BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: CLAIMANT vs. SAN GABRIEL / POMONA REGIONAL CENTER, Service Agency.	OAH No. 2017051067

DECISION

Chantal M. Sampogna, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on September 19, 2017, in Pomona, California.

Rosa Chavez appeared on behalf of the San Gabriel/Pomona Regional Center (SGPRC or Service Agency).

Mother and father appeared on behalf of claimant, who was not present. [1]

Oral and documentary evidence was received. The record was held open until January 29, 2018, for claimant to submit additional documentary evidence, an Independent Education Evaluation (IEE). On January 17, 2018, claimant timely filed the document, which was marked and admitted into evidence as claimant's exhibit T. Service Agency did not respond. The record was closed and the matter submitted on January 24, 2018.

[1] Titles are used to protect the family's privacy.

ISSUE

Whether claimant is eligible for services under the Lanterman Developmental Disabilities Services Act (Lanterman Act) (Welf. & Inst. Code, § 4500 et seq.).[2]

EVIDENCE RELIED UPON

Documents: Service Agency's exhibits 1 through 10; claimant's exhibits A through T.

Testimony: Dr. Deborah Langenbacher, Service Agency Staff Psychologist; Mother; Father.

FACTUAL FINDINGS

1. Claimant is a 16-year old boy, born November 11, 2001, who resides with his mother and father in California. Claimant's older brother primarily resides in San Diego, where he attends university. Claimant was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) at five years of age. Claimant's ADHD has been well documented, and the diagnosis has been confirmed by multiple evaluations and is not in dispute. Based on claimant's historical, continuing, and unresolved behavioral, relational, and communication challenges, claimant seeks a finding that he has a developmental disability as defined in the Lanterman Act under eligibility category of Autism Spectrum Disorder (ASD). (§ 4512, subd. (a).)

2. The Service Agency intake team determined claimant does not have a developmental disability. The Service Agency sent the April 11, 2017 Notice of Proposed Action (NOPA) to claimant informing him of its determination. Claimant submitted a fair hearing request on May 16, 2017.

[2] All further statutory references are to the Welfare and Institutions Code, unless otherwise specified.

EDUCATIONAL HISTORY

3. Since his infancy, claimant has had a history of behavioral, relational, socialization, attention, and communication challenges across all settings, including home, school, and public settings. As an infant, he was difficult to soothe and a fussy eater. Prior to starting preschool, he was fussy and difficult, with frequent temper tantrums. Due to repeated behavioral challenges, even during his infancy and early toddler years, relatives refused to babysit or be left alone with claimant. Claimant began preschool at two years of age, and at that time had difficulty relating appropriately with his peers; reports from claimant's preschool evidenced his poorly developed social skills and occasional disruptive behavior. Prior to entering elementary school, neighbors refused to allow claimant to play with their children because they perceived claimant to be mean and intimidating. During this time, claimant displayed unpredictable and impulsive behavior at home, in daycare, and at church. Parents sought help for claimant. Claimant was diagnosed with ADHD at five years of age by Jack Lindheimer, M.D.[3]

[3] Claimant's ADHD diagnosis was confirmed in 2009 by Dr. Powezek, Ph.D., in 2014 by Charles Imbus, M.D., and in 2017 by Bruce Abbott, M.D. The reports in evidence showed claimant has been on several medications to treat his ADHD including Concerta, Adderall, Vyvance, Focalin, Strattera, Intuniv, Tenex, Prozac, Celexam, and Seroquel. These medications were often stopped within months of trying them either because the parents determined they were not helpful with claimant's symptoms and often caused more aggression, or because claimant would refuse to take the medication. Dr. Abbott has been claimant's treating psychiatrist since 2016, and he explained in a September 2017 letter that claimant had taken a number of different psychiatric medications over his lifetime, with varying degrees of efficacy. At the time of the hearing, Concerta had proven the most effective medication for claimant's symptoms and behaviors.

