interaction, communication and restricted repetitive behavior were below the autism cutoff.

13(g). In evaluating the DSM-IV-TR criteria for diagnosing Autistic Disorder, in the category of Social Interaction, Dr. Levi noted that Claimant had a qualitative impairment in "the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures and gestures to regulate social interaction. She also noted a qualitative impairment in that Claimant demonstrated a "lack of social or emotional reciprocity." In the category of Communication, Dr. Levi noted a qualitative impairment in Claimant's "ability to initiate or sustain a conversation with others." No other qualitative impairments were noted. (Exhibit 13.)

13(h). Dr. Levi diagnosed Claimant with ADHD. She noted that, "[a]lthough he shows these [three] autistic characteristics, they are too few and mild to meet the DSM-IV-TR criteria . . . for Autistic Disorder or another Pervasive Developmental Disorder." (Exhibit 13.)

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[3] Although the body of Dr. Levi's report indicated that Claimant's scores in these three areas "were in the autism range," the actual scores documented at the end of her report indicated that his scores were not in the autism range. Consequently, it appears that the body of Dr. Levi's report erroneously neglected to include the word "not" before the words "in the autism range."

14(a). On June 4, 2012, Katherine A. Donahue, Ph.D., with Kaiser Permanente, conducted an evaluation of Claimant "to determine whether he meets the diagnostic criteria for an Autism Spectrum Disorder."

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14(b). Dr. Donahue noted Claimant's history, which included newly reported behaviors:

> Social Difficulties
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> Although [Claimant] is motivate to engage with peers, he struggles to sustain social interactions and friendships. Generally, [Claimant's] ability to interact with others is highly dependent upon his mood. When he does interact, such interactions are on his own terms, he attempts to control the play, and struggles to share and take turns. If he is not "in the mood" to interact with others [Claimant] will play by himself, avoid social interactions, and can present as aloof and distant at such times.
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> Communication
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> [Claimant] is capable of using language to communicate and get his needs met, but he does not consistently initiate conversations, seems to ignore what is said to him, and struggles to sustain a two-way conversation at times. His eye contact is poor, and he does not always look at others during conversations. It was also reported that his affect is

generally flat and he fails to demonstrate a range of facial expressions. At times, his speech will be garbled and difficult to understand, and he will repeat phrases over and over when his demands are not being met. For example, he has said "hungry" repeatedly when his parents did not immediately respond to his request for food. Furthermore, [Claimant] often struggles to understand jokes, metaphors, and figures of speech. [Claimant's parents] also reported that he will often repeat dialogues from movies, although occasionally he quotes will be appropriate to the conversation.

Restricted Areas of Interest/Repetitive and Stereotyped Behaviors

From early childhood, [Claimant] has been fond of spinning, flapping and rocking. When distressed, he will head-bang. He also has a long standing history of lining up his toys, being fascinated by parts of objects, and looking at things/toys from unusual angles. [Claimant's parents] stated that [Claimant] does not have any rituals, but that he often struggles with even minor changes in routine.

Other Behaviors of Concern

[Claimant] has a longstanding history of severe physical aggression toward family, peers, and school staff including: hitting, kicking, and throwing things. On two, separate

occasions, he attempted to attack his peers with a pencil and a pair of scissors. His aggression is so severe that he has been on medications to control his behavior and aggression since the age of two and one-half years. . . . According to [Claimant's mother], the family needs to "get the children out of the home" when [Claimant] is "raging] to avoid injuries. He also has a fascination with weapons, but he does not have access to weapons in the home. [Claimant's] mood was described as labile, and will often become angry or upset for no apparent reason. [Claimant] also exhibits sensitivity to sound, touch and light. He dislikes loud sounds, often has an unpredictable response to sound, and seems to hear sounds that other[s] cannot hear. He enjoys looking at himself in the mirror for extended periods of times [sic], and is fond of looking at shiny objects. He struggles with bright light and direct sunlight. [Claimant] dislikes being touched, and will describe touch as painful.

(Exhibit 14.)

