BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: CLAIMANT, vs. WESTSIDE REGIONAL CENTER, Service Agency.	OAH No. 2018031250

DECISION

Eileen Cohn, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on June 28, 2018, in Culver City, California.

Lisa Basiri, Fair Hearings Representative, Program Manager, represented Westside Regional Center (WRC or Service Agency). Mother represented Claimant, who was not present.[1]

Oral and documentary evidence was received at the hearing and the record was kept open until July 17, 2018 for the Claimant to submit a CD of the video shown at the hearing along with written closing argument to the WRC, and for the WRC to submit the CD, Claimant's written closing argument and the WRC's written closing argument to OAH. On July 17, 2018, the record was closed and the matter submitted.

On July 20, 2018, the record was reopened to accommodate the late submission from WRC of the following exhibits: Claimant's photographs and CD, marked and admitted as exhibit C-16; Claimant's written closing argument, marked only as exhibit C-

[1] The names of the family are not referenced to protect their privacy.

17; Claimant's addendum written closing argument, marked only as exhibit C-18; WRC's written closing argument and addendum written closing argument, marked only as exhibit WRC-16. The record was reclosed and the matter resubmitted on that date.

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ISSUE

Is Claimant eligible for services under the Lanterman Developmental Disabilities Services Act (Lanterman Act) under the category of autism?

EVIDENCE RELIED UPON

Documents: Service Agency's exhibits WRC-1-WRC-16; claimant's exhibits C-1-C-9, C-11, C-13-C-18.

Testimony: Rita S. Eagle, Ph.D., psychologist consultant to the WRC; Claimant's mother; Adam Bruno.

FACTUAL FINDINGS

PARTIES, JURISDICTION AND CATCHMENT AREA

1. Claimant is a 12 year-old male who lives at home with his mother. On February 21, 2018, Service Agency's multidisciplinary team determined that Claimant did not meet the eligibility criteria for services set forth in the Lanterman Act. The multidisciplinary team recommended a "residential program or partial hospitalization and intensive mental health." (Ex. 6.)

2. By a Notice of Proposed Action (NOPA) and letter dated February 26, 2018, the Service Agency notified Claimant that it denied his request for eligibility. On March 26, 2018, Claimant filed a fair hearing request to appeal the Service Agency's determination. All jurisdictional requirements have been met for this hearing to proceed.

3. When Claimant filed the fair hearing request, he was living within the

catchment area of the WRC, at his grandmother's home with his mother. However, at the hearing, Claimant's mother stated that she had purchased a home outside the catchment area, although she is in the process of selling that home. As such, for Claimant to receive services from the WRC or any other regional center based upon this decision, she must establish that she is within the appropriate catchment area.

CLAIMANT'S PSYCHOLOGICAL PROFILE AND AUTISM DIAGNOSIS FROM KAISER

4. (a) Claimant presents with a complex profile which, depending upon the assessment, has resulted in diagnoses of Attention Deficit Hyperactivity Disorder (ADHD) with a variety of psychiatric disorders and, more recently, Autism Spectrum Disorder[2] (ASD or autism) by his health care provider, Kaiser Permanente (Kaiser). Claimant insists that his historical behaviors masked his autism, or that his autism has more recently emerged, but the WRC insists that there is insufficient evidence from Claimant's early history to conclude that he has autism. The WRC does not challenge whether Claimant has a substantial disability, and limits its disagreement to whether Claimant meets the criteria for autism.

5. (a) Claimant is a 12-year old boy. He lives with his mother who has sole legal custody of him and visits with his father. Claimant's mother and father had a contentious relationship and separated when Claimant was about two years old. The split occurred as a result of Claimant's father's pattern of severe "verbal and psychological abuse," including "anger, tempers, and dysfunctional co-parenting," which notably affected Claimant. (Ex. WRC-12.) Claimant's mother is employed by the Air Force at its base in Los Angeles, as a Senior Contract Closeout Specialist. It is clear from the evidence and her testimony that Claimant's mother has sought and succeeded in obtaining comprehensive interventions for her son.

[2] The term autism shall be used interchangeably with the clinical term Autism Spectrum Disorder.

(b) Due to Claimant's severe maladaptive behaviors, his school district placed him in a nonpublic school, which is a school for children with special needs, called Village Glen. He is in sixth grade there, and is enrolled in the Science Technology Engineering and Math (STEM) program, a rigorous academic program; however, he continues to struggle with his severe maladaptive behaviors. Based upon Kaiser's diagnosis of autism, Kaiser referred Claimant to Easterseals of Southern California (Easterseals) for applied behavioral analysis (ABA) and autism services on September 8, 2017. Easterseals offered a six-month, sixty-hour, parent-training and consultation program.[3]

(c) Claimant was made eligible for special education by the Compton Unified School District (Compton) in 2015, when he was nine-years old, under the category other health impaired (OHI), due to his diagnosis of attention deficit hyperactivity disorder (ADHD), a neurodevelopmental disorder.[4] At the time of Compton's psychoeducational

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[3] Prior to its offer of services, Easterseals conducted an assessment of Claimant and prepared a report. However, for the purposes of this Decision, Easterseal's assessment report was given minimal weight in determining Claimant's eligibility, as its assessment relied primarily upon Kaiser's diagnosis and Kaiser's intake assessment. Such information was redundant of material information contained in other assessments, and primarily focused on behavioral and adaptive concerns to develop a treatment plan. (Ex. WRC-8.) Easterseals terminated the program because Claimant did not evidence the behaviors in the home and it did not receive the data it requested about his school behaviors. (Ex. C-7.)

[4] Cal. Code Reg. tit 5, section 3030 (b)(9) defines OHI as an impairment characterized by limited vitality or alertness, including a heightened alertness to environmental stimuli, that results in limited alertness with respect to the educational environment due to chronic health problems such as ADHD, and which adversely affects a child's educational performance.

assessment of Claimant in 2015, Claimant's maladaptive behaviors were so severe that he had been removed or expelled from kindergarten and, after his transfer to one religious school in third grade, was removed from that school after a few weeks. In total, between 2011 and 2015, between kindergarten and third grade, Claimant had attended five different schools. On the religious school's incident report, it was noted that he ran into the bathroom away from his teacher and dropped his pants and stood on the handicap rails so that he could not be grabbed by the pastor who intervened. After the pastor lifted him off the rails with a witness present, he crawled around the floor naked from the waist down, stomped on the pastor's foot who was trying to block him from exiting the bathroom, and only stopped when his father came to retrieve him and threatened to spank him if he did not get dressed.

6. (a) Claimant participated in outpatient psychotherapy between the ages of four and six, and returned to therapy in third grade due to his behaviors. He participated in weekly individual, family and group outpatient psychotherapy at Kaiser, beginning on February 2, 2011, where he was initially diagnosed with Adjustment Disorder and Disturbance of Conduct. (Ex. C-1.)

(b) In February 2015, psychiatric social worker, Stephanie A. Nakayama, MS., LMFT, began working with Claimant. She initially diagnosed him with ADHD, combined type and Oppositional Defiant Disorder. Shortly after Ms. Nakayama began therapy sessions with the family, Claimant's father advised Ms. Nakayama of Claimant's angry school outburst and his violence in the classroom, which resulted in the school calling the Department of Children and Family Services (DCFS) to investigate the family. During her treatment of Claimant, Ms. Nakayama noted a decline in Claimant's functioning including a decline in self-care, e.g., tying shoes, wiping his mouth, and pulling up his pants. (Ex C-1.) She also observed Claimant’s difficulty in articulating his thoughts, and his displays of emotional fragility. On one occasion, Ms. Nakayama witnessed Claimant, after he was

"triggered," crawl "under the couch and [curl] up into a ball and [make] whimpering sounds." (*Ibid.*) He came out from under the couch after his mother instructed him to do so and she comforted him by having him sit on her lap. Claimant's mother also showed Ms. Nakayama videotapes of Claimant's "emotional outbursts (yelling and throwing things)" and Claimant's father's "angry outbursts (yelling and cussing)" at Claimant or his mother. (*Id.*) Claimant was protective of his mother; he reacted to his father's yelling by telling him not to talk to "my mom like that." (*Id.*)

7. (a) Kaiser's child adolescent psychiatrist, Todd Bolinger, MD., also treats Claimant. At the time of Ms. Nakayama's treatment in 2015, he had diagnosed Claimant with Disruptive Mood Disregulation. (Ex. C-1.)

