BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of the Eligibility of: CLAIMANT, and INLAND REGIONAL CENTER, Service Agency.	OAH No. 2018050977

DECISION

Theresa M. Brehl, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter in San Bernardino, California, on June 28, 2018.

Stephanie Zermeño, Consumer Services Representative, Fair Hearings and Legal Affairs, Inland Regional Center, represented Inland Regional Center (IRC).

Claimant did not appear.[1] IRC elected to proceed with the hearing and presented evidence.

The matter was submitted on June 28, 2018.

ISSUE

Is claimant eligible for regional center services under the Lanterman Developmental Disabilities Services Act (Lanterman Act) as a result of a diagnosis of Autism Spectrum Disorder that constitutes a substantial disability?

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[1] Notice of the date, time, and place of this hearing was properly served by mail on May 23, 2018, on claimant's representative, his adoptive mother.

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FACTUAL FINDINGS

JURISDICTIONAL MATTERS

1. On April 16, 2018, IRC notified claimant that he was not eligible for regional center services.

2. On May 16, 2018, claimant's adoptive mother filed a fair hearing request, appealing IRC's decision. In the request, claimant's adoptive mother wrote the following reason for requesting a fair hearing:

> I do not agree with Assessment [sic] the report is inconsistent. The teacher . . . states she never had a conversation with anyone from Regional Center. He is Autistic. Has been diagnosed by a few Drs and I have the documentation to prove so.

DIAGNOSTIC CRITERIA FOR AUTISM SPECTRUM DISORDER

3. Official notice was taken of excerpts from the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-5*), which Holly A. Miller, Psy.D., IRC's expert, referenced during her testimony.[2] As Dr. Miller explained, the *DSM-5* provides the diagnostic criteria used by psychologists to make diagnoses of Autism Spectrum Disorder, which an individual must have to qualify for regional center services based on Autism.

4. Under the *DSM-5*, the criteria necessary to support a diagnosis of Autism Spectrum Disorder include: persistent deficits in social communication and social interaction across multiple contexts; restricted, repetitive patterns of behavior, interests,

[2] Dr. Miller's hearing testimony, written assessment, and opinions are discussed in more detail below.

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or activities; symptoms that are present in the early developmental period; symptoms that cause clinically significant impairment in social, occupational, or other important areas of current functioning; and disturbances that are not better explained by intellectual disability or global developmental delay.

BACKGROUND

5. Claimant is a six-year-old boy. He has lived with his maternal grandmother since 2014, and she legally adopted him in September 2015, when he was three years old. His adoptive mother reported to various evaluators and IRC that claimant's biological mother has struggled with substance abuse (methamphetamines), may have used drugs during the pregnancy, and may not have received adequate prenatal care. Claimant's adoptive mother also reported that he was born full-term, but there may have been complications due to domestic violence. Claimant lived with his biological parents for his first six months, but he was removed from their care and placed in foster care twice during his first 18 months. Claimant has speech and language delays, and he has been receiving speech and occupational therapy for one hour each week. He previously received Applied Behavior Analysis (ABA) therapy services from April to December 2017. He has been diagnosed and prescribed medication for Attention Deficit Hyperactivity Disorder (ADHD).

6. In 2014, claimant was referred by his physician for a speech evaluation due to concerns regarding his speech and language development. Tamara Cosby, M.S., CCC-SLP, Speech-Language Pathologist, at Littlefield Physical Therapy, evaluated claimant on October 28, 2014, when he was two years, three months old. Although Ms. Cosby's speech evaluation report stated that claimant's developmental milestones were unknown because claimant had not been primarily cared for by his maternal grandmother, Ms. Cosby's report noted that his developmental milestones were "reported to be delayed overall." Her report also stated that there was a concern about

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claimant exhibiting aggressive and self-abusive behaviors, hitting his grandmother, other children, and the dog. His grandmother reported to Ms. Cosby that claimant would hit his arm and say, "Bad boy"; he had inconsolable tantrums; twitches with his head; and he had gross motor difficulties, including tripping, falling, and walking on his tip toes. The summary portion of Ms. Cosby's report stated:

> [Claimant] is a 2 year, 3 month old boy with a medical diagnosis of Autism.[3] He is currently living with his maternal grandmother who is planning on adopting him. At this time, [claimant] no longer sees his mother. Medical history is remarkable for drug exposure in utero and global developmental delays. [Claimant] is a verbal communicator, however, his expressive vocabulary is limited to 6-8 words. He primarily communicates by pointing, crying, grunting, gestures, single and recently emerging, 2 word utterances. However, [claimant] does exhibit significant frustrations due to impaired communication as well as separation difficulties, and aggressive behaviors. Concerns were shared with his hearing, speaking in a loud volume, gross and fine motor concerns. Results of this evaluation indicate severely impaired receptive/expressive/pragmatic language and

[3] The report did not indicate the source of this information or who Ms. Cosby believed had diagnosed him with Autism. According to Dr. Miller, Ms. Cosby, as a speech-language pathologist, was not qualified to diagnose any condition outside the speech and language area and the information in Ms. Cosby's report did not support an Autism Spectrum Disorder diagnosis.

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articulation skills. Based on results of this evaluation, reported concerns and occurrences of difficult ambulation (trips, falls, walks on tip toes) and sensory skills, the following is recommended:

[Claimant's] significant delay/disorder requires speech-language therapy. Patient should continue to be seen 2 times per week for 25 weeks ith [sic] review of progress in 6 months

The patient requires a referral to occupational therapy to assess sensory/proprioceptive skills

The patient requires a referral to physical therapy

The patient requires a referral to an audiologist to further assess hearing[4]

7. Claimant's mother provided IRC a single page from "MHSA Lake Elsinore Clinic" regarding a clinic visit on February 9, 2017. That page lists three diagnoses: ADHD, listed as the "Primary diagnosis"; Autism Spectrum Disorder; and Hyposensitive or Under-Responsive Sensory Processing Disorder. The diagnosing clinician was listed as "Patel, Ravi," but there was no indication of the information upon which the diagnoses were based or how the diagnoses were reached.

CLAIMANT'S RECEIPT OF SPECIAL EDUCATION SERVICES

8. According to documentation from his school regarding his Individualized

[4] Referral to the Regional Center was not mentioned in this report.

Education Program (IEP), claimant receives special education services based on "Speech or Language Impairment (SLI)," because his "articulation delays negatively impact communication with peers and adults." Claimant attends a regular kindergarten classroom and he receives Resource Specialist Program Services (RSP), language/speech intervention, and behavior intervention. The school's May 23, 2017, Annual Goals and Objectives Progress Report, which was completed when claimant was four years old (less than two months before his fifth birthday), stated the following about his communication development, social/emotional behavior, and his adaptive daily living skills:

> **Communication Development:**
>
> [Claimant] is able to follow directions containing spatial concepts in, on, out, he points to body parts, and he understands concepts of more and most. He can give one item upon command, identifies items based on function, and understands possessives. [Claimant] asks questions, he uses sentences of at least 3-5 words, and he uses his language for a variety of functions. [Claimant's] articulation is judged to be 40% intelligible to an unknown listener. He presents substitution in the initial position. [Claimant] has some inconsistent sound replacements, and he has difficulty producing longer and more complex words and utterances.
>
> [¶] . . . [¶]
>
> **Social/Emotional/Behavioral**

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> [Claimant] follows the classroom routine with adult prompting. He knows the routine and engages in preferred activities. He has difficulty completing non-preferred tasks. He plays alongside his peers and will interact, but can have difficulty playing cooperatively with his peers. He may do something negative such as kick a toy or knock down a tower. [Claimant] loves to play outside and ride bikes. He is able to take turns with the bike when an adult is assisting. [Claimant] requires adult assistance to follow classroom rules and stay on task. He can become easily upset and leave the activity, throw objects or yell. When upset it will take time for him to calm and return to the activity. [Claimant] has recently enjoyed earning rewards and computer time.
>
> [¶] . . . [¶]
>
> **Adaptive/Daily Living Skills**
>
> [Claimant] is independent when eating. He is able to put on and zip his jacket. [Claimant] follows toileting routines and can state his first name and his age upon request.

According to an August 24, 2017, Positive Behavioral Intervention Plan, claimant had been observed to "elope or tantrum when presented with an undesirable task demand or action from a peer." However, the August 24, 2017, plan also noted that "[claimant] is displaying a progression in the area of social/emotional, as he significantly decreased the frequency of manipulative behaviors." On an IEP Team Amendment page, dated August 24, 2017, the behavior specialist noted that "[a]t this time, the school team

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has not observed any negative behaviors and recommends a reduction of support. . . . Mom agrees with consultation."