4. In elementary school, claimant's challenges with behavior, attention, socialization, communication, and relationships continued. Between 2008 and 2013 (second through fifth grade) claimant received special education speech services due to a speech delay, which was ultimately resolved. At the end of his speech services, claimant received a section 504 plan based on his diagnosis with ADHD. Though claimant's challenges continued, claimant's fifth and sixth grade years were unremarkable regarding school discipline. However, in seventh grade claimant had a marked increase in disruptive and dysfunctional behavior. Claimant's behavior continued to be socially inappropriate, but had escalated to physical aggression towards his peers. Based on this aggression, he had to transfer to the Opportunities program, an Arcadia Unified School District (AUSD) continuation school, where he completed his seventh grade year.

5. In September 2015, at the beginning of claimant's eighth grade year, the AUSD held an Individualized Education Plan (IEP) meeting and determined claimant was eligible for special education services under Other Health Impairment (OHI) based on his medical diagnosis of ADHD.[4] During claimant's 2016 – 2017 academic year (ninth grade), the IEP team determined claimant had demonstrated progress as seen by his academics, increased awareness of how his choices contribute to consequences, and his improved capacity to adhere to boundaries; the team found claimant continued to struggle with organization, completing assignments on time, and that his behavior continued to be

[4] The most recent IEP provided at the hearing shows claimant is placed in general education with resource specialist program services and support, and approximately four classes have been modified to accommodate his educational needs. Claimant also has a behavior plan based on his use of profanity, aggression, and his difficulty following directions and cooperating with authority figures.

off task and unfocused, as well as disruptive and aggressive. Based on an October 2016 psychological evaluation (independently sought by parents) conducted by Patricia Valdez, Ph.D., in which Dr. Valdez concluded that claimant has ASD, the parents requested an addendum IEP meeting for the IEP team to consider if claimant has ASD. (See Factual Findings 11-12.) In January and February 2017, AUSD had claimant assessed by Ione Mieure, Ph.D., and Jennie Mathess, Psy.D., who conducted a psycho-educational evaluation and a psychological assessment, respectively. (See Factual Findings 14-15.) The IEP team determined that claimant's behavior did not evidence behaviors associated with ASD that impeded his academic access, and maintained claimant's IEP eligibility under OHI. The parents disagreed with this determination and requested an Independent Education Evaluation (IEE). In January 2018, Michael Salce, Ed.D, with Spectrum Services, conducted the IEE, a Psycho-Educational Evaluation of claimant, and determined that in terms of claimant accessing his education, his primary disability is ADHD, and his secondary disability is ASD. (See Factual Findings 20-22.)

CLAIMANT'S HISTORIC AND CURRENT BEHAVIORS

6. The following behaviors are representative examples of behaviors documented by claimants parents, IEP teams, evaluators, and service providers (observers) over the course of claimant's life, and as recently as January 2018. These behaviors relate to claimant's deficits in communication, reciprocal social interaction, restrictive and repetitive behavior, and aggressive behavior.

Reciprocal Social Interaction

7. Though claimant can initiate conversations with others, claimant's focus and purpose of conversations is his attempt to have his needs immediately met, and he often initiates conversations by disrupting classroom instruction. Most observers have not believed that claimant recognizes the impact of his behaviors on others. Claimant

impulsively and without awareness continuously uses racial slurs or other offensive language (such as harsh comments about someone's body size) without understanding the impact on others. At other times, he will practice extreme isolating measures to remove himself from social situations, such as at 15 years of age crawling under the seats at church to isolate himself from the services and people.

Fixated and Rigid Communication

8. Claimant's perseverating behaviors include spending 10 to 30 minutes taking an item apart and taping it together again, such as headphones and mechanical pencils, and repeatedly asking about the size of a hair clipper during a haircut, causing the haircut to last three hours. In conversations, claimant is not able to change the focus of his conversation from his business idea (a primary focus) of selling clothes and objects to peers at his school, and he can have poor eye contact and uses pedantic or insistent and argumentative speech. Claimant also hoards items such as bikes that are not his, acne cream, hair products, and shoes. Historically, claimant played with toys for non-functional purpose, such as lining up Legos and shoes.