14(c). Dr. Donahue administered the ADOS. She noted:

The overall quality of his language was largely correct, and he demonstrated appropriately varying intonation, rate, and volume of speech. No immediate echolalia or idiosyncratic language was observed, but his use of words was more repetitive or formal tha[n] most individuals his age. [Claimant] offered information spontaneously on several

occasions, but failed to ask this examiner about her thoughts, feelings and/or experiences. There was little reciprocal conversation, and he seemed to follow his own train of thought, rather than participating in a social interchange. He failed to use conventional, instrumental, informational, or descriptive gestures. His eye contact was poor, and he rarely directed facial expressions toward this examiner. His affect was generally blunted, although he smiled on a few occasions. His vocalizations, facial expression, gaze and gestures were not smoothly integrated. [Claimant] exhibited little expressed pleasure in the social interactions, and repeatedly stated, "I need to get going. I need to go back to school." His empathy, insight and sense of responsibility were limited. The quality of social interactions [was] primarily one-sided, and focused more upon his areas of interest. [Claimant] exhibited a few creative comments and actions, but these actions were limited in range to the situation at hand. In terms of play, he demonstrated imitative and some creative play skills, but failed to exhibit interactive play. Additionally, [Claimant] attempted to control elements of the play and interact "on his own terms." No unusual sensory interests were noted an no behavioral stereotypies were observed. He mad occasional references to unusual and highly specific topics (e.g. build-a-bear passport and Mario Cart). No self-injurious

behavior was not observed [sic], nor were compulsions or rituals.

(Exhibit 14.)

14(d). Dr. Donahue listed Claimant's "ADOS Classification" as "Autism." No ADOS scores were listed.

14(e). Dr. Donahue administered the Childhood Autism Rating Scale, Second Edition (CARS-2), and found that his scores placed him in the Mild to Moderate Symptoms of Autism Spectrum Disorder group.

14(f). Claimant's mother was administered the Social Communication Questionnaire (SCQ), and his score did not indicate the presence of an Autism Spectrum Disorder.

14(g). Dr. Donahue administered the VABS-II to assess Claimant's adaptive functioning; his parents were the respondents. Based on his parents; reporting, Claimant's communication skills were in the severely impaired range, his social skills were in the severely impaired range, and his daily living skills were in the impaired range. (Exhibit 14.) These VABS-II scores were inconsistent with information from Claimant's IEPs indicating that his adaptive skills were age appropriate, and were significantly lower than those obtained in Dr. Levi's administration of the VABS-II only months prior. (Testimony of Dr. Fischer.)

14(h). Claimant was administered the WISC-IV to assess his cognitive functioning. He obtained a Full Scale IQ of 88, which is in the low average range.

14(i). In evaluating the DSM-IV-TR criteria for diagnosing Autistic Disorder, in the category of Social Interaction, Dr. Donahue noted a qualitative impairment in all four possible areas (marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction;

failure to develop peer relationships appropriate to developmental level; lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest); and lack of social or emotional reciprocity). In the category of communication, Dr. Donahue noted a qualitative impairment in two of the four areas (marked impairment in the ability to initiate or sustain a conversation with others; and lack of varied, spontaneous make-believe play or social imaginative play appropriate to developmental level). Despite noting in the body of her report that Claimant "does not have any rituals," in the category of restricted repetitive and stereotyped patterns of behavior, Dr. Donahue noted qualitative impairment in that Claimant had "apparently inflexible adherence to specific, nonfunctional routines or rituals." She also noted a qualitative impairment in that Claimant demonstrated "persistent preoccupation with parts of objects." (Exhibit 14.)

14(j). Dr. Donahue diagnosed Claimant with Autistic Disorder; Mood Disorder, Not Otherwise Specified; and Oppositional Defiant Disorder.

15. Dr. Donahue's diagnosis of Autistic Disorder appears to run counter to Claimant's documented history and evaluations and diagnoses of other assessors. Claimant has consistently been noted as being friendly, outgoing and demonstrating age appropriate communication and adaptive skills. Additionally, Dr. Donahue's report contained several newly- reported observations/behaviors such as: avoiding social interactions; flat affect; garbled speech; history of spinning, flapping and rocking; being fascinated with parts of objects; dislike of loud sounds; struggling with bright light and direct sunlight; and dislike of being touched as being painful. Her diagnosis of Autistic Disorder was based on several of these newly-reported observations/behaviors, which were not previously reported/observed or considered "qualitative impairments" by prior evaluators. Consequently, Dr. Donahue's report and diagnoses are viewed with some uncertainty.

15(a). On August 30, 2012, Sandi J. Fischer, Ph.D., conducted a records review and school observation of Claimant in order to reconcile the discrepancy in Claimant's diagnoses. Claimant was observed in is special day class from 9:30 a.m. to 10:40 a.m.

