BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: CLAIMANT, v. SAN ANDREAS REGIONAL CENTER, Service Agency.	OAH No. 2017010150

DECISION

Administrative Law Judge Michael A. Scarlett, State of California, Office of Administrative Hearings, heard this matter on August 1 and 16, 2017, in Campbell and San Jose, California, respectively.

James F. Elliott, Special Services/Fair Hearings Manager, represented San Andreas Regional Center (SARC or Service Agency).

Malorie M. Street and Melissa Wardlaw, Attorneys at Law, Office of the Public Defender, Molloy O'Neal, County of Santa Clara, represented claimant[1] who was not present at hearing.

The matter was submitted on September 1, 2017.

[1] Claimant's name is redacted to protect his privacy.

ISSUE

Is claimant eligible for regional center services based upon a diagnosis of Autistic Spectrum Disorder?

SUMMARY OF THE CASE

Claimant is an 18-year-old male who presents with a complex and extensive psychiatric history. He has been diagnosed with Schizophrenia, Post-Traumatic Stress Disorder (PTSD), Pervasive Developmental Disorder Not Otherwise Specified (PDD/NOS) and Autism Spectrum Disorder (ASD). Claimant asserts that he is eligible for regional center services based on the diagnosis of ASD. Claimant immigrated to the United States from Iraq in 2012 when he was 12 or 13 years old, and there are no medical or educational records to document his developmental history. Claimant's developmental history is based on reports by claimant's mother, who did not testify at hearing, and her reports were inconsistent and unreliable.

Service Agency evaluated claimant for eligibility in September 2015 and diagnosed him with Schizophrenia, and determined that claimant did not have ASD. Claimant's Schizophrenia diagnosis is well documented in the records. SARC asserts that claimant was misdiagnosed with ASD during his multiple psychiatric hospitalizations and that negative symptoms of Schizophrenia were mischaracterized as ASD symptoms which led to the ASD diagnoses.

A preponderance of the evidence established that claimant has Schizophrenia, and not ASD. Schizophrenia is a solely psychiatric disorder that does not qualify as a disability under the Lanterman Developmental Disabilities Services Act (Lanterman Act). Claimant's psychiatric evaluations that diagnosed ASD were based on clinical observations and claimant's mother's unreliable developmental history. The psychiatric evaluations also did not use clinical testing for a developmental disability or diagnostic

criteria for ASD in the American Psychiatric Association's Diagnostic and Statistical Manual, Fifth Edition (DSM-5). Consequently, the psychiatric evaluations relied upon by claimant were not persuasive evidence that claimant has ASD.

FACTUAL FINDINGS

PARTIES AND JURISDICTION

1. Claimant is an 18-year-old adult conserved male who was born in Iraq in 1999. His 18th birthday occurred during the pendency of this proceeding and claimant designated Malorie M. Street, Office of the Public Defender, County of Santa Clara, as his authorized representative. Claimant lived with his mother and brother in Santa Clara, California, until 2014, when he began exhibiting psychotic symptoms that required his psychiatric hospitalization on multiple occasions from 2014 through 2017. He has been placed in multiple group homes and is currently placed at Rebekah Children's Services (Rebekah), a residential group home in Gilroy, California. Claimant's seeks regional center services based on a diagnosis of ASD. [2]

2. On October 14, 2014, claimant's mother contacted SARC and requested regional center services for claimant. The Service Agency conducted an Intake Social Assessment on June 19, 2015, and thereafter evaluated claimant to determine whether he is eligible for regional center services under ASD. On September 25, 2015, a Lanterman Eligibility Evaluation Report (Eligibility Evaluation) was completed by Faith Langlois-Dul, Psy.D., SARC psychologist. Dr. Langlois-Dul diagnosed claimant with

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[2] Claimant has no history of Intellectual Disability (ID), epilepsy, cerebral palsy or evidence to support the Fifth Category basis for eligibility, and he does not assert these developmental disabilities as a basis for eligibility under the Lanterman Act.

Schizophrenia and determined that claimant did not have ASD, and therefore, denied his eligibility for regional center services.

3. On October 26, 2015, SARC notified claimant in a Notice of Proposed Action (NOPA) that he was denied eligibility for regional center services under the Lanterman Act because claimant did not demonstrate the presence of a developmental disability, which rendered him substantially handicapped in three or more of the seven major life domains, as required and defined by law. On October 26, 2014, SARC also informed claimant that interviews and observations at SARC with claimant and his mother, as well as records reviewed, indicated that claimant suffered from a mental health condition and not ASD.

4. In December 2016, claimant provided additional information to SARC and requested a second intake assessment. On December 5, 2016, SARC issued a second NOPA denying claimant's request for an intake assessment. The NOPA advised that "a clinical review has determined that at this time the applicant does not demonstrate the presence of a developmental disability." On February 14, 2017, Dr. Langlois-Dul prepared a Lanterman Eligibility Determination Summary (Eligibility Summary). She indicated that she had reviewed the additional information provided to SARC and determined that there were no new assessments that supported claimant's claim that he had ASD. She concluded that claimant's records continued to support a diagnosis of PTSD and Schizophrenia, and that although ASD and Schizophrenia had overlapping symptoms, claimant's symptoms were a result of claimant's mental health conditions, and not ASD.

