BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: CLAIMANT, vs. FAR NORTHERN REGIONAL CENTER, Service Agency.	OAH No. 2015060987

DECISION

This matter was heard before Administrative Law Judge Susan H. Hollingshead, State of California, Office of Administrative Hearings (OAH), on March 7, 2016, in Mount Shasta, California.

Phyllis J. Raudman, Attorney at Law, represented the Service Agency, Far Northern Regional Center (FNRC).

Claimant was represented by his mother with assistance from Stacey Maupin.

Oral and documentary evidence was received. The record remained open for submission of additional evidence and responsive declarations. Claimant submitted additional documentary evidence on March 17, 2016. The documents admitted into evidence on that date were those that were in existence but unavailable at the time of hearing. FNRC's responsive declarations were submitted on March 28, 2016. The record was closed and the matter submitted for decision on March 28, 2016.

ISSUE

Is claimant eligible to receive regional center services and supports based on a qualifying condition of autism pursuant to Welfare and Institutions Code section 4512?[1]

FACTUAL FINDINGS

1. Claimant is a 14-year-old young man who lives in the family home with his adoptive parents, who are his maternal aunt and uncle, and sister. He was born prematurely to a biological mother who reportedly had no prenatal care and used alcohol and methamphetamines on a daily basis. Toxicology screening at birth was positive for methamphetamines.

2. At age 25 months, claimant qualified for California Early Start services through FNRC pursuant to the California Early Intervention Services Act,[2] which provides early intervention services for infants and toddlers from birth to 36 months who have disabilities or are at risk of disabilities, to enhance their development and to minimize the potential for developmental delays. His mother had "ongoing concerns about his development, especially in the area of language development, and his overly active behavior."

3. Eligibility for Early Start extends only until a child is three years of age. After age 3, an individual must meet the eligibility requirements set forth in the Lanterman Act in order to qualify for regional center services and supports.

4. Pursuant to the Lanterman Act, Welfare and Institutions Code section 4500 et

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[1] Unless otherwise indicated, all statutory references are to the California Welfare and Institutions Code.

[2] California Government Code section 95000 et seq.

seq., regional centers accept responsibility for persons with developmental disabilities. Welfare and Institutions Code section 4512 defines "developmental disability" as follows:

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

5. California Code of Regulations, title 17, section 54000, further defines the term "developmental disability" as follows:

> (a) "Developmental Disability" means a disability that is attributable to mental retardation, cerebral palsy, epilepsy, autism, or disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation.
>
> (b) The Development Disability shall:
>
> (1) Originate before age eighteen;
>
> (2) Be likely to continue indefinitely;

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

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

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

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

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

6. Welfare and Institutions Code section 4512, subdivision (l), defines "substantial disability" as:

(I) The existence of significant functional limitation in three or more of the following areas of major life activity, as determined by a regional center, and as appropriate to the age of the person:

(1) Self-care.

(2) Receptive and expressive language.

(3) Learning.

(4) Mobility.

(5) Self-direction.

(6) Capacity for independent living.

(7) Economic self-sufficiency.

7. California Code of Regulations, title 17, section 54001, provides:

(a) "Substantial disability" means:

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

(2) The existence of functional limitation, 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:

(1) Receptive and expressive language.

(2) Learning.

(3) Self-care.

(4) Mobility.

(5) Self-direction.

(6) Capacity for independent living.

(7) Economic self-sufficiency.

8. FNRC determined that claimant, at age 3, did not meet eligibility requirements for regional services under the Lanterman Act. FNRC did not find him to have a substantially disabling developmental disability.

9. Over the years, claimant's mother reports struggling with claimant's behaviors. In February 2015 she contacted FNRC to refer claimant "based on a suspicion of Autism Spectrum Disorder (ASD). [Claimant] has reportedly been diagnosed with Asperger's Disorder in addition to ADHD. Request is for diagnosis and eligibility determination."

10. FNRC referred claimant to Clinical Psychologist J. Reid McKellar, Ph.D., for an ASD evaluation. As part of Dr. McKellar's "best practices" evaluation, he conducted observations and interviews, and completed a full records review that included prior psychological testing/records, educational records and mental health clinical records. He also utilized the following testing instruments:

Autism Diagnostic Observation Schedule 2-Module 3 (ADOS-2)

Adaptive Behavior Assessment System-Second Edition (ABAS-II)

Millon Adolescent Clinical Inventory (MACI)

DSM-5 Review of Symptoms

11. The Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition (DSM-5) was the standard for diagnosis and classification at the time of this evaluation.

