BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: CLAIMANT, and FRANK D. LANTERMAN REGIONAL CENTER, Service Agency.	OAH No.: 2013060697

DECISION

Jennifer M. Russell, Administrative Law Judge with the Office of Administrative Hearings, heard this matter in Los Angeles, California on November 20, 2013.

Pat Huth, Attorney at Law, represented Frank D. Lanterman Regional Center (FDLRC or service agency). Parent represented Claimant who did not appear at the hearing.[1]

Testimonial and documentary evidence was received, the case was argued, and the matter was submitted for decision on November 20, 2013. The Administrative Law Judge makes the following Factual Findings, Legal Conclusions, and Order.

ISSUE

Whether Claimant is eligible for regional center services and supports under the

[1] Claimant and his family members are not identified by name to preserve their privacy and to ensure confidentiality.

qualifying category of autism as provided for in section 4512, subdivision (a) of the Welfare and Institutions Code.

FACTUAL FINDINGS

1. Claimant is a 13-year-old adolescent male residing with his parents and twin brother. Beginning in January 2013, FDLRC evaluated Claimant to determine his eligibility for services and supports provided for in the Lanterman Developmental Disabilities Services Act (Lanterman Act).[2] FDLRC has determined that Claimant is ineligible for Lanterman Act services, and Claimant has appealed.

2. By all accounts, Claimant's development was unremarkable until the transitory period between fifth and sixth grade. During that time, Claimant reportedly expressed incredible rages when it became apparent that his infatuation with one of his female classmates was unrequited and when, as the fifth grade concluded, he was not designated "Student of the Week." In addition, Claimant was disappointed to learn that he had not been accepted to a desired charter middle school along with his peer group. During the summer between fifth and sixth grades, Claimant reluctantly attended sleep-away camp, and became despondent when his father broke a promise to pick him up prior to the conclusion of the camp. Claimant had also proclaimed that he was gay during the latter half of the fifth grade, and he commenced the sixth grade with pink hair wearing a rainbow shirt. Students attending Claimant's middle school bullied him.

3. Claimant has had at least four psychiatric hospitalizations with varying lengths of confinement for depression and suicidal ideation and behavior. During one such hospitalization, the UCLA Resnick Neuropsychiatric Hospital (NPH) diagnosed

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[2] Welfare and Institutions Code section 4500 et seq. All statutory citations are to the Welfare and Institutions Code unless otherwise specified.

Claimant with Depressive Disorder Not Otherwise Specified and Autism Spectrum Disorder (ASD). For four weeks, Claimant was enrolled in the ABC Program at the NPH where he received intensive out-patient treatment. While in treatment at the NPH, Claimant's adaptive functioning in communication, daily living, and socialization was assessed using the Vineland Adaptive Behavior Scales-II (Vineland) and his social interactions and expressions were evaluated with an administration of Module III of the Autism Diagnostic Observation Schedule-2 (ADOS-III) on October 19 and 22, 2012. The resulting October 2012 Confidential Psychological Testing Report indicates that while Claimant attained an Adaptive Behavior Composite score of 107 (average level) on the Vineland, he demonstrated relative weakness in the socialization domain with a score of 87 (low average). Claimant scored a 120 (high adaptive level) in the communication domain suggesting that his language skills were generally above those of his same-aged peers. Claimant's performance in receptive language (18 years), expressive language (22 years) and written expression (15 years 3 months) was reported as consistent with his above-age-level functioning on previous intellectual performance tests. (Ex. G). The Confidential Psychological Report indicates that in the daily living domain Claimant scored a 110 (average adaptive level), which suggests that his personal and domestic skills were comparable to same-aged peers. Claimant's functioning in self-help (14 years), assisting with chores at home (15 years 3 months), and community daily living (12 years) was within the average to high-average range. (*Ibid.*)

4. In the Language and Communication Domain assessed on the ADOS-III, Claimant demonstrated little reciprocal conversation, limited use of spontaneous descriptive hand gestures, and limited detail when reporting on non-routine events. In the Reciprocal Social Interaction Domain assessed on the ADOS-III, Claimant reportedly looked away from the examiner and appeared unconcerned whether the examiner looked at him during administration of the ADOS-III. His communication with the examiner was object-

oriented or in response to questions. His behavior appeared mechanical and restricted in range of social overtures. Claimant demonstrated little insight into his role in social relationships. (*Ibid.*) In the Restricted and Repetitive Behavior Domain, Claimant's "overly formal use of words," such as "ever so carefully," was noted. (*Ibid.*)

