

BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

ANDREW A.,

Claimant,

vs.

SAN GABRIEL/POMONA REGIONAL
CENTER,

Service Agency.

OAH No. 2011080300

DECISION

Administrative Law Judge Michael A. Scarlett, Office of Administrative Hearings, State of California, heard this matter on January 31, 2012, in Pomona, California. Daniela Martinez, Fair Hearing Manager, represented San Gabriel/Pomona Regional Center (Service Agency or SGPRC). Andrew A. (Claimant) was present and was represented by his adoptive mother, Martha R. (Mother).¹

Oral and documentary evidence was received and argument was heard. The record was closed, and the matter was submitted for decision on January 31, 2012. On April 4, 2012, the record was re-opened to allow Service Agency to supplement the record with a complete copy of Exhibit 9, the June 22, 2010 psychological evaluation performed by Dr. Rita Collins-Faulkner, Ph.D., which was missing Page 3. The resubmitted complete evaluation was marked as Exhibit 10 and admitted into evidence without objection. The case was re-submitted for decision on April 4, 2012.

ISSUE

Does Claimant have a developmental disability entitling him to regional center services?

¹ Claimant's and his mother's last initials are used in this Decision, in lieu of their surnames, in order to protect their privacy.

FACTUAL FINDINGS

1. Claimant is a seven-year, four-month-old boy who was adopted on November 18, 2011, by his foster parents Martha R. and Oscar P. Claimant has resided with his adoptive parents since he was three years old. He is currently attending second grade in the Pomona Unified School District. Mother is concerned that Claimant is not progressing in school and believes he needs regional center services. Mother has not articulated a basis for Claimant's eligibility, but she believes he was exposed prenatally to alcohol and drugs and that this may be negatively impacting Claimant's development. Claimant's overall physical and medical condition are considered good, although he wears eye glasses and has had three surgeries due to eye problems. Thus, there appears to be no issue regarding eligibility based on cerebral palsy or epilepsy.

2. In August 2010, Service Agency determined that Claimant was not eligible for regional center services because he did not suffer from a qualifying developmental disability. Based on this determination, the Service Agency denied services to Claimant, but Claimant did not appeal the denial. On July 19, 2011, following Claimant's second referral for regional center eligibility, Service Agency again notified Claimant that he was not eligible for regional center services. Service Agency considered the psychological evaluation from Dr. Rita Collins-Faulkner dated June 22, 2010, the psychological and psycho-educational assessment from Dr. David Roman Leonelli, Ph.D., dated July 14, 2010, and the psychological evaluation from Dr. Victor C. Sanchez, Ph.D. dated July 19, 2010, in denying eligibility. These evaluations are the same evaluations used by Service Agency to deny Claimant's eligibility in 2010. Service Agency did not conduct new evaluations for the 2011 eligibility determination. Claimant did not submit any new assessments or evaluations to Service Agency for consideration prior to the date of hearing. At hearing, however, Claimant offered a second psycho-educational assessment from the Pomona Unified School District conducted in June 2011. Claimant submitted a request for fair hearing, and this hearing ensued.

3. On June 2, 2010, Dr. Collins-Faulkner evaluated Claimant, then age five years, 5 months. Dr. Collins-Faulkner administered the McCarthy Scales of Children's Abilities (McCarthy Scales), the Wechsler Individual Achievement Test-WIAT-II, and the Vineland Adaptive Behavioral Scales-Survey Interview II (Vineland) in evaluating Claimant. She used the "Play Observation," "Three Wishes," "Draw-A-Person," and clinical observations as assessment tools during the evaluation. Her observations were that Claimant presented as being very friendly and was excited by the toys in the examiner's office, he was exploratory and exhibited no fear, he often asked questions about the assigned tasks, and he told examiners he had friends at home. Dr. Collins-Faulkner noted Claimant's strengths were his "ability to attend, to imitate, he is exploratory, and he had an interest in the materials." On the McCarthy Scales Claimant tested in the low average range of ability, with indications that he had delays in all areas assessed. His general cognitive score was 81 based upon a standard mean score of 100. He also scored 39 on the verbal assessment, 35 on the perceptual performance, 37 on the memory assessment, and 22 on the motor skills assessments, with all scores calculated using a standard mean of 50. On the WIAT II, which

