BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: CLAIMANT, vs. TRI-COUNTIES REGIONAL CENTER, Service Agency.	OAH No. 2017070728

DECISION

The hearing in the above-captioned matter was held on January 16, 2018, in Simi Valley, California, by Joseph D. Montoya, Administrative Law Judge (ALJ), Office of Administrative Hearings. Claimant was represented by his grandmother, hereafter Parent.[1] The Service Agency, Tri Counties Regional Center (TCRC or Service Agency) was represented by Mary Ellen Thompson, Services and Supports Manager.

Evidence was received, the case was argued, but the record was held open so that parent could produce a copy of video played at the hearing. When the video was not received in a timely manner, the ALJ reopened the record so as to obtain the video. The record was reopened on January 31, 2018. The video was received on February 5, 2018, and is received as exhibit 17. The matter is deemed submitted for decision on that date.

[1] Titles are used in the place of the names in the interests of privacy. Claimant's grandmother has custody of him (along with her husband), and functions as his mother.

ISSUE PRESENTED

Is Claimant eligible for services from the Service Agency on the grounds that he suffers from autism spectrum disorder (ASD)?

As detailed below, Claimant established, by the required preponderance of the evidence, that he is eligible for services from the Service Agency.

FACTUAL FINDINGS

THE PARTIES AND JURISDICTION

1. Claimant is a six-year-old boy (born in October 2011) who seeks services from the Service Agency under the Lanterman Developmental Disabilities Services Act (Lanterman Act), California Welfare and Institutions Code, section 4500 et seq.[2] based on a claim that he suffers from ASD.

2. On May 17, 2017, TCRC notified Parent that he was not deemed eligible for services under the Lanterman Act. TCRC asserted that Claimant did not have an eligible disability within the meaning of the Lanterman Act. (Ex's. C, D.)

3. On July 13, 2017, Parent submitted a Fair Hearing Request, and this proceeding ensued. (Ex. E.) The matter went to mediation, and further assessment steps were taken, but the parties could not resolve the case. It then went forward for hearing on January 16, 2018, as noted above. All jurisdictional requirements have been met.

CLAIMANT'S FAMILY HISTORY AND GENERAL BACKGROUND

4. Claimant and his older brother live with their paternal grandparents, who are their legal guardians, within the Service Agency's catchment area. Claimant's biological

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

parents have been separated since he was an infant. His mother has no presence in his life her whereabouts are unknown—but he sees his father, who lives in Kern County, with some regularity. Both of his parents struggled with drug and alcohol addiction, though it appears that his father's situation has improved. Claimant's older brother receives services from TCRC because he suffers from ASD.

5. In addition to her problems with drugs and alcohol Claimant's mother suffered from uncontrolled diabetes. Parent does not believe that Claimant was exposed to drugs in utero, and it has not been established that any of his behaviors flow from fetal drug or alcohol exposure, though there is some speculation about that in the record. Claimant met motor milestones in a timely manner, and was using words at 12 months, and two and three word sentences at 30 months. (Ex. I, p. 2.) He sat unassisted at seven months, crawled at nine months, and walked at 14 months. (Ex. 1, p. 6.) Toilet training was difficult, taking longer than expected. As an infant he whined and cried. (Ex. I, p. 2.) He received "Early Start" services from TCRC until he was three-years-old. It is reported that the Early Start services were for speech and language delay, and that the services commenced when Claimant was 18 months old. (Ex. M, p. 2.) He has been receiving special education services from his school district since he turned three.

DIAGNOSTIC CRITERIA FOR ASD

6. In the assessments discussed below, references are made to the diagnostic criteria for ASD. Explication of those criteria is appropriate at this point.

7. (A) The Diagnostic and Statistical Manual, Fifth Edition, commonly known as the DSM-5, is a standard reference manual used by mental health professionals to diagnose developmental disabilities, and various mental disorders. It is utilized by the Service Agency and other regional centers to determine if a person suffers from one of the developmental disabilities that might establish eligibility. A copy of the portion of the DSM-5 diagnostic criteria that pertains to ASD was received as exhibit K. However,

citations to the balance of the DSM-5 pertaining to ASD may be necessary hereafter. Citations to the DSM-5 shall be to its page numbers.

(B) The Lanterman Act defines autism as one of the developmental disabilities that makes a person potentially eligible for services from the regional centers. (See Legal Conclusions 2 & 5(B), below.) That is the term that has been used for many years in the applicable statute. However, the definition of autism, and indeed, the name for that disorder, was substantially revised with the May 2013 publication of the DSM-5. "Autism Spectrum Disorder" is now the diagnostic nomenclature, and it encompasses several diagnostic criteria previously used in the DSM-IV-TR, the prior and now superseded version of the Diagnostic and Statistical Manual. Thus, individuals who in the past might receive a diagnosis of autistic disorder, Asperger's disorder, or PDD-NOS, might now receive the diagnosis of Autism Spectrum Disorder, if the new criteria are otherwise met. (DSM-5, at 51.)