8. (a) In December 2015, Claimant's mother requested that Kaiser evaluate Claimant for autism. Her request of Kaiser was made after the Harbor Regional Center (HRC), Claimant's catchment area at that time, completed its evaluation, as set forth in the findings below, and concluded Claimant did not have autism. According to Ms. Nakayama, "at that time," Kaiser also concluded that Claimant did not meet the criteria for autism because Claimant "was still able to engage socially with others." (Ex. C-1.)

(b) In January 2016, Claimant began treatment in Kaiser's Norwalk psychiatric clinic; he participated in a children's social skills group and individual therapy. He also participated in an ADHD group and an anger management group at Kaiser's Psychiatry Clinic in Lomita from February 2016 through November 2017.

(c) On December 12, 2017, Ms. Nakayama terminated individual and family therapy because Claimant "was unable to appropriately interact and engage with her" during therapy. (Ex. C-1.) Claimant's mother had to provide him "continual guidance" including "appropriate responses" to Ms. Nakayama's questions; he also needed constant physical contact with his mother "in order to be comforted." (*Ibid.*) During sessions, Ms. Nakayama observed Claimant spending "most of the time during session wandering

around the office hand-flapping in front of his face sitting down rocking himself in chair (self-stimulating behavior common to Autistic children). (*Id.*) She also observed him getting "easily agitated when he didn't get his way." (*Id.*)

9. (a) Based upon his changed behaviors, particularly his further decline in functioning and display of behaviors similar to autism (e.g., hand-flapping, rocking, mumbling), Kaiser agreed to reevaluate Claimant. On June 19, 2017, when Claimant was 11 years old, Kaiser clinical psychologist Angie Morrow, Ph.D. diagnosed him with autism. The diagnosis was largely based on behaviors noted by Ms. Nakayama and Dr. Morrow such as repetitive behaviors (e.g., rocking, tapping, wandering around the office), poor eye contact, hiding under the therapist's couch and refusing to engage. (Ex. C-1.) The assessment also substantially relied upon Claimant's mother's reports, reflected in her interview and completion of rating scales. Dr. Morrow observed Claimant in the testing setting only.

(b) Complicating Dr. Morrow's assessment, was Claimant's persistent refusal to cooperate. Dr. Morrow reported in her summary observations and diagnostic impressions:

> [Claimant] presented as an uncooperative 11 year old boy...
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> [Claimant] presented with a flat affect, limited range of facial expressions and poor eye contact. [Claimant's] speech ranged from rapid to within normal limits, was monotone and he often made babbling sounds or made non-sensical spontaneous comments. When he used full sentences, he was easy to understand and follow. [Throughout] the evaluation he was observed as fidgety, rocked his body and moved around in his seat, was unable to remain seated and had odd finger movements/tapping and flicking on his head. He did not initiate social interaction and exhibited difficulty

> maintaining a reciprocal conversation with ease. Initially, [Claimant] was somewhat cooperative but then became uncooperative and refused to do tasks or respond to questions. He stood up with his back to this examiner and responded to questions with 'leave me alone' over and over again. He was observed to pace the office, crawled behind the couch and lay there for several minutes making babbling sounds. According to his mother's report, [Claimant] is sensitive to loud sounds, clothing textures, and does not like to be touched. [Claimant] rocks, flicks his fingers and hands, holds objects very close to his eyes, makes babbling sounds and has poor fine motor skills. He is said to have tantrums and explosive meltdowns destroying objects. The result of this evaluation are a likely valid representation of [Claimant's] current abilities.

(Ex. C-1, p.5; emphasis added.)

(c) Despite Dr. Morrow's admission that Claimant was uncooperative during his assessment, Dr. Morrow concluded that he "appears to meet the criteria" for autism spectrum disorder in the DSM-5 due to his exhibition of "persistent deficits in social communication and interaction across contexts as well as restricted, repetitive patterns of behavior, interests or activities." (C-1, p. 5.)

(d) Dr. Morrow used a variety of assessments, including: the Autism Diagnostic Observation Scale, Second Edition (ADOS-2); Checklist for Autism Spectrum Disorder; Child Autism Rating Scale, Second Edition-Standard Version (CARS-2); Gilliam Autism Rating Scale, Third Edition (GARS-3); and the Social Responsiveness Scale 2. Dr. Morrow also conducted a behavior observation, a clinical interview, a mental status examination and a

review of records, including the assessment conducted on behalf of the Harbor Regional Center (HRC) in 2015, where the assessor determined Claimant did not have autism, and the Compton Unified School District's assessment, where it was determined that Claimant had ADHD, as more fully discussed below. She did not comment on the validity of the HRC's assessment, or discuss the distinction between her results and the results reached by the HRC. She did not consider Claimant's assessment and developmental history. Dr. Morrow did not testify so it was not possible to clarify her assessment or her impressions.

(e) The validity of the assessments administered by Dr. Morrow were impacted by her reference to Claimant's inability to fully cooperate, her lack of specificity regarding the components of each test, her failure to account for Claimant's behavior in multiple contexts, and her seemingly singular reliance on Claimant's mother to complete rating scales on measures of autism. Claimant's behavior as measured in Dr. Morrow's cursory report of these assessments mirrored certain aspects of autism. With regard to the ADOS-2, a "semi-structured observation assessment of communication, social interaction, and imaginative use of materials"[5], Dr. Morrow observed Claimant to have: little reciprocity in his communication; poor eye contact and a flat affect, with limited vocalizations, facial expressions gaze and gestures; little expression of pleasure interacting with the examiner, although some pleasure in his own actions and non-interactive components of the ADOS-2; limited insight and understanding of emotions, and no social give and take, with the "overall quality of the session" marked by "discomfort" with the examination; and stereotypical behaviors of "finger flicking, head tapping, and odd hand movements." (Ex. C-1, pp.1-2.) Dr. Morrow appeared to use the broad language of the criterion without direct support, such as her observation of "stereotyped and unusual patterns of interest

[5] The description of ADOS-2 was supplied by the assessor for the Harbor Regional Center, John T. Stephenson, Ph.D. (Ex. WRC-11, p.12)

and repetitive behaviors" which interfered with communication, and "unusual routinized speech and activities." (*Ibid.*) Apropos to Claimant's resistance to testing, Dr. Morrow noted his "overactive behaviors were difficult to interrupt and the level of activity disrupted the ADOS-2 assessment." (*Id.*)

(f) Dr. Morrow also administered a Mental Status Examination, a structured assessment of behavioral and cognitive functioning based upon her observations. Dr. Morrow reported: Claimant's good grooming; poor eye contact; "uncooperative" and overly defiant" behavior and manner; mood "anxious"; affect, "flat, showed anxiety with fidgetiness"; speech, "clear" with fully understandable sentences in a monotone, "did not consistently respond to directed questions, no reciprocity noted;" language, "no difficulty expressing himself fully"; thought process and content, concrete and appropriate; sensory and cognition, "attention poor, cognition intact, memory unimpaired"; insight and judgment, "fair" and impulse control, "poor." (Ex. C-1, p.4.)