15(b). Dr. Fischer authored a lengthy report of her observations and summarized her lengthy findings in her Diagnostic Considerations as follows:

> During the school observation, [Claimant] was observed making limited eye contact. It was not possible to see his facial expressions as the assessor was seated behind him. [Claimant] made some gestures (e.g. flying [a paper] airplane while pretending it was on a mission.) There is some impairment in [Claimant's] use of nonverbal gestures used to communicate.
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> [Claimant] has difficulty interacting appropriately with his peers; he has a history of aggression. The school psychologist reported that [Claimant] can be rigid when interacting with peers and . . . reported that [Claimant] has a tendency to mimic others. There is significant impairment in his development of age appropriate peer relationships although these behaviors are likely related to mental health issues and his behavior rather than behaviors associated with Autism.
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> [Claimant] shared enjoyment with the teacher's assistant when he told him about having finished his work during recess. He also spoke with a peer about the [paper] airplane

that he made. There is not impairment in his ability to share enjoyment, interests or achievement.

[Claimant] wrote on the point sheets of other students, including putting Xs where they had not met their goals which was likely to result in negative reactions from his peers. [Claimant's] interactions with his peers were extremely limited. There appears to be qualitative impairment in his social and emotional reciprocity.

[Claimant's] attainment of early language milestones were reported to be within normal limits but his ability to maintain conversations is not at the level that would be expected for a child of his age and cognitive ability. There is significant impairment in his ability to sustain conversations.

[Claimant] was not heard engaging in repetitive use of language or idiosyncratic language. This was not observed during Dr. Levi's assessment and his teachers did not indicate significant use of repetitive or idiosyncratic language. There was no marked impairment in this area.

[Claimant] engaged in imaginative play (e.g. pretending a paper airplane was on a mission.) His use of spontaneous make-believe play is developing but is somewhat limited in relation to his developmental level.

[Claimant] did not exhibit any preoccupations with stereotyped patterns of interest during the school

observation. Dr. Levi reported that he has some difficulty in this area but not a qualitative impairment in this area. [Claimant's] teachers did not indicate any preoccupations.

[Claimant] did not engage in inflexible adherence to specific, nonfunctional routines or rituals during the school observation. [Claimant's current teacher] indicated that [Claimant] does some things ritualistically or repetitively although it is unclear to what she was referring. [Claimant's teacher from the prior year] indicated that he did not do things repetitively or ritualistically. There was not marked impairment in this area.

[Claimant] very briefly flicked his fingers at one time during the observation. He did not engage in any of these behaviors during Dr. Levi's testing. [Claimant's current and former teachers] did not endorse these types of behaviors (e.g. finger flicking, hand flapping) although they both noted that he rocks either frequently or sometimes. Rocking could be related to anxiety rather than Autism. [Claimant] does not exhibit repetitive motor movements which represent a marked impairment in this area.

[Claimant] did not engage in persistent preoccupation with parts of objects. There was not marked impairment in this area.

(Exhibit 15.)

15(c). Dr. Fischer diagnosed Claimant with ADHD and Oppositional Defiant Disorder (by history).

16(a). Dr. Fischer testified credibly at the fair hearing and her testimony was given great weight.

16(b). Based on her review of records, interviews with Claimant's school psychologist and teachers, and her school observation, Dr. Fischer did not believe that Claimant meets the diagnostic criteria for Autistic Disorder or even for Pervasive Developmental Disorder, Not Otherwise Specified. He does demonstrate difficulty with nonverbal communication. While he demonstrates a qualitative impairment in his interactions with his peers, Dr. Fischer opined that this is related to his mental health issues. She observed him share enjoyment with the teacher's assistant and his records evidence that observation by other sources. Additionally, while he does have impairment in social/emotional reciprocity, it is not demonstrated in an "autistic" manner. Instead, She noted that Claimant's writing on the other students' point sheets showed a level of manipulation and awareness of the potential negative reaction which is unlike a child with Autistic Disorder. He did not demonstrate repetitive or idiosyncratic use of language, and none of the other evaluators observed this either. He engaged in imaginative play with a paper airplane, pretending it was flying in outer space. Claimant did not demonstrate a preoccupation with stereotyped patterns of interest or any nonfunctional routines, and he did not exhibit a persistent preoccupation with parts of an object.

16(c). Dr. Fischer opined that Claimant does not meet the diagnostic criteria for a diagnosis of Autistic Disorder and does not have any diagnosis which would qualify him to receive regional center services.

