BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: CLAIMANT, v. ALTA CALIFORNIA REGIONAL CENTER, Service Agency.	OAH No. 2018060468

DECISION

The fair hearing in this matter was heard by Administrative Law Judge Marcie Larson (ALJ), Office of Administrative Hearings (OAH), State of California, on September 4 through 7, 2018, in Sacramento, California.[1]

Alta California Regional Center (ACRC) was represented by Robin Black, Legal Services Manager.

Claimant's mother represented claimant.

Evidence was received, the record was closed and the matter was submitted for decision on September 7, 2018.

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[1] This matter was conducted as a consolidated hearing with two fair hearing requests for two of claimant's siblings, OAH Case Nos. 2018060450 and 2018060463. Separate decisions have been issued for those matters. Interpreters Maria Fletes, Jennifer Gibson and Raquel Sigal were sworn and provided English/Spanish and Spanish/English translation for claimant's mother.

ISSUES

Does claimant qualify for services from ACRC under the Lanterman Developmental Disabilities Services Act (Lanterman Act), Welfare and Institutions Code section 4500 et seq., because he is an individual with autism, or intellectual disability, or because he has a disabling condition that is closely related to intellectual disability or requires treatment similar to that required for individuals with an intellectual disability?

FACTUAL FINDINGS

1. Claimant was born in May 2013. Claimant is currently five years old. Claimant lives with his parents and his five siblings, in Sacramento, California. On January 26, 2017, claimant was assessed at the Kaiser Permanente Autism Spectrum Disorders Center (Kaiser Center) and diagnosed with Autism Spectrum Disorder (ASD). The Kaiser Center referred claimant's mother to ACRC for inquiry into whether claimant qualified for regional center services.

2. In approximately March 2017, claimant's mother, sought services for claimant from ACRC under the Lanterman Act, for ASD. On May 16, 2018, ACRC denied her request, asserting that claimant was not eligible for regional center services because he does not have autism, intellectual disability, or a disabling condition that is closely related to intellectual disability, nor requires treatment similar to that required for individuals with an intellectual disability. There was also no evidence that claimant had epilepsy or cerebral palsy. ACRC based the determination on a Social Assessment completed by David Webb, M.A., a psychological evaluation completed by Katherine Redwine, Ph.D., and other records provided to ACRC.

3. Claimant appealed the denial. A fair hearing was held on his appeal. During the fair hearing, claimant's mother argued that based on the Kaiser Center

evaluation, claimant is eligible for ACRC services under the Lanterman Act because claimant is an individual with ASD.

KAISER CENTER EVALUATION AND ABA SERVICES

4. Claimant was referred to the Kaiser Center by Amarjeet Singh, Licensed Clinical Social Worker, with the Early Developmental Screening Program. Ms. Singh opined that results on "screening measures" were suggestive of ASD. As a result, claimant was referred for an ASD evaluation. On January 26, 2017, an ASD evaluation was performed by Laura Shrader, Psy.D., Psychological Assistant, with consultation from Vanessa C. Fontes, Psy.D., Clinical Psychologist. Dr. Shrader issued a report detailing her findings. No Kaiser Center practitioners testified at hearing.

5. Dr. Shrader noted that claimant is a Latino-male, who was three years, seven-months old at the time of the evaluation. Claimant's mother is Hispanic and speaks Spanish. Claimant speaks English. A Spanish-language interpreter was present at the evaluation to translate for claimant's mother. Claimant's mother completed a history questionnaire prior to the evaluation. During the evaluation, medical, family, psychiatric, psychosocial and developmental histories were obtained, claimant's Kaiser medical records were reviewed, claimant's mother was interviewed and tests were administered, including: the Adaptive Behavior Assessment System, 3rd Edition (ABAS-3): Parent Form (Ages 0-5); the Ages and Stages Questionnaire, 3rd Edition (ASQ-3): 42 month Questionnaire; Autism Diagnostic Observation Schedule, 2nd Edition (ADOS-2): Module 1; and Child Developmental Inventory (CDI). The evaluators also reviewed the Diagnostic and Statistical Manual for Mental Disorders, Fifth Edition (DSM-5).

6. Claimant's mother reported she first became concerned with claimant when he was two-years old. He was aggressive, did not respond to rules or instructions and was sensitive to noises. Academically, claimant's mother reported that he was not enrolled in pre-school or daycare. She also reported that claimant's social skills were

poor, that he had no "real friends" and that he had temper tantrums when thing do not go a certain way. During the tantrums he sometimes urinated on the floor and pulled on his genitals. In August 2016, claimant was diagnosed with developmental expressive language disorder and behavior problems.

7. Claimant's mother reported that claimant's father, who is also Spanish-speaking only, was diagnosed with bipolar disorder and schizophrenia. Neither parent was employed. Claimant's father was disabled and claimant's mother stayed home to care for the children. Claimant's mother also reported that three of claimant's siblings were diagnosed with ASD and one sibling had learning challenges.

8. Dr. Shrader noted under the "Behavior Observations" portion of the Kaiser Center evaluation report, that claimant was uncooperative through the majority of the evaluation. She described claimant as "avoidant and aggressive." He yelled at Dr. Shrader when she looked at him, smiled or talked. He appeared irritable and his mood was "congruent though undirected." Claimant avoided eye contact with Dr. Shrader. Over the course of the three-hour evaluation, claimant "appeared to have a slow-to-warm up temperament" and became more tolerant, more vocal and more interactive.