5. On December 30, 2016, claimant's authorized representative filed a Fair Hearing Request (FHR) on claimant's behalf. The FHR asserts that claimant has been diagnosed with ASD and a mental illness, and despite being presented with new

information, particularly updated psychiatric evaluations, SARC inappropriately denied claimant's eligibility for regional center services.[3]

CLAIMANT'S FAMILY BACKGROUND

6. Claimant was born in Iraq in 1999 and lived in Baghdad until approximately 2010 when his mother took him to Jordan to await processing of his documents to immigrate to the United States. Claimant immigrated to the United States in 2012 with his mother and brother, when he was 12 or 13 years old. Other than mother's reports, there is no information regarding claimant's developmental years. There are no medical or educational records for the period claimant lived in Iraq from 1999 to 2012. Consequently, mother's reports and recollection were relied on to establish claimant's developmental history. The records indicate that claimant's mother's recollection was vague and inconsistent at best, and claimant's mother did not testify at hearing. Thus, claimant's mother's reports regarding his developmental history are unreliable and not credible.

7. Claimant endured the 2003 Iraq war as a very young child and was kept in isolation for extended periods as a result of this conflict. Based on claimant's reports, he heard shootings, bombings, and explosions as a child in Baghdad, Iraq, and lived in constant fear as a result of these incidents. Mother reported that claimant's father was physically and verbally abusive to claimant and his mother. According to claimant's mother, claimant's father did not allow claimant to leave the home or allow visitors into the home. Although the record is unclear as to the exact dates of events, claimant's

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[3] At hearing, the parties agreed that the issue in the FHR is whether claimant is eligible for regional center services based on a diagnosis of ASD, even though the December 5, 2016, NOPA was for the denial of an intake reassessment.

mother and father reportedly divorced in approximately 2006, and his mother immigrated to the United States in 2008. Claimant and his brother lived with their father until approximately 2010, when their mother returned to Iraq and moved them to Jordan. Claimant's mother believed his father continued to abuse claimant during the four years claimant lived with his father.

8. Claimant's mother reported that her pregnancy with claimant was full term, but was stressful and difficult. Claimant spoke his first word, "mama," at six months, but he "didn't talk much," and was toilet trained by three years old. She reported that claimant began saying single words when he was six months old, and that when he began speaking in phrases, he said "I love you mom," but he did not speak a lot. Claimant's mother did not recall when claimant walked, crawled, held his head up alone, sat alone, stood, or fed himself. However, claimant's mother stated that at a young age, claimant was "unable to concentrate" and "shy," could not "express himself," did not eat well, and had a lot of fevers and seizures. Mother described claimant as being "withdrawn from others and society" and having "poor social skills." Claimant could not distinguish faces and rarely memorized names (prosopagnosia) as a child. Claimant had no friends and loved to play video games, which his father used to keep him occupied.

9. Conversely, claimant's mother reported on multiple occasions that she did not recall claimant having any developmental delays or regressions. She reported that claimant reached normal developmental milestones and had no speech or motor delays. She described claimant as being "selectively mute" and stated that he did not have significant behavioral issues until he entered his teenage years. Claimant's mother indicated in 2015 that up until a "couple years ago," claimant had behaved in a normal fashion. Claimant's mother also stated at one point that she did not recall claimant exhibiting any repetitive behaviors as a young child.

CLAIMANT'S SCHOOL HISTORY

10. Prior to 2012, claimant's educational background is not clearly developed. Claimant's mother reported that claimant attended school in Iraq from first through third grade, and then moved to Jordan, where he did not attend school. Because there are no education records from Iraq, it is impossible to confirm whether and how long claimant attended school in Iraq. However, it is clear from the record that claimant missed more than four years of school prior to immigrating to the United States in 2012.

11. In May 2012, claimant enrolled in school in the Santa Clara Unified School District (District) in the seventh grade in general education classes. Records show that during the 2012-2013 school year, claimant had no academic difficulties or behavioral concerns. In January 2014, during the 2013-2014 school year, mother referred claimant for a psychoeducational study due to behavioral concerns and lack of academic progress. Subsequent testing showed that claimant's nonverbal cognitive ability and his visual-motor integrations skills were in the average range and that he performed approximately three years below grade level in reading and mathematics, and approximately four years below grade level in written language. Claimant scored somewhat low in the area of social-emotional development and his scores on the behavioral tests generally revealed significant problems. The school psychologist concluded that claimant qualified for special education services under the category of Other Health Impaired (OHI), emotional disturbance, noting that claimant had a diagnosis of PTSD.

12. On January 17, 2014, in a Health Status Assessment Report at the District, claimant's mother reported that he had met all developmental milestones within the expected age range, and did not report any developmental delays. However, she reported claimant was then exhibiting severe maladaptive behaviors, including amongst others, having repetitive thoughts and behaviors, tics/unusual movements/strange

noises, lack of desire to attend school, difficulty making and keeping friends, difficulty adjusting to change, poor self-esteem, preference to being alone, abnormal worries and fears, difficulty making eye contact, sexual behaviors, nightmares, and stubbornness.