17(a). Claimant's parents noted that his variety of medications throughout the years have affected his behaviors. According to Claimant's mother, when Claimant was taken off all medications in the summer, symptoms began to arise, but with the

reinstitution of stimulants, his hand flapping and echolalia decreased. Additionally, they noted that Claimant was "always on medication" during his evaluations and had been "warned" about the evaluations beforehand. (Testimony of Justin and Jennifer S.)

17(b). However, Dr. Fischer informed them on her cross examination that an autistic child will be autistic no matter what is said to them prior to evaluation. Dr. Fischer had not seen medications "shape the behavior" of children such that symptoms of Autistic Disorder could not be observed.

18. The totality of the evidence did not establish that Claimant suffers from Autistic Disorder.

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LEGAL CONCLUSIONS

1. Claimant did not establish that he suffers from a Autistic Disorder which would entitle him to regional center services. (Factual Findings 1 through 18.)

2. Throughout the applicable statutes and regulations (Welf. & Inst. Code, §§ 4700 - 4716, and Cal. Code Regs., tit. 17, §§ 50900 - 50964), the state level fair hearing is referred to as an appeal of the Service Agency's decision. Where a claimant seeks to establish his eligibility for services, the burden is on the appealing claimant to demonstrate that the Service Agency's decision is incorrect. Claimant has not met his burden of proof in this case.

3. In order to be eligible for regional center services, a claimant must have a qualifying developmental disability. As applicable to this case, Welfare and Institutions Code section 4512, subdivision (a), defines "developmental disability" as:

> a disability which originates before an individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. . . . This [includes] mental retardation, cerebral palsy, epilepsy and autism. [It also includes] disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals, but shall not include other handicapping conditions that are solely physical in nature.

4(a). To prove the existence of a developmental disability within the meaning of Welfare and Institutions Code section 4512, a claimant must show that he has a "substantial disability." Pursuant to Welfare and Institutions Code section 4512, subdivision (l):

> "Substantial disability" means the existence of 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.

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4(b). Additionally, California Code of Regulations, title 17, section 54001 states, in pertinent part:

> (a) "Substantial disability" means:
>
> (1) A condition which results in major impairment of cognitive and/or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential; and
>
> (2) The existence of significant functional limitations, as determined by the regional center, in three or more of the following areas of major life activity, as appropriate to the person's age:
>
> (A) Receptive and expressive language;
> (B) Learning;
> (C) Self-care;
> (D) Mobility;
> (E) Self-direction;
> (F) Capacity for independent living;
> (G) Economic self-sufficiency.

5(a). In addition to proving a "substantial disability," a claimant must show that his disability fits into one of the five categories of eligibility set forth in Welfare and Institutions Code section 4512. The first four categories are specified as: mental retardation, epilepsy, autism and cerebral palsy. The fifth and last category of eligibility, also known as the "fifth category," is listed as "disabling conditions found to be closely related to mental

retardation or to require treatment similar to that required for individuals with mental retardation." (Welf. & Inst. Code, § 4512, subd. (a).) This category is not further defined by statute or regulation.

5(b). Whereas the first four categories of eligibility are very specific, the disabling conditions under this residual fifth category are intentionally broad to encompass unspecified conditions and disorders. However, this broad language is not intended to be a catchall, requiring unlimited access for all persons with some form of learning or behavioral disability. There are many persons with sub-average functioning and impaired adaptive behavior; under the Lanterman Act, the Service Agency does not have a duty to serve all of them.

5(c). While the Legislature did not specifically define the fifth category, it did require that the qualifying condition be "closely related" (Welf. & Inst. Code, § 4512, subd. (a)) or "similar" (Cal. Code. Regs., tit. 17, § 54000) to mental retardation or "require treatment similar to that required for mentally retarded individuals." (Welf. & Inst. Code, § 4512, subd. (a).) The definitive characteristics of mental retardation include a significant degree of cognitive and adaptive deficits. Thus, to be "closely related" or "similar" to mental retardation, there must be a manifestation of cognitive and/or adaptive deficits which render that individual's disability like that of a person with mental retardation. However, this does not require strict replication of all of the cognitive and adaptive criteria typically utilized when establishing eligibility due to mental retardation (e.g., reliance on I.Q. scores). If this were so, the fifth category would be redundant. Eligibility under this category requires an analysis of the quality of a claimant's cognitive and adaptive functioning and a determination of whether the effect on his performance renders him like a person with mental retardation. Furthermore, determining whether a claimant's condition "requires treatment similar to that required for mentally retarded individuals" is not a simple exercise of enumerating the services provided and finding that a claimant

would benefit from them. Many people could benefit from the types of services offered by regional centers (e.g., counseling, vocational training or living skills training). The criterion is not whether someone would benefit. Rather, it is whether someone's condition *requires* such treatment.