12. DSM-5 section 299.00, Autism Spectrum Disorder, states:

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

> communication and social interaction across multiple contexts, as manifested by the following, currently or by history: (1) deficits in social-emotional reciprocity, (2) deficits in nonverbal communication behaviors used for social interaction, and (3) deficits in developing, maintaining, and understanding relationships. The individual must also have restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history: (1) stereotyped or repetitive motor movement, use of objects or speech, (2) insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior, (3) highly restricted, fixated interests that are abnormal in intensity or focus, and/or (4) hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment. In addition, symptoms must be present in the early developmental period and must cause clinically significant impairment in social, occupational, or other important areas of current functioning.

13. Dr. McKellar completed his comprehensive assessment of claimant and provided his report dated June 2, 2015. His report noted that claimant was "referred for evaluation due to the fact that among his clinical treatment diagnoses were PDD/NOS, Asperger's Disorder."

14. Claimant was administered the ADOS-2, which is included in a "best practices" evaluation. Dr. McKellar explained that the ADOS-2 is "a semi-structured, standardized assessment of communication, social interaction, play/imaginative use of materials, and

restricted and repetitive behaviors for individuals referred due to possible presence of an Autism Spectrum Disorder." The ADOS is considered by practitioners to be "the gold standard" when assessing for ASD. Claimant's scores were as follows:

> Social Affect
>
> Communication
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> During administration of the ADOS-2, [claimant] reported routine and non-routine events in a flexible manner, and his verbalizations included expressive intonation. [Claimant's] defiance resulted in short lived conversations, yet he provided spontaneous elaboration to many of the writer's questions. [Claimant] exhibited use of descriptive, conventional and instrumental gestures during the evaluation process.
>
> Reciprocal Social Interaction
>
> [Claimant] exhibited fair eye contact once the writer used sarcasm to establish rapport, and his facial expressions were affectively congruent. [Claimant] exhibited shared enjoyment during several of the ADOS-2 tasks, and his social overtures were of fair quality, albeit demanding at times. Rapport with [claimant] was short lived, as he felt free to express his boredom or desire to go on his reward outing as the evaluation progressed. [Claimant's] social responses were of fair quality, and variable. When engaged in a task, [claimant's] responses were of good quality. However, when [claimant] was

intent on getting his own way, his responses were terse and often rude.

In the Social Affect domain, [claimant] obtained a score of 6.

Restricted and Repetitive Behavior

During administration of the ADOS-2, [claimant] did not exhibit unusual sensory issues, complex motor mannerisms, oddities of speech or stereotyped behaviors.

In the Restricted and Repetitive Behavior domain, [claimant] obtained a score of 0.

ADOS-2 Summary

[Claimant's] participation in the ADOS-2 resulted in a score of 6, well short of the ADOS-2 classification of Autism or Autism Spectrum. [Claimant] obtained a comparison score of 3, indicating that he exhibited a low level of Autism Spectrum related symptoms during administration of the ADOS-2.

15. Dr. McKellar also performed a DSM-5 Review of Symptoms and concluded as follows:

Persistent deficits in social communication and social interaction across multiple contexts

1. **Deficits in social-emotional reciprocity**

[Claimant] exhibits an awareness of social emotions, and an age appropriate sense of humor. Although easily frustrated by

others, [claimant] exhibits an ability to comprehend non-verbal communication and he is able to engage in reciprocal conversations.

[Claimant] does not meet criteria for this item

2. **Deficits in non-verbal communication behaviors used for social interaction**

[Claimant] exhibits flexible eye contact in certain settings, and he avoids making eye contact in others. [Claimant] exhibits use of expressive gestures, and he is able to effectively integrate verbalizations with gestures.

[Claimant] does not meet criteria for this item.

3. **Deficits in developing, maintaining and understanding relationships**

Educational records indicate that [claimant] exhibits an interest in peers and relationships, however his social efforts are impeded by pronounced deficits in frustration tolerance. [Claimant's] mother reports that [claimant] typically prefers to spend time alone, although he has a history of social anxiety.

[Claimant] meets criteria for this item.

In the persistent deficits in social communication and social interactions across multiple contexts, [claimant] meets criteria for one item.

Restricted, repetitive patterns of behavior, interests or activities

1. **Stereotyped or repetitive motor movements, use of objects or speech**

   Observational, testing and collateral data indicate that [claimant] does not meet criteria for this item.

2. **Insistence on sameness, inflexible adherence to routines, or ritualized patters of verbal or non-verbal behavior**

   [Claimant] has difficulty with transitions, and he does not respond well to change. However, [claimant] does not exhibit non- functional routines or rituals and he does not meet criteria for this item.

