BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: CLAIMANT, and WESTSIDE REGIONAL CENTER, Service Agency.	OAH No. 2018010327

DECISION

This matter was heard by David Rosenman, Administrative Law Judge (ALJ) with the Office of Administrative Hearings, on July 24, August 21, November 7, and December 19, 2018, in Culver City, California. Claimant was represented by his mother (Mother), who is his authorized representative.[1] Claimant's father (Father) was also present. Westside Regional Center (WRC or Service Agency) was represented by Lisa Basiri, Fair Hearing Specialist. Oral and documentary evidence was received, and argument was heard. The record was closed, and the matter was submitted for decision on December 19, 2018.

ISSUE

Is Claimant eligible for services from WRC under the Lanterman Developmental Disabilities Services Act?

[1] Titles are used to protect the privacy of Claimant and his family.

EVIDENCE RELIED UPON

Testimony: Thompson Kelly; Kaely Shilakes; Janet Vivero; Claimant's Mother and Father.

Documents: WRC exhibits 1-10; Claimant's exhibit A.

Official Notice is taken of the Diagnostic and Statistical Manual-Fifth Edition (DSM-5).

SUMMARY

Claimant was diagnosed by his pediatrician with Autism Spectrum Disorder (ASD). He requested services from WRC. WRC had its consultant, Dr. du Verglas, assess Claimant. Dr. du Verglas made a diagnosis of ASD. WRC subsequently determined that Claimant's behaviors were more indicative of a mental health condition, and eligibility was denied. After Mother filed a Fair Hearing Request, WRC had another consultant, Mayra Mendez, Ph.D., observe Claimant at his treatment program. Dr. Mendez observed behaviors of Claimant that were inconsistent with a diagnosis of ASD. Claimant submitted a report from Pediatric Minds Early Childhood Treatment Center which included observations, tests and interviews from November 2017 through January 2018. The conclusion of the staff at Pediatric Minds was that Claimant meets the criteria for ASD with accompanying language impairment (articulation difficulties). The evidence supports the conclusion that Claimant is eligible for services.

FACTUAL FINDINGS

PARTIES AND JURISDICTION

1. Claimant is seven years old, born in September 2011. He seeks eligibility for regional center services based on a diagnosis of ASD.

2. WRC sent a letter (dated December 8, 2017) and a Notice of Proposed Action (dated December 6, 2017) to Claimant's parents, informing them that WRC had determined

that Claimant is not eligible for regional center services because he did not meet the eligibility criteria of the Lanterman Developmental Disabilities Services Act (Lanterman Act).[2] Claimant requested a fair hearing. (Exhibit 2.)

EVIDENCE OF CLAIMANT'S BEHAVIORS AND DIAGNOSES, AND OBSERVATIONS OF CLAIMANT

3. As noted in more detail below, eligibility for services from a regional center requires the consumer to be diagnosed with an eligible condition, and to be substantially disabled due to that condition. ASD is an eligible condition.

4. A record from Claimant's visit to his pediatrician, Jana Tavyev, M.D., in June 2017 (exhibit 6) includes a "problem list" of numerous conditions, including, among other things, ASD, developmental coordination disorder, developmental delay, gross motor delay, language delay, hyperactivity, seizure and transient alteration of awareness. The record does not indicate the reason for the doctor visit or the bases upon which any of the listed problems was diagnosed. While it is likely that these diagnoses and problems were discovered earlier, there is no information of how or when the problems presented or were determined to exist.

5. Starting in 2014, Claimant attended the Gindi Maimonides Academy. Two letter were submitted by its Director of Early Childhood, Claire Peikon,[3] dated May 19 and August 28, 2017. (Exhibit 8.) The letters identify Ms. Peikon as "M.A.," a standard reference to

---

[2] The Lanterman Act is found at Welfare and Institutions Code section 4400 et seq. Further references to a statute are to the Lanterman Act unless noted otherwise.

[3] The first letter is signed by Claire Marciano, but it appears this is the same person as Claire Peikon.

someone who has earned a Master of Arts degree. The May 19 letter references that Claimant has been a student for three years, during which there were several meetings to "discuss interventions, modifications, and accommodations that are necessary to support [Claimant's] classroom and social growth."

> Although significant supports have been implemented for [Claimant], he still has extensive difficulties accessing the developmental curriculum requirements and socializing effectively in class. [Claimant's] extensive need for sensory stimulation, his inattention, difficulties expressing himself, and need for support integrating into social situations have been his primary areas for support.

(Exhibit 8.)

The August 29, 2017 letter adds that Claimant requires one teacher with him at all times to follow the group, and gives several examples wherein Claimant cannot sit for periods in large and small group activities.

> At these times, he will often leave the group and go play with building manipulatives, or walk around the classroom touching toys and furniture. During these times, [Claimant] distracts his classmates from learning. In order to help him, [Claimant] requires one-to-one teacher attention, often by taking him by the hand, redirecting him to the group, and offering to sit with him. If that is still too distracting for his peers, he will then be offered a quiet activity at a table.

(Exhibit 8.)

Safety concerns were noted in that Claimant often ran out of the room unsupervised. Also, in an argument with peers about a game they were playing, Claimant became enraged, picked up a chair and threw it in the direction of a friend/participant, and then ran out the door to hide. He was found and brought to the office, when he ran out again and could not be found until security intervened.