5. The Confidential Psychological Report concludes that Claimant "has above-average verbal adaptive functioning and presents as an intelligent young adolescent; however, his adaptive functioning in the socialization domain lags behind his other domains of functioning. In particular, [Claimant] has difficulty with social conversation, including starting small talk with others and talking about things that interest others. Although he is creative and attractive and draws interest from peers, he struggles to maintain friendships. . . . [O]bservation of his social skills with the same aged peers, his lack of reciprocal social behavior, lack of awareness of others' emotions and of his effect on others, his difficulty with changes in routine, and perseverative behaviors, ideas, and interests, strongly suggest that he meets criteria for Autistic Disorder." (*Ibid.*)

6. A November 5, 2012 NPH OutPatient Progress Note indicates that Claimant has an "ADOS score . . . [of] 14 consistent with autism spectrum disorder." A diagnostic impression reads: "12 yo boy with history of Asperger's disorder and depressed mood with suicidal thoughts and behavior. [Claimant] likely has a mood disorder with poor coping skills, affect management and family dynamics that exacerbate tempestuous behavior." A diagnosis of "Depression NOS; High Functioning Autism Spectrum Disorder" appears in the progress note. (Ex. H.) Two days later, a November 7, 2012 NPH Outpatient Discharge Summary identifies Claimant's discharge diagnosis as "299.00 Autism Spectrum Disorder." (Ex. I.)

7. Ryan K. I. Davis, M.D., a child, adolescent, and adult psychiatrist, has been treating Claimant since November 17, 2011. Dr. Davis prepared an August 14, 2013 letter "to confirm" that Claimant presented to him with "ASD . . . [that] affect[s] his functioning in

areas #2, #3, and #5 of the life activity areas in the regional centers [*sic*] criteria from section 4512 of the CA Welfare & Institutions Code." (Ex. R.) According to Dr. Davis's letter, in the area of receptive and expressive language, Claimant's "deficiencies in social skills and understanding limits [*sic*] conversation especially with peers, causes [*sic*] misunderstandings & dis-regulation outbursts, and consequent withdrawal and depression. He often completely misinterprets the meaning in normal communications." (*Ibid.*) In the area of learning, Dr. Davis writes that Claimant's "intellectual abilities are overshadowed by his social deficiencies. This has become pronounced in the middle school environment where children tend to tease and taunt. He can completely misinterpret the meaning of even a normal conversation. He suffers disproportionally from this and has become depressed from not knowing how to interact. . . . Although he draws interest from peers, he has problems interacting with peers and maintaining friendships. He has marked difficulty tolerating changes in routine or unfamiliar people." (*Ibid.*) In the area of self-direction, Claimant reportedly "shows low frustration tolerance, poor emotion regulation and social communication difficulties. These make it difficult for him to self-direct effectively." (*Ibid.*)

8. Dr. Davis testified at the hearing and his testimony was consistent with the content of his August 14, 2013 letter. On cross-examination, Dr. Davis indicated that his analysis of Claimant's condition was not premised on any assessment he personally administered to Claimant, but rather, on information originating from Claimant's UCLA records. Dr. Davis testified that he has a lot of faith in UCLA.

9. Timothy D. Collister, Ph.D., FDLRC's consulting clinical psychologist, evaluated Claimant on January 17, February 17, and March 21, 2013, conducted a record review of Claimant's medical history, and administered several assessments to Claimant to determine his eligibility for Lanterman Act services and supports. Dr. Collister prepared a Psychological Evaluation in which he reports that Claimant's cognitive function as

measured using the Wechsler Intelligence Scale for Children, Fourth Edition "was strong." Claimant's verbal working memory index was in the 60th percentile, in the upper end of the average range. His verbal comprehension index was in the 55th percentile, which is in the middle towards the upper end of the average age. His nonverbal perceptual reasoning was around the 60th percentile in the upper end of the average range and his nonverbal processing speed was in the lower end of the average range. These verbal and nonverbal indices in the aggregate yielded a numeric for general cognitive function that was in the upper end of the average range around the 50th percentile. Dr. Collister additionally reports that Claimant's academic achievement, as assessed using the Wide Range Achievement Test, Revision 4, "is very strong." Claimant's reading skills were assessed in the 90th percentile or high average range and his mathematics skills in the 75th percentile in the high average range. (Ex. F, page 15.)