However, during the course of the evaluation, he had limited range of gestures with brief eye contact, did not play with materials during the testing, did not direct facial expressions towards others, stared up at the ceiling, repeatedly opened the door, used three-word phrases and had little spontaneous speech. Additionally, his speech was difficult to understand. At times he became upset, kicked his feet on the floor, cried and whined. Claimant's mother attempted to give him her cell phone to use to calm him down. He pushed the phone away. Claimant often ignored his mother when she spoke to him and at one point called her "stupid." Claimant's mother cried two times during the evaluation. The first time claimant approached his mother to feel the tears on her cheek, but did not appear to be concerned. The second time he did not respond.

9. Claimant's mother completed the ABAS-3, which is a "questionnaire designed to evaluate whether an individual displays various functional skills necessary for daily living without the assistance of others." Claimant's mother ranked claimant as extremely low for conceptual, social and practical areas. His overall score was 48 which fell into the less than 0.1 percentile.

10. Dr. Shrader attempted to test claimant's cognitive functioning with the Mullen Scales of Early Learning (Mullen): Visual Reception Scale. However the test was discontinued because claimant refused to participate. As a result, his intellectual development was assessed with the CDI, which was completed by claimant's mother. The CDI measures development in eight areas: social, self-help, gross motor, fine motor, expressive language, language comprehension, letters and numbers. The results, based on claimant's mother's report, indicated that claimant had a 54 percent delay.

11. An evaluation of claimant's social functioning was also based on a parent rating questionnaire, which indicated that claimant had clinically significant scales for emotional reactive, withdrawn, attention problems, aggressive behavior, depressive problems, autism spectrum problems and oppositional defiant problems. Somatic complaints fell into the borderline clinical range.

12. Claimant was assessed using the ADOS-2: Module 1. Dr. Shrader noted that during the assessment claimant said one word, "stupid." Otherwise, he was silent. He did not use gestures and his "eye conduct was poorly modulated and avoidant." He did not engage in any social interaction, did not play with toys, and did not express any pleasure. He "exhibited deficits in joint attention as he did not make any attempts to direct others to items of interest through social gaze, and did not follow the examiner's use of gaze either." Dr. Shrader described claimant as "underactive and unwilling to participate throughout the ADOS-2 administration." Dr. Shrader also noted that claimant "did not demonstrate any sensory seeking behaviors or sensory interest in play

materials." He also did not exhibit "any hand, finger or other complex mannerisms." Dr. Shrader also did not observe any "repetitive or stereotyped behaviors."

13. Dr. Shrader utilized the DSM-5 criteria for ASD. DSM-5 section 299.00, ASD, lists the follow Diagnostic Criteria that must be met in order to diagnosis an individual with ASD:

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive; see text):

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.

Specify current severity:

Severity is based on social communication impairments and restricted, repetitive patterns of behavior (see Table 1).

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypes, 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 hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

Specify current severity:

Severity is based on social communication impairments and restricted, repetitive patterns of behavior (see Table 1).

C. Symptoms must be present in the 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.

E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

(Italics and bolding in original.)

14. Dr. Shrader noted that "for a diagnosis of [ASD], an individual must demonstrate marked deficits in each of the first criteria (A), and at least 2 marked criteria in the second category (B), in addition to meeting criteria for the categories of C, D, and E."

Dr. Shrader opined that claimant demonstrated marked deficits in each of the three diagnostic criteria in Criteria A. Specifically, in the first criterion of Criteria A which includes "social emotional reciprocity…," specific examples included that claimant "gave an avoidant/aggressive response to others' attempts to socially engage him." Additionally, he "did not make any social initiations with the examiner during the evaluation" and "exhibited no social-emotional reciprocity." The remainder of examples was based on claimant's parents' report. These included that claimant did not approach other children to play, but "rather he approaches peers to stare at their shirt or shoes." Claimant's parents have to call his name two or three times before he responds. He does not share or give spontaneous affection. He shows no concern for others and does not "initiate family activities." When prompted to respond to greetings, he "looks blankly at his mother and looks down at the floor."

Dr. Shrader also determined that claimant had deficits in second criterion of Criteria A, which concerned nonverbal communicative behaviors. Specific examples included that claimant's "eye contact is avoidant, with some instances of staring at

others, expressionless, and on his terms." The examiner also noted that claimant did not use any gestures, and turned his body away from "social games." Based on claimant's parents' report, claimant also made "little eye contact with his family members," did not use "descriptive or informal gestures," "point[ed] to objects with no integrated speech and use[d] emotional gestures undirected to others." His parents also reported that he had "limited range of facial expressions" and "d[id] not appear to read others' facial expressions."

Dr. Shrader also determined that claimant had deficits in the third criterion of Criteria A, which concerned "developing, maintaining, and understanding relationships…" Specific examples included that claimant did not play with toys during the evaluation and did not show interest in his mother or the examiner. He was also not cooperative with Dr. Shrader. Based on claimant's parents' report, claimant also would throw items off of grocery store shelves and throw the items at people. He also did not engage in "pretend play and prefers to play alone." He also showed no interest in his peers.