> [Claimant] continues to need assistance facilitating appropriate expressive and receptive language. He uses his hands first, instead of words, to express when he is upset. . . . [Claimant] continues to be given suggestions about how to express his needs appropriately, with the goal of keeping him and his peers safe. Additionally, [Claimant] still has a strong desire to touch his peers, as well as put toys in his mouth.
>
> [Claimant's] literacy skills are difficult to evaluate. He can identify the letters of his name and sometimes associate the correct sound with each letter. He may recognize the sound and symbol of other letters, but he becomes limp when asked to complete a literacy extension.

(Exhibit 8.)

6. At WRC's request, Claimant was evaluated by consultant psychologist Gabrielle du Verglas, Ph.D., who observed Claimant three times (October 11, and November 5 and 15, 2017), including at school. Dr. du Verglas administered various tests and assessments, interviewed Mother, reviewed documents, and issued a written report (exhibit 4). Utilizing criteria from the DSM-5, Dr. du Verglas made the following diagnosis: Autism Spectrum Disorder, associated with pragmatic language impairment, not associated with intellectual

disability; social emotional reciprocity level 2, requiring substantial support; restrictive, repetitive patterns of behavior level 2, requiring substantial support. Details of testing administered by Dr. du Verglas and her report are discussed in more detail below.

7. Dr. du Verglas reviewed the letters from Claimant's school and the medical report, noted above. Dr. du Verglas added that Claimant was discharged from the school and stayed home until Mother contacted the Regional Center, after which a referral was made to the local school district and special education services were granted. At the time of Dr. du Verglas's observation, Claimant was participating in a regular classroom curriculum at Westwood Charter School with an Individual Education Plan (IEP) and the support of an individual aide, but his difficulties continued. For example, Dr. du Verglas noted that during her classroom visit, his teacher remarked that Claimant made reference to the one-on-one instructional support being his "maid," he makes inappropriate violent comments in class, and has difficulties with social engagement with his peers. The school evaluations were not available for review. The school psychologist who evaluated Claimant was scheduled to start counseling services to provide additional support.

8. Dr. du Verglas observed Claimant at school on November 15, 2017, for about one hour. The aide was concerned with safety as Claimant tried to use a pair of children's scissors. Claimant sat with his back to the class and would turn away from the aide. The classroom aide told Dr. du Verglas that Claimant was upset when she was trying to redirect him as he was cutting across the picture he was supposed to use for design, and he mumbled, "Leave me alone," and then added "I am drawing you[r] funeral." He added he will cut her up and then draw the funeral. A few days prior, Claimant was drawing pictures of bombs during an exercise to draw words with the letter "B."

Those type of behaviors led to contact with the school psychologist for additional support. When the teacher came to give him instructions, Claimant did not look at or establish appropriate social reference. Although other students responded to prompts to finish the

project, Claimant did not. Claimant was slow to get his snack and at first was alone, but other students and a worker joined him, and he engaged in conversation. He did not finish with the others and, despite prompts, continued to eat by himself while other students finished and lined up. The teacher told Dr. du Verglas that Claimant needs additional support to participate with the group and to have all of the belongings he needs for an activity. The teacher expressed concern about Claimant's drawing of bombs and his aggressive themes.

9. Dr. du Verglas did a behavioral observation and administered the following tests: Wechsler Preschool and Primary Scale of Intelligence-Fourth Edition (WPPSI-IV); Gilliam Autism Rating Scale-3 (GARS-3); Adaptive Behavior Assessment System-Second Edition (ABAS-II); and Autism Diagnostic Observation Schedule (ADOS-2), Module 2. Mother commented that she was impressed with Claimant's ability to stay focused and attentive during the WPPSI-IV, as he usually did not display such focus. Short breaks were needed, with toys as reinforcers, to maintain his attention. Other behavioral observations were generally not unusual or remarkable.

10. Claimant's cognitive abilities were assessed using the WPPSI-IV, a standardized measure in the domains of Verbal Comprehension, Visual Spatial, Fluid Reasoning, Working Memory and Processing Speed. Claimant's scores ranged from the low average to the average range, and he scored a full scale intelligence quotient (IQ) of 89, in the upper range of low average abilities. Dr. du Verglas concluded the scores were not indicative of intellectual disability.

11. Adaptive functioning was assessed with the ABAS-II, with Mother serving as the informant. In the three composite domains, Claimant scored in the extremely low range. The Conceptual domain includes Communication, Functional Academics and Self-Direction Skill Areas. Notes included that Claimant can tell friends and family about his interests, he uses sentences with a noun and a verb, and he sometimes looks at others in the face when they are talking. He does not appropriately greet others, and he does not name 20 or more

familiar objects. Claimant can read and write his own name; he is not able to locate important dates on a calendar; he does not work on home or school projects for at least 15 minutes; and he does not control his feelings and gets upset when others break the rules. The Social domain includes the Social and Leisure Skill Areas. Dr. du Verglas noted that Claimant laughs in response to funny jokes; he has a good relationship with his parents and other adults; he has more than one friend (relatives); he does not stand a comfortable distance from others during conversations; and he is able to apologize if he hurts the feelings of others when prompted but not independently. Claimant attends fun activities at another's home, but he does not wait his turn when playing games; and he is not able to follow rules in games. The Practical domain includes the Community Use, Home Living, Health and Safety, and Self-Care Skill Areas. Dr. du Verglas noted that Claimant does not look both ways before crossing the street; he is not able to find the appropriate restroom in public places; he does not wipe up spills at home, and he does not put things in the proper place when done using them. Claimant shows caution around hot or dangerous items; he buckles his own seatbelt in a car; he can swallow liquid medication; and he does not test hot food before eating it. Claimant uses the restroom at home.