PSYCHOLOGICAL EVALUATIONS AND ASSESSMENTS

Thomas F. Gross, Ph.D.'s October 27, 2015, Evaluation

9. Claimant was evaluated by Thomas F. Gross, Ph.D., on October 27, 2015, after claimant was referred to IRC. Claimant was then three years and three months old. Dr. Gross administered the Vineland Adaptive Behavior Scales-II, Childhood Autism Rating Scales 2-ST, and Leiter International Performance Scales-3rd Edition, reviewed records, interviewed claimant's adoptive mother, and observed claimant. In Dr. Gross's written evaluation, he noted the following observations of claimant:

> [Claimant] was evaluated with his grandmother/adoptive mother present. He was cooperative and participated in all aspects of the assessment. I found [claimant] to be quite social. He made good eye contact. He initiated interactions with his mother and me. He responded to interactive bids. He engaged in frequent joint attention and social referencing with his mother and me.
>
> I saw no odd, repetitive, or stereotyped behavior. During free play, he played imaginatively with toy vehicles. Toy use was appropriate. No small part focus or repetitive manipulation of small object parts was seen. No odd object use was seen.
>
> [Claimant] used misarticulated single words or two to three word phrases to relate ideas to others. He responded to simple questions asked of him. He reliably responded to his

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> name. His use of language and his response to language was purposeful and appropriate to context.

Dr. Gross did not find claimant to meet the diagnostic criteria for Autism Spectrum Disorder. In the conclusions portion of his report, he noted that although claimant' adoptive mother described claimant as exhibiting behaviors seen in children with Autism Spectrum Disorder, Dr. Gross "saw none of those features" during his observation of claimant. Instead, Dr. Gross wrote:

> I do not believe that he experiences persistent deficits in social communication and social interaction across multiple contexts. With encouragement and prompting, it is noted that [claimant] will engage and interact with other children. I found him to be very sociable, e.g., engaging in persistent joint attention, initiating social interactions, responding to interactive bids. I did not find him to exhibit deficits in nonverbal communication used in social interaction. He will monitor others [*sic*] gestures. He made good eye contact. He does appear to have difficulty developing, maintaining, and understanding relationships. He plays with imagination. He does seem curious about peers.

Dr. Gross pointed out that claimant exhibited characteristics of children who experience "Sensory Integration Dysfunction" and he appeared to have "substantial Speech/Language delay."

Hemet Unified School District IEP Team's June 30, 2016, Early Childhood Assessment

10. On June 16, 2016, the Hemet Unified School District's IEP Team, which

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included Michael A. Ropchak, Ed.S., School Psychologist; Jenny Spencer, M.S., CCC/SLP, Speech/Language Pathologist; and Carolyn Love, M.S., Early Childhood Special Education Teacher, conducted an early childhood evaluation of claimant when he was three years and eleven months old. The team's June 30, 2016, Early Childhood Assessment report noted that claimant was referred for assessment by claimant's adoptive mother due to concerns regarding behavior and speech. Claimant's adoptive mother reported to the team that both claimant's biological parents "may have suffered from mental illness / emotional difficulties such as bipolar disorder. Additionally, it was revealed that [claimant] has siblings whom have been diagnosed with ADHD." His adoptive mother also reported that "there may be a medical diagnosis of Autism, developmental delay, and behavior problems however no medical report was furnished by the time of this report."

The report included the following observations of claimant (italicized emphasis in original):

> *Testing*
>
> [Claimant] was friendly toward the assessors, however showed little enthusiasm for the testing materials and the activities presented to him. He was somewhat active and very distracted by new materials as he discovered them, but he was eventually willing to attempt some structured tasks. He had difficulty following verbal prompts, this sometimes required two or three repetitions of directions. It was also noted that he seemed to be very impulsive and unable to focus on tasks. [Claimant] was observed to participate in

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sequential and imaginative play, and he was able to compare tasks such as sorting and matching of objects.

Pre-school

June 30, 2016

An observation was conducted in [claimant's] pre school class at . . . in Hemet, CA. Upon arrival the children were having lunch. [Claimant] was observed to request food to be passed, feed himself using utensils, and assist a peer in obtaining a dropped spoon. [Claimant] turned and noticed the assessor and waved, smiled, and said hi. He was observed to be appropriately engaged in conversation with his teacher and responded to her questions and comments. At completion of his meal, [claimant] waited in line to clean his plate and put his dishes in the dirty dish tub. [Claimant] then told his teacher he needed to go to the bathroom and she instructed the class to line up at the door for bathroom time. [Claimant] waited appropriately. [Claimant] followed bathroom and hand washing routines. After bathroom time [claimant] and his peers returned to the class to prepare for nap time. Teacher interview indicated that [claimant] is a happy, outgoing participant in class. She reported that she has been his teacher for one year. She shared that [claimant] has specific routine to his time in class but when the routine is interrupted, [claimant] is able to manage the change without significant disruption to his daily routine. Teacher

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> indicated that [claimant] is able to express his wants and need [sic] throughout the school day and participates in class activities.