13. On October 13, 2015, a Psycho-Educational Assessment was completed by the school psychologist Mydzung Bui, Ph.D. Dr. Bui noted that claimant could not answer questions on a mental status examination, that he spoke in a quiet volume with limited vocabulary, and that his eye contact was inconsistent. Claimant's test results indicated that his overall intellect was at least in the average range, and that there were significant concerns regarding claimant's ability to control his behaviors. Dr. Bui administered the Autism Spectrum Rating Scales (ASRS) test for autism. Claimant "consistently demonstrated very elevated scores with tolerating changes in routines, attention or motor impulse control, limited capacity to engage with peers, repetitive behaviors, and overreacting to certain experiences or sensory." However, Dr. Bui noted that the "onset of the severity of these behaviors were not in his early development, but was consistent with the onset of other mental health conditions." Dr. Bui concluded that although claimant had many behavioral characteristics similar to youth diagnosed with ASD, these characteristics had emerged along with other mental health conditions. Dr. Bui concluded that claimant: "presents a range of symptoms that have features of Autism. However, his inability to use oral language for communication declined along with other psychological symptoms and were not present at an early age. His history of social withdrawal have also been adversely affected by family factors and can be better explained through other mental health conditions."

14. From 2015 to 2016, claimant's Individualized Education Programs (IEP's) indicated that he engaged in the following behaviors at various times: displayed chopping or repetitive movements of his arms; performed strange repetitive movements at times; made minimal eye contact with staff and peers; was reluctant to engage in

conversations with peers; was selectively mute, indicating that he was able to speak but chose not to because he did not like his accent; did not speak in class unless asked; and used a small white board to communicate. It was also noted that he "listens to his peers" and "hangs out" with a few students. Claimant is described as being funny, intelligent, bright, sweet, liked by staff, and creative, and it was noted that he benefited from being able to trust others with whom he built a relationship; the greater the trust, the greater the understanding. Claimant also communicated strange ideas or thoughts (being afraid of flowers) or perseverated on various topics depending on his mood or focus. He was aggressive and violent at home but such behaviors were not seen at school. Claimant eloped from staff and the classroom on a few occasions and attempted to enter other classrooms and disrupted these classrooms, and he entered cafeteria work areas (behind counters) without permission.

15. On March 8, 2016, Ahsan Shaikh, M.D., Child and Adolescent Psychiatrist at Eastfield Ming Quong (EMQ), FamiliesFirst and Rebekah Children's Services, submitted an Application for a Home Teacher to the Santa Clara Unified School District on behalf of claimant. The application indicated that claimant had been diagnosed with ASD and PTSD.

CLAIMANT'S PSYCHIATRIC/MENTAL HEALTH HISTORY

16. From June 2014 to July 2017, claimant was involuntarily hospitalized under Welfare and Institutions Code, section 5150 status (5150) for psychiatric evaluations on at least seven occasions. On June 25, 2014, Alex Smirnoff, M.D., at John Muir Behavioral Health (John Muir) diagnosed claimant with Intermittent Explosive Disorder, PTSD, and PDD/NOS. On December 20, 2014, Timothy Lawver, D.O., at St. Helena Hospital, diagnosed claimant with PDD and mood disorder, not otherwise specified, rule out autism, and rule out PTSD. On June 4, 2015, Catherine Mason, M.D., at EMQ, diagnosed claimant with "psychotic disorder NOS, r/o [rule out] PTSD, mood disorder NOS, and an

autism disorder, by history." On August 17, 2016, Dr. Smirnoff diagnosed claimant with "unspecified schizophrenia spectrum disorder," PTSD, and ASD. On November 12, 2016, Shabbaz Khan, M.D., at Santa Clara Valley Medical Center, Barbara Arons Pavilion (BAP), diagnosed claimant with Schizophrenia, PTSD and ASD after claimant had been involuntarily admitted on September 13, 2016. On March 10, 2017, Moeen Bhatti, M.D., at Rebekah, diagnosed claimant with Schizophrenia and ASD. Claimant was also hospitalized under 5150 status for psychiatric evaluations on January 1, 2017, and July 8, 2017, but the medical records of these two hospitalizations were not made available.

17. During claimant's psychiatric hospitalizations, he presented with hallucinations, delusions, disorganized speech (mumbling and talking to himself), repetitive motor movements, and diminished emotional expression or avolition. Claimant also presented with symptoms described as chopping or odd motions with his arms; lack of eye contact; being mute or non-responsive (although frequently described as "selectively mute" or "selectively social"); and displaying rocking and agitated behavior (grimacing, "being hyperkinetic," and making "hemibalistic movements"). There is no dispute that claimant has been properly diagnosed with a mental health condition, i.e., Schizophrenia and PTSD. However, because some of the symptoms associated with these psychiatric disorders overlap with symptoms of ASD, claimant was given a dual diagnosis of a mental health condition and ASD by several of his treating psychiatrists.

18. Claimant's ASD diagnoses, however, were not supported by clinical testing for a developmental disability and the psychiatrists did not apply the DSM-5 Diagnostic Criteria for ASD in making their diagnoses. The psychiatrists were treating claimant under a 5150 involuntary psychiatric evaluation to determine whether claimant was a danger to himself or others, and were not specifically focused on evaluating whether claimant had a developmental disability. Claimant's psychiatric evaluations also relied

on inconsistent and unreliable reports from claimant's mother about claimant's developmental history. Consequently, the ASD diagnoses were based on unreliable developmental history. The psychiatric evaluations also did not consider claimant's educational records in rendering the ASD diagnoses. Thus, the ASD diagnoses in the psychiatric evaluations were not supported by sound clinical analysis regarding the presence of a developmental disability. The psychiatrists evaluating claimant were primarily focused on claimant's psychiatric disorders and consistently and convincingly diagnosed him with a mental health condition, i.e. PTSD and Schizophrenia.