8. The DSM-5 provides a summary description of ASD, stating that it is characterized by persistent deficits in social communication and social interaction across multiple contexts, including deficits in social reciprocity, nonverbal communicative behaviors used for social interaction, and skills in developing, maintaining, and understanding relationships. In addition to the social communication deficits, the diagnosis of ASD requires the presence of restricted, repetitive patterns of behavior, interests, or activities. Because symptoms change with development and may be masked by compensatory mechanisms, the diagnostic criteria may be met by historical information, although the current presentation must suggest significant impairment. (DSM-5, pp. 31-32.)

9. The DMS-5 diagnostic criteria for ASD were relied upon by the experts in this case. As can be seen from the quote that follows, there are four main criteria, the first two having subparts. To make a diagnosis of ASD, all of the tests set out in part A must be

met, and at least two of the four set out in part B must be met. The criteria are as follows:

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

1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history:

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).

3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).
4. Hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sound or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

C. Symptoms must be present in early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).

D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

SCHOOL ASSESSMENTS AND SERVICES

10. (A) The Simi Valley Unified School District (District) conducted an assessment of Claimant in September 2014, one month before his third birthday. It is inferred he was being assessed for special education services because his early intervention services from TCRC were about to run out. The assessment report, exhibit 16, indicates that he had been receiving speech services up until that point.

(B) The assessment concentrated on speech and language; there is no indication that his IQ was tested, nor was ASD considered. It was determined that Claimant suffered from a language disorder, as he had an expressive or receptive language disorder that would adversely affect his educational performance. (Ex. 16, pp. 3-4.)

11. A 2016 report by Shiro Perera Torquato, Ph.D. (ex. M), references some special education documents not independently received in evidence. Dr. Torquato's report discusses more than one Individual Education Plan (IEP) generated between 2014 and 2016. In 2015, when he was in preschool, Claimant was receiving speech and

language services for 105 minutes per week, but he was in a general education classroom. The District perceived that he had met goals in April 2016, and therefore indicated he was no longer eligible. Parent objected to that, and further assessments were conducted. (Pp. 6-7.) As set out in Factual Finding 31, a November 2017 speech and language assessment recommended further speech and language therapy.

12. Special education services did not terminate, and they continued when Claimant went to kindergarten, and thereafter. Thus, by November 2017, when Claimant was in first grade, he continued to receive speech and language consultation, and the District began providing social skills interventions on a weekly basis during that month. (Ex. 6, 2d page.)

13. Parent and Dr. Torquato testified that the social skills interventions were recommended by an experienced teacher at the school site, who perceived, unlike his classroom teacher, that intervention was needed. The teacher making the recommendation is a resource specialist. (Claimant's classroom is a general education classroom.) According to an assessment plan from November 2017, Claimant engages in parallel play with peers, but has social needs, and he needs adult help to navigate peer conflict or situations that are frustrating. And, it was reported that by October 2017, he was having weekly tantrums that had escalated into property destruction and physical aggression toward adults, as well as elopement off campus. (Ex. 6, 3d page.)

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SERVICE AGENCY ASSESSMENTS

14. (A) When Parent sought Lanterman Act services for Claimant, TCRC conducted an intake assessment, on November 29, 2016. The intake was performed by Edward L. Perez, LCSW/MFT. Perez is the Intake Service Coordinator for the Service Agency, and has many years of experience.

(B) Claimant and Parent were both present during the intake, and Parent provided information, including some reports, to Perez. It was reported that there are some motor limitations, as he sometimes fell when running, could not catch a ball, and threw one with limited control. He had enough fine motor to attempt printing, but could not legibly print his name. He had trouble with buttons. (Ex. A, p. 2.) For eating, he needed a lid on a cup to prevent spilling. He could use a fork or spoon, but not a knife. He was toilet trained at the time of the intake interview. He could perform many tasks of personal care, with prompting, but needed Parent's full assistance for bathing or showering. He could dress himself but needed help with fasteners. He needed someone nearby to help avoid harm in unfamiliar settings. He would play with Lego's for 30 minutes or more. In terms of safety awareness, he knew to look for cars and to look before crossing the street, but due to impulsive behavior, still needed to be accompanied. He had not developed age appropriate separation anxiety, and when frustrated would sometimes whine instead of seeking help. (*Id.*, p. 3.)

(C) Parent described Claimant's social and behavioral function to Perez. She indicated that in an unfamiliar social setting he would not initiate, but would respond to another child and played with them if interested. In a familiar setting at school, he might talk to someone who is close to the play equipment that Claimant was interested in, but most of the time he showed limited to no interest in engaging his peers. He could play interactive board games, with difficulty listening and following along. Parent reported that Claimant engaged in ritualistic behaviors centered around hand washing, he liked spinning objects, and liked playing alone. He had sensory issues related to some noises, and he had a restricted range of interests that were limited to solitary activities, such as swinging, at the same time not liking interactive activities with other children. He exhibited problems with change and transition unless he saw other kids transitioning. She reported Claimant usually responded to others when called. (Ex. A, pp. 4-5.)