3. **Highly restricted, fixated interests that are abnormal in intensity or focus**

   [Claimant] has several age appropriate interests and an intense interest in video games.

4. **Hyper or Hypo reactivity to sensory input or unusual interest in sensory aspects of the environment**

   [Claimant] reportedly "hates" water, he does not like being touched and he is reportedly sensitive to certain textures (food).

   [Claimant] meets criteria for this item by report.

   In the restricted, repetitive patterns of behavior, interests or activities domain, [claimant] meets criteria for one item.

> **In summary, the DSM-5 review of the diagnostic criteria for Autism Spectrum Disorder indicates that** [claimant] does not meet diagnostic criteria for Autism Spectrum Disorder.

16. The MACI is a self reported measurement of expressed concerns, personality patterns and clinical syndromes. Dr. McKellar explained that he was hoping to obtain additional information regarding claimant's clinical profile. Claimant began to complete the MACI after administration of the ADOS-2. Testing did not prove to be productive as detailed in Dr. McKellar's report:

> [Claimant] was initially resistant to completing the task, however he was able to pressure his mother into a promise of a tangible reward for completing the test. [Claimant] completed just over half of the 160 items, however he refused to continue once he realized he would be getting a reward for coming to the evaluation appointment regardless of his willingness to complete the questionnaire.

17. Dr. McKellar also administered the ABAS-II. He described the ABAS-II as "an instrument designed to provide a norm-referenced assessment of adaptive skills for individuals ages birth to 89 years. The test is administered as a questionnaire, measuring adaptive skills in nine areas as reported by claimant's mother. The obtained adaptive behavior rating profile indicates that [claimant's mother] perceives [claimant] has pervasive and significant deficits in adaptive functioning, with the exception of a relative strength in academic functioning."

EDUCATIONAL RECORDS

18. Dr. McKellar reviewed claimant's educational records and included the following summary:

> [Claimant] has been receiving special education services for a qualifying condition of Emotional Disturbance, and a review of numerous educational records indicate that this troubling educational condition best describes [claimant's] chronic difficulty with mood instability and aggression. [Claimant] has exhibited a tendency to be controlling in his style of communicating, absent monologues, and his significant mood issues have negatively impacted social efforts. However, these issues do not appear to have merited an educational diagnosis of Autism.

19. On February 16, 2005, Tim Hoff, Modoc County Office of Education School Psychologist, performed a developmental evaluation of claimant for purposes of determining whether early intervention services were warranted. The evaluation was requested by FNRC "due to concerns regarding [claimant's] exposure to illicit drug use (via his biological mother) during his pre natal development." Claimant was 2 years, 11 months old. Mr. Hoff summarized that testing results suggested that claimant possesses average cognitive abilities. Areas of concern included communication and socialization and it "was apparent that [claimant's] defiant/obstinate behaviors could impact his learning if such behaviors continue. Medical intervention strategies are currently being pursued to assist [claimant's] behavior."

It was noted that claimant "does not sleep well at night" and, at that time Adderall was prescribed to "calm down his activity levels and improve his behaviors." Claimant's

mother informed the examiner that the medication did not produce the desired results.

20. It was recommended that claimant receive special education services from the Modoc County Office of Education through the Early Childhood Special Education program.

21. A special education triennial evaluation was completed by School Psychologist Hoff, who issued his report on January 28, 2008. Mr. Hoff summarized that results "concluded with average fine-motor output, deficient visual perception skills, average academic skills albeit very limited in how many skills areas were assessed, expressive language difficulties, and a history of challenging behaviors that have occurred and continue to occur across settings representative of emotionally-based issues allegedly caused by prenatal exposure to illicit substances."

Mr. Hoff offered the following:

> **Brief Education Information**
>
> Medical reports attest that [claimant], during his prenatal development, was exposed to various illicit drugs. After his birth [claimant] showed signs of withdrawal symptoms from methamphetamine exposure according to hospital reports. [Claimant] has been diagnosed, via his child psychiatrist (Robert Sears, M.D.) with Fetal Alcohol Syndrome (FAS). At 2 years of age, Far Northern Regional Center requested a developmental evaluation on [claimant]. The Bayley Development Scale revealed a developmental index ranging from 87 to 105 @ the 95th confidence interval. In addition, the Vineland Adaptive Scale revealed low communication skills, adequate daily living skills, moderately low socialization skills,