(g) Claimant's mother completed the rating scales ASRS and the GARS-3. These tests are generally used to screen for autism[6] and provide additional information to support the diagnosis and to guide treatment and ongoing monitoring of Claimant. Based on his mother's report alone, Claimant achieved scores which placed him, in the very elevated classification for autism on the ASRS and the very likely probability classification for autism on the GARS-3. Claimant's mother also completed the SRS-2 which addresses interpersonal behavior, communication and repetitive or stereotypical behaviors common to autism. Mother's ratings placed Claimant in the severe range for autism requiring

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[6] The GARS-3 has described by the assessor for the Harbor Regional Center, John T. Stephenson, Ph.D., as a "screening autism questionnaire used as one source of information toward a comprehensive picture of the person being assessed. A diagnosis cannot be made based upon the results of this one measure." (Ex. WRC-11, p.7.)

substantial interventions.[7] Dr. Morrow does not reference who completed the CASD or CARS-2, or how and when it was administered, but scores were obtained on both scales which placed Claimant, respectively, in the autism range and the severe group for autism. Given that only one date was scheduled for Claimant's assessment, the scales were either completed by Claimant's mother or by Dr. Morrow with mother's input, or as a result of her observations of Claimant during her assessment where Claimant was reported to be uncooperative.

CLAIMANT'S DEVELOPMENT AND ASSESSMENT HISTORY

10. At the time he transferred to Compton in the fourth grade, Claimant was seeing a psychologist or psychiatrist and was being home-schooled by his mother. Claimant's mother referred him to Compton for a special education assessment with the hope that specialized services would afford him the opportunity to attend school setting with his peers. By the time the psychoeducational assessment was administered by Compton, Claimant had missed school seven times during the months of March and April

[7] The DSM-5 (p.52) defines the "requiring very substantial support" severity level of autism spectrum disorder as follows:

> Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others. For example, a person with few words of intelligible speech who rarely initiates interaction and, when he or she does, makes unusual approaches to meet needs only and responds to only very direct social approaches.

2015 for psychiatric visits.

11. (a) The psychoeducational assessment was administered by school psychologist Felicia Lee on April 2015. As part of the assessment, the school psychologist conducted interviews with Claimant's mother and educators, and also observed and spoke directly with Claimant. Ms. Lee did not conclude that Claimant was eligible for special education services under the category of emotional disturbance.[8] Ms. Lee did not testify or otherwise explain her opinion dismissing emotional disturbance, or the psychiatric disorders subsumed under this catchall special education eligibility category, but her report noted that claimant's medication was not substantiated by the prescribing (or any) medical doctor, and exceed her qualifications as a school psychologist.

(b) Mother was interviewed and disclosed a family history of various medical, psychiatric, and disability-related issues including mental illness, intellectual disability, and speech problems related to autism. Mother also disclosed that Claimant was prescribed medication for ADHD, which the assessor advised could lead to side effects including

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[8] California Code of Regulations, Title 5, section 3030, subdivision (b) (4) defines emotional disturbance as a condition "exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance: (A) An inability to learn that cannot be explained by intellectual, sensory, or health factors; (B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers; (C) Inappropriate types of behavior or feelings under normal circumstances; (D) A general pervasive mood of unhappiness or depression; (E) A tendency to develop physical symptoms or fears associated with personal or school problems; (F) Emotional disturbance includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance under subdivision (b)(4) of this section."

psychiatric problems and manic symptoms. The medication prescribed was Vyvanse.

(c) Mother reported that Claimant was toilet trained at the age of two and had no accidents in bed until recently. (Ex. WRC12, p.2.) She reported that Claimant "had temper tantrums when he wants to have his way. This had been going on since he was a few months old, and continues until the present." (*Ibid.*) Mother did not report any unusual repetitive behaviors. She attributed his behaviors to his father.

(d) Claimant was diagnosed with ADHD, but had not been administered medication until around the time of Ms. Lee's psychoeducational assessment. Claimant had witnessed psychological abuse from his father to his mother and also had experience the death of someone close. Mother described Claimant's social behaviors as "bossy, clingy to adult (mom) sometimes, and loves to laugh and have fun." (Ex. WRC-12.) She shared that he "plays with other neighborhood children on weekends. He invites friends home and sometimes goes to other's house." (*Ibid.*)

(e) Mother also reported that Claimant participates in a variety of activities including martial arts, basketball, football, soccer, guitar playing, tap dancing, drama class, and piano lessons, and that he has "many adaptive skills just like children his age." (*Id.*)

(f) Ms. Lee also interviewed and observed Claimant. She remarked that Claimant "is a very special young man who likes to do things his way. He appeared intelligent and is observed to be articulate, has good motor skills, eye contact, and is also manipulative," which she opined may be the result of the family situation and his need for control, or as his mother stated, "the father's influence." (Ex. WRC12, p.5.) She observed that Claimant "would manipulate situations to gain his way." (*Ibid.*) When Claimant accompanied his mother for her interview, he was cooperative until his mother left the room and then "[Claimant] immediately became a different person. He was defiant, talked back, uncooperative, and refused to do any task presented of him." (*Id.*) When Ms. Lee told Claimant that she would not proceed, and instructed him to wait for his mother to

return and retrieve him, "[h]e sat there with a smirk on his face until the examiner called the mother on her cell phone asking her to hurry back." (*Id.*) After the call and the examiner turned to other matters, Claimant asked her to resume the test, but the examiner told him it was too late. Claimant than began crying "like a little 2-year old would" which was a stark contrast to "his regular demeanor as a smart-mouthed adult." (*Id.*) When Claimant returned the third time for testing, he was compliant as long as his mother was in the room, but once again, as soon as Claimant's mother started to leave, his "smirk" and "winning look" resumed, and he began "acting up" again. (*Id.* p.5.)

(g) Ms. Lee concluded that the rating of Claimant's mother of "high probability" on an instrument measuring emotional disturbance was misguided, as his mother only saw one side of him, the "sad" side. (*Id.*) Ms. Lee believed his mother did not see the true picture of Claimant's "manipulation," and "games playing" with "everything and everyone around" him. (*Id.*) Ms. Lee's distinction between "sad" and "manipulation" in support of her conclusion that Claimant was not eligible for special education under the category of emotional disturbance was not supported by the definition of emotional disturbance in the Education Code, and without further diagnostic explanation, made little sense.

12. (a) Respondent was administered a battery of standardized assessments and rating scales to assess Claimant's academic and social-emotional functioning. No formal testing of Claimant's cognitive functioning was administered.

(b) Ms. Lee administered the Woodcock-Johnson Test of Achievement (WJ-III) to assess Claimant's verbal abilities including his vocabulary and understanding of everyday speech. Claimant tested in the higher end of the average range of his same-aged peers in reading and math, and average in writing. The reading score was an "underestimation" because he stopped working. (Ex. C-13.) Claimant tested lower in the area of writing skills, specifically at the 2.6 grade level, and for this reason, a writing goal was developed by the Individualized Education Program (IEP) team. (Ex. C-13.)

(c) Ms. Lee administered the Developmental Test of Visual-Motor Integration (VMI) which measured Claimant's visual-motor coordination by his ability to copy line drawings of increasing complexity. Claimant performed in the average range of his same-aged peers.

(d) Ms. Lee administered the Test of Auditory Processing Skills, 3rd Edition (TAPS-3), which measures areas of auditory functioning including phonemic (word discrimination) skills, auditory memory and cohesion (comprehension). Ms. Lee could not measure Claimant's word discrimination skills because he became uncooperative, but, while he was cooperative, she measured the rest of his skills, and he scored in the average range in all those areas. (Ex. WRC-12, pp. 5-6.)