15. Dr. Shrader opined that claimant demonstrated marked deficits in each of the four diagnostic criteria in Criteria B. Dr. Shrader's determination appeared to be based exclusively on claimant's parents' report. For the first diagnostic criterion described as "stereotyped or repetitive motor movements, use of objects, or speech … ," Dr. Shrader noted that claimant used "routine and scripted speech." He also "rocks his body from side to side," "spins in circles, lines up cars, shoes, and toothbrushes and water bottles in the bathroom." His parents also reported that he "stacks shoes," "makes facial grimaces in the mirror, and quickly flips through photos on the phone repeatedly." He also "turns the light switches on and off and opens and shuts the refrigerator door repeatedly."

Dr. Shrader also determined that claimant met the second diagnostic criterion in Criteria B, which is described as "insistence on sameness, inflexible adherence to routines or ritualized patterns of verbal or nonverbal behavior … " Examples provided by claimant's parents included that he "repetitively watches a video recording from his birthday of the happy birthday song." He also "insists on brushing his teeth himself and refuses to let his mother provide assistance." His parents also reported that "all interactions must be done on claimant's terms."

For the third diagnostic criterion described as "highly restricted, fixated interest that are abnormal in intensity and focus," Dr. Shrader determined that claimant met the criterion based on claimant's parents' report that he had "restrictive interest in shoes and cats." Examples provided by his parents included that he "stares and touches others' shoes." He also "stacks and lines up shoes." He likes to put various types of shoes on and he looks up pictures of shoes on cell phones. He also asked if "cats are hot or cold." He points at cats and looks for videos of cats on cell phones or his electronic tablet.

Dr. Shrader also determined that claimant met the fourth diagnostic criterion described as "hyper or hypo-reactivity to sensory input or unusual interest in sensory aspect of the environment … " Examples provided by claimant's parents included that he "does not like to be held or kissed." Claimant also "watches his own finger movements." He likes to turn his toys cars over and "watch the wheels spin." He screams when he takes a bath and does not like water on his face. However, he likes to watch water come out the faucet. He also "covers his ears in response to toilets flushing and others talking." He "refuses to wear socks." He "prefers to sleep with no clothes on." He puts items such as coins, dice and food from the floor, into his mouth. He also "chews on his shirt." Claimant's parents believe that he is indifferent to temperature because he will wear layers of clothes on hot days. He also covers his eyes when he spins.

16. Dr. Shrader opined that claimant met Criteria C, D, and E. She provided no explanations as to why he met each of the criteria. However, she opined that claimant did not have intellectual impairment or language delay, as part of the ASD diagnosis.

17. Dr. Shrader opined that the results of the evaluation "are suggestive" of ASD. Dr. Shrader noted that "based upon observed behaviors throughout this evaluation and behaviors reported by parents, [claimant] meets the DSM-5 criteria for a diagnosis of ASD." Dr. Shrader further noted that "[p]arent report on the Child Developmental Inventory indicates a 54% delay in his development; however, it is unclear whether he appears to be delayed due to avoidant behaviors as opposed to delay in actual ability." As a result, Dr. Shrader recommended that claimant's intellectual functioning be reassessed.

Dr. Shrader also noted that claimant would be referred for a formal speech and language therapy evaluation and occupational therapy evaluation. Dr. Shrader did not provide any differential diagnosis, which may have also explained claimant's behavior and deficits. However, Dr. Shrader recommended claimant's parents contact Kaiser's Department of Child Psychiatry to provide "therapy and medication as needed." Additionally, Dr. Shrader informed claimant's parents that "therapeutic services for children with autism are offered through" California Regional Centers.

18. The ASD report issued by the Kaiser Center contained a note which provided an explanation concerning use of the report. The note states in pertinent part:

> This report is not a comprehensive psychological report that details all of the patient's history and all possible concerns. Rather, it is a very brief report of the patient's history and symptoms specifically related to the diagnosis of Autism Spectrum Disorder (ASD). The reader is referred to the medical chart for more thorough review of patient

information. The results of this evaluation may not be valid after 12 months due to changes in development and/or medical status.

19. After the Kaiser Center diagnosed claimant with ASD, he was provided Applied Behavior Analysis (ABA) services in his home, from Learning Solutions. Part of the process in obtaining ABA services included evaluations conducted on August 10 and 17, 2017, with behavioral specialists. Claimant's mother was present for the evaluations. She described claimant's on-going behavior issues, including his fixation on "Chucky," a character from a horror movie. Claimant viewed a "brief clip of the movie" when an older sibling was watching the film. Since that time, claimant had requested a Chucky doll and asked to watch clips of the movie on "YouTube." Claimant's mother stated that other than stuffed animals, his favorite objects to play with were a cell phone and electronic tablet.

Over the course of the evaluations, claimant was observed throwing tantrums, and engaging in defiant behavior such as "rubbing his groin against his mother's back while laughing." He would often ignore verbal instructions given by his mother. However, the assessor noted that claimant was "observed complying with the assessor's instructions after building rapport involving play with his phone." Additionally, claimant was "seen playing and conversing with the assessor in the absence of maladaptive behaviors."

SOCIAL ASSESSMENT PERFORMED BY ACRC

20. After claimant's mother requested services from ACRC, David Webb, Intake Counselor for ACRC, performed a social assessment of claimant on April 7 and August

22, 2017.[2] On April 7, 2017, Mr. Webb met with claimant, his mother and his sibling. On August 22, 2017, he finished the assessment with claimant's mother over the telephone. Thereafter, Mr. Webb prepared a report. Mr. Webb testified at the hearing in this matter.