and high motor skills. [Claimant's] behavior at the time of the assessment was described as "very oppositional." In addition, [claimant] showed poor awareness to dangerous situations, excessively high energy levels, and a marked difficulty in sleeping. In accordance with the marked behavioral problems exhibited by [claimant], a behavioral evaluation was conducted when [claimant] was 3 years old. School personnel and parents provided survey information which lead to the conclusion of the Burks Behavior Rating Scale purporting very significant levels corresponding to poor attention, excessive anxiety, aggressiveness, and resistance. The Connors Rating Scale further indicated high T scores indicative of impulsiveness, hyperactivity, and learning problems. Preschool observations found a preponderance of obstinate/tantrum-type behavior. Succinctly, [claimant] was unwilling to listen to and obey the typical structure of the school environment. [Claimant] would frequently try to escape from the classroom via running towards the parking lot. When he was stopped he would scream, cry and become physically aggressive. Numerous times, [claimant] had to be restrained. A behavior support plan was implemented, new medical interventions pursued, and a teaching aide was assigned to [claimant]. Presently [claimant] continues to take several medications (i.e., Risperdal, Clonidine, Focalin, and nebulizer treatments for asthma), demonstrates bouts of defiant behavior, and frequently shows frustration, inattention, and mood swings (as charted by his aide) while

> attending school. To mitigate and eventually replace the noted behavior problems still evident, a behavior goal and BIP [Behavior Intervention Plan], were created for implementation per the acceptance of the IEP [Individualized Education Program] team. Furthermore, a specific behavioral flowchart . . . was drawn up to be a quick reference guide to be implemented by [claimant's] aide when he begins to show aggravation, obstinate behavior, emotional distress, etc.

22. A special education triennial evaluation was next completed by School Psychologist Hoff, who issued his report on January 19, 2011. It was again noted that claimant qualified for special education services after being identified as a student with emotional disturbance, and remained on various medications for his condition. Mr. Hoff concluded that claimant "continues to demonstrate mood alterations, blatant non-compliance/rebellion, and excessive energy while in the educational setting. With the assistance of an aide, his behavior is containable and for the most part, responsive to various interventions that are suggested/provided by the aide."

23. Claimant's next triennial Psychoeducational and Psychological Evaluation was administered by Modoc County Office of Education School Psychologist Stephen P. Bratton, Ph.D., who issued his report on January 21, 2014. Dr. Bratton noted that claimant "qualifies for special education as having a severe Emotional Disturbance. His behavior at school included frequent severe tantrums that required either removing him from the room or removing the rest of the students. Though his behavior is much improved, he continues to have problems with mood lability related to low frustration tolerance and general problems with emotional, behavioral and thought regulation. He has obsessive thoughts, problems decentering from an area of focus to a new activity or subject." Portions of the report were missing. However, Dr. Bratton concluded:

> When considering [claimant's] history, current performance in school academically, socially and behaviorally and his current testing results he is best diagnosed with Unspecified Schizophrenia Spectrum and Other Psychotic Disorder (298.9).

24. Claimant's January 22, 2014 Modoc County Special Education Local Plan Area (SELPA) IEP indicated that claimant continued to qualify for special education services based on a primary disability of Emotional Disturbance (ED). No secondary disability was noted. The IEP explained that claimant "has a severe thought disorder that impacts his ability to regulate his attention, thoughts, feelings and behavior that negatively impacts his relationships and makes it harder for him to tolerate and complete academic tasks in a timely matter." Also recorded was health information indicating that claimant's "mood swings, aggressive and unpredictable behavior is severe to the point that [claimant's] psychiatrist has prescribed for him Intuniv 4mg (morning); Risperidone 0.5 (morning; at school 12:00); Deximethylphen 15 mg in morning and at school 12:00."

25. Claimant's Annual IEP dated January 20, 2015 continued to qualify him for services based on Emotional Disturbance with no secondary disability noted.

26. On January 18, 2016, claimant's annual IEP was completed in the Lassen SELPA. He left the traditional school setting and was being homeschooled with support from New Day Academy, an independent study program that "supports families dedicated to schooling their children at home." The IEP indicated that New Day Academy was a charter school that is operated as its own LEA [Local Education Agency]/District. Claimant's primary disability was changed to Autism, with no secondary disability noted. His behaviors remained a concern.

The IEP stated that claimant's "current diagnosis is Autism Spectrum Disorder. This diagnosis is based upon assessments made by Dr. Robert Sears and Dr. Charles Jensen." Prior to this time, there was no mention of autism as a consideration for special education

eligibility.

MEDICAL RECORDS

27. Claimant's mother submitted a letter dated August 21, 2015, from Anthony D. Browning, a Family Psychiatric Nurse Practitioner at Klamath Basin Behavioral Health. He explained that he had recently taken over claimant's case from Nurse Practitioner Linda Terpening, and Ms. Terpening and Pediatric Psychiatrist Dr. Robert Sears had seen claimant for approximately seven years (2007-2014).