12. Mother was the informant for the GARS-3, designed to identify individuals ages 3 through 22 years of age who have severe behavioral problems that may be indicative of autism. The GARS-3 is composed of 58 items divided into six subscales that describe specific, observable, and measurable behaviors. Claimant's score of 125 fell in the range of "High Probability" of ASD. Mother endorsed significant difficulties with restrictive, repetitive patterns of behavior, social interaction, social communication, emotional response, with some difficulties in cognitive style, reporting he attaches concrete meaning to words and verbal expressions, sometimes focusing excessively on a single subject, and makes naive remarks, unaware of the reaction it produces in others. Mother did not endorse that Claimant has superior knowledge in a subject or uses exceptionally precise speech.

Additional items in the maladaptive speech section were endorsed, such as using an inappropriate tone of voice, repeating of information and words, and speaking in a flat tone of voice.

13. Mother was the informant for the ADOS-2, an assessment of communication, social interaction, and/or play, or imaginative use of materials. It is intended for use with individuals suspected of having ASD. The module is subdivided into several components: communication, qualitative impairment in reciprocal social interaction, imagination/ creativity, and stereotyped behaviors and restricted interests. Mother's responses were consistent with a diagnosis of ASD.

Communication: Claimant was able to speak in short sentences but he mostly responded to specific queries. On two occasions, he provided spontaneous remarks, and he also queried if he could borrow the spinner as he was very much interested in using it.

Reciprocal Social Interaction: Eye contact was poorly modulated and fleeting. Claimant would occasionally look up but he did not maintain gaze; he did not respond to his name. Claimant's play with items had aggressive themes. People were fighting (figurines). He responded to the birthday baby party with imaginative play, however, was repetitively pushing the doll's eyes and on one occasion slammed her face into Play Doh.

Stereotyped Behaviors and Restricted Interests: Claimant occasionally made high-pitched sounds, less so when he was directly involved but, when left to explore toys on his own, the high-pitched sounds increased. When making repetitive sounds, Claimant frequently banged objects on the table. When asked to play on his own, Claimant chose a pin art toy, which he totally reassembled, taking all the pieces apart, in essence, destroying the toy.

Scores were consistent with an autism spectrum diagnosis. The behaviors of concern were the difficulties with appropriate eye contact and Claimant's ability to maintain

social interaction, his repetitive sounds, aggressive play with toys, and infrequent initiation of verbal responses.

14. WRC held a meeting of its eligibility team on December 6, 2017. The team concluded that Claimant was not eligible for services. The reasoning is discussed in the findings below on testimony from Thompson Kelly, Ph.D., WRC's chief psychologist. The note of the meeting (exhibit 5) includes that the team did not agree with the ASD diagnosis by Dr. du Verglas; rather, her behavioral descriptions of Claimant appear more indicative of a mental health condition.

15. Dr. Kelly testified credibly that Dr. du Verglas followed best practice guidelines in the choice of tests and assessments to administer, and that she adequately explained her reasoning in reaching the conclusion that Claimant has ASD. However, the team also discussed that some of the behaviors described in her report included clear emotional indicators that were operating underneath. The team concluded that there were explanations that were more likely than ASD. For example, if Claimant was very depressed or schizophrenic, he might present with atypical response and interaction styles due to the mental health disorder(s) that would nevertheless appear significant in indicating the presence of ASD.

16. In December 2017, WRC sent Mother a letter and Notice of Proposed Action indicating that Claimant did not meet the eligibility criteria for services, and Mother submitted a Fair Hearing Request.

17. On November 20, 2017, Claimant entered an intensive three-month outpatient program, five days per week, three hours per day, at Pediatric Minds (PM) Early Childhood Treatment Center. Mother obtained a letter from PM, dated January 2, 2018, signed by Nicole Callella, Psy.D., a post-doctoral psychological assistant, and Dr. Janet Vivero, Ph.D., a psychologist (exhibit 7). The letter states that its purpose is to document Claimant's current diagnosis of ASD, level 2, with language impairment. It noted Dr. du Verglas's testing, as well

as recent PM administration of the ADOS-2 and ADI-R, discussed in more detail below. The letter specifically notes that Claimant:

> [D]isplays inconsistent eye contact and his social and reciprocal interactions are severely limited. Although he can engage in some imaginative play, his ideas and themes are odd, one-sided, and restricted to an excessive morbid quality. His ability to foster social relationships is also restricted due to limited social awareness and social skills. [Claimant] does not engage well with peers and is often rejected. In response, it appears that [Claimant] has become extremely aggressive and has already been 'kicked out' of private school. He currently attends public school, has an IEP under the ASD qualification and has been provided a one to one aide to help manage his behaviors.
>
> [Claimant] also presents with comorbid mood related symptoms which complicates his total psychological picture. We are continuing to assess his overall functioning across several environmental settings. At this time, and given the findings described above, in addition to the DSM-5, [Claimant] currently meets criteria for Autism Spectrum Disorder.