19. The ASD diagnoses were not definitive or unequivocal, and indicated that claimant's symptoms may not be related to ASD, but could be a result of his mental health conditions. For example, Dr. Lawver opined that claimant's case was very complicated and that although claimant presented as "frankly autistic," there were factors that prevented a definitive ASD diagnoses. He noted claimant's language barrier, abuse by claimant's father, and the "strange nature" of claimant's relationship with his mother as factors that could lead to a characterization of claimant's symptoms as "not frank autism but an expression of an inability to cope with reality." Dr. Khan concluded that claimant's ASD was comorbid with his Schizophrenia. However, he opined that claimant's "social and relationship deficits could be due to ASD and at the same time some of the patient's social deficits could be due to the negative symptoms of Schizophrenia." He also specifically noted that claimant's "early developmental history is negative for speech delay and motor milestone delay." Diagnoses by Dr. Lawver, Dr. Kwan and Dr. Bui, all suggested claimant's symptoms could be the result of his confirmed mental health condition, and declined to make a definitive ASD diagnosis.

20. In addition, Dr. Smirnoff, who diagnosed claimant with PDD/NOS and ASD in June 2014 and August 2016, noted that claimant's psychiatric conditions significantly

improved with psychotropic medication during claimant's hospitalizations at John Muir. Significantly, ASD symptoms do not typically abate with medication, suggesting that the symptoms observed by Dr. Smirnoff were more accurately attributed to claimant's PTSD and Schizophrenia, and not ASD. Dr. Mason, who treated claimant in June 2015, diagnosed based on claimant's historical ASD diagnoses alone, thereby rendering her ASD diagnosis not credible.

21. Dr. Bhatti, who also diagnosed claimant with Schizophrenia or ASD, testified that he was reluctant to diagnose claimant with ASD because of claimant's age and because claimant had already been diagnosed with Schizophrenia. He testified that it was difficult to make an ASD diagnosis when Schizophrenia was already present because claimant's psychosis could hide or "mask" ASD symptoms. The record reflects that Dr. Bhatti treated claimant from February 2017 through July 2017, a period in which claimant was presenting with symptoms of Schizophrenia and during which time he was admitted for 5150 status psychiatric evaluations in January and July 2017. Dr. Bhatti's treating notes indicate that he was primarily attempting to adjust claimant's anti-psychotic medication regime, and there is no indication that he performed any clinical testing for a developmental disability or applied the DSM-5 Diagnostic Criteria for his ASD diagnoses. Of note, Dr. Bhatti's treatment notes indicate that claimant made good eye contact and was conversational, depending on his emotional state and the effect of his anti-psychotic medications. When claimant was hallucinating, delusional or exhibiting negative symptoms of Schizophrenia, his eye contact and communication level was markedly different. This suggests that claimant's psychotic medications were impacting his symptoms. As stated above, ASD symptoms ae not impacted by medications in that manner. Finally, Dr. Bhatti testified that he concluded that claimant had ASD prior to his diagnosis of Schizophrenia, based primarily on claimant's mother's

developmental history. Because claimant's mother is an unreliable historian, Dr. Bhatti's ASD diagnosis is viewed with skepticism.

22. Clayton Tamura, M.D., one of claimant's treating psychiatrists at BAP, testified at hearing and opined that claimant's symptoms were not typical of patients with mental health conditions. He testified that ASD symptoms such as repetitive behavior, lack of eye contact, social withdrawal, and deficits in communication, were not typically seen in patients with Schizophrenia or Bipolar Disorders. Dr. Tamura, however, was alone in this opinion, as all other psychiatrists and psychologists suggested that some ASD and Schizophrenia symptoms could overlap. He also testified that claimant's psychotic symptoms improved with medication, but his ASD symptoms did not. However, the record indicated that claimant was exhibiting active symptoms of psychosis during the entire period he was being treated by Dr. Tamura from September 2016 through January 2017. Finally, Dr. Tamura has limited training and experience diagnosing and treating patients with developmental disabilities. He also did not perform any clinical testing or apply the DSM-5 Diagnostic Criteria to diagnose claimant with ASD.

SARC'S ELIGIBILITY DETERMINATION

23. On September 25, 2015, Dr. Langlois-Dul prepared the Eligibility Evaluation which denied claimant's eligibility for regional center services. Claimant's evaluation was conducted during and shortly after one of his psychiatric hospitalizations in June 2015. Dr. Langois-Dul was unable to administer the Autism Diagnostic Observation Schedule, Second Edition (ADOS-2) due to claimant's "severe

disorientation, poor attention, and deficient comprehension." [4] She interviewed claimant and claimant's mother on three occasions, administered the Adaptive Behavior Assessment System, Second Edition (ABAS-2), the Mini-Mental Status Examination (MMSE), and reviewed claimant's educational and mental health records.[5]

24. An assessment of claimant's nonverbal cognitive ability, as scored on a January 2014 Matrix Analogies Test-Expanded Form administered by the school district, showed that claimant was in the average range for nonverbal cognitive ability. Dr. Langlois-Dul administered the MMSE two times which indicated a significant impairment in claimant's thinking. She noted that claimant's primary language of Arabic may have contributed to his low scores, but concluded that claimant was "disoriented, scattered and unable to follow instructions sufficiently to complete further formal testing with an expectation of valid results." This is consistent with the fact that claimant was experiencing psychotic symptoms during the eligibility evaluation.

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[4] Claimant displayed psychotic symptoms during the interviews. He indicated that he saw shadows by his face, heard people laughing, saw a spot on the floor that was increasing and decreasing in size, saw people outside of a window looking at him when there were no people outside of the window, and at times appeared to be paranoid.