(e) To measure Claimant's social-emotional skills, Ms. Lee administered the Behavior Assessment System for Children, 2nd Edition (BASC-2), a rating scale which she gave to Claimant's mother. The BASC-2 elicits information to determine whether Claimant fits the profile of a child with certain emotional and behavioral disorders and, if so, the results of the BASC-2 can be used to design an appropriate treatment plan. Claimant's mother rated him in the highest at-risk range of "serious" in the area of depression and atypical school problems; she rated him in the lower, but at-risk range of "significant" in hyperactivity and school problems of withdrawal and attention. She also rated him in the significant range for behavioral symptoms. Claimant's mother reported only slight attention problems. The BASC-2 also provided a rating scale for adaptive skills. Claimant's mother reported adequate or better adaptive skills in the area of social skills, daily living, leadership and functional. She reported inadequate adaptive skills in the area of adaptability. (Ex. WRC12, p.7.)

(f) Ms. Lee also administered the Scale for Assessing Emotional Disturbance, 2nd Edition (SAED-2), which utilizes rating scales. Ms. Lee gave a rating scale to Claimant's mother, and received input only from her for the SAED-2. The results from Claimant's

mother indicated that Claimant met the criteria for emotional disturbance under the Education Code in the areas of relationship problems, inappropriate behavior, unhappiness or depression and physical symptoms. Nevertheless, Ms. Lee discounted the scores of Claimant's mother by reason of Ms. Lee's observations of Claimant over the course of three meetings, and maintained that what Claimant's mother considered behaviors associated with emotional disturbance were in fact Claimant's attempt to manipulate and control situations "to get his own way." She opined: "It is this examiner's belief that he does not have ED, but is seeing everything as a game and he wants to be in control. Seeing how his medication can have certain side effects, the escalated behavior issues in schools can also be due to medication." (WRC12, p. 8.) Mother agreed Claimant should not be designated as ED. Ms. Lee recommended eligibility on the basis of OHI due to Claimant's ADHD and concluded that Claimant's "disability is not the result of visual, hearing, motor impairment, autism, emotional disturbance, or intellectual disability."

(g) Ms. Lee administered the Attention Deficit Hyperactivity Test (ADHDT) which is a rating scale that measures attention, activity and impulsivity of a child. Based upon the response from his mother and therapist, Claimant met the criteria for ADHD in the areas of hyperactivity, impulsivity, and inattention. (Ex. WRC12, p. 8.) Claimant's diagnosis of ADHD was also supported by an assessment scale administered to his teacher in March 2015, the National Institute of Children's Health Quality (NICHQ) Vanderbilt Assessment Scale. (Ex. WRC-11, p. 4.) On May 12, 2015, when Ms. Lee was writing the assessment report, Claimant's mother provided her with a letter from Claimant's doctor at Kaiser, Todd Bolinger, M.D., with his diagnosis of ADHD. (*Ibid.*) Dr. Bolinger's letter is not in evidence.

(h) Ms. Lee did not address autism as a suspected disability or identify any hallmarks of autism from her interviews with Claimant and his mother, or the rating scales administered. Autism under the Education Code is more broadly defined for purposes of

special education eligibility than it is for regional center eligibility,[9] where the assessors general rely upon the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).[10] Ms. Lee's recommendations included continued therapy and medication for ADHD without side effects, organization skill training such as calendars, schedules, charts, designated folders, routines, daily emphasis on spelling and writing and reading skills, areas of weakness, choice of hobbies, and discussion of career goals as incentive for better behavior.

(i) Following the school psychologist's report, the IEP team met on June 10, 2014 and developed Claimant's IEP. Compton offered to place Claimant in a general education class to address academic goals in the area of writing, provide counseling

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[9] Pursuant the California Code of Regulations, title 5, section 3030, subdivision (b)(1), "[a]utism means a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age three, and adversely affecting a child's educational performance. Other characteristics often associated with autism are engagement in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences. (A) Autism does not apply if a child's educational performance is adversely affected primarily because the child has an emotional disturbance, as defined in subdivision (b)(4) of this section. (B) A child who manifests the characteristics of autism after age three could be identified as having autism if the criteria in subdivision (b)(1) of this section are satisfied."

[10] The DSM-5 is a generally-accepted manual listing the diagnostic criteria and discussing the identifying factors of most known mental disorders. It is published by the American Psychiatric Association. Based upon the parties' stipulation during the hearing, the ALJ took official notice of the DSM-5 pursuant to Government Code section 11515.

services, and address social skills goals regarding peer interactions. Claimant's mother wanted him placed in a nonpublic school immediately, but Compton convinced her to place Claimant first in a general education class and await the results of a functional behavior assessment (FBA) and a resource specialist's observation of him in this placement. An FBA is not in evidence.

(j) In April 2017, the IEP team placed Claimant in a nonpublic school, Village Glen, due to his behaviors. Claimant had been suspended from two more schools by the time of this placement. It is unknown why the IEP team chose Village Glen.

13. During that same year, Claimant also requested eligibility for regional center services from the Harbor Regional Center (HRC). Two different assessments were conducted on behalf of the HRC when Claimant was nine-years old. At the time of the assessment, Claimant, who had been diagnosed with ADHD, was being treated by Dr. Bollinger, who reported that Claimant exhibited disruptive behaviors. (Ex. WRC-11, p. 4). Claimant was still on Vyvanse and taking a low dose, which was "somewhat helpful." (*Id.,* p.3.) Claimant was in the fourth grade in a general education class at Cowan Elementary School in Westchester with an IEP. A June 9, 2015, letter from Claimant's previous teacher at the religious school confirmed that in addition to the bathroom incident with the pastor, Claimant had been disruptive in the classroom, suspended for 12 days, and also had displayed poor social interactions on the playground. Claimant's previous teacher did not think he displayed learning difficulties. (*Id.*, p. 4.)

14. (a) The first HRC assessment focused on eligibility under the category of autism. It was conducted on behalf of the HRC by John T. Stephenson, Ph.D., a licensed clinical psychologist and a diplomate of the American Board of Pediatric Neuropsychology. The assessment occurred over three sessions: one in late September 2015 and two in October 2015. In contrast to Compton's assessment, Dr. Stephenson's assessment including cognitive testing.

(b) At the time of the request, Claimant's mother reported an increase in "emotional dysregulation, including quite severe tantrums," and she believed Claimant's behaviors were consistent with autism based upon a similar description of a nephew with autism and her readings about Asperger's Syndrome. (Ex. WRC-11.) Claimant's mother showed the HRC a video of Claimant in the middle of a tantrum which depicted him screaming and throwing his toys. Claimant's mother reported a list of concerns, including: his relatively slow ability to learn and complete school assignments, especially math, and his difficulty with writing; his frustration when he is not understood; his reduced eye contact; his socialization difficulties with making friends, including fighting, getting teased, and reacting in anger; impulsivity; his age-inappropriate interest in stuffed animals; his trouble with social cues; suspension from school due to behavior which included tantrums and rages, including four rages or severe out of control tantrums in the last four months; bullying; and curling up and crying at school. (Ex. WRC-11, p.2.)

(c) Dr. Stephenson's reported that Claimant had fluctuating attention and/or motivation when he administered standardized assessments, and as such concluded that the assessment results "might underestimate Claimant's full abilities." (Ex. WRC-11, p. 6)

(d) To assess Claimant's cognitive abilities, Dr. Stephenson administered the Wechsler Intelligence Scale for Children, Fourth Edition (WISC-IV), an assessment which measures areas of cognitive ability including verbal comprehension, visual perception, working memory and processing speed. Claimant's full scale intelligent quotient (FSIQ), a composite of the areas of cognitive ability, as measured in terms of a standard score (SS) with an SS of 100 being the mean, was 84, or in the low average range. Claimant obtained an SS of 73, a score in the borderline range, in the area of verbal comprehension. In the area of visual spatial abilities, Claimant obtained a SS of 90, an average range score. In the area of working memory, Claimant obtained a SS of 97, an average range score. In the area of processing speed, Claimant obtained a SS of 83, a low average range score. (Ex.

WRC-11, p.6.)