assesses word reading, Claimant had a standard score of 106 (average score being 100), and was reading at age level five years, eight months, and grade level kindergarten 4. On the Vineland, which assesses adaptive behavior/performance of day-to-day activities, Claimant was assessed across four domains: communication, daily living skills, socialization, and motor skills. Claimant's adaptive behavior composite was one year, eight months and he posted an adaptive behavior composite standard score of 51, with 100 being considered an average score. Respondent tested at the five year, one month age level in the communication domain, and under the daily living domain, he tested at the two years, three months age level, with an indication that his "domestic skills" tested at the ten month age level.

4. Dr. Collins-Faulkner diagnosed Claimant as follows²:

Axis I: 313.9 Disorder of Childhood, Developmental Delays, and 312.9 Disruptive Behavior Disorder Secondary to Learning Issues

Axis II: V71.09 Deferred

Axis III: Medical: none reported

Axis IV: Psychological Stressors: Easily frustrated, irritable secondary to learning issues, developmental delays.

Axis V: GAF = 47/100

She ultimately concluded that Claimant suffered from significant delays in his primary skill areas. She indicated that he would require "some intervention in the classroom" and "he would be seen as a slow learner" as a result of these delays. Dr. Collins-Faulkner also noted that Claimant's disruptive behaviors "seems to come out of his frustration and inability to remember how to follow through" on assigned tasks. Essentially Dr. Collins-Faulkner's evaluation concluded that Claimant was experiencing some developmental delays, but that he was not showing significant cognitive delay, noting some of his skills were above age level, others were not. She suggests that the primary reason for Claimant's delays may be attributable to his childhood separation from his biological parents, as well as possible exposure to alcohol or drugs during birth, although she had no definitive evidence of this exposure. But she believed Claimant exhibited many of the symptoms of children so exposed. Dr. Collins-Faulkner indicated that, due to Claimant's developmental delays, he would initially be a slow learner in the classroom and would need tutoring and additional help in this area. She also noted that Claimant's frustration and irritability resulting from his difficulty in learning would sometimes result in disruptive behaviors that would require therapy or intervention.

² The diagnosis was derived from the Diagnostic and Statistical Manual of Mental Disorders, 4th ed., Text Revised (DSM-IV-TR), published by the American Psychiatric Association. The Administrative Law Judge takes official notice of the DSM-IV-TR as a generally accepted tool for diagnosing mental and developmental disorders.

5. Dr. Leonelli conducted a psychological and psycho-educational assessment on July 14, 2010. He noted during observations that Claimant showed interest in the test material and stimuli, and that he appeared to give adequate effort in his attempts to complete the tasks that were presented to him.” Although Claimant was “fidgety and distractible” and had “some difficulty maintaining attention and concentration towards tasks,” he was “friendly and cooperative with the examiner throughout the testing process.” Dr. Leonelli administered the McCarthy Scales, the Children’s Apperception Tests, the Vineland, and the Woodcock-Johnson Psycho-Educational Battery – Revised (Woodcock).

6. On the McCarthy Scales Claimant’s raw scores on the verbal, perceptual/performance and quantitative scales combined to create a general cognitive composite raw score of 152 which translated into a general cognitive index score of 102, (based upon a mean of 100) placing Claimant in the average range of cognitive ability. Claimant’s mental age was found to be five years, ten months, which Dr. Leonelli believed was above the level expected of a child of Claimant’s chronological age group. The McCarthy Scales also assessed Claimant’s short-term memory using the “memory scale.” He had a raw score of 28 which translated into an index score of 39 based upon a mean of 50. This placed Claimant in the borderline range of cognitive ability for short-term memory. Claimant’s motor skills tested at a raw score of 45, and an index score of 49, placing in the average range for a child of Claimant’s chronological age.