This letter addressed a school recommendation that claimant return to school full-time and without any 1:1 aid/assistance. Mr. Browning opined that claimant was not "ready to return to the school environment under these conditions as he continues to have significant mood lability and behavioral outbursts requiring physical restraint and police involvement. He has run away from home on at least two different occasions in the recent past and has a history of running from school as well. Moreover, client has a history of becoming very aggressive and destructive in the school environment. I am in the process of making some medication changes for [claimant] in order to better control his symptoms but do not believe he is adequately managed at this time."

Mr. Browning stated further that, "[Claimant] represents a diagnostic challenge and I am aware that he has received some differing diagnoses over the years. Dr. Sears, who has worked most with him (since approximately 2006), is in the process of reviewing his previous records in order to offer his own additional insights and provide some recommendations for moving forward with this case. It was Dr. Sears' most recent clinical impression that [claimant] falls on the autism spectrum and I agree with this assessment based on my own interactions with him thus far."

28. A letter dated August 25, 2015, signed by Charles Jenson M.D. stated:

> I am the psychiatrist at Klamath Basin Behavioral Health. I have reviewed [claimant's] (DOB: 2/26/2002) records and agree with Anthony Browning's (MSN, PMHNP-BC) assessment and diagnosis of [claimant]."

29. Some of the final notes entered in the medical records by Family Nurse Practitioner, Linda Terpening on January 28, 2015, offered this insight:

> [Claimant] is having major troubles. He's been on Risperdal for 7 years and over the last several months it seems that it is not working at all. [Claimant] says today that he is hearing voices in his head that have gotten worse recently even while taking a good dose of Risperdal. He says the voices tell him to either "kiss" or to "kill" and he knows he can't do either one. His focus is good as long as he takes his focalin 15mg TID. When it wears off he is out of control. He is not able to go to school at the moment because his behavior is not acceptable. He is due for focalin right now and he is all over the room at this point . . . Anger/behavior-Miserable the last few weeks-yelling, demanding, obsessive and can't stop on whatever his concern is. He is yelling in the office today. He says he hears things and can't stop them . . . is unable to go to school at this point due to violence and anger . . . he is getting big enough that he is a little scary when he's aggressive.

30. Dr. Sears provided a letter dated September 29, 2015, at the request of claimant's mother. Dr. Sears was then residing in Kentucky and was no longer claimant's psychologist. It was his understanding that his "diagnosis of Autism Spectrum Disorder

(ASD) has come into question after having seen another practitioner and been given a diagnosis of Bipolar Disorder instead. I have not been [claimant's] psychiatrist for several months now, so I am not in a position to say with certainty that he does not have Bipolar Disorder. However, I was [claimant's] psychiatrist from 2007 until late 2014 and can state with confidence that he does meet criteria for ASD, and this is not a diagnosis that goes away."

Dr. Sears wrote:

> In reviewing my chart notes over several years, the diagnosis of Pervasive Developmental Disorder (a subtype of Autism from the DSM IV)[3] goes back to at least the beginning of 2011 when I first saw him at Klamath Youth Development Center. Prior to that he was my patient at the Klamath Youth Development Center but, although I do not have those notes, I distinctly remember his presentation as a 5 year old when his mother had to restrain him in the clinic.
>
> ASD as defined in the DSM V:

- First requires that symptoms be present in an early developmental period (although it is clear that these symptoms can be masked later on). *[Claimant's] mother described seeing irritability, speech problems, very low tolerance for change, and severe tantrums by age 3.*
- Then it requires that there be "Deficits in social/emotional reciprocity." *[Claimant] had abnormal play-he might play along-side other children but*

[3] Please see Factual Findings 34 and 35. PDD is not a "subtype of Autism."

only played with them when he was much older and then only if he could tell them what to do. He would not carry on a normal back and forth conversation, ignored other people's affect, and did not initiate social interactions unless he wanted something.

- "Deficits in non-verbal communication behaviors" are required: *[Claimant] has always lacked a full range of facial expression and it is often difficult to tell what he is feeling unless one is very familiar with him. He made notably poor eye contact during the years he was under my care.*
- "Deficits in developing maintaining and understanding relationships": *there was a teacher evaluation that asked, "Will [claimant] ever be able to make a close friend?" Although he has certainly had some interest in friendships, he typically [has] not been able to develop areas of shared interests with peers, and generally just makes them uncomfortable.*
- Individuals with ASD must (at some point) show more than one "repetitive pattern of behavior, interests, or activities." *[Claimant] often was repetitive with his play-lining up toys and playing with the same ones repetitively-something I would see in my office. Often his tantrums were the result of very rigid thinking, and low tolerance of change was something observed repeatedly by his mother and the school. He perseverated on various interests over the years, and even at my last visit with him his mother said that he would obsess over his current interests for hours and that it was "really interfering with his function."*
- Which is that last requirement of the diagnosis: that these symptoms cause clinically significant impairment in social or occupational functioning, a point which is obvious. (Italics in original.)