10. In the area of communication, Dr. Collister notes Claimant's ability to sustain a conversation and the absence of any unusual markers for atypical language. "He did not show any echolalia or stereotyped and repetitive use of language or idiosyncratic language." On the Wechsler verbal subtests, Claimant's scores were in the middle of the average range or higher. "Verbal abstract reasoning and fund of vocabulary were both at the upper end of the average range. Comprehension with appreciation of social norms and social judgment as well as ability to mentally manipulate unrelated bits of verbal information were [*sic*] in the middle of the average range." (Ex. F, page 16.)

11. Assessment of Claimant's sensorimotor skills showed "only slight scatter" on the Wechsler nonverbal subtests. Claimant's visuocontructive skills with blocks were into the high average range. Nonverbal learning, speed of writing, and ability to swiftly discriminate visual targets from distracters were in the middle of the average range." (Ex. F. page 16.) Dr. Collister administered the Beery Developmental Test of Visual-Motor Integration, Fifth Edition, to Claimant, whose scores were in the lower end of the borderline

range at a 7-year, 6-month equivalent.

12. Dr. Collister assessed Claimant for autistic spectrum symptoms using the Gilliam Asperger's Disorder Scale (Gilliam Asperger), the Asperger Syndrome Diagnostic Scale (Asperger Syndrome), the Gilliam Autism Rating Scale, Second Edition (Gilliam Autism), and the Autism Diagnostic Observation Schedule, Module IV (ADOS-IV). Dr. Collister reports that both Gilliam Asperger and Asperger Syndrome scales were significant for Asperger's Disorder: "The Asperger's disorder quotient at 90 was into the range suggesting probability of Asperger's disorder to be 'high/probable. The Asperger Syndrome Diagnosis Scale quotient was 99. This is well into the probability range for Asperger's being 'likely.'" (Ex. F, page 18.) Both the Gilliam Asperger and the Asperger Syndrome scales are based on information Claimant's mother provided to Dr. Collister.

13. The ADOS-IV produced scores which Dr. Collister deemed significant under a mathematic algorithm he employed using the Diagnostic Statistical Manual of Mental Disorders, 4th ed., Text Revised (DSM-IV-TR). In the communication domain Claimant scored two, which is the cutoff score for autism spectrum. In the reciprocal social interaction domain Claimant scored three, which is below the cutoff scores for both autism spectrum and autism. Claimant's total communication and reciprocal social interactions score of five was below the autism spectrum cutoff score of seven and the autism cutoff score of 10.

14. By contrast to the Gilliam Asperger, the Asperger Syndrome, and the ADOS-IV, Dr. Collister reports that in the domains of behavior and communication Claimant's scores on the Gilliam Autism was "devoid of any markers for autism or an autism spectrum disorder." According to Dr. Collister's Psychological Evaluation, "The domain that was a bit significant, but only at the 9th percentile, was for social interaction. On the social interaction domain, the mother reported that [Claimant] is fearful in new situations. He becomes very anxious. This also creates difficulty when there are changes in routine. The

mother said, 'He doesn't want to do something new. It causes huge anxiety attacks, like even buying clothes.'" Dr. Collister reported that he queried Mother about "ritualistic aspects," and that Mother described Claimant "putting his mattresses together, 'Like a hugging machine, to comfort himself.'" Dr. Collister noted that no other ritualistic aspects or repetitive aspects were noted. (Ex. F, page 17.)

15. Dr. Collister's Psychological Evaluation additionally reports that "other indicators on the social interaction domain were not endorsed." He elaborated that Claimant enjoyed being praised and was affectionate—both giving and receiving affectionate responses. "He does not withdraw at all from others. He does not fail to recognize the presence of another. There is no laughing or crying without precipitants. Repetitive behaviors are not noted. He does not line up objects in a precise, orderly fashion and become[s] upset if the order be disturbed." (Ex. F, page 17.)