Due to claimant's adoptive mother's autism related concerns, the report noted that the Childhood Autism Rating Scales, 2nd Edition (CARS-2) was given to his adoptive mother to complete. According to the team's report, the CARS-2 "rating scales indicate impairment in all areas however the rating form was incomplete therefore this area will be thoroughly assessed through additional evaluation."

The report's summary stated:

> This assessment indicates that [claimant] exhibits average cognitive development, average adaptive (self-help) behavior, below average motor skills, below average social emotional development. [Claimant] exhibits delayed-below average receptive language, below average expressive language, and impaired intelligibility.
>
> Due to Parent ratings on the CARS-2 Assessment and parent request, additional evaluation to determine eligibility under Autism IDEA category area requested.

Hemet Unified School District School Psychologist's October 17, 2016, Early Childhood Assessment-Autism Assessment

11. Terri Foster, Ed.S., Nationally Certified School Psychologist, conducted an autism assessment of claimant on August 21 and 31, and September 26, 2016, and issued a report on October 17, 2016, when claimant was four years, three months old. The report noted that the reason for the assessment was that claimant's grandmother "expressed concerns with autism behaviors and wanted additional testing done in this

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area." According to her report, Ms. Foster reviewed records; obtained developmental, family, and sociological/experiential histories from claimant's adoptive mother and teachers; made clinical observations; gave claimant's teacher and adoptive mother the Autism Spectrum Rating Scale (ASRS) and Childhood Autism Rating Scale, Second Edition (CARS-2) to complete; and attempted to administer the Autism Diagnostic Observation Schedule-2nd Edition (ADOS-2). However, the attempted ADOS-2 was "unsuccessful."

Claimant's mother reported to Ms. Foster that claimant was diagnosed with ADHD in September 2016, and that he would be referred to Rady Children's Hospital for an autism evaluation.[5] According to the October 16, 2016, report, claimant's adoptive mother described claimant to Ms. Foster as follows:

> Mother rated [claimant's] overall social/emotional adjustment as below average. She notes that [claimant] does not seek out other children for play and takes a while to warm up. He is reported to be very moody, scratches and hits himself, and has sleeping issues (wakes up every two hours). Inattentive behavior was reported as 'always-on-the-go', fidgety, restless, can't pay attention or concentrate. [Claimant] was also reported to be aggressive, with arguing, screaming, yelling, temper tantrums and throwing things.

Ms. Foster interviewed claimant's preschool teacher on the last day of school. The preschool teacher reported that claimant had "attention difficulties," could become

[5] There were no records from Rady Children's Hospital presented during this hearing.

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"frustrated when he didn't get what he wanted," and sometimes had "difficulty separating from his grandmother when she dropped him off at school." However, he did fine in the classroom after his grandmother left, and he interacted and played with other children. The preschool teacher had "some difficulty with understanding his speech but reported no unusual behaviors or need for specific routines in the preschool setting."

Ms. Foster's report noted that medical records from December 29, 2014, indicated "Autism Disorder of Childhood Onset." However, her report also stated: "It is not known when the Autism was diagnosed and there does not appear to have been psychological assessment to substantiate this report."

Ms. Foster's report described her observations of claimant as follows (italics emphasis in original):

> *Testing*
>
> Autism assessment with the ADOS-2 was attempted with [claimant] on 9/26/16 with his mother present. Upon entering the room, [claimant] exhibited reluctance to go into the play area and when encouraged by the assessor, sat on his mother's lap facing her with his arms tight around her neck. [Claimant] refused to get down and interact with the assessor at any time during this appointment and after approximately 20 minutes, the assessment was discontinued.
>
> *Preschool*
>
> An attempt was made to observe [claimant] at his preschool setting, however, he was not in attendance on the day this was attempted. As stated previously, his teacher was

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> interviewed regarding his behavior in class and her concerns. Poor attention and distractibility was noted, along with low frustration tolerance. No unusual behaviors were reported and [claimant] was noted to interact with his peers with no need for specific routines in the classroom setting.