(D) Perez reported that during the interview Claimant responded consistently when called upon, answering basic questions with one word responses, but showed "noticeable difficulty" answering questions requiring expressions of his thoughts and feeling. Claimant told Perez his age and birthday, and Perez reported that the boy engaged Perez on a reciprocal level verbally when Perez directed and maintained the conversation about a friend Claimant liked at school. According to Perez Claimant did not display any behavioral excesses or stereotypes, but showed some evidence of possible attention difficulties. (Ex. A, p. 4.)

(E) Perez recommended that Claimant undergo psychological testing to establish whether Claimant suffered from ASD and was substantially disabled by it. He did not believe that Claimant suffered from Intellectual Disability or any other eligible condition. (Ex. A, p. 7.)

15. (A) The Service Agency's first psychological assessment of Claimant took place on December 14, 2016, when Claimant was five years, two months of age. The assessment was conducted by Tammy K. Brandt, Psy.D., who is a licensed educational psychologist. She wrote an assessment report which was received in evidence as exhibit I.

(B) Dr. Brandt reviewed the intake assessment report, a District speech and language assessment and another speech evaluation, and she utilized test instruments, including parts of the Stanford Binet V, an IQ test; the Adaptive Behavior Assessment System (ABAS-3); and the Autism Diagnostic Observation Scale-II (ADOS), module 2. (P. 1.) She also used the Gilliam Autism Rating Scale-3 (GARS-3). (P. 6.)

(C) Two subtests of the Stanford Binet were utilized. On the Knowledge Factor subtest, Claimant's score was a 97, well in the average range. On the other subtest, Fluid Reasoning, his score was in the low average range. Dr. Brandt noted that Claimant performed significantly better on the nonverbal subtest than on the verbal one; this is especially true when the Fluid Reasoning score is considered. (Pp. 5, 10.)

(D) Parent served as the reporter when the GARS-3 was used. That instrument is used to screen for possible autism. The overall score fell within the "very likely" probability of ASD, with a severity level of 3, requiring "very substantial support." (P. 6.)

(E) Parent also served as the informant when the ABAS-3 was utilized. His overall General Adaptive Composite score was 75, in the low range, placing him in the fifth percentile. (Pp. 5-6.)

(F) The ADOS, module 2, was utilized as it is considered the module appropriate for children with phrase speech who are not yet fluent, meaning children not yet consistently combining two relatively complex ideas together in sentences to talk about object or events that are not present. Claimant's overall score was a seven, just below the autism cutoff score of eight. His score on social affect was a five, and his score for restricted and repetitive behaviors was a two. A comparison score of three was found, which Dr. Brandt indicated meant that Claimant fell into the low evidence of ASD related symptoms when compared to other children with his language level, and his age. (Pp. 6-7, 10.)

16. (A) Dr. Brandt used the DSM-5 to determine if Claimant had ASD. As detailed above, the diagnostic criteria requires, in Part A, deficits in use or understanding of social communication and social interaction, manifesting in three areas. Those areas are deficits in nonverbal communicative behaviors for social interaction; deficits in social-emotional reciprocity; and, deficits in developing and maintaining relationships appropriate to developmental level. Further, Part B requires findings of restricted repetitive patterns of behaviors, interests, or activities. These patterns must be shown in at least two of four areas.

(B) Dr. Brandt "endorsed" findings that Claimant met all four of the possible criteria in the area of restricted, repetitive patterns of behavior, interests or activities (Part B). But, she found that he only met two of the three criteria from Part A, relative to the areas of social communication and social interaction. That is, she endorsed findings of deficits in

nonverbal communication and in developing and maintaining relationships, although the endorsement of that latter area was "mild." (Pp. 7-8.) She did not find deficits in social-emotional reciprocity.

(C) Dr. Brandt concluded that Claimant did not meet the DSM-5 criteria for ASD although he did present with many behaviors associated with it. She recommended that the clinical team make the final determination.

17. Since Dr. Brandt's report, three other efforts at assessment have been made by TCRC; two have been conducted at Claimant's school, and the other was conducted at TCRC by Dr. Brandt and Robert E. Nopar, M.D., the staff physician for TCRC.

18. Dr. Brandt and Dr. Nopar observed Claimant on February 14, 2017. They met with Parent and Claimant, and Parent provided two reports written by Dr. Torquato, who had diagnosed Claimant with ASD. They concluded that his behaviors were similar to what was seen during Dr. Brandt's ADOS test. According to their report, Claimant greeted them appropriately, and he shared enjoyment and played with a variety of toys in an appropriate way. He brought toys to them and referenced adults. After a few minutes he played quietly and appropriately with only two toys and no longer engaged with the two clinicians. However, when it was time to leave, he tantrummed, became non-compliant, refused to help clean up, and he whined and protested. The two reviewed the matter with Parent, and stated that they would like to perform a school observation. (Ex. G.)