[5] Dr. Langlois-Dul did not review Dr. Kwan's November 2016 evaluation and the John Muir records from August 2016, or the October 2015 psycho-educational assessment as these reports and evaluations were rendered and prepared after Dr. Langlois-Dul's September 25, 2015 eligibility evaluation.

25. Claimant's Intake Social Assessment completed on June 19, 2015, indicated that claimant was limited in his ability to communicate. [6] However, Dr. Langlois-Dul observed several behaviors during her interviews that indicated claimant's communication and social skills were not typical of a person with ASD. Claimant made eye contact which was "quite good" when he asked questions. When Dr. Langlois-Dul asked him about his behaviors towards others, claimant stated that "I want to see other peoples' reactions. I try to use it and see what people will say." Claimant also reported that he had a friend, K., with whom he video chatted and played games, and that he had another friend named B., and a P.E. teacher with whom he could easily talk. Claimant also reported that he had a friend that he annoyed on purpose by calling him names in text messages. When asked about this incident, claimant stated "I felt like I did a good job annoying him." Claimant's mother confirmed this behavior by stating claimant "enjoys pissing people off."

26. Although claimant presented as "highly fidgety," and spoke in a low volume, Dr. Langlois-Dul observed no echolalia, stereotypical speech, posturing or repetitive behavior. Claimant used gestures and showed varied emotions during his interviews. In describing an incident where he damaged a car, claimant used a toy car and toy doll to act out the scenario of the incident. He laughed and made eye contact

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[6] During the Intake Social Assessment, claimant's mother described his social skills as being almost nonexistent. Claimant's mother stated that claimant showed no interest in making friends, and for the most part, did not know how to maintain friendships. Conversely, however, claimant's mother also reported that claimant initially had no problem making friends when he moved to the United States in 2012, stating that his social skills begin to decline in June 2014, when claimant began to exhibit psychotic behaviors.

with his mother, and was animated, smiled and used facial expressions when communicating with his mother. Claimant fluctuated between being violent with his mother (placing his hands around mother's neck tightly and punching her arm lightly) and being affectionate (sitting by his mother and holding her hand, kissing her hand, playing with her fingers, and snuggling into mother's shoulders). Claimant displayed behaviors intent on getting response from SARC staff. At one point, claimant left the interview room, went out of the intake door and SARC's front door, while looking back to see if staff was following him.

27. The results of the ABAS-2, which measures claimant's adaptive functioning based on responses provided by claimant's mother and teacher, indicated that claimant was able to perform self-help and independent living skills. He can complete most household chores, including wiping up spills, putting dirty clothing in a hamper, clearing the table, sweeping the floor, washing dishes, and taking out trash. Claimant adequately demonstrated to Dr. Langlois-Dul that he can use money and tell time using an analog clock. He located dates on a calendar and recited the days of the week, although he did not know what day the evaluation was taking place. Claimant also can send email and use the internet to research topics of interest.

28. Claimant can complete most self-care tasks with prompting, including oral hygiene tasks, bathing, and waking up with an alarm clock. He can use silverware, but sometimes uses his hands when eating, and he does not like to use metal eating utensils. Mother expressed concerned about claimant's safety when using knives and scissors. However, when asked how he carries scissors, claimant took two markers and used them to demonstrate how he carried scissors. Again, claimant used objects to demonstrate, which is a behavior not typical of a person with ASD. Claimant can make simple foods such as sandwiches and can warm foods in a microwave. Claimant dresses

himself, makes independent clothes choices and demonstrated that he can tie his own shoes.

29. Finally, claimant's school records and his teacher's responses on the ABAS-2 also indicate that claimant has social and communication skills that are not typical of a person with ASD. Claimant often wrote using a white board rather than speaking, and spoke as needed depending on his emotional state. He listened to, hung out and interacted with peers at school. When interacting with peers, who talked to him, claimant would write sarcastic and joking responses on the white board. Although claimant's school records indicated he communicated bizarre thoughts, such as fear of flowers, and that he engaged in disruptive behaviors, Dr. Langlois-Dul believed these behaviors were consistent with his qualification for special education based on OHI (emotional disturbance).

30. Dr. Langlois-Dul ultimately concluded that claimant did not have ASD, but that his symptoms were consistent with a diagnosis of Schizophrenia. She applied the DSM-5 Diagnostic Criteria for ASD and Schizophrenia in rendering her diagnosis. Dr. Langlois-Dul concluded that claimant did not have deficits in social communication and social interaction. She found he had no deficits in social-emotional reciprocity citing: (1) claimant's earliest words were "I love you mom;" (2) his willingness to speak was dependent on his emotional state (selectively mute); (3) he fluctuated between being affectionate and violent with his mother; (4) he sought peoples' reactions to his conduct; (5) he made eye contact and smiled when asking questions; and (6) he was observed leaving the intake office and checking to see if anyone was following him.

She concluded claimant had no deficits in nonverbal communication as evidenced by: (1) his using demonstrations with objects to enhance communication (using markers to show how he used scissors; using a toy doll and car to act out how he damaged a car); (2) he showed various emotions during his interviews, i.e., agitation,

paranoia, and was animated and showed facial expressions; and (3) although claimant's eye contact varied and he kept his head down for most of the assessment, when he asked questions, claimant raised his head and made eye contact.