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Sensory Sensitivity

9. Claimant has demonstrated the following sensory sensitivity: claimant is bothered by direct sunlight, to the point that he frequently yells at the sun while in the car, and insists that the sun is following him; he covers his ears to loud sounds; he has hypersensitivity to food odors; and when at home he repeatedly walks around the house in his underwear because he does not like the feel of his clothing on his skin.

Aggression

10. Since approximately seventh grade, claimant's violent rages have increased in frequency and intensity. At the time of the hearing, the parents had called

the police over nine times to their home due to claimant's violence against family members, including wielding knives, punching and kicking, and threatening to harm. At school, claimant is on a behavior plan based on his use of profanity, and his difficulty following directions and cooperating with authority figures, arguing with teachers, and aggressive comments, such as "I'm going to hurt and kill you." (Ex. 4.)

EVALUATIONS PRIOR TO SERVICE AGENCY DETERMINATION

September 2016 Psychological Evaluation, Dr. Valdez

11. In 2016, Jon Hernandez, Licensed Marriage and Family Therapist, claimant's therapist at the time, referred claimant to Dr. Valdez for a psychological evaluation for diagnostic clarity due to claimant's challenges with attention and impulsivity, odd behaviors, poor compliance with rules and requests, deficits in social skills, anxiety, and aggressive and destructive outbursts. Mr. Hernandez found the ADHD diagnosis insufficient in describing claimant's unpredictable behavior. On September 27, 2016, Dr. Valdez conducted a multiple- hour psychological evaluation of claimant. Among other tests, she administered the Autism Diagnostic Interview – Revised (ADI-R) assessment, on which claimant scored the following: reciprocal social interaction 12 (cutoff score for ASD eligibility (cutoff) 10); communication 8 (cutoff 8); restricted, repetitive and stereotyped patterns of behavior 5 (cutoff 3). Dr. Valdez observed that while claimant initially presents typically, his behavioral challenges inevitably affect functioning across domains and have had a severe and pervasive impact on his relationships. Dr. Valdez concluded claimant has the following diagnoses: ASD; ADHD, combined presentation; Disruptive Mood Dysregulation Disorder Provisional (DMMD); Narcissistic Personality Features; history of vision problems; and problems with primary support group: parent-child relational problems.[5] Dr. Valdez explained in her subsequent

[5] Dr. Valdez also found claimant has an underlying mood disorder, DMDD, based

August 2017 letter that it is not uncommon for youth with ASD with normal intelligence and age-level verbal skills to have their ASD go unidentified as co-morbid problems with ADHD become more of the focus.

12. Dr. Valdez found that claimant demonstrated persistent deficits in social-emotional reciprocity, nonverbal communicative behaviors used for social interactions, and developing, maintaining, and understanding relationships. Dr. Valdez found the following behaviors support claimant's ASD diagnosis. Claimant has significant challenges with social-emotional understanding, which was apparent in his difficulty identifying other's facial expressions and understanding their tone of voice, and in his inconsistent ability to take on other's perspectives, missing of social cues, blurting racial slurs and obscenities, and not expressing empathy appropriately. Claimant also has longstanding difficulty maintaining normal relationships, and those relationships he has had have been very short lived, often due to claimant's eccentric behaviors and one-sided relationships which are more opportunistic, and less mutual. Claimant's challenges with communication include poor eye contact, pedantic or insistent speech, repetitive language, and tending to fixate his conversations on self-interests with abnormal intensity. Finally, claimant presented restricted, repetitive, and stereotyped patterns with his excessive adherence to routines and fixated interests that are abnormal in intensity and focus, e.g., claimant's fixation on his business which consists of him accumulating

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on claimant's outbursts which are significantly out of proportion in intensity and duration to the situation or provocation. The Diagnostic and Statistical Manual of Mental Health Disorders, Fifth Edition (DSM-V) core feature of DMDD is chronic, severe, persistent irritability, which manifests as frequent temper outbursts typically occurring in response to frustration, and which are verbal or behavioral. Dr. Valdez found that claimant did not meet the criteria for any specific mood disorder (i.e., Bipolar Disorder).

items and persistently attempting to sell these items to his peers at school, tinkering with mechanical objects, rigidity with transitions, and a history of sensory issues. (See Factual Findings 6-9.)