19. (A) Dr. Brandt performed a school observation on May 10, 2017. She spent 50 minutes observing Claimant, the first 25 minutes in the classroom, and the balance outside in the playground.

(B) In the classroom, Dr. Brandt observed that Claimant, when working on a project at a table with other students, spoke to another student using coordinated eye contact. She observed him to initiate conversation with another boy, as well as respond to overtures from a girl. When he was out of the classroom on recess, he sat at a table with

other children and was seen to initiate conversation with a boy who was sitting near him,

(C) During recess, Dr. Brandt observed Claimant sitting at a table with three boys and a girl, while they ate snacks. He initiated conversation with one of the boys, and talked to peers. She described an interaction where he had another child watch him while he licked his lips, and when that child did the same thing, Claimant smiled. Dr. Brandt observed other interaction between Claimant and peers at and around a swing set, which included him gesturing and smiling, and taking turns on the swing. (Ex. H, p. 1.)

(D) In her summary, Dr. Brandt described Claimant as able to engage in reciprocity with peers, that he pointed out items of interest to others, and that he showed an interest in his peers. She deemed her observations to support prior findings that Claimant could engage in appropriate levels of social communication.

20. (A) The Service Agency conducted a second school observation on October 4, 2017. It was conducted by a staff psychologist, Ronald Brand, Ph.D. His report is found at exhibit J.

(B) Dr. Brand gave various examples of Claimant interacting with peers, or his teacher. However, he also stated in the first paragraph of his report that during the session in class, and during the overall observation, "[Claimant] was usually distracted and appeared to be lost in his own world." (P. 1.) He observed Claimant and another student in a speech class, working with an interactive video. Back in the main classroom, Claimant would "briefly" engage a peer, and he would participate in the instructional activity when called on. He showed interest in a handicapped child and appeared to try and help her. When a dancing video was shown, he danced, and took the hand of the girl next to him, and they danced together. (*Id.*)

(C) During a recess, Claimant spent some time eating in the classroom, and he sat with his handicapped peer, showing some interest in her. He went outside, and sat with some other girls, and then ran to the play structure. Dr. Brand observed him laughing

while other students chased him around the fixture, and Claimant appeared to be interacting appropriately. However, he was knocked down, and taken to the nurse's office, which ended Dr. Brand's observation time. (P. 1.)

(D) Dr. Brand reviewed the diagnostic criteria for ASD against his observation of Claimant. He stated that he observed some "soft-symptoms that could be attributed to autism spectrum disorder, but did not observe enough significant symptoms that would support a full diagnosis . . . ." (P. 2.) Thus, despite the interaction he observed, Dr. Brand stated that Claim had some difficulty engaging with peers. He noted that Claimant had some "soft signs" where his eye contact "can be fleeting." (*Id.*) Regarding the diagnostic criteria pertaining to deficits in developing and maintaining relationships, Dr. Brand stated that "[Claimant] has difficulty maintaining relationships, however he does attempt to adjust and try to engage other children and shows some capacity for empathy as he is able to help a child less fortunate than he." (*Id.*) Dr. Brand stated that Claimant had engaged in toe-walking, but otherwise stereotypic behaviors were not observed.

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ASSESSMENTS BY DR. TORQUATO

21. Dr. Torquato is a licensed clinical psychologist. She has assessed Claimant on two occasions, issuing two reports. The first report was issued in late 2016. The second report was issued on February 8, 2017; it is denominated as an addendum to the earlier report.[3]

22. (A) The report from late 2016 is found at exhibit M. It shows assessment work on nine days between September 7, and November 23, 2016. It reveals that Dr.

[3] The second report states a date of assessment, and a date of report. The first identifies several dates of assessment in late 2016, but it does not state a date of report.

Torquato used a number of test instruments, including the Wechsler Preschool and Primary Scale of Intelligence, fourth edition (WPPSI-IV), and the Woodcock-Johnson Fourth Edition Tests of Achievement. She also utilized two versions of the Child Caregiver Checklist and the Bender Visual Motor Gestalt Test, Second Edition. She performed a classroom evaluation, interviewed Claimant and Parents, and she reviewed records. (Pp. 1-2.)

(B) Claimant's full scale IQ was 93, placing him in the average range. Subtests for visual spatial and processing speed had the two lowest scores, the former score being in the ninth percentile, the latter at the 18th percentile. (P. 10.) Academic achievement, tested with the Woodcock-Johnson, showed Claimant processing just above age-level in reading and written language, but he was well below age level in math. (P. 11.)