7. Dr. Leonelli’s administration of the Vineland test to Claimant yielded an adaptive composite age level of five years, and an adaptive composite standard score of 87. His communication scores (84 standard score) indicated that he had adequate receptive, expressive, and written language skills, although he had some delays in his expressive language skills, due to difficulty articulating words. Within the daily living skills domain (standard score 91), Claimant’s had adequate personal hygiene skills, he was able to accomplish some domestic living skills, and had developed some community living skills. The socialization domain (standard score 91) indicated that Claimant had adequate interpersonal relationship skills, he usually made adequate use of his play time, and he had developed some coping skills. Within the motor skills domain (standard score 97), Claimant showed adequate gross and fine motor skills. Within the maladaptive behavior domain (standard score 87), Claimant engaged in a few maladaptive behaviors, such as at times displaying poor attention and concentration, aggressive acting out behavior, and negativism and defiance.

8. On the Woodcock-Johnson, Claimant’s standard scores were in the average to low average range between 115 to 82, with the exception of his math scores that were below average (standard score 75). Dr. Leonelli stated that these levels were to be expected given Claimant’s general cognitive index scores. He concluded that Claimant did not show evidence of a learning disability, but that he would benefit from tutoring. Finally, on the Children’s Apperception Test, Claimant’s responses indicated that he had yet to learn “age-appropriate problem-solving skills,” and that he struggled with abandonment and isolation issues.

9. Dr. Leonelli diagnosed Claimant as follows:

Axis I: 995.5 Abuse and Neglect (Victim)
309.4 Adjustment Disorder with Mixed Disturbance of Emotions
and Conduct
R/O 315.39 Phonological Disorder

Axis II: V71.09 No Diagnosis on Axis II

Axis III: None, by History

Axis IV: Problems with primary support group; early childhood abuse and
neglect, removal from parent and placement in foster care

Axis V: Current GAF: 58

He concluded that Claimant was functioning in the average range of cognitive ability, with strengths in perceptual-performance skills and weaknesses in his qualitative and memory skills. Claimant was at age level for academic achievement with the exception of his math score, and his adaptive living skills were at an age-appropriate level. Claimant's overall psychological profile was indicated as being that of a "child who struggles with immature emotional development." Dr. Leonelli believed Claimant struggled with abandonment and isolation issues, factors that negatively affected his academic performance and his emotional development. Ultimately, Dr. Leonelli concluded that Claimant did not show any learning or cognitive disabilities, but recognized that he would need assistance in math due to his below age-level math scores. He recommended individual counseling, tutoring, and greater academic support, among other interventions not mentioned here, to assist Claimant in addressing the identified developmental delays. Dr. Leonelli also recommended a follow-up evaluation within one year.

10. On July 19, 2010, Service Agency referred Claimant to Dr. Victor C. Sanchez for a psychological evaluation. Dr. Sanchez evaluated Claimant to determine eligibility for regional center services based upon mental retardation or autism. Dr. Sanchez administered the Wechsler Preschool and Primary Scale of Intelligence (WPPSI-III), which measures the intelligence quotient (IQ) of young children, the Vineland, the Gilliam Autism Rating Scale Index (GARS), and the Autism Diagnostic Interview-Revised. He observed that Claimant spoke using sentences with reasonable clarity, he established good levels of eye contact, was friendly and cooperative during the assessment, and he seemed interested in the assessment materials and appeared to be giving good effort. Claimant did not exhibit significant problems with overactivity, distractibility, or impulsivity. Claimant was noted to be enjoying the assessment, "smiling readily and responding positively to praise," and was observed playing appropriately with toys during the free play segment of the assessment. Claimant displayed no "unusual behaviors whatsoever," and "no self-stimulatory, ritualistic, or perseverative interests" were observed.

11. Dr. Sanchez that indicated that Claimant's cognitive skills, based upon the results of the WPPSI-III, were in the low average to average range, with a verbal IQ score of 91, performance IQ score of 88, processing speed of 88, and full scale IQ score of 88. Dr. Sanchez administered the Vineland test just one month following Dr. Collins-Faulkner's administration of the test to Claimant and had significantly different results. Claimant scored significantly higher on the Vineland administered by Dr. Sanchez. Claimant scored in the "average range" on the Vineland with scores as follows: communication 90; daily living 90; and socialization 100. Claimant's GARS score was 46, which Dr. Sanchez indicated was below the level that would generally be seen if autism was present. He also noted that Claimant's scores on the Autism Diagnostic Interview-Revised "produced scores below levels which would clearly indicate the presence of full syndrome autism."