16. Dr. Collister reports that in the communication domain on the Gilliam Autism, Claimant exhibited "no echolalia, repeating words out of context, or repeating words and phrases over and over. There is no dysprosodia, with normal tonal rhythms. He does not look away with any gaze aversion when his name is called or when others look at him. He asks for what he wants appropriately. On the stereotyped behaviors domain, there were no items endorsed. Again there is no avoidance of eye contact, although he will not spontaneously give eye contact at times. There is no finger flicking, finger posturing, or visual preoccupation. . . . There is no licking inedibles or placing inedibles in his mouth, nor any smelling inedibles. There is no spinning in place, rocking, jumping in place, or hand or arm flapping. There is no tiptoe walking. There is no auditory self-stimulation nor is there any self-injurious behavior." (*Ibid.*)

17. Dr. Collister reports Claimant's adaptive behavior composite on the Vineland as "at the lower end of the low range." According to Collister's Psychological Evaluation, "The communication domain was in the middle of the average range [SS=97], with daily

living skills in the middle of the low average range [SS=85] and socialization dropping into the lower end of the borderline range [SS=73]." (Ex. F, pages 1 and 21.)

18. Dr. Collister's Psychological Evaluation contains the following pertinent discussion of Claimant:

> [Claimant] . . . clearly has experienced substantial depression and anxiety. By the information which was provided by the parents, which was well in line with the information provided by [Claimant], it appears there were no significant behavioral, emotional, or social problems into the 5th grade. He attended a very preferred, difficult to enter school from K through 5th. He describes having many friends and enjoying the school, with all aspects there being very positive. Records suggest that there were stressors hitting towards the end of the 5th grade. Records suggest at one place that he was infatuated with a girl who did not reciprocate, with that leading to depression. He also describes losing about ¾ of his friends around this time. Around this time it became clear that he would not be attending the middle school that he wanted to because he did not prevail in a random drawing to enter the school. His grades were great and he wanted to, and described being very sad as he could not continue on with friends from the previous school who he had been with from kindergarten through 5th. Around that time there were also migraines or severe headaches, to the point there was consideration of seizures, with him being followed by a neurologist for workup.

It also appears that [Claimant] has come to believe that he is of a gay orientation. He became assertive about this recently. One would expect that there may have been things occurring in his experience back at age 11, before actually becoming more formally assertive at being gay at age 12. That was in the context for the difficulty in the summer about not wanting to go to camp. He certainly did not want to go, but was pressured to, with the promise that his father would pick him up in a few days. That never occurred. He remained the entire time, with this being a very difficult experience for him. . . . In any case, as he moved into school the next year . . . he was bullied quite badly. That may have actually occurred at the end of 5th grade at the previous elementary school, where he describes three-quarters of his friends leaving him, with aggressive horseplay. In any case, there certainly have been "setting events" or said otherwise, environmental stressors hitting on [Claimant] very hard psychodynamically and emotionally. This appears to be the case from the end of the 5th grade on, with him then asserting his homosexual orientation more strongly, with problems compounding until finally attending the current school where this is accepted. What is important to consider is that the chronology of development is entirely unremarkable until late 5th grade, both by the parents' report as well as by [Claimant's], then with substantial stressors hitting him and then with emotional deterioration. The

deterioration was so serious that there have been significant attempts at suicide. One would conclude by that history that his depression has been to the level of a major depressive disorder, and that with marginal psychotic features when it was perhaps the most pronounced. In addition, there has been significant anxiety which could be accounted for by the environmental stressors without need to look to the autism spectrum for any cause.

With respect to the question of a diagnosis from the autism spectrum, DSM-IV-TR . . . still considers three areas of diagnostic consideration, qualitative impairment in social interaction, qualitative e impairment in communication, and restricted, repetitive, and stereotyped patterns of behavior, interests, and activities. There must be at least one of four subcriteria met in each of the last two categories. These are not seen. 2a) is not present, for any delay or total lack of the development of spoken language. 2b) is not present. He does not show any impairment in the ability to initiate or sustain a conversation with others. He certainly showed his ability to thoroughly interact during this evaluation. 2c) is not present, for stereotyped and repetitive use of language or idiosyncratic language. Formal language or using vocabulary that is above average does not relate to this [*sic*] subcriteria. 2d) is not present, for lack of spontaneous make believe play or social imitative play appropriate to

developmental level. Thus, diagnosis of an autistic disorder is ruled out.