21. Mr. Webb noted that claimant was to be assessed due to "concerns related to learning and cognitive skills as well as concerns related to social communication and behavioral difficulties." The purpose of the social assessment was to obtain information about claimant's family, his medical and psychiatric history, to document behavior concerns and social functioning, and to obtain information about claimant's adaptive skills such as self-care, receptive and expressive language, learning, mobility, and self-direction.

22. When the claimant and his family arrived at the assessment on April 7, 2017, Mr. Webb noted that claimant did not greet him or look at him when he greeted claimant. Claimant appeared to be shy. Claimant immediately ran to his siblings, huddled together and began to talk and whisper. Mr. Webb observed claimant to joke and giggle with his siblings. He also observed that claimant exhibited "appropriate social eye contact with the sibling when he spoke to them." He gestured, smiled and giggled. Mr. Webb also noted that during claimant's interactions with his siblings, his "affect seemed flat." Claimant spoke in two or three-word phrases. At various times, Mr. Webb attempted to engage in conversation with claimant. However, claimant did not appear to be interested in responding. He also did not follow his mother's requests.

[2] The Social Assessment report reflects interview dates of April 7, and August 23, 2017. However, based on Mr. Webb's notes he completed the interview portion of assessment concerning claimant over the telephone with his mother on August 22, 2017.

At times, Mr. Webb had a difficult time understanding claimant's "articulation of words." However, other times claimant's speech was clear. Mr. Webb did not notice any repetitive movements, echolalia, or other unusual behaviors. Mr. Webb testified that based on his observations, claimant did not present as a child with autism. Though claimant's speech articulation was not clear at times and communication with adults was not appropriate, his interactions and communication with his siblings appeared appropriate and he did not exhibit unique speech, repetitive language or behavior typically seen in children with ASD.

23. Claimant's mother reported to Mr. Webb that claimant is "very aggressive." He plays rough "with everyone." When he gets upset he urinates and "plays rough with his private parts." He also "rubs his private parts everywhere." He also tends to "scratch, hit and bit everyone." He is a picky eater and will eat less than 10 food items. He runs around in the house in a "back and forth" patterns. She reported that his speech was repetitive. She also reported that claimant "becomes very focused on his electronic tablet" and "watches videos of cars and motorcycles 'over and over again.'" If his tablet is taken away he becomes aggressive. She also reported that he has daily tantrums that may last up to 30 minutes.

Claimant's mother further reported that claimant needs help with self-care, such as dressing. He also does not like water touching his hair or face. He fights and resists having his teeth brushed. Claimant's mother also expressed concerns that claimant is behind in his learning of the alphabet, colors and numbers. Claimant's mother only speaks Spanish. Claimant speaks English and understands some Spanish. Claimant's mother explained that "she does not have the ability to fully communicate with [claimant] so it is difficult to gauge his full learning ability."

24. After Mr. Webb prepared his report, ACRC referred claimant to Katherine Redwine, Ph.D., Licensed Clinical Psychologist, for a psychological evaluation and testing.

PSYCHOLOGICAL EVALUATION AND TESTING PERFORMED BY DR. REDWINE

25. Dr. Redwine has been a Licensed Clinical Psychologist since 2007. Dr. Redwine currently works as a contracted psychologist performing psychological evaluations to determine whether a client is eligible for ACRC services. Dr. Redwine also operates a private practice performing psychological assessments, including administering testing to determine cognitive function and diagnosing of ASD. Dr. Redwine performs approximately 350 assessments per year.

26. On April 30, 2018, Dr. Redwine completed an evaluation of claimant. Dr. Redwine prepared a Psychological Evaluation Report and testified at the hearing in this matter. Dr. Redwine's report explained that the reason for the referral was to "assess [claimant's] level of intellectual and adaptive functioning" and "consider a diagnosis of autism" to assist in the determination of claimant's eligibility for ACRC services.

27. Dr. Redwine interviewed claimant's mother and reviewed available records, including the social assessment performed by Mr. Webb, and the Kaiser Center psychological evaluation. Dr. Redwine also administered claimant several tests, including the Wechsler Preschool and Primary Scales of Intelligence (WPPSI-IV), the ABAS-3, and the ADOS-2. Dr. Redwine also reviewed and applied the DSM-5 diagnostic criteria for ASD. At the time of the evaluation, claimant was almost five years old.

28. Dr. Redwine obtained a family, developmental, social, medical and psychiatric history for claimant. Claimant's mother reported that claimant was one of six children. One of his siblings was a client of ACRC. Claimant's mother reported that she obtained a sixth grade education. Claimant's father obtained a tenth grade education.

Claimant's mother speaks Spanish. His father speaks Spanish and English. Claimant speaks English.

In terms of claimant's early development, he was delayed in sitting, crawling and walking. He did not begin to speak until he was two and one-half years old. When claimant began to speak, he had speech problems. Claimant was receiving speech therapy twice per week with some success. Claimant's mother informed Dr. Redwine that claimant "tends to speak more about toys than about his needs." However, while claimant's mother was explaining this to Dr. Redwine, claimant approached his mother and asked when they could leave. He also "showed other appropriate requests."