(e) To assess Claimant's acquired academic abilities, Dr. Stephenson administered the Wide Range Achievement Test, Fourth Edition (WRAT4). Claimant obtained an average range score, SS 92, in the area of word reading, and an average range score, SS 93, in the area of spelling. Claimant's math computation scores were not assessed because he did not cooperate. (Ex. WRC-11, p.6.)

(f) To assess Claimant's adaptive behavior in the areas of community use, functional pre/academics, home living, health and safety, leisure, self-care, self-direction, and social, Dr. Stephenson administered the Adaptive Behavior Assessment Scale, Second Edition (ABAS-II). Claimant's mother completed a rating scale for the ABAS-II and the results of her score placed Claimant in the extremely low range on the global adaptive composite, SS 64, the borderline range on the conceptual composite, SS 72, the extremely low range on the social composite, SS 66, and the borderline range on the practical composite, SS 66. (Ex. WRC-11, p. 7.) Dr. Stephenson questioned the severity of Claimant's mother's findings based upon his own observations of Claimant. He provided specific examples of adaptive skills "endorsed" by Claimant's mother: sometimes listens to family or friends who need to talk about problems; sometimes refrains from saying something that might embarrass or hurt others; sometimes completes projects on time; sometimes cuts his own fingernails and toenails; he can tie his own shoes, and sometimes invites others home for a fun activity. (*Ibid.*)

(g) To assess Claimant for autism, Dr. Stephenson administered the GARS-3 and the ADOS-2. Claimant's mother provided rating scale responses to the GARS-3 and as they did in Dr. Morrow's assessment, her responses resulted in an "extremely high autism rating," placing Claimant in the "very likely" range for autism. (Ex. WRC-11, p.7.) Among other observations, Claimant's mother reported his finger flapping and lack of interest in social interaction, his poor understanding of social communication, his frustration, and

need for excessive amount of reassurance.

(h) However, Dr. Stephenson considered his mother's ratings not "reflective of [Claimant's] history and presentation" and concluded that it is "likely that many endorsed behaviors are due to other factors, such as emotional dysregulation and ADHD." (*Ibid.*) As a result of his observations during the administration of the ADOS-2, Dr. Stephenson rated Claimant in the non-autism range. In the area of communication, Dr. Stephenson concluded that Claimant's ability to report events in his life was adequate, his conversation was age-appropriate, and he demonstrated the use of age-appropriate gestures. (*Id.*) In the area of reciprocal social interactions, Dr. Stephenson reported that Claimant had adequate eye contact, until he was upset "in the moment" which "hindered his performance." (*Id.*) He reported Claimant's facial expressions to be directed at the examiner, that he demonstrated shared enjoyment in interactions, and that he displayed "adequate" social overtures, a reasonable amount of reciprocal social communication and social responses, although his rapport was reduced by "his being angry and not fully cooperative." (*Id.*) Dr. Stephenson did not observe Claimant engaging in stereotypical or idiosyncratic use of words or phrases, unusual sensory interests in play materials, hand or finger, or complex mannerisms, excessive interest in specific topics or objects, or repetitive behaviors. (*Id.*)

(i) Dr. Stephenson's report was very specific and clearly identified Claimant's behaviors from his observations which were consistent with Claimant's history. He maintained that although Claimant exhibited "impulsivity" in his "quick answering of test items and careless mistakes," he did not exhibit the benchmarks of autism in his verbal and nonverbal communication and behaviors. (WRC-11, p.8.)

15. (a) Dr. Stephenson discussed in his report the first two criterion, A and B, of the diagnostic criteria for autism spectrum disorder under the DSM-5, which are the first two benchmarks of the diagnosis. Each criterion is discussed in more detail below. Dr.

Stephenson concluded that Claimant did not satisfy criterion A or B, and, as such, did not need to assess the remaining criterion (i.e., criterion C, D, and E).

(b) The DSM-V, section 299.00 discusses the diagnostic criteria which must be met to provide a specific diagnosis of Autism Spectrum Disorder, 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.

Specify current severity:

Severity is based on social communication impairments and restricted repetitive patterns of behavior. . . . [Italics and bolding in original.]

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 stereotypes, 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 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 interest).

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 of objects, visual fascination with lights or movement).

Specify current severity:

Severity is based on social communication impairments and restricted, repetitive patterns of behavior . . . . [Italics and bolding in original.]

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 developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

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

(c) With regard to criterion A(1), Dr. Stephenson concluded that Claimant exhibited adequate reciprocity "unless he was upset or in trouble." (WRC-11, p.9.). As to criterion A(2), Dr. Stephenson concluded that Claimant did not exhibit any "significant deficits." (*Ibid.*) Dr. Stephenson recognized that Claimant did not always make eye contact and noted that Claimant's "eye contact will be reduced when he is upset or in trouble." (*Id.*) With regard to criterion (A)(3), Dr. Stephenson attributed Claimant's social difficulties to emotional or behavioral disturbance; he noted that Claimant exhibits social interest and can engage with others "reasonably well until conflict arises." (*Id*). With regard to criterion (B), Dr. Stephenson concluded Claimant did not meet any of the components of this criterion.

(d) As set forth above, Dr. Stephenson did not directly address the remaining DSM-5 criterion for autism spectrum disorder, because Claimant did not meet the first two criteria. However, considering Claimant's history and Dr. Stephenson's observations of Claimant, Dr. Stephenson attributed Claimant's behaviors to his inability to control his emotions and to his ADHD.

16. (a) Dr. Stephenson diagnosed Claimant with the following DSM-5 diagnosis: (296.99) Disruptive Mood Dysregulation Disorder (DMDD); (314.01)

Attention-Deficit/Hyperactivity Disorder, Combined Presentation; and (315.1) Provisional, Specific Learning Disability, With Impairment in Mathematics. (Ex. WRC-11, p. 10-11.)

(b) DMDD is characterized by severe and recurrent tantrums and/or physical aggression towards people and property. (Ex. WRC-10, p.7.) The salient features of DMDD are: A. Severe recurrent temper outbursts manifested verbally (e.g., verbal rages) and/or behaviorally (e.g., physical aggression toward people or property) that are grossly out of proportion in intensity or duration to the situation or provocation; B. The temper outbursts are inconsistent with developmental level; C. The temper outbursts occur, on average, three or more times per week; D. The mood between temper outbursts is persistently irritable or angry most of the day, nearly every day, and is observable by others (e.g., parents, teachers, peers). E. Criteria A-D have been present for 12 or more months and throughout that time, the individual has not had a period lasting three or more consecutive months without all of the symptoms in Criteria A-D; and F. Criteria A and D are present in at least two of three settings (i.e., at home, at school, with peers) and are severe in at least one of these. The critical part of the diagnosis is the presence of severe irritability and angry mood present most days in between tantrums and noticeable by others; the tantrums are in response to frustration; and the tantrums are not associated with other conditions, particularly bi-polar disorder which is characterized by episodic tantrums not associated with a persistent irritability, or autism spectrum disorder. (DSM-5, pp.155-156.)

(c) Dr. Stephenson advised the family to explore mood stabilizing medication to moderate Claimant's "emotional and behavioral disturbance." (WRC-11, p.10.) He also offered that due to Claimant's reduced motivation "due to emotional dysregulation," it was difficult to ascertain whether he had specific learning disabilities, especially in math, but that it was possible he did.

(d) Dr. Stephenson acknowledged Claimant's mother's concerns that from her reading and what has been described to her, her son's disability is similar to what used to be referred to as Asperger's Syndrome, or what would be considered high functioning autism. Dr. Stephenson was firm in his conclusion that Claimant's "struggles are psychiatric in nature;" he does not show the "quality of his deficits in communication, social interactions, and repetitive mannerisms." (Ex. WRC-11, p. 10.)