(C) Dr. Torquato had both Parents, as well as his teacher, complete the Childhood Behavior Checklists. The Parents' responses indicated clinically significant scores pertaining to aggression, social problems, attention problems, and thought problems. On the other hand, the teacher's responses did not indicate any concerns. "These results suggest that despite exhibiting numerous behavior problems at home, in the school setting [Claimant] has very typical behavior for a boy his age." (P. 13.) A similar dichotomy occurred when the Parents and the teacher completed the Sensory Processing Measure. Parents' responses indicated potential sensory integration problems, and definite sensory dysfunction, while teacher's responses did not indicate any issues. Finally, Parent and teacher completed the Social Responsiveness Scale-2, and the same divide appeared. Parent's response indicated moderate deficiencies reciprocal social behavior associated with awareness and motivation, cognition, and ritualistic behavior. But, the teacher's responses placed Claimant in typical range on four domains, with only social motivation falling in the subclinical range. (Pp. 14-15.)

(D) During her interaction with Claimant, he had insisted on going to the bathroom

more than once. Parent explained that he just wanted to wash his hands. He wanted to do so more than once during an assessment session. When the bathroom ran out of soap, Claimant insisted on going home because he had to wash his hands. Dr. Torquato convinced him that he could use soap in her office, and the boy did so. But, soon, he was again claiming the need to use the restroom. During her school observation of Claimant, Dr. Torquato saw Claimant get up during the middle class, and go and wash his hands.

(E) When Dr. Torquato observed Claimant at school, in and out of the classroom, she found minimal interaction with peers. She described him as walking around the playground observing others, but not necessarily joining in. While eating his snack, Claimant did not interact with the students sitting around him. He did hold the hand of a girl in his class while the students lined up to go back to class, but this appeared to her as a rare interaction. (Pp. 7-8.)

(F) Dr. Torquato stated that taken together, it appeared that at home Claimant was exhibiting numerous behaviors suggestive of ASD. But, it was noted that his brother suffers from ASD, was then receiving TCRC services, and that Claimant's behavior could be imitative of his older brother. Dr. Torquato gave a diagnostic impression of Generalized Anxiety Disorder and Expressive Language Disorder by previous evaluation. She provided "rule out" for ASD, Visual Processing Disorder, and Auditory Processing Disorder. (P. 15.) In her lengthy summary, Dr. Torquato discussed Parent's concern that Claimant might be exhibiting "mild" symptoms of ASD, given his brother's diagnosis. She also discussed the fact that at school the behaviors were not being observed and reported. She stated that Claimant might be mimicking his brother's behaviors at home, but expressed concern that as Claimant got older and moved on in school, gaps in his social and communication skills might surface, more clearly pointing to ASD. She advised, therefore, careful monitoring over the next two or three years.

23. (A) Dr. Torquato conducted another assessment on February 6, 2017, and

issued her addendum report on February 8, 2017. She noted that previously there had been concern that Claimant was imitating his brother's behavior, but noted that therapy had been improving the brother's behavior, while Claimant's continued to be problematic. (Ex. N, p. 1.)

(B) Dr. Torquato administered the Autism Diagnostic Interview-Revised (ADI-R). The ADI-R is known as a "gold standard" instrument, the ADOS having that same status. The latter is typically used when observing the person being evaluated for ASD. The ADI-R is not administered to the subject being evaluated, but instead is used to obtain information from other informants. Here, that informant was Parent.

(C) In all four domains of the ADI-R Claimant met the diagnostic cut-offs. In the area of Reciprocal Social Interactions, the score was 18, where the diagnostic cutoff is 10. The score for the Communication domain was 16, where the cutoff is 8. In the area of Stereotypical Behaviors, the score was 7, where the cutoff is 3. Finally, in the domain of Abnormal Development, the score was 4, where the cutoff is 1. (Ex. N, p. 2.)

(D) The report was replete with examples of symptomatic behavior, much of which was discussed during the hearing.

DIAGNOSIS BY VENTURA COUNTY BEHAVIORAL HEALTH

24. According to a letter from Victoria Goltsman, M.D., Claimant had a psychiatric evaluation on October 31, 2017, where he was "diagnosed with symptoms of Autism Spectrum Disorder. No consistent symptoms of ADHD were identifies (sic) at this point. He has Expressive Language Disorder according to previous speech evaluations." (Ex. 4.) Dr. Goltsman is a Child and Adolescent psychiatrist with Ventura County Behavioral Health.

25. No details were provided as to how the diagnosis was reached. The County is funding some therapeutic interventions for Claimant.

PROVISION OF APPLIED BEHAVIORAL ANALYSIS (ABA) SERVICES BY FIRST STEPS

26. According to a report issued by First Steps for Kids, Inc. (First Steps) on August 1, 2017, Claimant began receiving behavioral interventions on April 4, 2017. This was based on Dr. Torquato's reports, diagnosing Claimant with ASD. The services started at eight and one-half hours per week. (Ex. 11.)