31. Claimant's mother submitted an additional letter from Mr. Browning dated

February 25, 2016, after he had been working with claimant for approximately eight months.

Mr. Browning explained the challenging circumstances surrounding claimant's birth and that he began "having problematic symptoms/behaviors" at an early age. He stated that around age four, according to available documentation, claimant was determined to have had both Attention Deficit Hyperactivity Disorder (ADHD) as well as a Pervasive Developmental Disorder (PDD). Mr. Browning offered the following observations, and concluded "in my opinion and in the opinion of Dr. Sears who has worked with him for many years, [claimant] does in fact have ASD":

> [Claimant] has had significant behavioral problems throughout his life which have led to difficulties in school, at home, and in most other environments. He has been known to place himself in danger by running away from schools and home and occasionally into traffic or into other dangerous situations. He has a long history of behavior tantrums which have also placed himself and others in physical danger. These have not uncommonly required police assistance/involvement. Dr. Sears has noted that while working with him he noted significant speech/communication delays, repetitive behaviors, frequent irritability and low frustration tolerance, abnormal play with other children and difficulties with social interactions generally, lack of facial expressions, difficulties with transitions, perseverative interests, etc. These symptoms are included in the diagnostic criteria for ASD in the Diagnostic and Statistical Manual of Mental Disorder, Fifth Edition

(DSM-V). I have observed these same symptoms in working with this young man.

32. Records from Klamath Basin Behavior Health document that Dr. Sears, was the Therapist of Record/Case Manager for claimant and that his service type was "medication management." The following diagnosis was included throughout:

Axis I: Clinical Disorders
Primary: 299.80 – Pervasive Developmental Disorders
Secondary: 314.01- Attention Deficit Disorder of Childhood with Hyper
Tertiary: 307.20 – Tic Disorder, Unspec
Axis II: Personality Disorders and Mental Retardation
Primary-NO diagnosis on Axis II
Secondary-
Axis III: General Medical Conditions
Primary: 348.30-Encephalopathy, Unspecified
Secondary-
Axis IV: Psychosocial and Environmental Problems (Stressors)

33. A February 7, 2012 record indicated that claimant's diagnosis was changed to: "Primary: 299.80-Pervasive Developmental Disorders/Asperger's."

34. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR[4]) was the standard for diagnosis and classification at the time

[4] The DSM-IV-TR is a multiaxial system which involves five axes, each of which refers to a different domain of information as follows:

Axis I Clinical Disorders
Other Conditions That May Be a Focus of Clinical Attention

claimant received his "299.80 Pervasive Developmental Disorders" diagnosis, and subsequent "299.80 Pervasive Developmental Disorders/Asperger's" diagnosis from Dr. Sears.

In the DSM-IV-TR Pervasive Developmental Disorders were grouped as a category of disorders "characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills, or the presence of stereotyped behavior, interests, and activities." This section "includes Autistic Disorder, Rett's Disorder, Childhood Disintegrative Order, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified."

The code 299.80 used by Dr. Sears included diagnosis of Rett's Disorder, Pervasive Developmental Disorder NOS and Asperger's Disorder.

DSM-IV-TR section 299.00, Autistic Disorder, stated:

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

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Axis II	Personality Disorders
	Mental Retardation
Axis III	General Medical Conditions
Axis IV	Psychosocial and Environmental Problems
Axis V	Global Assessment of Functioning

> and affects both verbal and nonverbal skills . . . Individuals with Autistic Disorder have restricted, repetitive, and stereotyped patterns of behavior, interests, and activities.
>
> To diagnose Autistic Disorder, it must be determined that an individual has at least two qualitative impairments in social interaction; at least one qualitative impairment in communication; and at least one restricted repetitive and stereotyped pattern of behavior, interests, or activities. One must have a combined minimum of six items from these three categories. In addition, delays or abnormal functioning in at least one of the following areas, with onset prior to age three, is required: (1) social interaction, (2) language as used in social communication, or (3) symbolic or imaginative play.

35. The DSM-IV-TR classified PDD-NOS and Asperger's Disorder separately from Autistic Disorder as follows:

> 299.80 Pervasive Development Disorder Not Otherwise Specified: This category shall be used when there is a severe and pervasive impairment in the development of reciprocal social interaction associated with impairment in either verbal or nonverbal communication skills or with the presence of stereotyped behaviors, interests, and activities, but the criteria are not met for a specific Pervasive Developmental Disorder, Schizophrenia, Schizotypal Personality Disorder, or Avoidant Personality Disorder.