(Exhibit 7.)

18. The WRC eligibility team decided to have Claimant observed by another experienced evaluator, Mayra Mendez, Ph.D., Licensed Marriage and Family Therapist. Dr. Kelly testified that Dr. Mendez has extensive experience in observing children with a suspected diagnosis of ASD, as well as children with mental health conditions.

19. Dr. Mendez observed Claimant at the PM program on February 16, 2018, the last day of Claimant's participation in the program. (A later report from PM, and testimony from Dr. Janet Vivero, the primary assessor of Claimant, are summarized below.) Dr. Mendez wrote her report (exhibit 3) without referencing the diagnostic criteria of ASD from the DSM-5. Rather, her report focuses on the second aspect of eligibility; that is, whether an applicant is substantially disabled by a developmental disability. (As discussed in more detail below, the criteria to be found eligible include that a person has a developmental disability, and that the person is substantially disabled by the developmental disability.) This determination is made by reference to seven criteria, adjusted to the applicant's age: learning, self-direction, motor skills, communication, self-care, and capacity for independent living. Due to Claimant's age, the area of economic self-sufficiency is not applicable.

20. In her report, Dr. Mendez noted that Claimant was found eligible for special education services due to a classification of Autism. She observed Claimant during a session with his individual staff and two other children with their own individual staff. With respect to learning, Dr. Mendez reported that Claimant demonstrated attention, eye contact, and cooperative behaviors, sustained focus on the activities, and he was not observed to distract or disrupt the other children. Claimant was calm and was heard responding to the staff using sentences. He selected items and objects for engagement with the staff. Claimant was observed to share the toys readily and to demonstrate imaginative play with expansion of play themes. Examples of his appropriate conduct were included. Claimant was playful and engaged with the staff and then transitioned to another toy. Dr. Mendez noted that "During this observation, [Claimant] demonstrated attention, emotional regulation, symbolic play skills, adequate capacity for processing information and sharing thoughts in a reciprocal manner with the individual adult staff." (Exhibit 3.)

21. In a portion of the report related to Claimant's self-direction (including social, attention, self-regulation and self-care), Dr. Mendez observed that Claimant sustained

attention and engagement with staff, followed the directions from the staff, and demonstrated calm and easy transitions between tasks. He demonstrated shifts in emotions, yet he remained appropriately emotionally engaged. Claimant demonstrated conversation skills with the staff and displayed stable emotional regulation throughout the individual observation as well as during an observation of small group play in the gym room. He engaged the two other peers with appropriate excitement and identified emotions that he ascribed to a puppet in relevant ways. Claimant identified feelings of happiness and demonstrated capacity for turn-taking with the staff and with the other children.

22. Claimant demonstrated age-appropriate motor skills and staff had no concerns with his self-care skills, which had been taught during the PM program.

23. With respect to communication, Dr. Mendez reported that Claimant spoke in complete sentences and consistently responded to staff redirection to state "please," "thank you," and "excuse me." He demonstrated consistent accuracy with receptive and expressive language skills. Examples were observed of Claimant's communication and interactions that were consistent with his play, and an apology when he bumped into others.

24. In her summary, Dr. Mendez included that the PM staff reported that Claimant presented as he typically does when participating in the program. She noted that Claimant presented as cheerful and well engaged, with functional skills in communication, motor and emotional regulation, a high functioning child who demonstrated excellent engagement skills in a one-to-one situation with the staff as well as during free play in the gym, where he remained well-engaged and aware of boundaries and space. Claimant displayed symbolic play in varied and sustained cooperative behaviors and accurate cognitive processing specific to the situation. Dr. Mendez recommended that Claimant continue his current treatment plan due to his learning and demonstrating positive social-emotional responsiveness to intervention.

25. Dr. Kelly testified that the behaviors observed by Dr. Mendez were not representative of a person with ASD. He was asked if it was significant that Dr. Mendez observed Claimant on the last day of a three-month intensive program. He responded that a lot of skills can be taught through intervention and programming, but that someone with ASD retains a certain quality that can be perceived by someone with training and experience. He emphasized that ASD is a pervasive disability, not likely to be absent in some settings or on some days. However, he did acknowledge that, like everyone else, people with ASD can have good days and bad days. Dr. Kelly noted that Dr. Mendez described Claimant as having a spontaneous, fluid style that is not consistent with ASD. The WRC eligibility team met and reviewed Dr. Mendez's report and determined that the team would not change its decision to deny eligibility.

26. Dr. Kelly explained that there are significant differences in the process for a school district to determine eligibility under the Education Code as opposed to the WRC process to determine eligibility under the Lanterman Act, and that there are fewer and broader requirements under the Education Code. He further explained that certain school psychologists and assessors use different assessment tools and, by virtue of their licensure, may not be able to make a diagnosis of ASD under the criteria of the DSM-5. He did not believe that other assessors who found Claimant to have ASD were wrong; rather, he believed there were different opinions based on the behaviors of Claimant. Dr. Kelly did not observe Claimant, but commented that certain of his behaviors, including aggression and improvement over the three-month PM program, were more indicative of an emotional disturbance and would be unusual for someone with ASD. Based on the observation and report by Dr. Mendez, he stated that there were two areas of possible concern about Claimant, out of the seven areas of consideration of whether developmental disability is a substantial disability. He stated that Claimant was definitely limited in his self-direction, and arguably in the area of capacity for independent living. However, at least three of the areas

must be present to find eligibility. Dr. Kelly stated that an observation such as that undertaken by Dr. Mendez should take about one hour to one and one-half hour.