13. Dr. Valdez's evaluation also provided examples of how claimant's challenges interfered not only with his receptive and expressive language, but also with his learning and self-care. Dr. Valdez noted how his behaviors have interfered with claimant's learning, for example when claimant will have outbursts, or perseverate on a topic, or dismantle mechanical pencils, rather than attending to curriculum. As well, Dr. Valdez noted that claimant's behaviors impeded his self-care, for example when he repeatedly asked what type of hair clipper was being used and how much hair was going to be cut, such that a normal self-care activity can extend to a three-hour activity. Dr. Valdez concluded that although claimant's behavioral conditions have been longstanding, his developmental delays have not been recognized, claimant has not had the benefit of adequate necessary supports, and the parents have had unrealistic expectations, resulting in significant parent-child relational problems.

January 2017 Psycho-Educational Evaluation, Ione Mieure, Ph.D.

14. In response to the parents' submission of Dr. Valdez's evaluation, the IEP team had claimant evaluated in January 2017 to determine if claimant met the criteria as a student with ASD for the purpose of eligibility for special education services. Dr. Mieure conducted a thorough psycho-educational evaluation of claimant in the classroom setting on several different days throughout various times of day. Claimant scored within average range relative to his peers on the social perception domain, showing an ability to read the expressions of others through pictures presented to him, and to give logical answers regarding a social content presented to him through pictures. Dr. Mieure determined claimant's academic access was impeded by his well-documented diagnosis of ADHD and did not find that claimant had ASD.

February 2017 Psychological Evaluation, Jennie M. Mathess, Psy.D.

15. Dr. Mathess's psychological evaluation of claimant was for the purpose of assessing Intellectual Disability or ASD. She met with claimant for approximately 30 minutes and administered the ADI-R, Autism Diagnostic Observation Schedule – 2nd Edition (ADOS-2), and the Vineland Adaptive Behavior Scales – 3rd Edition (Vineland-3). Claimant had the following results on the ADI-R assessment: reciprocal social interaction 16 (cutoff 10); communication 9 (verbal cutoff 8); restricted, repetitive, and stereotyped patterns of behavior 2 (cutoff 3).[6] Dr. Mathess found claimant did not demonstrate restrictive and repetitive behaviors during the ADOS-2 administration, that the overall interaction between claimant and she was comfortable and appropriate to the context of the assessment, and that claimant's overall total ADOS-2 results showed claimant to not have ASD. Dr. Mathess concluded that because a DSM-V ASD diagnosis requires the person demonstrates restricted, repetitive patterns of behavior, interests or activities, as manifested by certain behaviors identified in the DSM-V, and during her evaluation

[6] Claimant scored in the low range on the Vineland Adaptive Behavior Scales Third Edition in communication and language functioning, independence and self-care, and social functioning. Though Dr. Mathess did not find that claimant has ASD, her evaluation included examples of how claimant's behaviors and characteristics impede his self-care and independence. At the time of this evaluation, claimant would at times leave home without telling his parents his whereabouts and would call an Uber or get in cars with strangers to go to Los Angeles, had taken video of himself on top of stopped trains at the train yard, and would urinate in the bathroom sink and defecate on the front lawn when he is upset or for no reason. In addition, Dr. Mathess noted claimant cannot use a spoon without spilling, is not careful around hot objects or when using sharp objects, and does not follow safety precautions in work or leisure activities.

claimant did not demonstrate these patterns of behavior, interests and activities, that claimant does not meet the criteria for an ASD diagnosis. Dr. Mathess recommended claimant be assessed for bipolar disorder and possible psychotic features due to claimant's behavioral challenges.