27. The reports of the provider indicated behaviors of the type associated with ASD. According to the August 2017 report, he was tantrumming at the rate of .3 times per hour. He was eloping .6 times per hour. The ABA providers were concerned with that behavior because he would run across the street, placing himself at risk. Claimant was exhibiting perseverative statements at the rate of .4 times per hour during instructional sessions. As an example, he continued to ask his interventionist about her car after that question had been answered, and after new conversation topics or activities had been attempted. (Ex. 11, p. 8.) It was reported that during play opportunities with peers or his brother, Claimant did not independently initiate or join in social play, instead opting to play with much younger play partners or he would play alone. If prompted to join social play, he would engage in maladaptive behavior if the play activity was not his preferred choice. (*Id.*, p. 9.) He was observed to be both physically and vocally non-compliant when he was presented with social play choices that were not of his selection or preference. (*Id.*, p. 10.)

28. A report by First Steps dated December 1, 2017, was received as exhibit 12. It states that there had been improvement in maladaptive behaviors, but they had not been eliminated or replaced. Tantrum behavior had reduced to .2 times per hour, but it remained an area of concern. He still exhibited aggressive behavior. (Ex. 12, p. 9.) Elopement had been reduced to .24 times per hour. In the area of social play, it was reported that Claimant was learning to engage in cooperative social play and did so for about five minutes once the activity had been facilitated by an adult. "He does not yet

independently join social play opportunities that are not his choice, and he often protests when prompted to do so." (*Id.*, p. 13.) He was improving his ability to negotiate play opportunities, and he had developed new play activities, but "his play remains limited in scope and duration." (*Id.*)

29. Despite improvement, continued ABA services were recommended in the December 2017 report.

NOVEMBER 2017 SPEECH/LANGUAGE EVALUATION

30. Some speech and language assessments were available, though it appears that some were not offered by either party, as Claimant's receipt of speech services began in 2013 under the aegis of the Early Start program.

31. (A) Priti Shah, M.S., CCC/SLP, a licensed speech and language pathologist, issued a report dated November 5, 2017, based on an assessment conducted on October 19, 2017.

(B) During the testing period, Claimant's level of activity was seen as atypical for his age. He was fidgeting and squirming, and rubbing his body on the rug, seemingly to obtain sensory input. He asked for frequent breaks to get a drink or use the restroom, which was considered by the assessor as an avoidance behavior.

(C) The Clinical Evaluation of Language Fundamentals-Five (CELF-5) was administered. In eight subtests, Claimant scored in the below average to average range, anywhere from the ninth to seventy fifth percentile.[4] However, scores on the "pragmatic

[4] A chart on page two of the report shows various subtests falling into the average range, even though percentile scores were as low as ninth percentile. In the discussion of the subtests, two subtests charted in the table as average scores are described as below average in the text that follows. (Compare p. 2 with p. 4.)

profile," for which Parent, Claimant's ABA therapist, and a teacher responded, brought scores well below average. The results of Parent's responses placed Claimant at the .4 percentile, and the ABA therapist score placed him in the first percentile. The report by the teacher placed him in the ninth percentile. (Ex. 5, p. 2.)

(D) According to the report, Claimant's ABA therapist, Ms. Sheenan, reported that Claimant often responded to greetings to and from others, and showed a sense of humor during communication. However, he only "sometimes" observed turn-taking rules, and "never or almost never" began or ended conversation appropriately, maintains eye contact, joined or left conversation appropriately, nor did he adjust body language appropriately. (Ex. 5, p. 6.) Other pragmatic communication deficits were reported by Parent and the teacher, Ms. Reitz.

(E) In the summary, it was reported that there was a statistically significant difference in scores for expressive and receptive language skills, the former being the stronger of the two. While Claimant had age appropriate social language skills, he presented with significant deficits in the area of social communication skills. "Though [Claimant] presents with knowledge of social language skills, he has significant difficulty implementing them in his day to day life." (Ex. 5, p. 7.) Speech and language services were recommended, and it was further recommended that he receive services to improve his functional social communication skills. (*Id.*)

TESTIMONY RECEIVED DURING THE HEARING

32. During his testimony, Mr. Perez stated that he had to initiate and direct conversation with Claimant during the intake assessment process. But, across 90 minutes, Claimant did not show overt behavioral issues of the type to be expected from a person with ASD. Perez did testify that Claimant spoke in single word phrases, and there was no spontaneous initiation of conversation by Claimant. Perez also testified that Dr. Torquato is well known, and a former vendor of TCRC, and her recommendation was sufficient to

trigger the assessment process.

33. Dr. Nopar testified about his assessment of Claimant, acknowledging that it was not a formal structured assessment. Notwithstanding that, Dr. Nopar was of the opinion that Claimant did not meet the diagnostic criteria of ASD in the DSM-5. He perceived the boy as socially interactive, with good eye contact, and who could engage with others. Claimant returned greetings, and he had no problem, in Dr. Nopar's view, with non-verbal communication.