Dr. Langlois-Dul also concluded claimant did not have deficits in developing, maintaining and understanding relationships. She indicated that claimant had some social skills deficits, but these deficits resulted from his aggressive behaviors, rather than autistic behaviors. Dr. Langlois-Dul noted claimant's communication with other students, his ability to comprehend jokes and sarcasm, and claimant's reports that he had friends, including friends he liked to annoy, as evidence that claimant did not have deficits in developing and maintaining relationships.

31. Regarding deficits in restricted, repetitive patterns of behavior, interests, or activities, Dr. Langlois-Dul concluded that claimant had deficits in two of the four behaviors identified in the DSM-5 Diagnostic Criteria. She indicated that claimant engaged in stereotyped or repetitive motor movements, use of objects or use of speech (clubbing or chopping motions), and that he had highly restricted and fixated interests that were abnormal in intensity and focus (video game addiction). She opined, however, that claimant's highly restricted and fixated interest behaviors were caused by claimant's isolation and abusive father in Iraq, where his only source of entertainment was violent video games. Dr. Langlois-Dul concluded that there were no deficits for the behaviors of insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior; or hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment.

32. Dr. Langlois-Dul diagnosed claimant with Schizophrenia, applying the DSM-5 Diagnostic Criteria for Schizophrenia. She concluded that claimant exhibited behaviors that met all five criteria for Schizophrenia, i.e., delusions, hallucinations,

disorganized speech, grossly disorganized catatonic behavior, and negative symptoms (diminished emotional expression or avolition). She concluded that:

> [claimant] meets DSM-V criteria for 295.90 Schizophrenia. There is no indication that he had a pre-existing developmental disorder. His mother had reported that *until a few years ago, [claimant] behaved in a normal fashion.* His records indicate that he first required special education intervention in 2014 (2 years after arrival in USA), and there is not a record of intervention prior to 2014, which is consistent with mother's report. [Claimant] does not have an eligible condition, and therefore, is not eligible for regional center services.

33. On February 17, 2017, after reviewing additional information provided by claimant, Dr. Langlois-Dul prepared the Eligibility Summary. She noted that claimant exhibited some symptoms that overlapped with ASD and Schizophrenia. However, Dr. Langlois-Dul concluded that because claimant also exhibited symptoms that were only associated with Schizophrenia, i.e., hallucinations and delusion, these served to differentiate claimant's diagnosis from ASD. She ultimately again concludes that claimant's symptoms are more accurately attributed to Schizophrenia, rather than ASD. Dr. Langlois-Dul noted that claimant's ability to use nonverbal gestures to enhance communication, that he interacted with and made friends prior to his psychotic episodes, and that he is selectively mute dependent on his mental state, evidenced that claimant does not have ASD. She emphasized that claimant does not have a history of developmental delays, and that he functioned normally before experiencing his first episode of decompensation as an adolescent in 2014. Again, she points out that

claimant's psychotic symptoms improved with antipsychotic medications, and that some of his symptoms may be a result of the complex trauma claimant experienced as a child in Iraq.

34. Dr. Langlois-Dul again concluded that:

> [claimant] does not meet full DSM-V criteria for an Autism Spectrum Disorder. Although some of his behaviors may appear to be autistic-like on the surface, a review of the behaviors that are common among children who have experienced complex trauma or who have a psychotic disorder clarify that his symptoms are consistent with these conditions. The onset of his symptoms in adolescence, and the occurrence of many other mental health symptoms at the same time as these symptoms further indicate that the symptoms relate to complex trauma and psychosis, and not to ASD.

35. At hearing, Dr. Langlois-Dul credibly testified that the ASD diagnoses made by claimant's pychiatrists were done without clinical testing for a developmental disability and were primarily based on observations and historical references to other ASD diagnoses. She believed that claimant's symptoms were not a result of a developmental disability, but rather were symptomatic of his mental health conditions, Schizophrenia and PTSD. Dr. Langlois-Dul credibly testified that many of claimant's symptoms, i.e., the lack of eye contact, repetitive stereotyped movements or behaviors, and selective muteness or mumbling overlapped with Schizophrenia symptoms (disorganized speech, grossly disorganized or catatonic behaviors, and negative symptoms). She opined that claimant exhibited symptoms of "avolition," which she

defined as showing no will or motivation to interact with others.[7] Avolition is a negative symptom of Schizophrenia which frequently manifests itself during a prodromal phase or period when active episodes or symptoms of Schizophrenia are not present. Dr. Langlois-Dul noted that it was significant that claimant's behaviors also decreased or improved with psychiatric medications, stating that ASD symptoms were not typically modulated with medication.

36. Dr. Langlois-Dul also credibly testified that claimant's school records indicated that claimant hung out with his peers, joked and engaged in sarcasm with others, was selectively mute, but able to communicate using a white board, and had social interactions with peers and teachers until he began to experience psychotic episodes in 2014. She placed significance on the fact that claimant did not show any symptoms of ASD during the 2012-2013 school year, and believes it was not possible for school staff to have overlooked ASD symptoms for an entire school year.

37. Finally, Dr. Langlois-Dul emphasized that claimant's psychotic behaviors appeared in 2014, when claimant was almost 15 years old, and his child developmental history is void of any reliable evidence of a developmental disability.