SERVICE AGENCY DETERMINATION

16. Based on Dr. Mathess's evaluation, the Service Agency determined claimant does not have ASD. Dr. Langenbacher, a Service Agency psychologist and part of the Service Agency intake team, further reviewed claimant's intake information and determined claimant was not eligible for services under the fifth category of eligibility for regional center services.[7] Dr. Langenbacher testified in support of Dr. Mathess's evaluation and conclusion. She reiterated Dr. Mathess's evaluation which found claimant does not demonstrate repetitive or restrictive behaviors. Dr. Langenbacher found this conclusion was supported by Dr. Mathess's observations that though claimant has difficulty with peer relationships and some reduced eye contact, his use of gestures seems appropriate and he has the capacity to initiate and have reciprocal communication. Dr. Langenbacher did not dispute Dr. Mathess's or Dr. Valdez's determinations that claimant did demonstrate ASD in the areas of communication and reciprocal social interaction. However, Dr. Langenbacher questioned the accuracy of Dr. Valdez's evaluation because Dr. Valdez did not administer the ADOS, a highly regarded test by professionals evaluating and working with children with ASD, and because based

[7] Under section 4512, a person may be eligible for regional center services under the fifth category if he or she has 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, but does not include other handicapping conditions that are solely physical in nature.

on her own experience adolescents with ASD demonstrate the symptoms more through isolation and social issues, and not with explosive behavior. Dr. Langenbacher was further convinced that claimant did not have ASD because of his clear history of ADHD, that he was not diagnosed with ASD at an early age, when it would have been expected, and because the AUSD did not find claimant had ASD under the Education Code's regulatory definition, a more lenient definition than the DSM-V.[8] (See Cal. Code of Regs., tit. 5, § 3030, subd. (b)(1).)

17. In its NOPA, the Service Agency informed claimant it found him not eligible for regional center services and recommended claimant receive the following: intensive mental health services, including medication management, and a residential treatment program; individual and family therapy through therapeutic behavior services; a mental health services assessment to rule out Other Specified Bipolar and Related Disorder as well as grandiose thoughts and other behaviors; that claimant continue with special education services and appropriate supports and services from school; and that claimant consider eligibility for special education services under Emotional Disturbance and consider a nonpublic school placement.

EVALUATIONS SUBSEQUENT TO SERVICE AGENCY DETERMINATION

July 2017 California Psychcare Psychological Assessment, Ani G. Nikolova, Ph.D., LP

18. Dr. Nikolova found that claimant displayed moderate symptoms of ASD based on the claimant's behaviors. (See Factual Findings 6-9.) Dr. Nikolova noted that though claimant has friends and enjoys spending time with them, he sees them as

[8] The fourth edition of the DSM, the DSM-IV, does not allow ADHD and autism to be diagnosed together. It was not until May 2013 that the DSM-V was published, which allows the comorbidity of ASD and ADHD.

opportunities to further his business of selling items, and not to maintain the friendships. As did Dr. Valdez, Dr. Nikolova noted claimant's irregular gait and lack of sustained eye contact, his restricted and repetitive behaviors (e.g., lining up shoes and organizing them into various categories), and though he maintained a conversation during the assessment, the conversation was focused on claimant's own interests, and he did not follow up with assessors' personal statements.

August 2017 California Psychcare Functional Behavioral Assessment and Treatment Plan, Kevin Lovelace, Behavior Interventionist

19. Herbert Chow, M.D., referred claimant for a functional behavioral assessment due to claimant's persistent deficits in social communication and social interaction, including his difficulty understanding facial expressions and gestures and adjusting his behavior to fit social contexts, safety concerns caused by claimant's aggression towards self and others, his lack of awareness of common environmental dangers, and his restricted and repetitive range of interest in conversation topics. Kevin Lovelace, behavioral interventionist, found that claimant had significantly challenging behaviors which included aggression and elopement which impacted his ability to participate in daily activities at home and in the community. Mr. Lovelace also found that claimant displayed several symptoms of ASD which required substantial support, including marked deficits in verbal and nonverbal social communication skills, social impairments apparent even with supports in place, limited initiation of social interactions, and reduced or abnormal responses to social overtures from others.