Concerning claimant's medical history, he was a physically healthy child with "no history of accidents, illnesses, surgeries or seizures." However, he "exhibited enuresis and encopresis behaviors when his is upset."[3] Claimant was also diagnosed with obesity. He had several "bad cavities" and after having crowns placed on his teeth, he is fearful of going to the dentist. Claimant's mother also report that claimant rarely sleeps and typically does not go to bed until 2:00 a.m. He is also a "picky eater."

29. Claimant's mother reported many areas of concern. She reported that he is "easily confused." For example, he will tell his mother that his eye hurts, but he point to his mouth. He is also very attached to his mother and cries if he is separated. He will not engage in self-care and will only allow his mother to help him. If other members of the family try to help claimant, he hits and throws things. Claimant sleeps with his mother. Additionally, she had just recently taken him off of a bottle. Claimant's mother was also concerned that claimant likes "'scary, ugly things' such as Chucky." He "watches and

[3] Enuresis refers to the discharge of urine. Encopresis refers to the discharge of bowel movements.

seeks out disturbing content on his tablet and then says that the scary characters are his friends."

If claimant's siblings attempt to sit next to him, he tells them to move; if they do not comply, he hits them and pulls their hair. He "loves guns" and will cry and scream if his mother does not purchase what he wants. As a result, claimant's mother has purchased the guns "so that he is not aggressive." He also becomes upset when his penis is erect and tries to hurt it. He tells his mother to "take it away." He also urinates on purpose when he is angry and when he was younger he would fling fecal matter when he was angry. He also tries to grab the private parts of his siblings.

30. Claimant's mother also reported that in the area of social functioning, claimant prefers to play with younger children, but he does not approach children to play. If a child approaches claimant, he will become aggressive. He tells the children to "shut up." Claimant's mother explained that he engages in imaginary play with his cousins. However, he does not show sympathy to people and he "does not change his behavior to suit different social situations."

31. Dr. Redwine made numerous behavior observations of claimant during the course of the evaluation. Initially when Dr. Redwine greeted claimant, he "appeared to have a flat affect." Claimant did not exhibit any anxiety or distress. Dr. Redwine proceeded to explain the testing process. Claimant's mother "reacted angrily saying in significant detail how much difficulty [claimant] has behaviorally and that he is unable to be separated from his mother and will scream and cry and hit." Dr. Redwine observed that as claimant's mother was expressing her concerns, claimant became "visibly angrier and ran out of the room to the couch where he continued to appear angry and increasingly defiant." Dr. Redwine asked claimant's mother to encourage him to cooperate with the evaluation, to do his best, and to trust Dr. Redwine to do a good job.

Claimant returned to the testing room, but became angry and left the room again when Dr. Redwine attempted to close the door. Dr. Redwine agreed to leave the door open.

During the administration of the cognitive measures, Dr. Redwine also observed that claimant had a "significant amount of resistance to controls and oppositional and defiant behaviors." Claimant showed "variable eye contact and guarded facial expressions." However he also showed "beautiful social smiles and very prominent affect of anger." He also used descriptive gestures. He spoke in "intelligible, simple sentences with some grammatical errors." Claimant's "infection, pitch, tone, rhythm, rate, and volume were appropriate." Claimant also "did not display any repetitive or idiosyncratic use of language or motor mannerisms."

Claimant initiated conversation with Dr. Redwine about his experiences. He spoke about his interest in wrestler John Cena, and showed Dr. Redwine the arm and wrist bands he wore that were similar to that worn by Mr. Cena. He also engaged in imaginary play such as "holding up his finger and pretending to cut it off." He also talked about characters he viewed on his tablet. During the clinical interview with claimant's mother, claimant played with toys and asked Dr. Redwine questions about the toys. He played with the toys in an appropriate fashion. He also showed Dr. Redwine pictures of his new puppy that were on his mother's cellphone. He demonstrated good contact and pointing.

Claimant also appeared to be paying close attention to his mother's conversation with Dr. Redwine. Claimant "sat on his mother's lap and interjected comments." Examples included when claimant's mother talked about his "social difficulties and aggression." Claimant interjected that he was "gonna kill people because they're trying to play with me." When claimant's mother discussed his aggression towards his siblings he responded "I pull their hair." Over the course of the interview claimant became tired and asked when the evaluation would be done. When he was told by his mother that it

would be "five more minutes," claimant began "whining and becoming increasing distressed." The only thing that distracted him was his mother's cell phone, which she gave him.

32. Dr. Redwine administered claimant the WPPSI-IV to assess his intellectual ability. Dr. Redwine explained that the results were "somewhat limited due to [claimant's] noncompliance on three subtests." Claimant's Verbal Comprehension Index fell in the Extremely Low range, with a standard score of 69, his Visual –Spatial Index fell into the Borderline range with a standard score of 70, and his Fluid Reasoning Index fell into the Low Average range, with a standard score of 88. His prorated Full Scale intelligence quotient (IQ) fell into the Borderline range with a score of 74.

33. Claimant's mother completed the ABAS-3, which is a "survey completed by parents, caregivers, and/or teachers regarding adaptive behavior of the person being evaluated." Answers to questions regarding the frequency of behavior observed, "provide a comprehensive picture of a person's ability to function in ten different domains." Based on the responses, claimant obtained a General Adaptive Composite standard score of 45, which is "extremely low." However, Dr. Redwine opined that the results "should be interpreted with extreme caution as … mother may have underestimated some of his abilities."