299.80 Asperger's Disorder: By definition the diagnosis is not given if the criteria are met for any other specific Pervasive Developmental Disorder or for Schizophrenia (although the diagnosis of Asperger's Disorder and Schizophrenia may coexist if the onset of the Asperger's Disorder clearly preceded the onset of Schizophrenia.

36. DSM-5 was released in May 2013. It no longer recognizes a specific diagnosis of autistic disorder. The DSM-5 established a diagnosis of autism spectrum disorder which encompasses disorders previously referred to as early infantile autism, childhood autism, Kanner's autism, high-functioning autism, atypical autism, pervasive developmental disorder not otherwise specified, childhood disintegrative disorder, and Asperger's disorder.

The plain language of the Lanterman Act's eligibility categories includes "autism" but does not include PDD or the other related diagnoses included in the DSM-IV-TR (Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and PDD-NOS). The Lanterman Act has not been revised since the publication of the DSM-5 to reflect the current terminology of Autism Spectrum Disorder. Claimant was originally diagnosed under the DSM-IV-TR, while the DSM-5 was the operative version during his most recent evaluation.

37. The Medical records for claimant reflected administration of a wide variety of medications over time including Ativan, Focalin, Intuniv, Risperidone, Melatonin, Remeron, Adderall, Methylphenidate, Clonidine, Seroquel, Zyprexa, Depakote, Olanzapine, and Prozac. The primary purposes for the prescribed medications were to assist claimant with behaviors, activity, anxiety and sleep.

38. Claimant presented a letter from the Social Security Administration dated February 11, 2016, stating that claimant "was approved for SSI Disability due to autism."

39. The FNRC Eligibility Team determined that claimant did not meet the eligibility criteria for regional center services. As a result of that determination, a Notice of Proposed Action (NOPA) was issued on June 3, 2015, informing claimant that FNRC determined he was not eligible for regional center services. The NOPA stated:

> Reason for action:
>
> [Claimant] does not have intellectual disability and shows no evidence of epilepsy, cerebral palsy, autism, or a disabling condition found to be closely related to intellectual disability or to require treatment similar to that required for individuals with intellectual disability. Psychological records show evidence of Bi-Polar I Disorder but that is not a qualifying condition for regional center services. Eligibility Review (multi-disciplinary team) determined [claimant] was not eligible for FNRC services based on medical dated 09/27/2005-09/08/2010 by The Children's Clinic of Klamath, Medical dated 06/16/2011-01/28/15 by Klamath Basin Behavioral Health, Medical dated 01/13/2011-03/30/2011 by Klamath Falls Developmental Center, Psychological dated 01/21/2014 by Stephen P. Bratton, School Psychologist, Psychological dated 01/19/2011 and 01/28/2008 by Tim Hoff, School Psychologist, Psychological data 05/18/2015 by J. Reid McKellar, Ph.D., Intake Summary dated 02/05/2015 by Wendy Bell, Intake Specialist, IEP dated 01/20/2015 and 01/22/2014 by Modoc County SELPA.

40. Claimant's mother filed a Fair Hearing Request dated June 8, 2015, disputing claimant's ineligibility for regional center services. The reason for requesting a fair hearing was, "I believe [claimant] fits the criteria to get service with you guys and your decision was based off one doctor. I feel that [claimant] would benefit from your help." The Request sought "…services through [FNRC]."

41. Robert Boyle, Ph.D., is an FNRC Staff Psychologist. In that role, he is part of the multi-disciplinary team and participates on the Eligibility Review Committee. He testified that there were concerns at intake that claimant's history contained references to PDD/Asperger's but there was no evidence of a best practices evaluation for ASD ever being performed. It was decided that claimant would be referred to Dr. McKellar for evaluation.

Dr. McKellar completed his evaluation and concluded that claimant's ADOS scores and DSM-5 Review of Symptoms did not support a diagnosis of autism. Dr. Boyle testified that claimant presented with a constellation of symptoms. Medical and school records documented psychological and behavioral struggles that have continued to impact claimant. School records consistently found claimant qualified for special education services as a student with an emotional disturbance. Records noted "unspecified schizo and other psychotic disorder," hyperactivity, impulsivity, oppositional deviance, ADHD, and behaviors as concerns. He also explained that qualifying criteria for special education, and for the Social Security Administration, may be different than that set forth in the Lanterman Act.