January 2018 Psycho-Educational Evaluation, Michael Salce, Ed.D., Spectrum Services

20. At the parents' request for an IEE, in January 2018 Dr. Salce conducted a psycho-educational evaluation of complainant. Dr. Salce administered multiple assessments, including the Childhood Autism Rating Scale – Second Edition (CARS2) and

the Gilliam Autism Rating Scale – Third Edition (GARS-3). Dr. Salce observed claimant across three school sessions and found claimant to be a talkative and socially impulsive male who walked with an even gait, whose speech was normal in rhythm and rate, and who perceives he can manage the expectations placed upon him by his current education plan. Claimant's raw score of 28 on the CARS2 assessment showed claimant to have mild-to-moderate symptoms of ASD. The GARS-3 assessment was based on responses from parents and two teachers, who rated claimant as very likely, probably, and unlikely to have ASD, respectively. Dr. Salce concluded that for the purpose of accessing his educational needs, claimant was consistently deficient in his ability to utilize attention, organization, and planning skills, and that these executive functioning deficits impeded claimant's ability to access the curriculum, making him eligible for education services under OHI, based on his diagnosis of ADHD. However, Dr. Salce found that ADHD did not explain all of claimant's behaviors, characteristics, or challenges. Dr. Salce determined claimant is eligible for special education services due to claimant's ASD, claimant's secondary disability in regards to IEP services.[9] Finally, Dr. Salce concluded that claimant did not present with Serious Emotional Disturbance.

21. Dr. Salce relied on the following information to support his conclusion that

[9] Dr. Salce used the Education Code's regulatory definition of Autism, as found in California Code of Regulations, title 5, section 3030, subdivision (b)(1), a different standard than the DSM-V ASD criteria: Autism means a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age three, and adversely affecting a child's educational performance. Other characteristics often associated with autism are engagement in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual response to sensory experiences.

claimant is eligible for special education services due to his ASD. Claimant had strengths in certain forms of communication; specifically his comprehensive/expressive and receptive language skills. Dr. Salce found these strengths significant given that across several raters (teachers and parents) claimant had such poor ratings in the area of social communication. Dr. Salce found this weakness and discrepancy to be characteristic of an adolescent with ASD. For example, Dr. Salce found claimant is extremely reliant on logical thought processes, even when situations may require a more emotional response, characteristics consistent with mild ASD. Further, claimant's restrictive interests in things such as clothing and shoes, and his perseveration on selling these items for a profit at the expense of others, has a significant impact on claimant's communication functioning and relationship development at home and at school, to the exclusion of more age appropriate topics and behaviors. Information provided to Dr. Salce by teachers and services providers provided additional examples of claimant's behaviors and characteristics which are not attributable to ADHD or an emotional disturbance, but are attributable to ASD. As an example, Carolina Hardman, the Supervising Behavioral Therapist at California Psych Care (where claimant receives therapeutic behavior services), reported that over the 20 sessions of therapeutic behavior services provided since October 2017, claimant had made some progress with his hyperactivity and impulsivity, but claimant's ASD characteristics negatively impacted further progress. She noted that no progress had been made on claimant's moderate to severe rigidity of thoughts and behaviors associated with his belongings.

22. Dr. Salce's evaluation also provided examples of how claimant's challenges interfered not only with his receptive and expressive language, but also with his learning and self-care. In regards to self-care, one example included in Dr. Salce's evaluation showed that Ms. Hardman had changed the hours for some delivery of services to assist claimant with his behaviors which interfere with claimant's ability to wake up and

prepare for school. Similarly, Dr. Salce found that claimant's social deficits, including his peer relationships that are less than age appropriate, his socially inappropriate and disrespectful behavior toward peers and staff, and his restricted and repetitive behaviors impeded claimant's access to learning and that the qualities of claimant's behaviors are not sufficiently explained solely by impulsivity and his other ADHD characteristics. Claimant's characteristics and patterns of thinking and cognitive integration skills led Dr. Salce to conclude that claimant has ASD which requires special education services.