(e) With regard to his extreme rage episodes, Dr. Stephenson emphasized that these episodes are inconsistent with a diagnosis of autism, but are consistent with a "separate mood-related condition." (Ex. WRC-11, p. 10.) Dr. Stephenson recommended treatment focused on his emotional dysregulation, including behavior therapy, directed at creating a high level of behavior structuring and management for emotional disturbance, "rather than behavior therapy for deficits in basic behaviors that is applied to children with autism." (Ex. WRC-11, p. 10.)

17. (a) The HRC commissioned a second evaluation with licensed psychologist, Krystel Edmonds-Biglow, Psy.D., which was conducted over three sessions in December 2015. The referral focused on whether Claimant's behaviors supported the criteria for a diagnosis of autism. (Ex. WRC-11, p. 10.) The assessment included Claimant's mother's report, Claimant's education and school history, and assessments, some repetition of, or a slight variation from, Dr. Stephenson's or Compton's assessment tools. Claimant's mother reported a variety of maladjusted behaviors in all environments consistent with his school history and previous assessments, including his tantrums which involve tearing paper, destroying property, eloping from school, engaging in antagonizing interactions with peers, and his escalating behaviors over time. Mother reported that she discontinued his ADHD medication prior to the assessment in November 2015. Claimant displayed a degree of opposition to the assessment, such that one assessment was attempted, but not completed. Mother's report through a rating scale, the Conners' Parent Rating Scale-

Revised, noted clinically significant behaviors in all domains: oppositional, inattention, hyperactivity and ADHD.

(b) Dr. Edmonds-Biglow reached a similar conclusion to that reached by Dr. Stephenson, based upon her observations of Claimant during testing and during the administration of a portion of the ADOS-2. During her administration of the ADOS-2, Claimant reported having friends and could name them and describe their activities and he demonstrated age-appropriate understanding of "relational themes." (Ex. WRC-10, p. 4-5). Dr. Edmonds-Biglow reported Claimant's negative self-referential comment, "I'm bad." She observed Claimant moving a lot; he was able to sustain attention during an activity, and he remained relatively calm when the conversation was about "benign" subjects. Claimant became more "distracted by the conversation about his behaviors." She observed him making eye contact and engaging in reciprocal communication including "small talk" where he asked Dr. Edmond-Biglow about the upcoming holidays. He became uncooperative during a discussion about his behavior. Dr. Edmond-Biglow did not observe any restricted or repetitive movements. (*Ibid.*)

(c) Claimant was more agitated during the second session because he was not allowed to bring his stuffed animal to the session as he had before. He engaged in maladaptive behavior, refusing to talk, kicking the wall and answering "no" in a "baby voice" and also attempted to avoid the assessment by crawling under the table. (Ex. WRC-10, p. 5.)

(d) Claimant eventually came out from under the table and completed the Childhood Depression Inventory (CDI), a self-reporting tool not previously administered. Claimant's responses were clinically significant for anhedonia ineffectiveness (inability to experience pleasure); interpersonal problems and negative mood. (Ex. WRC-10, p. 6.)

(e) Dr. Edmonds-Biglow provided additional information about Claimant by observing him in his Winter Break camp as her third assessment session. She observed

him talking with the counselor and playing with other children. Claimant made eye contact with her when he saw her, smiled and continued to play. Claimant greeted her, exchanged small talk about his jacket, the cold weather and his peers, and followed the group into the lunch room. Dr. Edmonds-Biglow observed Claimant waiting patiently for his lunch, speaking to his peers "regularly" and enjoying himself. (Ex. WRC-10, pp. 5-6.) She interviewed his counselor about Claimant's behavior and social interaction, who reported that Claimant initiates social interaction, responds positively to others, regularly plays with other children, but gets "an attitude" when things do not go his way. The counselor stated that he does not present a significant problem for them. (*Ibid.*)

(f) Dr. Edmonds-Biglow offered the following diagnoses: DMDD, and Generalized Anxiety Disorder, Provisional (300.02). With regard to his DMDD, she noted that his frequent and severe tantrums (throwing objects, destroying property and aggressive behavior without clear provocation or in response to benign triggers), three to four times per week, and his persistent angry mood, is consistent with this diagnosis, which is one of the Depressive Disorders. With regard to the diagnosis of Generalized Anxiety Disorder, she looked to his history and symptoms of hyperactivity (restlessness) and difficulty concentrating. She disagreed with the previous assessment of ADHD, because it appeared that the stimulant medication made his behaviors worse, and he was not responding to therapy. She attributed his behavior more to his chaotic life, including his many school changes and family situation. She attributed the symptoms of ADHD to a mood and anxiety disorder. (Ex. WRC-10, p.7.)

(g) Dr. Edmunds-Biglow recommended medication management from his psychiatrist and different medication to reduce his reactivity and emotional dysregulation, and recommended continued family counseling. She also recommended a designation of emotional disturbance for special education eligibility and a nonpublic school with a comprehensive behavior program. (Ex. WRC-10, pp.7-8.)

18. On February 29, 2016, the HRC denied Claimant's request for eligibility.

WRC'S DETERMINATION OF CLAIMANT'S ELIGIBILITY AND EXPERT TESTIMONY

19. (a) In September 2017, Claimant's mother requested a transfer of records from the HRC to the WRC. Claimant's mother was interested in obtaining more social skills services from the WRC, and Claimant's school district informed her they would not be funding any services in the addition to those he receives at Village Glen. In October 2017, Claimant's mother met with Rebecca Choice of the WRC for the purpose of obtaining regional center services based upon an eligibility determination of autism. As of this meeting, Claimant was in the sixth grade at Village Glen, and was still receiving medication management from Kaiser's psychiatrist, although it is unclear whether Claimant had resumed his ADHD medication or was on some other medication at the time.

(b) Throughout her intake interview with Claimant and his mother, Ms. Choice observed Claimant to have a flat affect, avoid eye contact, and to speak in gibberish. He also exchanged few words, and resisted her efforts to encourage reciprocal communication. Claimant stayed close to his mother who informed Ms. Choice of his history, which was consistent with her previous reports, with few exceptions. Mother reported that Claimant had three friends from previous schools. During Ms. Choice's intake, Claimant wore a large quilted pad to self-soothe because, as his mother explained, he bangs himself on the forehead with his right hand. Claimant still had a favorite stuffed bear with which he slept along with a light blue pillow he used around the home to self-sooth. Claimant tapped rhythmically on the desk top and also clapped his hands to make a rhythm. Unknown to Ms. Choice was Claimant's reported musical ability.

(c) Claimant's mother did not recall his developmental milestones, other than his toilet training at 24 months and his independent toileting at 36 months.

20. Clinical psychologist Rita S. Eagle, Ph.D., who testified at hearing, was retained by the WRC to assess Claimant for eligibility. Dr. Eagle is an experienced licensed

clinical psychologist with about 50 years of experience diagnosing and treating individuals with autism. Her report and testimony were insightful and thoughtful. She conducted a comprehensive review of Claimant's records and assessment history and was able to observe Claimant during her assessment and at his school. Dr. Eagle was candid about her inability to conduct a valid assessment of Claimant due to his behaviors. Nevertheless, based upon her experience and her candor about her inability to administer a formal assessment, her expert testimony, encompassing Claimant's history, his previous assessments, and her observations of Claimant's behavior in two settings, was given great weight. While Dr. Eagle conceded that it was not consistent with WRC's protocols for her to be part of the multi-disciplinary team making the determination about Claimant's eligibility, her credible expert testimony, and its consistency with the assessment findings of Dr. Stephenson, demonstrate that any departure from WRC's protocol did not likely alter the multidisciplinary team's determination of Claimant's eligibility.

21. (a) During Dr. Eagle's testimony, which was consistent with Dr. Stephenson's report, she disputed Dr. Morrow's findings that Claimant appears to meet the criteria for autism spectrum disorder due to his exhibition, in part, of Claimant's lack of cooperation, and challenged some noted inconsistencies between Dr. Morrow's conclusions and some of her findings.