On the ASRS, claimant's mother rated him in the "Very Elevated" range in all areas, including Social Communication and Unusual Behaviors. However, when she completed the CARS-2, she responded that he had no problems responding to facial expressions, gestures, and different tones of voice; and no problems responding to, initiating, or sustaining social initiations from others or making and maintaining friendships. On the ASRS, claimant's teacher rated claimant as "Slightly Elevated" for Social Communication and "Very Elevated" for Unusual Behaviors.

The Summary portion of Ms. Foster's report stated:

> This assessment indicates that there are many inconsistencies on all autism testing completed by mother and teachers. Because [claimant] refused to participate in direct Autism assessment, there is not enough information to determine an eligibility of Autism at this time. Grandmother reports significant behaviors, yet several of the scales indicated no problems with the behaviors. Teacher reported no significant behavior concerns, unusual behaviors or difficulties with interacting with others, however, the autism rating scale indicated significant behavior concerns in these areas.

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Sara deLeon, Psy.D.'s November 11, 2016, Assessment

12. Sara deLeon, Psy.D., conducted an assessment of claimant on November 11, 2016, when claimant was four years and four months old. According to Dr. deLeon's report, claimant was referred to her to "[r]ule out Autism Spectrum Disorder and determine level of adaptive functioning." Dr. deLeon reviewed records, interviewed claimant's adoptive mother, and observed claimant. She also administered the Childhood Autism Rating Scales, 2nd Edition, Standard Version (CARS2-ST), ADOS-2, and Vineland Adaptive Behavior Scales, 3rd Edition (VABS-3).

Claimant's score of 33.5 on the CARS2-ST, which was based on parent reporting and observations of claimant, fell in the '"mild to moderate' range of symptoms for autism." Claimant's score on the ADOS-2 of 13, was described as "correlates to a 'moderate' level of autism spectrum-related symptoms compared to same age peers with ASD." Claimant's mother was interviewed to complete the VABS-3 to assess his adaptive functioning. The results indicated claimant exhibited "skills in the low range with mild deficits in his overall adaptive functioning based on an Adaptive Composite score of 64. His Communication (62) and Socialization skills (56) fall in the low range with mild deficits. His Daily Living Skills (72) fall in the moderately low range."

Dr. deLeon's report included descriptions of claimant's "Communication," "Reciprocal Social Interaction," "Play/Imagination & Creativity," and "Repetitive and Stereotyped Behaviors, Interests or Activities," which combined some of Dr. deLeon's observations with information reported by claimant's adoptive mother. Under the "Reciprocal Social Interactions" heading of her report, Dr. deLeon appeared to combine her observations with information provided by claimant's adoptive mother and stated:

> [Claimant] was difficult to engage; he was very withdrawn and negative when he first encountered the office. He gradually warmed up but his interaction was not fluid or

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> "easy." His gaze was sometimes appropriate but he tended to avoid eye contact. He directed a limited range of facial expressions to others to communicate affective or cognitive states. He briefly responded to social overtures extended to him by the examiner, though he was often withdrawn. [Claimant] did not initiate interaction with the examiner. He showed items to his mother and the examiner in a partial manner, frequently shoving things in the examiner's face. With other kids, he often watches but does not engage in cooperative play. He is affectionate with his family. When [claimant] melts down, his reactions are excessive and often difficult to manage. Often, his parents do not know why he is upset. His mother reports it is very difficult to soothe him when he is upset. When upset, he will scratch himself, bang his head, throw things, destroy areas of the house, and hit others. [Claimant] shows very poor safety awareness and often elopes. He exhibits significant anxiety when separated from his mother, in new places, doctor's offices, or when there are transitions or changes in his routine.

In the summary section of her report, Dr. deLeon wrote that, based in the information she gathered, it was her opinion that claimant met the criteria for a "provisional diagnosis of Autism Spectrum Disorder but that he should be re-assessed in three to five years to determine the appropriateness of the diagnosis as he develops. It is imperative to rule out ASD versus sensory processing disorder or an unspecified behavioral disorder." Dr. Miller explained during her testimony that a "provisional" diagnosis is made when there seems to be sufficient evidence that a patient meets the

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diagnostic criteria, but the clinician is unsure of the underlying factors or if the patient might meet the diagnostic criteria later.[6]