38. On July 19, 2017, Joshua Heitzmann, Ph.D., a psychologist for SARC, conducted a psychological evaluation of claimant and prepared a report on July 21, 2017. Dr. Heitzmann's evaluation was primarily to determine whether claimant was emotionally stable enough to undergo testing for ASD, and not a comprehensive psychological evaluation. Dr. Heitzmann concluded that claimant had not reached a baseline level of stability to assess claimant for a developmental disability. Dr. Heitzmann opined that prior to testing, claimant should reach a level of stability for a

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[7] The DSM-5 defines "avolition" as "a decrease in motivated self-initiated purposeful activities." (DSM-5, p. 88.)

minimum of three months, but recommended that claimant show stability for six months. Claimant's psychiatric evaluations from 2014 through 2017 were all conducted while claimant was actively exhibiting psychotic behaviors. He had not reached a level of emotional stability that would allow a definitive diagnosis of ASD. Dr. Heitzmann also testified, consistent with Dr. Langlois-Dul's testimony and opinion, that Schizophrenia and PTSD could manifest autistic-like symptoms, and that in his opinion, claimant's diagnosis of Schizophrenia was the appropriate diagnosis.

ULTIMATE FACTUAL FINDINGS

39. Dr. Langlois-Dul's eligibility evaluation diagnosing claimant with Schizophrenia, and not ASD, is more persuasive that claimant's psychiatric evaluations that rendered a dual diagnosis of Schizophrenia and ASD. Dr. Langlois-Dul's eligibility evaluation was rendered using the DSM-5 Diagnostic Criteria for ASD and Schizophrenia, and clinical observations specifically focused on assessing the presence of a developmental disability. Dr. Langlois-Dul also reviewed claimant's educational records. Claimant's ASD diagnoses were made without clinical testing and did not apply the DSM-5 Diagnostic Criteria for ASD, and were primarily based clinical observations focused on treating claimant's mental health conditions during his psychiatric hospitalizations. The ASD diagnoses were not definitive and indicated that many of claimant's symptoms could be attributed to his mental health conditions. The ASD diagnoses also relied on claimant's mother's unreliable developmental history.

40. Dr. Langlois-Dul and Dr. Heitzmann, conversely, have experience diagnosing developmental disabilities and making clinical observations regarding ASD symptoms. Dr. Langlois-Dul applied the DSM-5 Diagnostic Criteria, and based on her clinical observations and her review of claimant's educational records, she concluded that claimant did not have ASD, but that he was properly diagnosed with Schizophrenia. Dr. Heitzmann concurred in Dr. Langlois-Dul's opinion and diagnosis.

Consequently, it is determined that claimant suffers from a mental health condition, Schizophrenia, which is a psychotic disorder that that does not qualify as a developmental disability under the Lanterman Act.

41. Accordingly, it is determined that claimant did not establish by a preponderance of the evidence that claimant is eligible for regional center services based upon a diagnoses of ASD.

LEGAL CONCLUSIONS

1. The Lanterman Act governs this case (Welfare and Institution Code, section 4500 et seq.) [8] and provides that the State of California "accepts responsibility for persons with developmental disabilities and an obligation to them which it must discharge." (§ 4501.) Where, as here, claimant seeks to establish eligibility for services under the Lanterman Act, the burden of proof rest with the claimant. (*Lindsay v. San Diego Retirement Bd*. (1964) 231 Cal.App.2d 156, 161[disability benefits].) Claimant must establish by a preponderance of evidence that he has a qualifying "developmental disability" and that Service Agency inappropriately determined that claimant was not eligible for regional center services.

2. "In determining if an individual meets the definition of developmental disability contained in subdivision (a) of Section 4512, the regional center may consider evaluations and tests, including, but not limited to, intelligence tests, adaptive functioning tests, neurological and neuropsychological tests, diagnostic tests performed by a physician, psychiatric tests, and other tests or evaluations that have been performed by, and are available from, other sources." (§ 4512, subd. (b).) However, "the

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[8] All further statutory references shall be to the Welfare and Institutions Codes unless otherwise specified.

Lanterman Act and implementing regulations clearly defer to the expertise of the DDS (California Department of Developmental Services) and RC (regional center) professionals' determination as to whether an individual is developmentally disabled." (*Mason v. Office of Administrative Hearings* (2001) 89 Cal.App.4th 1119, 1127.) In *Mason*, the court focused on whether the applicant's expert witnesses' opinions on eligibility "sufficiently refuted" those expressed by the regional center's experts that the applicant was not eligible. (*Id.*, at p. 1137.)

3. Section 4512, subdivision (a), provides that a "developmental disability" is a disability that originates before the age of 18 years, continues indefinitely and constitutes a substantial disability. A developmental disability includes intellectual disability, cerebral palsy, epilepsy, and autism, and also disabling conditions that are closely related to intellectual disability or require treatment similar to that required for intellectual disability, but does not include handicapping conditions that are solely physical in nature. (§ 4512, subd. (a).) "Substantial disability" means the "existence of significant functional limitations" in three or more of the following areas of major life activity: (1) self-care; (2) receptive and expressive language; (3) learning; (4) mobility; (5) self-direction; (6) capacity for independent living; and (7) economic self-sufficiency. (§ 4512, subd. (l)(1); Cal. Code Regs., tit. 17, § 54001, subd. (a).)

4. California Code of Regulations, title 17, section 54000 defines "developmental disability" consistent with section 4512, subdivision (a), and requires that the disability originates before age 18, continues indefinitely and constitutes a substantial disability. Section 54000, subdivision (c), further provides that handicapping conditions that consist solely of psychiatric disorders, learning disabilities, or physical conditions do not qualify as developmental disabilities. Solely "psychiatric disorders" are defined as "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." (Cal. Code Regs., tit. 17, § 54000, subd. (c)(1).)