34. Dr. Brandt testified about her assessment efforts, and gave her opinion that Claimant does not suffer from ASD. She described Claimant's behavior, in the diagnostic category A2, as of mild severity. She testified that while she endorsed Claimant as meeting the criteria of part A3—peer relationships—she testified that after she saw him at school she would no longer endorse in that area. Regarding the school observation, she stated he did not isolate himself, and he shared joy. Based on the school observation, she would no longer endorse a finding that he met the criteria in category A2. However, she did find substantial disability in self direction.

35. (A) Dr. Torquato pointed out in her testimony that higher functioning autistic children often communicate better with adults, or children younger than themselves, than they do with peers, and this would explain Claimant's communication with Dr. Brandt and other assessors. She pointed out that during her school observation, Claimant interacted more with two girls, one who is in a wheelchair, and one in his speech class, than he did with boys his own age. In her experience, young boys with ASD are less likely to play with other boys. She noted the fact that an experienced teacher pressed for social skills training at the November 2017 IEP is evidence that Claimant's problems at school go beyond problems with speech and language. That teacher has been pulled into Claimant's class or the playground due to Claimant's "meltdowns," and that teacher has taken Claimant into her Special Day Class to calm him down.

(B) Dr. Torquato opined that Claimant is substantially disabled in the area of self-care because of his dangerous behaviors. She finds him substantially disabled in the area of self-direction, in part because he has trouble managing his emotions. She finds him substantially disabled in the area of language, pointing to the fact he has needed speech and language therapy since he was 18 months old, and pointing to the findings of poor pragmatic speech as recently as November 2017.

36. Parent provided testimony that highlighted some of the behaviors that support a finding of ASD. She described his obsession with hand washing, and an obsession with burnt out light bulbs; they must be tested regularly by turning on all the lights. He insists on a fire drill at home every day. His food preferences are limited to pizza, macaroni and cheese, and fruit loops. His eye contact is fleeting, and he tends to be in his own world. He exhibits toe walking, and has rituals, such as opening the garage door. She recounted a story about him insisting another family member obtain the same cable services as are available in his home. Parent described Claimant as having no fear, and he had recently run off of the school grounds, and was nearly hit by a car. She testified that Claimant is currently receiving occupational therapy, and that a county psychologist has been going to the school site. The ABA services are provided five days per week, two and one-half hours per day.

LEGAL CONCLUSIONS

JURISDICTION

1. Jurisdiction exists to conduct a fair hearing in the above-captioned matter, pursuant to section 4710 et seq., based on Factual Findings 1 through 4.

LEGAL CONCLUSIONS PERTAINING TO ELIGIBILITY GENERALLY

2. The Lanterman Act, at section 4512, subdivision (a), defines developmental disabilities as follows:

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

3. (A) Regulations developed by the Department of Developmental Services, pertinent to this case, are found in title 17 of the California Code of Regulations (CCR).[5] At section 54000 a further definition of "developmental disability" is found which mirrors section 4512, subdivision (a).

(B) Under CCR section 54000, subdivision (c), some conditions are excluded. The excluded conditions are:

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

[5] All references to the CCR are to title 17.

disorders even where social and intellectual functioning have become seriously impaired as an integral manifestation of the disorder.

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

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

4. Section 4512, subdivision (l), provides that,

> "substantial disability" means the existence of significant functional limitations in three or more of the following areas of major life activity, as determined by a regional center, and as appropriate to the age of the person:

(1) Self-care.

(2) Receptive and expressive language.

(3) Learning.

(4) Mobility.

(5) Self-direction.

(6) Capacity for independent living.

(7) Economic self-sufficiency.

5. (A) To establish eligibility, Claimant must prove, by a preponderance of the evidence, that he suffers from an eligible condition, in this case Autism. This Conclusion is based on section 4512, subdivision (a) and Evidence Code section 500. He must also prove

that he has a substantial disability as a result of his eligible condition, within the meaning of section 4512, subdivision (l).

(B) For many years, the undersigned and other ALJ's have considered that since the governing statute uses the term autism, and did not use the term Autism Spectrum Disorder, Asperger's Disorder, or PDD-NOS, then only the former condition was an eligible one. However, since the DSM-5 has been published, the term Autistic Disorder has been abandoned by the professionals who diagnose and treat the condition. When used in a statute, technical words are given their peculiar and appropriate meaning. (*Handlery v. Franchise Tax Bd.* (1972) 26 Cal.App.3d 970, 981; Civ. Code § 13.) Because that technical definition has changed, it appears appropriate to use the provisions of the DSM-5 to determine eligibility in this area. Otherwise, an absurd result could follow; that nobody could obtain services under the statutory rubric of autism. And, while it might be argued that the DSM-IV definition should continue to bind the definition of the condition, it has to be noted that the definition of autism was substantially different under the DSM-IV than it had been in prior editions of the DSM. Since the Lanterman Act was enacted in the mid-1970's, the DSM definitions of autism have changed more than once, without barring services to those deemed autistic within the technical definition then in place. The definition has changed again, and the latest definition is utilized.