27. As noted above, Claimant entered the three-month outpatient program at the PM Early Childhood Treatment Center on November 20, 2017, and he was discharged on February 19, 2018. PM issued a 50-page report (exhibit A), signed by its Medical Director, Dr. Pantea Sharifi-Hannauer, M.D., who is board licensed in psychiatry and neurology. Several other clinicians are also listed, including Dr. Vivero, Ph.D., psychologist, who testified at the hearing. Dr. Vivero administered several assessments and tests to Claimant and supervised others who administered other assessments. She was very familiar with Claimant's behaviors, the programs he participated in and treatment received while at PM, and his progress.

28. Claimant was admitted to PM with a diagnosis of Generalized Anxiety Disorder, with a rule out for Mood Disorder and ASD. (Rule out generally means there have been some indicators of a condition, and further assessment is needed to determine if the condition or disorder is actually present.) Claimant's discharge diagnosis was Major Depressive Disorder, with anxious distress; ASD, with language impairment (articulation difficulties), and without intellectual impairment; rule out Attention-Deficit Hyperactivity/Impulsivity Disorder (ADHD) Combined type.

29. Dr. Vivero explained that Claimant's most prominent condition at the outset of his participation in the PM program was his mood disorder of depression with anxious distress. Prior records included a diagnosis of ASD from several sources, so further assessments were conducted at PM to determine if it was present. The significant aspects of the assessments are summarized below. Dr. Vivero acknowledged in her testimony that the report was not designed for use in a fair hearing on the issue of eligibility under the Lanterman Act. More specifically, it did not reference as many examples of behavior or relate them to DSM-5 criteria as were included in Dr. du Verglas's report. Nevertheless, the assessments yielded very relevant information.

30. The ADOS-2 was administered. With respect to social affect, Claimant's eye contact was limited at first but significantly increased. He used gestures and facial expressions and engaged in shared enjoyment playing with action figures. Claimant's had articulation difficulties and had difficulty with having a back and forth conversation. He did not follow up on the examiner's open-ended statements and he tended to talk only about his preferred subjects. Claimant exhibited odd social overtures and social responses at times; his social responses tended to be based on what he wanted to say and dismissed the examiner's viewpoint and statements. As a result of these limits, the overall quality of the rapport between Claimant and the examiner was awkward. With respect to restricted and repetitive behavior, Claimant did not display stereotyped words or phrases and/or any unusual sensory interests, or hand and/or repetitive mannerisms or body movements. He did display unusual repetitive/stereotyped behaviors that were seen in his play with the action figures, including an excessive interest in destructive play. All his characters would either be killed with a knife, gun, or die someway. This was seen excessively and when the examiner would try to redirect the play, and Claimant would find a way to return to his destructive play. With respect to play skills, Claimant engaged in imaginative and functional play, but it always had a destructive quality and characters were constantly dying by very aggressive ways. In creating stories, they began typically, but then turned into an exaggerated story where he became fixated on continuing it. He was able to join in on the examiner's play during the joint interactive play. Claimant directed and was able to follow the examiner's directed play for an appropriate amount of time. The overall total score ascribed to Claimant on the ADOS-2 was 8, where the ADOS comparison score was 5. This indicated a moderate level of ASD-related symptoms.

31. Dr. Vivero administered the Autism Diagnostic Interview, Revised Edition (ADI-R), an interview of Claimant's parents that focuses on three core domains (Language/Communication, Reciprocal Social Interactions, and Restricted, Repetitive, and

Stereotyped Behaviors and Interests) that are characteristic of Autistic Disorder in the DSM-IV (the edition previously in use, and updated to become the DSM-5). In the Qualitative Communication domain, Claimant's parents were asked questions regarding his communication ability. The responses resulted in a raw score of 8, which is also the ADI-R cut-off score, indicating that Claimant does appear to have issues with the quality of his communication with others. In the Reciprocal Social Interactions domain, which measures aspects of social behaviors, the parents' responses resulted in a raw score of 12, which is above the cut-off score of 10, indicating that Claimant does appear to display significant issues with reciprocal social interactions. The Restricted, Repetitive, and Stereotyped Patterns of Behaviors domain assesses an array of atypical behaviors that significantly impact an individual's ability to function in his/her environment. Claimant's parents' responses resulted in a raw score of 9, which is above the ADI-R cut-off score of 3, indicating that Claimant may exhibit significant behaviors that would be classified as restricted, repetitive, and stereotyped in nature. Overall, Claimant's combined score of 21 was well above the ADI-R cut-off of 8, supporting a classification of Autism.

32. PM also used the Autism Spectrum Rating Scales (ASRS), surveys that were completed separately by Claimant's Mother and his teacher to evaluate behavior. The surveys gathered results in three areas (social/communication, unusual behaviors, and self-regulation) and in eight areas designated as DSM-5 scales to indicate how closely a child's symptoms match the DSM-5 criteria for ASD (peer socialization, adult socialization, social/emotional reciprocity, atypical language, stereotypy, behavioral rigidity, sensory sensitivity, and attention/self-regulation). Mother's survey results placed Claimant in the 99th percentile in every scale, classified as very elevated scores and indicating that Claimant displays many behavioral characteristics that are reflective of children diagnosed with ASD. The teacher's survey results placed Claimant in the average classification for unusual behaviors, stereotypy and attention/self-regulation, slightly elevated in peer socialization,

adult socialization, atypical language, behavioral rigidity and sensory sensitivity, and very elevated in social/communication and social/emotional reciprocity. The teacher's results also indicate that Claimant displays many behavioral characteristics that are reflective of children diagnosed with ASD.