DR. HOLLY A. MILLER'S ASSESSMENT OF CLAIMANT AND EXPERT OPINION TESTIMONY

13. Holly A. Miller, Psy.D., is a staff psychologist at IRC, where she has worked since 2016. Her duties include conducting psychological assessments to determine regional center eligibility. She received her Bachelor of Arts Degree in Psychology from the University of California, Riverside in 2002; Master of Science Degree in Psychology from University of La Verne in 2006; and Doctor of Psychology Degree from University of La Verne in 2009. She is licensed as a clinical psychologist by the State of California. Before working as a staff psychologist for IRC, Dr. Miller worked as a clinical supervisor for Olive Crest from 2013 to 2016. She has also worked as a part-time clinical psychologist at Foothills Psychological Services since 2013. Dr. Miller conducted an assessment of claimant to determine whether he is eligible for regional center services, she issued a report regarding her assessment, and she testified at the hearing. Her testimony was consistent with her written report.

14. Dr. Miller conducted her assessment on January 31, 2018, and March 30, 2018, when claimant was five years and six months old. She reviewed documentation, observed claimant in the office and at his school; interviewed his adoptive mother and teacher; and administered the Adaptive Behavior Assessment System, Third Education (ABAS-3), Parent Form; CARS2-ST; and Social Communication Questionnaire (SCQ), Lifetime version. Cognitive measures were not administered because previous records indicated that claimant has average cognitive skills.

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[6] Dr. Miller also pointed out that Dr. deLeon has been known to make referrals to IRC, but she did not refer claimant to IRC.

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In Dr. Miller's report, she described her behavioral observations as follows:

> [Claimant] is an adorable 5 year 6-month-old boy with short blond hair. He is accompanied to the assessment by his adoptive mother. He arrived adequately groomed and was dressed in a jacket, beanie, and wore boots. He carried an electronic tablet with him. He is ambulatory. Auditory and visual acuity appeared intact. [Claimant's adoptive mother] indicated that [claimant] had taken medications as prescribed on the morning of the evaluation. The purpose of the assessment was explained to [claimant's adoptive mother], who gave consent and was present for the duration.
>
> During the scheduled evaluation (1/31/18), [claimant] initiated little interaction and showed little interest in the evaluator. He displayed a negative mood, often hid his face, avoided speaking, and preferred to play on his tablet. He provided age but stated he could not recall his birthdate. He required significant encouragement to provide information to the evaluator, such as what he had eaten for breakfast. He used nonverbal strategies to indicate his lack of interest, such as when he rolled his eyes at the evaluator. His mood appeared irritable and he repeatedly asked to leave.
>
> Due to [claimant's] lack of interest during the first session and in order to obtain additional information regarding his social interactions and communication, a school observation was scheduled (3/30/18). [Claimant] was observed over the

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> course of 1 3/4 hours at . . . Elementary, which included structured academic time, unstructured time (holiday activity, recess, lunch), and an interview with his teacher, . . . [Claimant] wore a sweatshirt and shorts, along with gloves on his hands despite the warm weather. According to [claimant's teacher], [claimant's] presentation on this day was consistent with his general behavior at school.

Dr. Miller also wrote in other portions of her report that during her observations of claimant, he "appeared shy," spoke in a "low volume," and used phrases and short sentences. She did not observe any "echolalia or stereotyped/idiosyncratic use of words or phrases." Although he kept his eyes on Dr. Miller when she spoke to him, he "otherwise sought indirect eye contact." His "lack of verbal response appeared intentional," and he "used nonverbal communicative behaviors, such as facial expressions to express himself. For example, he gave a shy smile at times and, on multiple occasions, rolled his eyes" when Dr. Miller "attempted to be silly or make jokes." Dr. Miller did not see claimant "display restricted interests or repetitive or unusual behaviors or language," "engage in ritualistic or routinized behavior," or "use objects in unusual or repetitive ways." She observed him transition "well between activities." His "preference for certain activities appeared age-appropriate and did not appear unusual in intensity."