With respect to the third area, for restricted, repetitive, and stereotyped patterns of behavior, interests, and activities, 3a) is not present, with encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal in intensity or focus. 3b) is not present, for apparently inflexible adherence to specific nonfunctional routines or rituals. It is clear that he does not want to encounter new things and becomes anxious when new thins or situations present. However, is a fairly common general symptom for an anxiety disorder, and given the stressors to which he has been exposed since the 5th grade, it would not be surprising for him to have significant anxiety about new situations. 3c) is not present, for stereotyped and repetitive motor mannerisms. 3d) is not present, for persistent preoccupation with parts of objects. If one consider 3b) to be present for apparently inflexible adherence to specific nonfunctional routines or rituals, then the diagnosis would be possible for an Asperger's disorder. However, given the entire lack of criteria being present in qualitative impairment in communication, a formal autistic disorder is ruled out.

With respect to the first area of qualitative impairment in social interaction, 1a) can be construed to be present,

> marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expressions, body postures, and gestures to regulate social interaction. 1b) was not present until late 5th grade, then has occurred since, for failure to develop peer relationships appropriate to developmental level. This would not be met. 1c) could be construed to be present, although was not marked by any significant way, for a lack of spontaneous seeking to share enjoyment, interests, or achievements with others. 1d) is similar, possibly present, but certainly not in a pronounced way, for lack of social or emotional reciprocity. The reader must bear in mind that the impairment across the subcriteria in this area for qualitative impairment in social interaction are very commonly impacted by significant disorders of depression and anxiety. Moreover, these are not present before the end of the 5th grade, when the various stressors and psychiatric and behavioral deterioration began to occur.

19. Dr. Collister then opined that "there is no justification for a diagnosis of an Asperger's disorder. If that were believed to be present, as professionals at UCLA have opined at various points before they changed their diagnosis to 'high-functioning autism spectrum disorder,' the disorder would be mild, especially relative to the much more significant psychiatric difficulty." Dr. Collister testified at the hearing and his testimony was consistent with the content of his Psychological Evaluation report.

20. On February 5, 2013, Claimant's mother completed an Autism Spectrum Rating Scales (6-18 Years) Parent form (ASRS), which is used to gather information about the behaviors and feelings of children. Results from the ASRS indicate that Claimant "has

symptoms directly related to the DSM-IV-TR diagnostic criteria and is exhibiting many of the associated features characteristic of Autism Spectrum Disorders." (Ex. 2.) No expert testimony explaining or interpreting the ASRS was offered at the hearing.

21. The preponderance of evidence establishes that, employing the DSM-IV-TR, Claimant presents with Asperger's disorder.

LEGAL CONCLUSIONS

1. As Claimant is seeking to establish eligibility for government benefits or services, he has the burden of proving by a preponderance of the evidence that he has met the criteria for eligibility. (*Lindsay v. San Diego Retirement Bd*. (1964) 231 Cal.App.2d 156, 161[disability benefits]; *Greatoroex v. Board of Admin*. (1979) 91 Cal.App.3d 54, 57 [retirement benefits]; Evid. Code, § 500.)

2. Claimant must establish that he has a qualifying "developmental disability." Section 4512, subdivision (a), defines "developmental disability" to mean the following:

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

3. California Code of Regulations, title 17 (CCR), section 54000 further defines "developmental disability" as follows:

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

(b) The Developmental Disability shall:

(1) Originate before age eighteen;

(2) Be likely to continue indefinitely;

(3) Constitute a substantial disability for the individual . . . ;

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

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

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

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

4. Establishing the existence of a developmental disability within the meaning of section 4512, subdivision (a), requires claimant to additionally prove that he has a

"substantial disability," defined in CCR section 54001, subdivision (a), as follows:

(1) A condition which results in a major impairment of cognitive[3] and/or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential; and

(2) The existence of significant functional limitations, as determined by the regional center, in three or more of the following areas of major life activity, as appropriate to the person's age:

(A) Receptive and expressive language;

(B) Learning;

(C) Self-care;

(D) Mobility;

(E) Self-direction;

(F) Capacity for independent living;

(G) Economic self-sufficiency.