33. PM assessed Claimant's cognitive and intellectual functioning by use of the Wechsler Intelligence Scale for Children, Fifth Edition (WISC-V), and the Test of Nonverbal Intelligence, Fourth Edition (TONI-4). Claimant's full scale IQ, from a Standard Score of 97, was determined to be within the Average range. Subtests were scored within the average range, except for borderline results in the cognitive proficiency index and the processing speed index. The results of the TONI-4 placed Claimant in the average range, with an age equivalent of 6.3. When tested, Claimant was 6 years, 3 months of age.

34. Claimant's adaptive functioning was assessed by use of the Vineland Adaptive Behavior Scales, Second Edition (Vineland-II), assessed by a form completed by Mother. This assessment measures an individual's typical performance of day-to-day activities required for personal and social sufficiency, in three domains: Communication, Daily Living Skills, and Socialization. Numerous subdomains are also reviewed. The Adaptive Behavior Composite represents an individual's overall level of adaptive functioning. Based on his mother's input, Claimant's adaptive functioning was within the Low range. The ratings on this scale yielded a Standard Score of 60, which is ranked at the less than 1st percentile when compared to his same-aged peers. Mother's input resulted in adaptive levels of Low (the lowest score) for almost all domains/subdomains, and Moderately Low (second lowest score) in three subdomains. More specifically, in receptive communication, Claimant was functioning at the Low level, age equivalent 1:3 years. This was considered a personal weakness for Claimant. Expressive communication was at the Moderately Low level, age equivalent 4:5 years, considered as a personal

strength. In written communication, Claimant functioned at the Low level, age equivalent 4:6 years.

In the Daily Living Skills domains, Claimant functioned as follows: Personal self-care, Low level, age equivalency 2:1 years; Domestic (independent performance of household chores), Low level; age equivalency 0:01 years; Community (comprehension of societal rules, time, and money), Moderately Low level, age equivalency 3:5 years.

In the Socialization domains, Claimant functioned as follows: Interpersonal Relationship (ability to initiate and maintain relationships), Low level, age equivalency 1:6 years; Play and Leisure Time (participation in a range of activities and cooperative play), Moderately Low level, age equivalency 4:0 years; and Coping Skills, Low level, age equivalency 1:1 years.

Motor skills were also measured and Claimant functioned as follows: Gross Motor Skills, Low level, age equivalency 2:9 years; and Fine Motor Skills, Low level, age equivalency 3:5 years. Also, Maladaptive Behaviors were clinically significant.

35. Academic readiness and achievement were assessed by use of two measures. The Wide Range Achievement Test, Fourth Edition (WRAT-4) measures the basic academic skills of word reading, spelling, math computation, and sentence comprehension. The results were Standard Scores of 72 and 71, in the Low range. Specific domains of note: in the Reading Composite, Claimant's score could not be produced due to him not being able to read on the Sentence Comprehension subtest. His performance in the Word Reading index was in the Low range and significantly below that expected for his age and grade level. He could not read all the letters of the alphabet and was unable to read any of the actual words. It was noted that there may have been a lack of effort, as opposed to a lack of ability. Similarly, in the Sentence Comprehension Index, the score is invalid because he could not read the actual sentences. The Spelling Index and Math Computation Index scores were at the Low level, significantly below what would be expected for his age and grade level. The

overall WRAT-4 results showed a significant discrepancy between his overall cognitive abilities and his academics.

The Psychoeducational Profile, Third Edition (PEP-3) is a measure used for educational planning, based on assessment by a professional and, in the area of maladaptive behavior, input from Mother. In the tested domains, Claimant's adaptive level was scored as follows: Communication, in the mild range, 77th percentile; Motor, in the mild range, 88th percentile; Maladaptive behaviors, adequate range, 97th percentile. Problem behaviors were at the severe level, personal self-care was in the severe range, and adaptive behavior was at the moderate level.

36. Social and emotional assessment was accomplished by use of three tools. The Conners Comprehensive Behavior Rating Scales (Conners CBRS) gathered behavioral data from Mother and a teacher. The data is then analyzed with respect to numerous described areas (e.g., emotional distress total, upsetting thoughts/physical symptoms), and then as they relate to 11 different psychological or developmental diagnoses included in the DSM-5 (e.g., ADHD, Major Depressive Episode, Generalized Anxiety Disorder, ASD). Generally, Mother reported more elevated concerns than did Claimant's teacher. Mother's report included very elevated presence of indicators of all 11 DSM-5 diagnoses, while teacher's report included higher than average indicators for ADHD, Major Depressive Episode, Generalized Anxiety Disorder, Separation Anxiety Disorder, Obsessive-Compulsive Disorder and ASD. The Social Responsiveness Scale, Second Edition (SRS-2) assesses the severity of autism symptoms as they occur in natural social settings, by gathering information about a child's social impairments from the parents. It can also be used to distinguish autism symptoms and behaviors from other child psychiatric conditions by identifying the presence and extent of autistic social impairment. Claimant had significant issues with reciprocal social behavior, and the overall score was strongly associated with a diagnosis of ASD. The Spence Preschool Anxiety Scale is a questionnaire that parents complete to assess their child's level

of anxiety across six specific aspects (Generalized Anxiety, Social Anxiety, OCD, Physical Injury Fears and Separation Anxiety). Claimant was experiencing significant levels of generalized anxiety and physical injury fear. Other anxiety levels were normal.