Dr. Miller's report provided the following additional details regarding her observations of claimant at school and her interview of his teacher:

> During the school observation, [claimant] did not appear bothered when others were in his space or bumped into him, such as when lining up to exit the classroom. Socially, he was

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aware of others and his environment, and showed interest in what others were doing. He appeared to become somewhat easily distracted by sounds or people but easily redirected himself. He displayed several social behaviors, such as showing concern for a classmate when she sat on the blacktop crying, quickly stopping in order to avoid a tricycle collision, and initiating play with other classmates by drawing their attention with words and gestures (i.e. pointing, tapping, calling them over, "Look!"). He used gestures to augment communication (shrugging, shaking head yes and no). [Claimant's] facial expressions were restricted at times. However, when engaged, he smiled, laughed, and showed varied expressions, such as when engaging in a pretend ninja fight with a classmate. During unstructured time, he engaged with others and participated in group activities. He used the outdoor play equipment, chased others, competed in tricycle riding, offered his tricycle to a classmate, and opted to open his Easter eggs and eat candy on the grass with his classmates. At no time did he show preferences to isolate or engage in independent behavior when social activity/interaction was available. He showed preferences for two specific boys from his class, with whom he frequently sought interaction. When working individually with his RSP teacher, he appeared somewhat apprehensive, spoke softly, and visually monitored the evaluator from his periphery.

[¶] . . . [¶]

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> During an interview, [claimant's] teacher, . . . indicated that during the first couple months of the school year [claimant] was initially "on the outskirts" but showed social interest in others. Since that time and currently, he engages in group activities, joins others in activities during free time, and interacts directly with classmates. Socially, he is passive and more of a follower than a leader. He sometimes is slow to catch on. However, he monitors others' behavior and references his peers, such as looking to classmates and following their behavior when he becomes lost or misunderstands directions. [Claimant] does not spontaneously imitate [claimant's teacher's] nonverbal gestures and does not like "having attention on him." He avoids making eye contact when it is specifically asked/expected. He listens well, follows directions, and does not demonstrate any problematic behaviors at school.

The ABAS-3 was completed by claimant's adoptive mother and was used to gain information about claimant's adaptive behavior skills. The results from her responses reflected "Extremely Low" overall adaptive behavior, with most skills in the "Low" range. Based on his adoptive mother's ratings, claimant's area of strength is Self-Direction, in the "Below Average" range, and his areas of weakness are Health/Safety and Communication, both in the "Extremely Low" range. Claimant's adoptive mother also completed the SCQ, resulting in a score of 33 out of 40, "indicating that [claimant's adoptive mother] observes [claimant] to experience a high degree of social communication difficulties." The CARS2-ST was administered using Dr. Miller's observations and information provided by his adoptive mother. Claimant "attained a

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score of 26, which indicates his behavior falls in the non-spectrum range on this measure."

With respect to the notations in the records that claimant had a history of elopement and disruptive behavior at school, Dr. Miller wrote that "[a]ccording to [claimant's teacher], [claimant's] behavior has improved since he began taking medication. When doses are missed he is noticeably more distractible, disruptive, instigates problems with other students, and can become aggressive towards others/property. Otherwise these behaviors are no longer present." Dr. Miller did not observe claimant engage in any disruptive or aggressive behaviors. She explained during her testimony that while medication may cause a decline in ADHD related behaviors, Autism Spectrum Disorder "does not work that way," as it does not respond to medication.

Dr. Miller noted that while claimant's adoptive mother reported many behaviors that might suggest Autism Spectrum Disorder, Dr. Miller did not observe any of those behaviors in the office or school settings. He "seems to be a somewhat shy and passive child until he becomes comfortable. He appeared very aware of his social environment, and demonstrated a level of social interest atypical of children with ASD." His behaviors reported in the home setting were not evident across settings, which would be necessary to meet the diagnostic criteria for Autism Spectrum Disorder. Dr. Miller opined that claimant does not meet the *DSM-5* diagnostic criteria for Autism Spectrum Disorder, such that he is not eligible for regional center services. Dr. Miller's diagnostic impressions were consistent with the previous diagnoses of ADHD and Other Sensory Neurodevelopmental Disorder, sensory processing. Dr. Miller noted that claimant's behaviors may also be explained by his early difficulties, which claimant's adoptive mother had reported included suspected exposure to substances in utero and being taken away from his biological parents.

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LEGAL CONCLUSIONS

BURDEN OF PROOF

1. In a proceeding to determine eligibility, the burden of proof is on the claimant to establish he or she meets the proper criteria. The standard is a preponderance of the evidence. (Evid. Code, §§ 115 and 500.)