5. The Lanterman Act and its implementing regulations contain no definition of the neurodevelopmental condition autism. The customary practice has been to import the American Psychiatric Association's DSM-IV-TR definition of "autistic disorder" into the Lanterman Act and its implementing regulations when determining eligibility for services and supports on the basis of autism. That definition has been revised with the May 2013 publication of the Diagnostic and Statistical Manual of Mental Disorders, 5th ed., (DSM-5). "Autism Spectrum Disorder" is the APA's new diagnostic nomenclature encompassing the

[3] CCR section 54002 defines "cognitive" as "the ability of an individual to solve problems with insight to adapt to new situations, to think abstractly, and to profit from experience."

DSM-IV-TR's diagnoses of autistic disorder, Asperger's disorder, childhood disintegrative disorder, Rett's syndrome, and PDD-NOS. (DSM-5 at p. 809.) Thus, individuals with a well-established DSM-IV-TR diagnosis of autistic disorder, Asperger's disorder, or PDD-NOS are now given the diagnosis of Autism Spectrum Disorder. (*Id.* at 51.)

6. The DMS-5 diagnostic criteria for Autism Spectrum Disorder are as follows:

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history:

1. Deficits in social-emotional reciprocity, 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:

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 interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sound or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

C. Symptoms must be present in 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.

7. These essential diagnostic features of Autism Spectrum Disorder—deficits in social communication and social interaction (Criterion A) and restricted repetitive patterns of behavior, interests and activities (Criterion B)—must be present from early childhood and limit or impair everyday functioning (Criteria C and D).

8. Claimant has not met his burden of establishing by a preponderance of the evidence his eligibility for Lanterman Act services and supports under the qualifying category of autism as provided for in section 4512, subdivision (a) of the Welfare and Institutions Code. Claimant has a DSM-IV-TR diagnosis of Asperger's disorder, although there is an absence of consensus about the severity with which Claimant presents with the disorder. Applying the DSM-5, Claimant's Asperger's disorder diagnosis is reclassified as

Autism Spectrum Disorder, which is a developmental disability under the Lanterman Act.

The evidence establishes, however, that Claimant's developmental disability is not a "substantial disability," as required by CCR section 54001, which implements the Lanterman Act. The evidence does not establish that Claimant's disability results in a major impairment of his cognitive functioning. Assessments of Claimant's cognitive abilities consistently indicate his above average intellect. Claimant's recent challenges in his social interactions resulted, in part, from the convergence of several life episodes that caused him to experience disappointment with the unfortunate cruelty of his peers' reaction to his declared sexual orientation. (Factual Finding 2.)

Claimant's "difficulties" and "problems" are amply noted in his history. Nonetheless, the evidence does not establish that these difficulties and problems amount to *significant limitations* in at least three of the following areas: receptive and expressive language, learning, self-care, mobility, self-direction, capacity for independent living, and economic self-sufficiency. Assessment of Claimant's receptive and expressive language indicates that he functions above age-level in the range of an 18 to 22 year old. (Factual Finding 3.) His language skills are generally regarded as above average. (Factual Finding 3.) Claimant's assessed scores for academic achievement are strong indicating that his capacity for learning is undiminished. (Factual Finding 8.) There is no evidence indicating any limitations with Claimant's mobility. In the area of self-direction, Claimant reportedly shows low frustration tolerance, poor emotion regulation and social communication difficulties that make it difficult for him to self-direct effectively. (Factual Finding 6.) As a young adolescent, Claimant's capacity for independent living and economic self-sufficiency is age-appropriate—his well-being is dependent upon his parents.

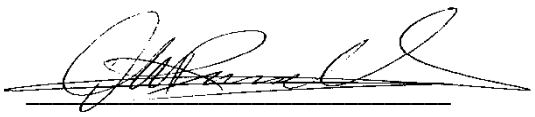
9. Cause exists by reason of Factual Findings 2 through 21, inclusive, and Legal Conclusions 1 through 8, inclusive, to deny Claimant's appeal.

ORDER

1. Claimant's appeal is denied.

2. Frank D. Lanterman Regional Center's determination that Claimant is ineligible for services and supports pursuant to the Lanterman Developmental Disability Services Act is affirmed.

Dated: December 6, 2013



JENNIFER M. RUSSELL
Administrative Law Judge
Office of Administrative Hearings

NOTICE

This is a final administrative decision. This administrative decision binds both parties. Either party may appeal this administrative decision to a court of competent jurisdiction within 90 days.