Dr. Redwine listed several discrepancies between certain skills claimant's mother stated he was unable to perform and what Dr. Redwine observed. For example, claimant's mother reported that claimant was not able to "name 20 or more familiar objects but he was observed to be speaking in full sentences." Claimant's mother also reported that he was "unable to use sentences with a noun and a verb, which he was observed to do in the Motor Section." She also reported that claimant "did not independently sit unsupported without falling over, but he was observed to do so throughout the evaluation session."

34. Dr. Redwine also administered the ADOS-2, Module 3, a standardized, semi-structured measure that allows examiners to observe and gather information regarding an individual's social, communication, and play behaviors. Overall, claimant scored "6." The autism cut-off score is "9." The autism spectrum cut-off is "7." Accordingly, Dr. Redwine opined that claimant meets the ADOS-2 classification for "non-spectrum." Dr. Redwine provided extensive examples of claimant's behavior in the areas of language and communication, reciprocal social interaction, imagination/creativity and stereotyped behaviors and restricted interest.

Claimant's language and communication abilities included his use of "relatively complex speech but with recurrent grammatical errors not associated with use of dialect." He demonstrated "appropriate varying intonation with reasonable volume, rhythm, and rate of speech." Notably, "he never displayed any immediate echolalia or any stereotyped or idiosyncratic use of words or phrases." He spontaneously offered his "own thoughts, feeling and experiences." He engaged in reciprocal conversation about a variety of topics and used descriptive gestures. He was also able to demonstrate tasks such as "brushing, spitting, drinking, and putting away a toothbrush."

Claimant showed emotions such as smiling when he was having fun, and annoyance, irritability and anger when he was upset. However, "he was not able to identify or communicate an understanding of emotions in other people" and had "no insight into typical social relationships but was generally also quite defiant during those questions." As a result, it was not clear to Dr. Redwine to "what extent he actually has insight into social relationships." Dr. Redwine described the "overall quality" of claimant's rapport during the testing as "sometimes comfortable but not sustained."

Claimant engaged in imaginative and creative play. He "showed several different spontaneous, inventive and creative activities, including "using action figures to pretend to be WWE wrestlers and was able to play along to some extent when [Dr. Redwine]

used [her] action figure to play with him." He made up a story using objects from the "Creating a Story task." Dr. Redwine noted that claimant's imaginary play "was consistently very aggressive and violent in nature, such as having a car crash and somebody die in his Creating a Story task."

Dr. Redwine also opined that claimant "did not demonstrate any unusual sensory interest or sensory-seeking behaviors," or any behaviors typically seen in a child with autism." Dr. Redwine opined that claimant "likely meets the criteria for oppositional defiant disorder [ODD] and disruptive mood dysregulation." Additionally, based on claimant's mother's report that he does not fall asleep until 2:00 a.m., he "likely qualified for a diagnosis of insomnia with its accompanying effects of sleep deprivation on mood behavior and cogitation."

35. Dr. Redwine utilized the DSM-5 to determine if claimant met the diagnostic criteria of ASD. In her report, Dr. Redwine included a chart containing the DSM-5 Diagnostic Criteria for ASD. Dr. Redwine provided specific examples in the chart concerning claimant's observed behavior, which supported her findings. In order to meet the diagnostic criteria for ASD, claimant must meet all three criterion under Criteria A, which addresses reciprocal social communication and social interaction. Claimant met one of three criteria. Specifically, under the criterion for deficits in developing, maintaining and understanding relationship, Dr. Redwine explained that claimant "does not have the ability to make and sustain friendships at a developmentally appropriate level; however, his significant physical and verbal aggressiveness toward others, consistent with his diagnosis of ODD and disruptive mood dysregulation disorder, interfere significantly with his abilities in those areas. He was able to share play, albeit in a very aggressive and morbid fashion."

36. Under Criteria B, which includes restricted, repetitive patterns of behavior, interests or activities, claimant must meet two of four criteria. Dr. Redwine opined that

claimant met one of the criteria. Specifically, under highly restricted, fixated interest, Dr. Redwine explained that claimant was "observed to display an unusual pattern of interest in violent or frightening themes or play and videos, causing [Dr. Redwine] significant concern as to what sort of material he is being exposed to on media and within his family play and discussions."

37. Dr. Redwine concluded that claimant did not meet the diagnosis of ASD. However, she did include several "rule out" conditions which should be considered, because these conditions may explain claimant's difficulty with adaptive functioning. The rule out conditions, also contained in the DSM-5, included: Insomnia disorder, enuresis, nocturnal and diurnal, unspecified depressive disorder, ODD, unspecified attention deficit/ hyperactivity disorder, and language disorder.[4]

38. Dr. Redwine also opined that although claimant was diagnosed with ASD through the Kaiser Center, claimant was described in the report "as being almost entirely noncompliant with the ADOS-2." The DSM-5 ASD criteria findings appeared to be

[4] Dr. Redwine's report included six recommendations including her opinions that claimant would benefit from a "referral for an evaluation for special education services through the school district, including an evaluation for speech therapy, occupational therapy, and behavioral intervention services," a referral to a mental health agency to receive family psychotherapy and/or medication, and limitations placed on his exposure to "television, computer and other screen time limited to no more than one hour per day to provide him with ample opportunity to engage in language and social-based activities." Dr. Redwine further recommended that claimant's parents monitor claimant to ensure that "he is only being exposed to appropriate content and is being shielded from media and/or family interactions that relate to violent or aggressive content and themes."

almost entirely based on claimant's mother's report. Dr. Redwine explained that "[i]n contrast, he was much more able to be compliant during the course of the evaluation session albeit with multiple episodes of elopement out of the office before being returned back to the evaluator's testing office." Additionally, the Kaiser Center did not consider differential diagnoses that may have provided alternate explanations for claimant's symptoms.