2. "'Preponderance of the evidence means evidence that has more convincing force than that opposed to it.' [Citations.]" (*Glage v. Hawes Firearms Company* (1990) 226 Cal.App.3d 314, 324-325.) "The sole focus of the legal definition of 'preponderance' in the phrase 'preponderance of the evidence' is on the *quality* of the evidence. The *quantity* of the evidence presented by each side is irrelevant." (*Ibid.*) "If the evidence is so evenly balanced that you are unable to say that the evidence on either side of an issue preponderates, your finding on that issue must be against the party who had the burden of proving it [citation]." (*People v. Mabini* (2001) 92 Cal.App.4th 654, 663.)

STATUTORY AUTHORITY

3. The Lanterman Act is set forth at Welfare and Institutions Code section 4500 et seq.

4. Welfare and Institutions Code section 4501 states:

> The State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge. Affecting hundreds of thousands of children and adults directly, and having an important impact on the lives of their families, neighbors, and whole communities, developmental disabilities present social,

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> medical, economic, and legal problems of extreme importance.
>
> [¶] . . . [¶]
>
> An array of services and supports should be established which is sufficiently complete to meet the needs and choices of each person with developmental disabilities, regardless of age or degree of disability, and at each stage of life and to support their integration into the mainstream life of the community. To the maximum extent feasible, services and supports should be available throughout the state to prevent the dislocation of persons with developmental disabilities from their home communities. . . .

5. Welfare and Institutions Code section 4512, subdivision (a), defines "developmental disability" as follows:

> "Developmental disability" means a disability that originates before an individual attains 18 years of age; continues, or can be expected to continue, indefinitely; and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, 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

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intellectual disability, but shall not include other handicapping conditions that are solely physical in nature.

6. California Code of Regulations, title 17, section 54000,[7] provides:

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

(b) The Developmental Disability shall:

(1) Originate before age eighteen;

(2) Be likely to continue indefinitely;

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

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

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

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

[7] The regulation still uses the former term "mental retardation" instead of "intellectual disability."

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(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.

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

(a) "Substantial disability" means:

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

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

(A) Receptive and expressive language;

(B) Learning;

(C) Self-care;

(D) Mobility;

(E) Self-direction;

(F) Capacity for independent living;

(G) Economic self-sufficiency.

(b) The assessment of substantial disability shall be made by a group of Regional Center professionals of differing disciplines and shall include consideration of similar qualification appraisals performed by other interdisciplinary bodies of the Department serving the potential client. The group shall include as a minimum a program coordinator, a physician, and a psychologist.

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(c) The Regional Center professional group shall consult the potential client, parents, guardians/conservators, educators, advocates, and other client representatives to the extent that they are willing and available to participate in its deliberations and to the extent that the appropriate consent is obtained.

(d) Any reassessment of substantial disability for purposes of continuing eligibility shall utilize the same criteria under which the individual was originally made eligible.

8. A regional center is required to perform initial intake and assessment services for "any person believed to have a developmental disability." (Welf. & Inst. Code, § 4642.) "Assessment may include collection and review of available historical diagnostic data, provision or procurement of necessary tests and evaluations, and summarization of developmental levels and service needs . . . ." (Welf. & Inst. Code, § 4643, subd. (a).) To determine if an individual has a qualifying developmental disability, "the regional center may consider evaluations and tests . . . that have been performed by, and are available from, other sources." (Welf. & Inst. Code, § 4643, subd. (b).)

9. California Code of Regulations, title 5, section 3030, provides the eligibility criteria for special education services required under the California Education Code. However, the criteria for special education eligibility are not the same as the eligibility criteria for regional center services found in the Lanterman Act and California Code of Regulations, title 17. The fact that a school may be providing services to a student based on the school's determination of an autism disability is not sufficient to establish eligibility for regional center services.

EVALUATION

10. The Lanterman Act and the applicable regulations set forth criteria that a claimant must meet to qualify for regional center services. Claimant suffers from speech and language delays for which he receives special education services. His adoptive

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mother justifiably wants to make sure her son receives any and all services for which he is eligible. However, the evidence introduced in this hearing was not sufficient to prove by a preponderance of the evidence that claimant suffers from Autism Spectrum Disorder. Accordingly, claimant is not eligible to receive regional center services at this time. Thus, his appeal from IRC's determination that he is ineligible to receive regional center services must be denied.

ORDER

Claimant's appeal from Inland Regional Center's determination that he is not eligible for regional center services and supports is denied.

DATED: July 10, 2018

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THERESA M. BREHL

Administrative Law Judge

Office of Administrative Hearings

NOTICE

This is the final administrative decision. Both parties are bound by this decision. Either party may appeal this decision to a court of competent jurisdiction within ninety days.

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