37. Claimant's speech and language were assessed with tools and observations. Areas of strength and weakness were noted. Many results were average, but there was noted a mild articulation deficit and pragmatic language deficit, and times when his speech was less intelligible, with some mumbling and grammatical errors. An occupational therapy consultation was also performed.

38. The PM report contains an extensive treatment plan that includes measures of behaviors and strategies to decrease them, social emotional realms and strategies and interventions to increase positive behaviors, and a plan of family participation. The report ends with a treatment summary and diagnostic impression, the significant parts of which are summarized as follows. Cognitively, Claimant's scores indicate overall abilities in the Average range when compared to his same aged peers. However, his low processing speed was impacted by symptoms of inattention, distractibility, and severe mood lability. He performed lower academically than expected, probably due to his significant interfering behaviors at school and inconsistent school placement. Assessments related to ASD provided consistent information that supported a clinical diagnosis of ASD with accompanying language impairment (articulation difficulties), and without intellectual impairment. Claimant's difficulties with mood and concentration may be better attributed to Major Depressive Disorder, with anxious distress. His experience of depression is likely underlying symptoms of diminished concentration, mood dysregulation and flattened affect. Additionally, Claimant's preoccupations with themes of death and morbidity are attributing to his feelings of depression.

> Based on his time at Pediatric Minds, it would appear that [Claimant] has difficulties with mood lability, behavioral

> dysregulation, thoughts of morbidity (e.g. thoughts with themes of dying and killing), poor frustration tolerance, severe impulsivity and noncompliance. Additionally, [Claimant] struggles with interactions with peers in which his impulsivity (e.g. snatching and grabbing), poor social awareness and lack of empathic responses negatively impacts his ability to socialize. His behavioral dysregulation and mood lability often leads to hostile interactions with peers in which [Claimant] disregards other's personal space. Despite [Claimant's] desire for social interaction and play, his maladaptive behaviors interrupt opportunities for social engagement.

(Exhibit A, p. 46.)

Treatment goals included social problem-solving skills, coping skills, increasing his body awareness and body regulation, identifying other's emotions and thoughts, and developing appropriate responses involving empathy. Claimant was prescribed Abilify to aid in managing his mood lability and depressive symptoms, and in the last month of his participation in the program, it was noted to result in significant progress for Claimant—his affect became much brighter, he was more engaged with peers, and he was able to show much more flexibility.

39. By her testimony, Dr. Vivero demonstrated that she is very familiar with Claimant. At the outset, Claimant demonstrated as very dysregulated; he had problems with managing his mood and emotions, often resulting in problematic behaviors. PM was concerned about possible severe anxiety disorder and behavior issues. As assessments were made and with further interaction with Claimant, it was determined that he needed treatment for a mood disorder. In the course of his treatment at PM, Claimant's depressive disorder was treated. In the opinion of Dr. Vivero, Claimant's mood disorder had masked

other aspects of his symptoms and behaviors. The various tests administered to determine whether Claimant met the clinical criteria for ASD were comprehensive and supported that diagnosis. In the opinion of Dr. Vivero, Claimant has dual diagnoses: mood disorder with anxious distress, and ASD.

40. Dr. Vivero noted that she was not known for making diagnoses of autism and that she was hesitant to discuss the diagnosis with Claimant's parents due to the number of stressors they experienced with Claimant. Dr. Vivero was aware of the observation and report by Dr. Mendez. Mother testified that she was present at PM when Dr. Mendez made her observation. Although Mother was not with Dr. Mendez during the observation, Mother was at PM for a meeting and she saw Dr. Mendez arrive and depart from PM. Dr. Mendez was present at PM for about 30 minutes. When asked, Dr. Vivendi testified credibly that an observation of 30 minutes is not sufficient to determine if a child has autism. In her opinion, due to the limited observation by Dr. Mendez, a qualitative judgment of whether Claimant has ASD cannot be made based on the report from Dr. Mendez.

41. Claimant has established that he has the developmental disability of ASD and is substantially disabled by his condition. Claimant meets the requirements for being eligible for regional center services.

LEGAL CONCLUSIONS

1. Claimant established that he suffers from the developmental disability ASD which would entitle him to regional center services under the Lanterman Developmental Disability Services Act (Lanterman Act; Welfare and Institutions Code section 4400 et seq.). (Factual Findings 1 through 41.)

2. Throughout the applicable statutes and regulations (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 by a preponderance of

evidence that the Service Agency's decision is incorrect. Claimant has met his burden of proof in this case.

3. In order to be eligible for regional center services, an applicant 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] autism."

4. A developmental disability within the meaning of section 4512 must also constitute a substantial disability. Definitions of substantial disability are found in Welfare and Institutions Code section 4512, subdivision (*l*), and in California Code of Regulations, title 17 (Regulation), section 54001. 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.