39. Dr. Redwine also concluded that claimant did not meet the diagnostic criteria for intellectual disability. Dr. Redwine opined that claimant's evaluation demonstrated that his cognitive abilities "fell into the Borderline range with regards to his prorated Rule Scale IQ." She further explained that although claimant "may be demonstrating some cognitive challenges, he is also currently showing some strengths, in particular his low average Fluid Reasoning abilities, that would preclude a diagnosis of Intellectual Disability" or borderline intellectual functioning.

ADDITIONAL TESTIMONY AT HEARING

Sindhu E. Philip Psy.D.

40. Sindhu Philip, Psy.D., has been employed as a Staff Psychologist at ACRC since 2011. Dr. Philip has over seven years of experience completing and reviewing assessments for intellectual disability and autism. In addition to performing evaluations, she reviews assessments and evaluations performed by vendored psychologists. Dr. Philip reviewed the Kaiser and Dr. Redwine reports and other documents concerning claimant's request for services to determine if he qualified for services under any of the five developmental disabilities delineated in the Lanterman Act: cerebral palsy, epilepsy, autism, intellectual disability, and/or a disabling condition found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability (fifth category). She also participated in an informal meeting

with claimant's mother concerning ACRC's decision that claimant was not eligible for services.

41. Dr. Philip explained that ASD is a diagnosis that is characterized as deficits in social communication, social interaction, repeated rigid behavior, or sensory issues. In order for an individual to become eligible for regional center services, a diagnosis of autism must be made by a qualified professional who administers standardized testing. If there are discrepancies in the testing, then ACRC considers information in education records, and other sources of information, such as the social assessments performed by ACRC.

42. Dr. Philip also explained that for a diagnosis of intellectual disability, as set forth in the DSM-5, an essential feature is low intellectual functioning as confirmed by clinical assessment and performance on standardized intellectual tests which measures IQ and deficiencies in adaptive functioning in at least one or more areas observable across multiple setting, which occurs during the early developmental period. In order to be eligible for ACRC services for intellectual disability, an individual must have a diagnosis of intellectual disability from a qualified professional, or meet Educational Code criteria for intellectual disability through a school district or show a long pattern of scores on IQ measures, which are consistent with a diagnosis of intellectual disability.

Additionally, Dr. Phillip explained that borderline intellectual functioning is a diagnosis or condition that is given when an individual has low intelligence but scores on IQ measures and assessment fall just above the range of mild intellectual disability, but still well below average. An individual with borderline intellectual functioning can be eligible for ACRC under the fifth category, which is defined as a condition closely related to intellectual disability, or requiring treatment similar to a person with intellectual disability. Dr. Philip explained that fifth category was also considered by ACRC when reviewing the information presented concerning claimant's request for services.

43. Dr. Philip reviewed the report prepared by the Kaiser Center. Based on the information included by the evaluators, Dr. Philip opined that claimant had behavioral issues the day of the evaluation. He was uncooperative, unwilling to participate, and seemed difficult for evaluators to establish a rapport, which she explained is important in helping to put the child in a natural setting so that he can do his best. Dr. Philip explained that when a child presents this way it is hard to determine the meaning of the behavior. In fact, the Kaiser Center evaluator explained that claimant had a "slow to warm up" temperament and recommended that his social temperament be monitored, as variability in his temperament and behavior issues had affected his performance. Dr. Phillip opined that the recommendation to monitor claimant's social development indicates that the Kaiser Center evaluator was not certain of the validity of diagnosis and claimant should continue to be monitored as more information becomes available.

44. In contrast, Dr. Philip opined Dr. Redwine's opinions and findings are accurate because she provided significant detail and discussions of observations in support of her findings. Additionally, claimant's communication skills and behavior presentation when he was well-regulated, relaxed and let his guard down, demonstrated social interest. He also did not have great difficulty using gestures, and he engaged with Dr. Redwine. Although there were adaptive difficulties in social functioning and behaviors, those likely point to mental health conditions rather than autism, as explained by Dr. Redwine. Additionally, the testing performed by Dr. Redwine and the documents reviewed did not find that claimant had intellectual disability, borderline intellectual functioning or a disabling condition found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability. Dr. Philip also noted that the Kaiser Center did not diagnose with intellectual delay.

45. Dr. Philp explained that ACRC most heavily relied upon Dr. Redwine's findings, to determine that claimant did not qualify for services from ACRC under the Lanterman Act.