(b) Specifically, in addition to what was referenced in finding 9 above, Dr. Eagle noted other inconsistencies in Dr. Morrow's assessment and her diagnosis, such as Dr. Morrow's repeated reference to an individual named "Grace," a different patient, instead of Claimant, and her assertion, without examples, that Claimant's behavior was inappropriate, and that he provided little give and take. Dr. Eagle also disagreed with Dr. Morrow's description of Claimant's oppositional behaviors.

(c) Specifically, Dr. Eagle noted that Dr. Morrow failed to distinguish between behaviors associated with autism and those which may not be, but which demonstrate

Claimant's lack of interest in the assessment and his refusal to cooperate. She also noted that Dr. Morrow failed to address Claimant's reported ability to express himself, failed to address the several situations where Claimant was able to display normal give and take, and failed to address findings of Claimant's reciprocity and social relatedness, as Dr. Stephenson, Dr. Edmunds-Biglow, and Dr. Eagle had found. Dr. Eagle was troubled by Dr. Morrow's report, from her one observation, of characteristics never established before, without examples, such as "unusual routinized speech and activities," "stereotyped and unusual patterns of interest and repetitive behaviors." Dr. Eagle also took exception to Dr. Morrow's failure to consider Claimant's self-report of his anxious, uncooperative and overly defiant behavior in his mental status exam when interpreting the ADOS. (Ex. WRC-4, pp. 6-7.) During her testimony at hearing, Dr. Eagle was dismissive of Dr. Morrow's emphasis on Claimant's disinterest in her, as "not one of the strongest cues" that an 11-year old was not interested in an adult assessor.

22. On November 22, 2017, Dr. Eagle met with Claimant and his mother to interview them and to conduct a multidisciplinary observation. Claimant refused to cooperate with Dr. Eagle and displayed extreme behaviors from the moment they were introduced in the waiting room and in the assessment room. Dr. Eagle described Claimant's behaviors in the waiting room as "whimpering, making noises, behaving in a disorganized manner;" his behaviors on the way to the assessment, after her efforts to engage him, as an attempt to disregard her, and out of control behavior "scary to others in the hallway, and the elevator." His maladaptive behavior continued unabated by his mother's attempts to soothe him and the large quilted pad with hoops she provided him for self-soothing. (Ex. WRC-4, p. 7.)

23. (a) In the assessment room he appeared afraid and when he was told he would be observed, especially when he noticed the camera, and was informed about the one way mirror, he became more agitated and his behavior escalated, "as if he were an

out-of-control, frightened, non-verbal feral child" eventually curling up tightly in a corner to avoid it. He refused to make a deal with Dr. Eagle when she offered to make sure no one would be watching, stating, "Tell them to stop, but no deal!" (Ex. WRC-4, p. 7.) Dr. Eagle tried many ways to obtain his cooperation, including introducing him to the examiners scheduled to observe him, closing the shades to the windows and covering the camera, but Claimant would not cooperate. Dr. Eagle initially formed the impression that Claimant was "putting on an act" or manipulating the situation to gain control "with his strange behavior," because he demonstrated that he could communicate what he was unhappy about while behaving as if he were frightened, but his mother assured her he was not. Dr. Eagle ultimately concluded that he was not in control of his emotions and that his actions were in response to fear and possibly his attempt to look less fearful. During her testimony, Dr. Eagle also concluded that Claimant's "strange behaviors" occurred when he was triggered, and were not routine.

(b) Eventually after the shades were drawn and the camera and sound were turned off, Claimant stopped his behavior "cold turkey." He agreed to talk, but did so in a low tone and from the floor in the corner of the room. He did interact in a limited way by making fun of Dr. Eagle, and telling her he liked his old school better than Village Glen because of the food choices and video games. Claimant turned to his mother for comfort and even his mother's efforts to soothe him were unsuccessful and the session closed.

24. After the first session, on December 8, 2017, Claimant's mother e-mailed Dr. Eagle to report an incident at Village Glen on December 6, 2017, where the police had been contacted after Claimant was threatening other students with an object that was publicized to be a knife, but was in fact a pencil used for his arts and craft project. Claimant was suspended. Claimant's mother did not want him to be referred to a residential treatment program; she wanted him to have an education which also included therapy.

25. On December 11, 2017, Dr. Eagle observed Claimant at Village Glen. She observed his class of six students. During class, Claimant did not listen to the teacher, "appeared sullen," and maintained a "somber and surly expression." He worked with another boy on a project and began to smile and laugh; he interacted with the other student and they were enjoying each other's company. Dr. Eagle observed Claimant to be calm with no strange movements or noises; she observed him cleaning up when told and leaving for lunch with the other students. He avoided looking at Dr. Eagle and it was obvious to her that he did not want to be observed. When he saw her at lunch, he left the area. (Ex. WRC-4, p.9.)

26. (a) As part of her assessment, Dr. Eagle spoke with Claimant's teacher and a Village Glen administrator. With regard to his placement in the STEM program, they informed Dr. Eagle that it might not be the best placement for Claimant, because when he joined the program, he was not as prepared academically as the other students. They also shared with Dr. Eagle that with regard to Claimant's emotional status, he acted out, especially in larger classes, and sometimes his acting out became so intense, the class had to be evacuated. However, his acting out was 50-50 under his control; and his acting up was the only way he could address situations he could not handle. The administrator stated that Claimant's behavior was not "atypical" for autism, but was for "his profile" (which was not explained). During Claimant's behavior episodes, the teacher and administrator had observed the following: Claimant scooting on the floor, exhibiting excessive flapping, hiding, rocking, displaying strange motor movements, twisting of his arms and feet, shaking, and demonstrating anxiety and agitation. During these episodes, the staff must avoid physical contact with Claimant or his behaviors and aggression escalate. The teacher and administrator expressed that staff found it difficult to break Claimant's behavior, although they try by reminding him of his preferred teacher and pleasant events. They noticed that Claimant's behaviors generally stopped when Claimant

became exhausted. (Ex. WRC-4, p.10.)

(b) The Village Glen administrator explained that Claimant's triggers include his "perception" that the work was too hard, and agreed with Claimant's mother that transitions, poor understanding of social cues, and Claimant's tendency to become easily overwhelmed, could also be triggers. The administrator reported that Claimant cannot tolerate "any negatives," and his play skills are that of an eight-year-old child.

(c) The administrator recommended keeping Claimant in the same class the following year so he could have a stable environment and an opportunity to learn the same material with an incoming class, after he caught up with the science and math.

27. During her testimony, Claimant's mother provided a videotape of Claimant melting down in the back seat of her car after a picnic event with the Army, and other pictures of his destructive behaviors. (Ex. C-16.) During the videotape, Claimant could not articulate why he was upset after repeated prompting by his mother, and eventually fell to his side and curled up into a fetal position. In the WRC's written rebuttal, Dr. Eagle and the multidisciplinary team reviewed the videotape and formed a new diagnostic impression, Stereotypic Movement Disorder (DSM-5, 307.3). The WRC's new diagnostic impression was considered as closing argument only and was not given any weight, as it was not derived from a comprehensive assessment or presented at the hearing by Dr. Eagle or a member of the multi-disciplinary team where Claimant's mother could have asked questions.