6. (A) In this case a number of qualified experts have assessed Claimant for ASD. While the TCRC staff do not believe Claimant meets the diagnostic criteria, Dr. Torquato, who enjoys the professional respect of the TCRC staff, disagrees. That there is disagreement itself does not establish that any one of the experts lacks credibility.

(B) There are differences in the opinions of Dr. Brandt and Dr. Brand. The former endorsed findings that Claimant met all four of the subparts of the part B diagnostic category. Dr. Brand thought only one was marginally applicable. Dr. Brandt was basing her findings on Parent's reporting, while Dr. Brand was basing his on what he saw during

his truncated observation at the school site. It may be found that Dr. Brandt and Dr. Torquato are in agreement that Claimant meets at least two of the four criteria that make up part B of the overall diagnostic criteria.

(C) Turning to the part A diagnostic criteria, Dr. Brandt initially endorsed one of the part A criteria, and mildly endorsed another. Dr. Brand found soft support for all three. Hence, Dr. Brandt initially found that Claimant had deficits in nonverbal communicative behaviors used for social interaction. (Ex. I, p. 7.) She did not find deficits in social-emotional reciprocity, and she no longer mildly endorses a finding that Claimant has deficits in developing and maintaining relationships. (Id., Factual Finding 34.) Dr. Brand observed Claimant to have difficulty with maintaining relationships, but found he attempted to adjust and to engage other children, showing empathy.

(D) Dr. Nopar perceived a child who could engage socially with others, making good eye contact and communicating with him and Dr. Brandt.

(E) However, the reports by school personnel, or by those providing behavioral interventions, don't paint such a good picture. The latter described Claimant as having problems engaging with others,[6] preferring to be alone or with younger children; when invited to participate in social play he engaged in maladaptive behavior if the play was not of his choice. This is reasonably consistent with Dr. Brand's observation that Claimant tended to be in his own world, and that he had trouble maintaining relationships. By December 2017, despite several months of behavioral interventions, he still did not

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[6] Which may be consistent with Mr. Perez noting that Claimant engaged in a reciprocal conversation that Perez had to direct and maintain. Likewise, Claimant had "noticeable difficulty" answering questions that required expressions of thoughts or feelings, which implicates a reduced sharing of feelings, a factor in criteria A-1.) (Factual Findings 14(D), 32.)

independently join social play opportunities, that were not of his choice. (Factual Findings 27, 28.) A school assessment plan generated in November 2017 (shortly after Dr. Brand's observation) stated Claimant was engaging in parallel play, and needed adult help to navigate peer conflicts and frustrating situations. (Factual Finding 13.)

(F) The reports by a teacher and an ABA therapist to Priti Shah in October 2017 indicate that Claimant has substantial deficits in social communication. He was described as "never or almost never" maintaining eye contact, nor did he adjust body language appropriately. (Factual Finding 31(D), citing ex. 5.) Further, he was described as not beginning or ending conversations appropriately, and he only "sometimes" observed turn-taking rituals in his social communication. That the ABA therapist's information led to a finding that Claimant was in the first percentile in the area of pragmatic social communication is significant.[7]

(G) These third-party reports indicate that there are recent deficits in social-emotional reciprocity and in nonverbal communication, notwithstanding the school observations by Dr. Brandt and Dr. Brand. These reports support Dr. Torquato's diagnosis of ASD.

7. On the issue of substantial disability, Dr. Brandt and Dr. Torquato agree that Claimant is substantially disabled in the area of self-direction. Dr. Torquato's finding that Claimant is substantially disabled in terms of speech and language is also found credible, and supported by the years of speech and language therapy, and an assessment finding

[7] Given the agreement between Dr. Brandt and Dr. Torquato regarding Criteria B, it does not appear that the findings of the speech assessment could support a separate diagnosis of Social (Pragmatic) Communication Disorder. That latter diagnosis is not given where the developmental history reveals any evidence of restricted/repetitive patterns of behavior, interests, or activities. (DSM-5, p. 49.)

him significantly impaired in pragmatic social speech, while there were significant differences in Claimant's expressive and receptive language skills. (Factual Finding 31.) She finds him substantially disabled in terms of self-care in light of dangerous behaviors that he has been exhibiting at school and home.

8. On balance, it is concluded that Claimant has carried his burden of establishing, by a preponderance of the evidence, that he suffers from ASD, a condition making him eligible for services under the Lanterman Act, and that he is substantially disabled by his condition.

ORDER

Claimant's appeal is granted, and he shall receive services from the Service Agency pursuant to the Lanterman Act, as determined from the Individual Program Plan to be developed hereafter.

Date:

Joseph D. Montoya
Administrative Law Judge
Office of Administrative Hearings

NOTICE

This is the final administrative decision in this matter, and both parties are bound by it. Either party may appeal this decision to a court of competent jurisdiction within ninety (90) days of this decision.