EVIDENCE SUPPORTING CLAIMANT'S DSM-V ASD DIAGNOSES

23. ASD is defined by the DSM-V in section 299.00. ASD is present if a person has persistent deficits in social communication and social interaction across multiple contexts, as manifested by deficits in social-emotional reciprocity, nonverbal communicative behaviors used for social interaction, and in developing, maintaining, and understanding relationships. These manifestations can be current or historical, but the symptoms must have been present in the early developmental period, even if not fully manifested until social demands exceed limited capacities, or even if they were masked by learned strategies in later life. The symptoms must cause clinically significant impairment in social, occupational, or other important areas of functioning. In addition, an ASD diagnoses requires the person demonstrates restricted, repetitive patterns of behavior, interests or activities, as manifested by at least two of the following: repetitive motor movements (e.g., lining up toys), insistence on sameness or inflexible adherence to routines (e.g., rigid thinking patterns), highly restricted, fixated interests that are abnormal in intensity or focus, and hyperactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., adverse response to specific sounds or textures).

24. The DSM-V provides additional information about what may constitute an ASD diagnosis. The deficits in social-emotional reciprocity, nonverbal communicative

behaviors used for social interaction, and in developing, maintaining, and understanding relationships can include abnormal social approach and failure of normal back-and-forth conversation, poorly integrated verbal and nonverbal communication, and difficulties adjusting behavior to various social contexts, respectively.

25. The DSM-V also provides additional clarifying information about how ASD may present in adolescents or adults. For persons with ASD, in adults without intellectual disabilities or language delays, the impaired use of language for reciprocal social communication may show in difficulties processing and responding to complex social cues (e.g., when and how to join a conversation, what not to say). Deficits in relationships may demonstrate in adults who struggle to understand what behavior is considered appropriate, or who desire to establish friendships which are one-sided or based solely on shared special interests. The DSM-V provides that a small proportion of individuals deteriorate behaviorally during adolescence, and though the individual may have lower levels of impairment and may be better able to function independently, the individual may remain socially naïve and vulnerable, and may have difficulties organizing practical demands without aid. Finally, functional consequences of a substantial disability may include a lack of social and communication abilities which impede learning, especially through social interaction or in settings with peers; in the home, insistence on routines may interfere with routine care, such as haircuts, making these activities extremely difficult.

26. The Service Agency's determination that claimant does not have ASD as defined by the DSM-V was based on Dr. Mathess's assessment scores and evaluation results. Dr. Mathess did find claimant's behavior to be described by ASD, communication and reciprocal social interaction, but also found that claimant did not have repetitive and restrictive behavior. The Service Agency also relied on Dr. Langenbacher's assessment, which relied on Dr. Mathess's assessment and the fact that

the AUSD had not found claimant has ASD, the fact that ASD was not diagnosed earlier in claimant's life, and claimant's clear history of ADHD. However, multiple service providers and evaluators found claimant's ADHD diagnoses did not address all of claimant's symptoms, characteristics, behaviors, or challenges, and emotional disturbance and bipolar disorder have been ruled out. The Service Agency's conclusion is faulty based on the evidence of the numerous other assessments which are replete with examples of claimant's significant, historic, and frequently occurring repetitive and restrictive behaviors, observed more acutely when the evaluators, commentators, or service providers spent more than 30 minutes with claimant. In addition, Dr. Valdez administered the ADI-R and found he scored a five in the area of repetitive and restrictive behavior, well above the cutoff of three. Further, Dr. Salce concluded that for the purpose of the educational code's regulatory definition of ASD, claimant has ASD. While this definition is less stringent than the DSM-V definition, when reaching his conclusion, Dr. Salce did not question claimant's demonstration of repetitive and restrictive behaviors. Further, there was significant evidence of how claimant's characteristics and behaviors significantly impaired his social area of function, and that they posed significant functional limitations in claimant's self-care, receptive and expressive language, and his learning.

LEGAL CONCLUSIONS

1. The Lanterman Act governs this case. An administrative "fair hearing" to determine the rights and obligations of the parties is available under the Lanterman Act. (§§ 4700-4716.)

2. The party asserting a claim generally has the burden of proof in administrative proceedings. (See, e.g., *Hughes v. Board of Architectural Examiners* (1998) 17 Cal.4th 763, 789, fn. 9.) In this case, claimant bears the burden of proving, by a preponderance of the evidence, that claimant is eligible for Lanterman Act services.

(Evid. Code, § 115.)