28. (a) Based upon the previous findings, Dr. Eagle's observations, report and testimony, and Dr. Stephenson's comprehensive assessment in particular, there is insufficient evidence that Claimant meets the diagnostic criteria for autism spectrum disorder under the DSM-5.[11]

[11] Ideally, the WRC would have fulfilled its commitment to conduct a comprehensive assessment using a battery of standardized measures, in addition to

(b) Dr. Eagle could not find persistent deficits in social communication and interaction across contexts and restrictive repetitive patterns of behavior interests and activities. By history, she could not find the presence of autism in the early developmental period. During her testimony, Dr. Eagle explained that the early developmental period for autism is considered three-years old. She considered it significant that Claimant did not evidence any of the benchmarks of autism at that age. According to Dr. Eagle, autism does not suddenly appear at age 11 or 12 when he was first diagnosed. She also did not consider the diagnosis to be delayed because the symptoms were masked until he was older. By history, Claimant was diagnosed and treated for ADHD and numerous psychiatric disorders. He was able to engage socially, he had friends, and he was subject to "profound" environmental influences at a young age from family strife, which clearly affected him. Further, Claimant did not evidence the same behaviors across contexts; he did not show restrictive or repetitive patterns, and could demonstrate humor. For example, in his interview with Dr. Eagle, he made fun of her mistakes about sports. He demanded that she turn off equipment in an attempt to gain control of the situation, and by doing so, in contrast to a child with autism, clearly communicated his needs. Children with autism might want things on their own terms, but generally because they can only do things a certain way. In previous assessments, he could interact, and was described as manipulative. Claimant clearly did not like to talk about his behaviors and would become agitated and uncooperative when this sensitive subject was broached.

(c) During her testimony, Dr. Eagle responded to Claimant's mother's description of Claimant rocking, and self-stimulatory behavior such as hand-flapping. Dr. Eagle insisted that such behaviors are not exclusive to children with autism. When

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observations and record review. However, given the history of Claimant's noncompliance, it is unclear when it will be possible to conduct another comprehensive assessment.

Claimant's mother insisted that his decline over the years recently revealed his autism, Dr. Eagle was also insistent that Claimant did not become autistic due to environmental stresses, and that what appeared to be traits of autism, when reviewed in the context of his history, was not.

(d) Dr. Eagle's efforts to provide a firm psychiatric diagnosis, was not only impeded by her inability to conduct a complete assessment, but the absence of information, including a completed, current and comprehensive functional behavior assessment, covering behaviors at home, at school, and with his mother and father, and progress reports on previous and ongoing behavior interventions. Dr. Eagle recommended further "comprehensive" testing through Claimant's school district. In addition to a functional behavior assessment, she recommended an assessment of his cognitive and learning styles, and a possible specific learning disability. She was doubtful that an ABA program would work; instead ways to break through his distrust of the therapist will have to be found so that he can develop a therapeutic working relationship. She recommended a therapeutic program, either residential or partial residential, if necessary. (Ex. WRC-5and WRC-6)

TESTIMONY OF CLAIMANT'S MOTHER AND ADAM BRUNO

29. (a) Claimant's mother provided sincere, compassionate and credible testimony of her observations and experiences with Claimant. She studied material on autism and used some of the interventions, such as the padded arm, in an attempt to soothe Claimant. She insisted that his behaviors over the years masked his true disability and pointed to his finger flapping, his sensitivity to fabric, his insistence on wearing soft sweat suits, even in warm weather, his meltdowns, and his problems with transitions. Claimant's mother objected to the WRC's discussion of his early developmental years as inconsistent with the Lanterman Act's identification of developmental years as any time before 18 years of age. Claimant's mother could not understand how the WRC could

reject Kaiser's diagnosis. Claimant's mother pointed to a more recent letter dated May 17, 2018, from University of California at Los Angeles (UCLA) admitting Claimant to a genetics study of autism based upon its "research assessment", using, among other measures, the ADOS-2. (Ex. C-15.) However, as Dr. Eagle testified, the UCLA letter noted "diagnostic requirements for research studies may be more specific or limited than the requirements for a clinical diagnosis." (*Ibid.*) The letter does not identify with specificity the results of the ADOS-2, and as discussed in the earlier findings, Claimant's behaviors were not assessed in different settings. Claimant's mother provided portions of Claimant's most recent IEP; however, there was nothing in the report about Claimant's behaviors that differed from than what Dr. Eagle observed at school or through her interviews with his teacher and administrator. Claimant's mother also provided a letter dated Mach 29, 2018, from the City of Carson where the staff of an afterschool play and child care program outlined Claimant's maladaptive behaviors including his refusal to follow directions, pushing and shoving other children, crying and insisting on calling his mother. This letter is reflective of Claimant's social-emotional status and behaviors, which include defiance, anger and violence, but does not establish that he meets the qualifying criteria of autism.

(b) Claimant's mother is correct that many of Claimant's behaviors are similar to those of individuals with autism, and that individuals with autism also can have meltdowns and psychiatric issues, referred to as co-morbid diagnoses. She provided witness testimony from Adam Bruno, a highly-educated and accomplished individual, who was diagnosed as autistic. Mr. Bruno obtained college and advanced degrees, and is currently a licensed marriage and family therapist. He was diagnosed with autism and other diagnoses including ADHD, depression, anxiety, obsessive compulsive disorder. However, there is insufficient evidence at this time that Claimant meets the criteria of autism and that his behaviors are not symptomatic of other neurodevelopmental disorders like ADHD,

combined with psychiatric or learning disorders.[12] At this time there is insufficient evidence by history and across contexts that Claimant meets the criteria for an autism diagnosis.

LEGAL CONCLUSIONS

1. Claimant did not establish that he suffers from autism spectrum disorder entitling him to change his eligibility category under the Lanterman Act, as set forth in findings 1 through 30, and legal conclusions 1 through 9.

2. Because Claimant is the party asserting a claim, he bears the burden of proving, by a preponderance of the evidence, that he is eligible for regional center services based on a diagnosis of autism spectrum disorder. (See Evid. Code, §§ 115 and 500.) He has not met this burden.

3. The Lanterman Act governs this case. (Welf. & Inst. Code, § 4500 et seq.) Eligibility for regional center services is limited to those persons meeting the criteria for one of the five categories of developmental disabilities set forth in Welfare and Institutions Code, section 4512, subdivision (a), as follows:

> "Developmental disability" means a disability that originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual.... [T]his term shall

[12] Claimant's mother suggests that he might be eligible under the so-called Fifth Category, but this fair hearing request is limited to autism. According to his IEP, Claimant's three-year triennial assessment should be administered around August 2018. Further cognitive and academic assessments would assist in making any future determination of eligibility under the fifth category.

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

4. (a) Welfare and Institutions Code section 4512, subdivision (*l*), provides:

'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:

(A) Self-care.

(B) Receptive and expressive language.

(C) Learning.

(D) Mobility.

(E) Self-direction.

(F) Capacity for independent living.

(G) Economic self-sufficiency.

(b) Here, the parties do not dispute that Claimant has a substantial disability. The question is whether Claimant qualifies for regional center services by meeting the diagnostic criteria of the developmental disability of autism as defined in finding 15.

5. Based upon Dr. Stephenson's comprehensive assessment in 2015, which was also supported by the assessments of Dr. Edmonds-Biglow, Dr. Eagles' expert testimony, and Claimant's early developmental history, the evidence did not establish that Claimant

met the first two criterion of autism. Claimant may have avoided eye contact during his assessment at Kaiser, but this behavior was not apparent in all assessments, or in all contexts. Claimant does have social communication deficits, especially in understanding nonverbal social cues, but again, Claimant demonstrated that he could engage in social communication with his peers. Claimant has the capacity to make friends; has engaged with his neighbors from early reports and self-reported three friends from previous schools. He has a short fuse and is easily enraged, but from observations and interviews at school, it is evident he has an interest in his peers. Claimant does not have unusual and focused interests. Claimant is clingy to his mother and seeks out comfort from his stuffed animal, but these behaviors are not necessarily signs of autism. The evidence did not establish that Claimant exhibits restricted, repetitive patterns of behavior, interests, or activities in all contexts. Claimant may have resorted to babbling, finger flapping and other maladaptive behaviors, but these behaviors were not persistent in all contexts, evident from Mother's reports of his early development, and were consistent with psychiatric disorders which were evident or diagnosed at an early age.

ORDER

Claimant's appeal is DENIED.

DATE:

_____
EILEEN COHN
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.