6. In order to establish eligibility, a claimant's substantial disability must not be solely caused by an excluded condition. The statutory and regulatory definitions of "developmental disability" (Welf. & Inst. Code, § 4512 and Cal. Code. Regs., tit. 17, § 54000) exclude conditions that are *solely* physical in nature. California Code of Regulations, title 17, section 54000, also excludes conditions that are *solely* psychiatric disorders or *solely* learning disabilities. Therefore, a person with a "dual diagnosis," that is, a developmental disability coupled with either a psychiatric disorder, a physical disorder, or a learning disability, could still be eligible for services. However, someone whose conditions originate from just 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.

7. The DSM-IV-TR discusses autism in the section entitled "Pervasive Developmental Disorders." (DSM-IV-TR, pp. 69 - 84.) The five "Pervasive Developmental Disorders" identified in the DSM-IV-TR are Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and PDD-NOS. The DSM-IV- TR, section 299.00 states:

> The essential features of Autistic Disorder are the presence of markedly abnormal or impaired development in social interaction and communication and markedly restricted repertoire of activity and interests. Manifestations of the disorder vary greatly depending on the developmental level and chronological age of the individual. Autistic Disorder is

sometimes referred to as early infantile autism, childhood autism, or Kanner's autism. (Emphasis in original.)

(Id. at p. 70.)

8. The DSM-IV-TR lists criteria which must be met to provide a specific diagnosis of an Autistic Disorder, as follows:

A. A total of six (or more) items from (1), (2) and (3), with at least two from (1), and one each from (2) and (3):

(1) qualitative impairment in social interaction, as manifested by at least two of the following:

(a) marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction

(b) failure to develop peer relationships appropriate to developmental level

(c) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)

(d) lack of social or emotional reciprocity

(2) qualitative impairments in communication as manifested by at least one of the following:

(a) delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gestures or mime)

(b) in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others

(c) stereotyped and repetitive use of language or idiosyncratic language

(d) lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level

(3) restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

(a) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus.

(b) apparently inflexible adherence to specific, nonfunctional routines or rituals.

(c) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)

(d) persistent preoccupation with parts of objects

B. Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years: (1) social interaction, (2) language as used in communication, or (3) symbolic or imaginative play.

C. The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning.

(Id. at p. 75.)

9(a). Although Claimant maintains that he is eligible for regional center services under a diagnosis of Autistic Disorder, this diagnosis was not established by the totality of the evidence.

9(b). While Dr. Donahue diagnosed Claimant with Autistic Disorder, her diagnosis

was based on newly-reported symptoms which no other evaluators had noted as being reported or observed during their evaluations. Consequently, her diagnosis was viewed with skepticism, and she did not testify to clarify any uncertainty. Additionally, the physicians at BHC Alhambra hospital, where Claimant was observed for 9 days, did not diagnose Claimant with Autistic Disorder or any other Pervasive Developmental Disorder. The diagnosis that all evaluators except Dr. Donahue could agree on was that Claimant suffered from ADHD.

9(c). In this case, the only psychologist who testified in support of her findings and diagnosis was Dr. Fischer. Her testimony was persuasive. Based on her extensive review of records (including documentation of Claimant's history in IEPs and the reports of other evaluators), her interviews with Claimant's school psychologist and teachers, and her personal observations of Claimant, Dr. Fischer credibly opined that Claimant does not meet the requisite clinical criteria to diagnose him with Autistic Disorder. While Claimant may manifest some impairment in his communication and social skills, he does not satisfy the required number of elements within the criteria of the DSM-IV-TR to diagnose him with Autistic Disorder. Consequently, Claimant has not established that he is eligible for regional center services under the diagnosis of autism.

10. The preponderance of the evidence does not support a finding that Claimant is eligible to receive regional center services.

ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

Claimant's appeal is denied. The Service Agency's determination that he is not eligible for regional center services is upheld.

DATED: February 1, 2013

_____/s/_____

JULIE CABOS-OWEN

Administrative Law Judge

Office of Administrative Hearings

NOTICE

This is the final administrative decision; both parties are bound by this decision. Either party may appeal this decision to a court of competent jurisdiction within 90 days.