5. Additionally, Regulation 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. [¶] . . . [¶]

> [Excluded are] (c)(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.

6. For a child of Claimant's age, the major life activity of economic self-sufficiency is not considered.

7. The DSM-5, section 299.00 discusses the diagnostic criteria which must be met to provide a specific diagnosis of ASD, as follows:

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive; see text):

1. Deficits in social-emotional reciprocity, ranging, for example from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
3. Deficits in developing, maintaining, and understanding relationships, ranging, for example from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers. [¶] . . . [¶]

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

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties

with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).

3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).
4. Hyper- or hyporeactivity to sensory input or unusual interests in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching objects, visual fascination with lights or movement). [¶] . . . [¶]

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

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

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

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

8. There is contradictory evidence of whether Claimant has symptoms and behaviors that support a diagnosis of ASD. The first indication is a "problem list" of numerous conditions, including, among other things, ASD, by Dr. Tavyev in June 2017. Dr. du Verglas observed Claimant three times, in October and November 2017 (just before Claimant began the three-month program at PM). Her report is comprehensive and includes numerous references to behaviors she observed, as well as the results of assessments and

tests she administered. Using tests considered to be the gold standard, Dr. du Verglas diagnosed Claimant with ASD. Nevertheless, the WRC eligibility team determined that the behaviors described by Dr. du Verglas were more indicative of a mental health condition, and WRC notified Mother that Claimant was not eligible for services. A few days after Dr. du Verglas's last observation, Claimant entered the PM program. Dr. Vivero agreed that he first presented with behaviors and symptoms consistent with a mood disorder. However, prior diagnoses of ASD were noted and PM performed numerous assessments of Claimant. His symptoms and behaviors associated with his mood disorder were treated. As noted by Dr. Vivero, those symptoms and behaviors masked the presence of an additional disorder, diagnosed as ASD. That diagnosis was communicated in a brief letter dated January 12, 2018 (exhibit 7), and later supported by a report after his discharge on February 19, 2018, with references to extensive testing and assessment (exhibit A). Dr. Mendez did her observation on February 18, 2018.

9. On balance, the evidence that Claimant has a diagnosis of ASD is sufficiently clear and consistent to satisfy the first portion of the statutory requirements for eligibility. The weight of the evidence is that Claimant also has a mental health condition, as suspected by the WRC eligibility team and as confirmed by PM. If the mental health condition was the sole cause of Claimant's disability, he would not be eligible, due to the exclusion of conditions that are solely psychiatric. However, Claimant has dual diagnoses. His ASD makes him potentially eligible for services under the Lanterman Act.

10. The evidence that Claimant does not have a developmental disability is not convincing. Dr. Kelly testified that the WRC eligibility team concluded that some of the behaviors noted in the report of Dr. du Verglas were more indicative of mental health condition, and eligibility was denied. The existence of Claimant's mental health condition was supported by the PM testing and the testimony of Dr. Vivero. However, the inquiry does not stop there. The more convincing evidence is that Claimant has both a mood disorder

and ASD. The relevant Regulation excludes eligibility if a disability is caused solely by a psychiatric disorder. Under Claimant's dual diagnoses, including ASD, he is potentially eligible for WRC services.

11. The statute and regulation must be reviewed for the determination of whether Claimant is substantially disabled in the six applicable areas of major life activity. Dr. Kelly acknowledged that Claimant demonstrated a substantial disability in the area of his self-direction, and arguably in the area of capacity for independent living. The extensive assessments performed at PM support the conclusion that Claimant is substantially disabled in the areas of major life activity of self-direction, capacity for independent living, receptive and expressive language, and learning.

12. Dr. Mendez organized her report to address these seven areas of major life activity. Although she did not include any ultimate opinions of whether Claimant was, or was not, substantially disabled in any of the seven areas, her descriptions of Claimant's abilities appear to show that, in the opinion of Dr. Mendez, he does not.

13. The report of Dr. Mendez is entitled to lessened weight based on various factors. Her observation lasted about 30 minutes, while Dr. Kelly would expect such an observation to last one hour to one and one-half hour. Further, Dr. Kelly said that persons with ASD can have good days and bad days, however in an adequate observation certain behavioral qualities would be noted. Dr. Vivero stated that an observation of Claimant for only 30 minutes would not provide clinically significant information under the circumstances. Further, Dr. Mendez observed Claimant on the last day of an intensive treatment program and while he was being treated with medication and behavioral interventions.

14. The totality of the evidence supports the conclusions that Claimant is substantially disabled in the areas of receptive and expressive communication, learning, self-direction, and capacity for independent living. The assessments and tests performed by PM

were comprehensive, and constitute substantial evidence sufficient to support this conclusion.

15. Admittedly, the evidence revealed some inconsistencies, in Claimant's behaviors, in the manner in which those behaviors were viewed by his parents, his teachers, and other observers, and in the documents in support of, and opposed to, his eligibility for regional center services. However, ultimately it was established that Claimant is properly diagnosed with ASD and that he is substantially disabled by ASD.

ORDER

The Service Agency's determination that Claimant is not eligible for regional center services is overruled, and Claimant's appeal of that determination is granted. Claimant is eligible under the Lanterman Act for services from the Service Agency.

DATED:

DAVID B. ROSENMAN
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.