Dr. Boyle expressed concern with Klamath Falls Youth Development Center records finding of PDD, noting that they were primarily signed by the nurse practitioner, and contained no evidence of a best practices autism assessment. The Nurse Practitioner stated that he agreed with Dr. Sears who did not perform an evaluation.

42. When claimant's mother disagreed with the results of Dr. McKellar's report, FNRC scheduled an informal hearing to discuss her concerns. She did not appear for the scheduled meeting.

Dr. Boyle consulted with Lisa Benaron, M.D., FAAP, FACP, who is the Medical Director for FNRC and an expert in neurodevelopmental disabilities. Drs. Boyle and Benaron then recommended an additional evaluation with Dorcas Liriano Roa, Ph.D., with the U.C. Davis MIND Institute. Claimant's mother stated that claimant's behaviors are so difficult that she could not transport him to the evaluation safely. She opined that if he was medicated for travel, the tests results might not be accurate. Instead, an evaluation was scheduled with a psychologist in Medford, Oregon. The family failed to appear for the scheduled evaluation and the psychologist was reportedly unwilling to reschedule.

43. Dr. Boyle concluded that while claimant has significant concerns, the genesis of his symptoms are most likely associated with his ADHD, fetal alcohol syndrome, behavioral, and psychiatric issues. Prior to Dr. McKellar's report, there was no evidence of a "best practices" or other autism evaluation. Dr. Sears shared some opinions, primarily from memory, of his experiences with claimant while providing medication management. Dr. Boyle opined that this was a clinical opinion based on a retrospective review of what he remembered, without the use of the ADOS or other recognized testing instrument, and would not be consider "best practices."

44. Claimant's mother testified to the difficulties claimant has had during his life. It was evident that she is doing all she can to obtain the help she believes he needs. That same opinion has been noted throughout claimant's records.

She voiced frustration with Dr. McKellar's report and the fact that he only spent the time with claimant that was necessary for completing the ASD evaluation, and did not have the same history as Dr. Sears. She also explained that Dr. Sears "didn't diagnose [claimant]

for a really, really long time because he didn't want to rush into a diagnosis. They used ED on his IEP since he didn't have a diagnosis."

Claimant's mother explained the struggle she has transporting claimant for any distance in her car, as he will exhibit behaviors and attempt to get out while she is driving. His behaviors at school are such that he is now being homeschooled.

At hearing, she presented documentary evidence and it became evident that additional documents existed that were not available for submission. It was determined that the record would remain open to allow time for her to submit additional documentary evidence that would have been available at the time of hearing.

DISCUSSION

45. When all the evidence is considered, claimant did not establish that he qualifies for services from FNRC under the Lanterman Act. Dr. McKellar's conclusions, based on a comprehensive "best practices" evaluation, were persuasive. Although claimant exhibited some symptoms associated with autism, the evidence was insufficient to establish that he has an Autism Spectrum Disorder. Claimant does not have a persistent impairment in reciprocal social communication and social interaction, or the restricted, repetitive patterns of behavior, interests, or activities necessary for a diagnosis of Autism Spectrum Disorder. While claimant has many challenges and exhibits a wide array of symptoms, his challenges and symptoms result from his medical and mental health issues, which do not constitute a developmental disability under the Lanterman Act. Consequently, claimant's request for services and supports from FNRC under the Lanterman Act must be denied.

LEGAL CONCLUSIONS

1. Eligibility for regional center services is limited to those persons meeting the eligibility criteria for one of the five categories of developmental disabilities set forth in section 4512 as follows:

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

Handicapping conditions that consist solely of psychiatric disorders, learning disabilities or physical conditions do not qualify as developmental disabilities under the Lanterman Act.

2. Claimant bears the burden of establishing that he meets the eligibility requirements for services under the Lanterman Act.[5] He has not met that burden. The

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[5] California Evidence Code section 500 states that "[e]xcept as otherwise provided by law, a party has the burden of proof as to each fact the existence or nonexistence of which is essential to the claim for relief or defense that he is asserting."

evidence presented did not prove that claimant is substantially disabled by a qualifying condition that is expected to continue indefinitely. He did not meet the diagnostic criteria for an ASD and there was no evidence to show that he has epilepsy, cerebral palsy, intellectual disability, or a disabling condition found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability. Accordingly, claimant does not have a developmental disability as defined by the Lanterman Act. Consequently, he is not eligible for regional center services.

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ORDER

Claimant's appeal from the Far Northern Regional Center's denial of eligibility for services is DENIED. Claimant is not eligible for regional center services under the Lanterman Act

DATED: April 12, 2016

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SUSAN H. HOLLINGSHEAD

Administrative Law Judge

Office of Administrative Hearings

NOTICE

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