Claimant's Mother and Graciela Medina

46. Claimant's mother explained her youngest child, a daughter, has been diagnosed with autism and is a client of ACRC. Since claimant was two years old, individuals who have come into their home to help her daughter have suggested that claimant be evaluated to find out if he has a condition that causes his behavior. As result, claimant's mother was eventually referred to the Kaiser Center. Claimant's mother admitted that claimant did not cooperate with the evaluation conducted by Kaiser Center. She explained that he would not look at the evaluators and at one point he stood up to spin in circles. After the Kaiser Center evaluation, she was told to bring claimant back to Kaiser for further testing. Claimant's mother took him back, but he would not cooperate. He kicked and pulled the hair of the evaluator. The evaluation was cancelled.

47. Claimant has been receiving ABA services in his home. Claimant's mother explained that some of the ABA providers will not work with claimant because he is so aggressive. Despite receiving ABA services five days a week for four hours per day, his behavior has not improved. She explained that claimant has no control. He spits and urinates on people. He also hits people with objects. Claimant's doctors have recommended that he be placed on medication, but claimant's mother has not done so.

48. Graciela Medina also testified on behalf of claimant. Ms. Medina works for Norcal Mental Health America-Sacramento Advocacy for Family Empowerment (Norcal). She has known claimant for three years. Claimant's mother requested services from Norcal. Ms. Medina assists claimant's parents with completing paperwork and supporting the family in obtaining mental health services.

Ms. Medina has interacted with claimant. She described claimant as "very aggressive." She has observed claimant raise his middle-finger at his mother and call people "stupid." Ms. Medina explained that she has observed people try to control claimant and work on his behavior, with no success. Ms. Medina explained that her role is not to provide medical or clinical support to claimant or his family. She has no clinical training in diagnosing ASD or intellectual disability. Rather her role is advocate for claimant's family.

DISCUSSION

49. When all the evidence is considered, claimant's mother did not establish that claimant is eligible for services from ACRC under any of the categories of developmental disabilities covered under the Lanterman Act. Dr. Redwine's opinion that claimant is not an individual with autism or an intellectual disability, and does not qualify for services under the fifth category, was persuasive. Dr. Redwine's evaluation is comprehensive, thorough, and convincing. Claimant was almost five years old at the time of the evaluation. While claimant was at times oppositional and defiant over the course of the evaluation, claimant's participation and the findings of the assessment demonstrate that, although claimant has adaptive functioning deficits, these deficits were not due to any developmental disability recognized in the Lanterman Act.

50. In contrast, the evaluation performed by the Kaiser Center is lacking in many respects. The evaluation was conducted when claimant was three years, seven months old. Claimant was non-compliant for the assessment. His cognitive functioning could not be measured and the determination that claimant had a diagnosis of ASD appeared to be based on claimant's mother's report, rather than observed behaviors. Additionally, the evaluators failed to consider differential diagnoses that may have better explained claimant's symptoms. Significantly, the report contains a disclosure that the findings of the report may not be valid after 12 months due changes in

development and medical status. As a result, the evaluation performed by the Kaiser Center is not reliable.

51. The legislature made the determination that only individuals with one or more of the five specified types of disabling conditions identified in the Lanterman Act are eligible for services from regional centers. The legislature chose not to grant services to individuals who may have other types of disabling conditions, including mental health disorders, if it is not demonstrated that the conditions fall within one of the five categories delineated in the act. The legislature did not grant regional centers the authority to provide services to individuals whose disabilities fall outside the five specified categories.

In addition, the legislature provided that, in order for an individual to qualify for services under the Lanterman Act, the individual's developmental disability must be substantially disabling and must be the cause of the adaptive deficits to which the requested services relate. Although it is apparent that claimant's mother is very concerned about claimant's behavior and well-being, she did not establish that claimant is eligible for services under the Lanterman Act because she failed to demonstrate that claimant is an individual with autism or an intellectual disability, or that he has a disabling condition that is closely related to intellectual disability or requires treatment similar to that required for individuals with intellectual disability. Therefore, claimant's request for services from ACRC must be denied.

LEGAL CONCLUSIONS

1. Pursuant to the Lanterman Act, Welfare and Institutions Code section 4500 et seq., regional centers accept responsibility for persons with developmental disabilities. Welfare and Institutions Code section 4512 defines developmental disability as follows:

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

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

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

(b) The Development Disability shall:

(1) Originate before age eighteen;

(2) Be likely to continue indefinitely;

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

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

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

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

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

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

3. An administrative "fair hearing" to determine the rights and obligations of the parties, if any, is available under the Lanterman Act. (Welf. & Inst. Code §§ 4700 through 4716.) Claimant's mother requested a fair hearing to appeal ACRC's denial of her request that claimant be found eligible for services. The burden is on claimant to establish that he is eligible for services. (See *Lindsay v. San Diego Retirement Bd.* (1964) 231 Cal.App.2d 156, 161.)

4. As set forth in the Factual Findings, claimant's mother did not establish that claimant qualifies for services under the Lanterman Act because he is an individual with autism or an intellectual disability, or because he has a disabling condition that is closely related to intellectual disability or requires treatment similar to that required for individuals with an intellectual disability. Consequently, she did not establish that claimant qualifies for services from ACRC under the Lanterman Act. Claimant's appeal must therefore be denied.

ORDER

Claimant's appeal is DENIED. Alta California Regional Center's denial of services to claimant under the Lanterman Act is SUSTAINED.

DATED: September 21, 2018

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MARCIE LARSON

Administrative Law Judge

Office of Administrative Hearings

NOTICE

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