5. The DSM-5 Diagnostic Criteria for ASD require that there be persistent deficits in social communication and social interaction across multiple contexts as manifested by (Criteria A): (1) deficits in social-emotional reciprocity; (2) deficits in nonverbal communicative behaviors used for social interaction; and (3) deficits in developing, maintaining, and understanding relationships. There must also be restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following (Criteria B): (1) stereotyped or repetitive motor movements, 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 (4) hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment. (DSM-5 at p. 50.)

6. The DSM-5 also provides that the ASD symptoms must be present in the early development period (typically during first two years of life), cause clinically significant impairment in social, occupational, or other important areas of current functioning, and the disturbances are not better explained by intellectual disability or global developmental delay. (DSM-5 at p. 50.)

7. The DSM-5 Diagnostic Criteria for Schizophrenia provides that two or more of the following behaviors must be present for a significant portion of time during a one-month period, with at least one of the symptoms being (1), (2), or (3): (1) delusions; (2) hallucinations; (3) disorganized speech (frequent derailment or incoherence); (4) grossly disorganized or catatonic behavior (mutism, repeated stereotyped movements, staring, grimacing and echoing of speech); and (5) negative

symptoms (diminished emotional expression or avolition). (DSM-5 at pp. 88, 99.) Continuous signs of the disturbance must persist for at least six months and the six-month period must include at least one month of symptoms that are active-phase symptoms, i.e., delusions, hallucinations, disorganized speech, grossly disorganized catatonic behavior, and negative symptoms, and may include periods of prodromal or residual symptoms. (DSM-5 at p. 99.)

ELIGIBILITY DETERMINATION

8. Claimant failed to establish by a preponderance of the evidence that he has a qualifying developmental disability under the Lanterman Act. Claimant's ASD diagnoses were not supported by clinical testing for a developmental disability and the DSM-5 Diagnostic Criteria for ASD was not applied. Conversely SARC established that claimant's symptoms are attributable to his mental health condition, Schizophrenia and not ASD. Dr. Langlois-Dul's diagnosis of Schizophrenia was supported by the evidence, and she provided sufficient evidence that claimant did not satisfy the DSM-5 Diagnostic Criteria for ASD.

9. Claimant's developmental history was not established because there are no medical or educational records for claimant before 2012. Claimant's mother reports of his developmental history are unreliable and she did not testify hearing. However, where developmental history is no available, the DSM-5 provides that an ASD diagnosis may be made "where clinical observation suggests criteria are currently met, autism spectrum disorder may be diagnosed, provided there is no evidence of good social communication skills in childhood." (DSM-5 at p. 56.) However, evidence that an individual had reciprocal friendships and good nonverbal communication skills during childhood would rule out a diagnosis of ASD. (*Ibid.*)

10. Here, although claimant's developmental history was not reliably established, claimant's school records, e.g. IEP's from 2015 to 2016, indicate that

claimant communicated and socially interacted with other students and teachers, and that these interaction and communication levels diminished with the onset of his mental health conditions in 2014. Claimant also exhibited behaviors during his SARC Eligibility Evaluation that suggested claimant did not have deficits in social communication and social interaction. Claimant engaged in conversations with Dr. Langlois-Dul, made eye contact and smiled when asking questions, and exhibited behaviors that sought peoples' reactions to his conduct. Claimant used demonstrations with objects to enhance nonverbal communication and also exhibited a range of emotions during his interviews with Dr. Langlois-Dul.

11. Claimant exhibited deficits in the area of stereotyped and repetitive motor movements and speech (chopping movements and echolalia), but these behaviors/symptoms were more accurately attributed to his mental health conditions and not ASD. Claimant also had restricted and fixated interests, i.e. his video game addiction. However, this deficit could have been influenced by claimant's extensive use video games for entertainment while he was isolated in his room in Iraq. However, even if claimant had deficits in these two areas of restricted and repetitive patterns of behavior, the lack of deficits in the area of social communication and social interaction negates a diagnosis of ASD under the DSM-5.

12. Finally, although the evidence established claimant was significantly impaired in social, occupational, or other important areas of functioning, this impairment appears to be a result of his mental health condition, and not ASD. He has been experiencing psychotic symptoms from June 2014 through July 2017, as evidenced by his psychiatric hospitalizations during this time period. Claimant has been placed in multiple group homes as a result of his mental health conditions and he had not established a baseline level of emotional stability during the eligibility evaluation in 2015, or again during Dr. Heitzmann's psychological evaluation in July 2017.

Consequently, the evidence established that claimant's mental health conditions significantly impaired important areas of functioning and were substantially disabling.

13. Claimant has a confirmed diagnosis of Schizophrenia, which is a solely psychiatric disorder that does not qualify as a developmental disability under the Lanterman Act. (Cal. Code Regs., tit. 17, § 54000, subd. (c)(1).) Accordingly, claimant failed to establish by a preponderance of the evidence that he has ASD, or that he is substantially disabled as a result of a developmental disability.

ORDER

Claimant's appeal of SARC's denial of eligibility based on a diagnosis of ASD is denied.

DATED: September 27, 2017

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MICHAEL A. SCARLETT

Administrative Law Judge

Office of Administrative Hearings

NOTICE

This is the final administrative decision pursuant to Welfare and Institutions Code section 4712.5, subdivision (a). Both parties are bound by this decision. Either party may appeal this decision to a court of competent jurisdiction within 90 days.