3. A developmental disability is a disability that originates before an individual turns 18-years-old. This disability must be expected to continue indefinitely and must constitute a substantial disability for the individual. Developmental disabilities are limited to cerebral palsy, epilepsy, autism, an intellectual disability, or a disabling condition found to be closely related to intellectual disability or to require treatment similar to that required for an individual with an intellectual disability. Developmental disabilities do not include other handicapping conditions that are solely physical in nature. (Welf. & Inst. Code, § 4512, subd. (a), Cal. Code of Regs., tit. 17, § 54000.)[10]

4. A substantial disability is the existence of significant functional limitations in three or more of the following areas of major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency, as appropriate to the person's age. (§ 4512, subd. (*l*); Cal. Code of Regs., tit. 17, § 54001, subd. (a).)

5. As defined under the Lanterman Act, developmental disability does not include the following: 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; solely learning disabilities which manifest 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; and disabilities that are solely physical in nature. (Cal. Code of Regs., tit. 17, § 54000, subd. (c).)

6. Claimant's behaviors and characteristics meet the definition of ASD and he

[10] All further statutory references will be to the Welfare and Institutions Code unless otherwise noted.

is eligible for services under section 4512, subdivision (a) under the diagnosis of ASD. Claimant has persistent deficits in social communication and social interaction across multiple contexts, as manifested by his deficits in social-emotional reciprocity, nonverbal communicative behaviors used for social interaction, and in developing, maintaining, and understanding relationships. These manifestations are both current and historical, and the symptoms have been present since his early developmental period. Historically and currently claimant has demonstrated abnormal social approaches and a failure to have normal back-and-forth in conversation as appropriate to his age. Claimant has historically and currently demonstrated restricted, repetitive patterns of behavior, interests or activities, as found, by example, in him lining up toys and disassembling and assembling headphones and mechanical pencils, and by his highly restricted, fixated interests in accumulating items and selling items to his peers, with an abnormal intensity and focus. As well, claimant has a hyperactive response to sunlight, sound, and clothing textures. The evidence showed that his symptoms have been masked by service provider's sole focus on claimant's ADHD, and the more recent query into now dispelled questions about emotional disturbance and bipolar disorder. Claimant's symptoms cause him clinically significant impairment in social, occupational, or other important areas of functioning, as has been demonstrated by how his symptoms interfere with his school day, peer and family relationships, and self-care. Claimant's behaviors in his adolescence shows claimant continues to struggle to understand what behavior is considered appropriate, that he establishes one-sided friendships, and though he has some capacity to function independently, his behaviors impede common routine care needs, such as haircuts.

7. The DSM-IV does not allow ADHD and ASD to be diagnosed together. It was not until May 2013 that the DSM-V was published (claimant was already 11 years old), which allows the comorbidity of ASD and ADHD. The Service Agency's conclusion

that claimant does not have ASD was based in part on the fact that claimant has ADHD, and in part on the Service Agency's question as to whether claimant has a psychiatric disorder. However, Dr. Valdez determined claimant does not have bipolar disorder, and Dr. Salce determined claimant does not have emotional disturbance, the two psychiatric disorders the Service Agency questioned. In addition, multiple service providers and evaluators reported that ADHD does not significantly describe or address claimant's characteristics and behaviors. The accuracy and sufficiency of the Service Agency's conclusion that claimant does not have ASD falls short. Claimant did establish that he has ASD, comorbid with his ADHD.

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8. Claimant has a substantial disability as defined under section 4512, subdivision (*l*), and California Code of Regulations, title 17, section 54001, subdivision (a). Claimant's ASD symptoms pose significant functional limitations in the three major life activities of self-care, receptive and expressive language, and learning, and are a substantial disability for claimant.

9. Claimant did establish eligibility under the Lanterman Act under the category of ASD. For the foregoing reasons, claimant is eligible for services under the Lanterman Act.

ORDER

Claimant is eligible for services under the Lanterman Act. Claimant's appeal is granted.

DATED:

CHANTAL M. SAMPOGNA

Administrative Law Judge

Office of Administrative Hearings