12. Dr. Sanchez diagnosed Claimant as follows:

Axis I: 309.4 Adjustment Disorder with Mixed Disturbance of Emotions and Conduct
307.60, .70 Enuresis/Encopresis

Axis II: V71.09 No Disorder

Axis III: See medical records

He recommended a referral to a mental health specialist for extended evaluation/intervention for treatment of the adjustment disorder. He also recommended that Mother have Claimant re-evaluated periodically to monitor his overall progress, citing concerns that Claimant's "in-inutero [sic] drug exposure" placed him at risk for "learning and/or other problems."

13. On June 16, 2011, a subsequent psycho-educational assessment was conducted by the Pomona Unified School District. Dr. Elizabeth Stark, psychologist, administered the Bateria III Woodcock-Munoz Pruebas de Habilidades Cognitivas (BMW III COG) to test Claimant's cognitive abilities in his native language (Spanish). Claimant scored in the average range across most domains of cognitive ability, with only two domains indicating less than average: short-term memory (below average) and comprehension-knowledge (low average). Dr. Starks also considered the Behavior Assessment System for Children, Second Edition (BASC-II) and the Conners 3rd Edition (Conners) which was administered by Claimant's mother and school teacher. The BASC-II and the Conners are assessment tools used to characterize a child's behaviors. Both of theses assessments identified deficiencies in the areas of communication and social relationships. However, Dr. Starks concluded that overall Claimant had average to high average intellectual functioning. She noted that there was a severe discrepancy between Claimant's cognitive ability and his academic achievement in the areas of reading comprehension and math calculation.

Dr. Stark's associated the discrepancy with a learning disability due to deficits in attention as well as delays in auditory processing.

14. The evidence did not establish that Claimant has mental retardation. Consequently, Claimant does not qualify for regional center services under a diagnosis of mental retardation.

15. The evidence did not establish that Claimant has a condition similar to mental retardation, or that he requires treatment similar to that of people with mental retardation. Consequently, Claimant does not qualify for regional center services under the fifth category.

16. The evidence did not establish that Claimant has autism. Consequently, Claimant does not qualify for regional center services under a diagnosis of autism.

LEGAL CONCLUSIONS

1. Claimant has not established that he suffers from a developmental disability entitling him to regional center services. (Factual Findings 1 through 16.)

2. Throughout the applicable statutes and regulations (Welf. & Inst. Code, §§ 4700 - 4716, and Cal. Code Regs., tit. 17, §§ 50900 - 50964), the state level fair hearing is referred to as an appeal of the Service Agency's decision. Where a Claimant seeks to establish his eligibility for services, the burden is on the appealing Claimant to demonstrate that the Service Agency's decision is incorrect. Claimant has not met his burden of proof in this case.

3. In order to be eligible for regional center services, a Claimant must have a qualifying developmental disability. Welfare and Institutions Code section 4512³ defines "developmental disability" as:

a disability which originates before an individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual, and includes mental retardation, cerebral palsy, epilepsy, autism, and disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals, but shall not include other handicapping conditions that are solely physical in nature.

³ All further references are to the Welfare and Institutions Code unless otherwise indicated.

4. To prove the existence of a developmental disability within the meaning of section 4512, a Claimant must show that he has a “substantial disability.” California Code of Regulations, title 17, section 54001 states, in pertinent part:

(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.

5. Claimant must show that his “substantial disability” fits into one of the five categories of eligibility in section 4512. These categories are mental retardation, epilepsy, autism and cerebral palsy, and a fifth category of eligibility described as having “disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation.” (Welf. & Inst. Code, § 4512.) The fifth category requires that the qualifying condition be “closely related” (Welf. & Inst. Code, § 4512) or “similar” (Cal. Code. Regs., tit. 17, § 54000) to mental retardation or “require treatment similar to that required for mentally retarded individuals.” (Welf. & Inst. Code, § 4512.) Under the Lanterman Act, “developmental disability” excludes conditions that are solely physical in nature. (Welf. & Inst. Code, § 4512, and Cal. Code. Regs., tit. 17, § 54000). California Code of Regulations, title 17, section 54000, also excludes conditions that are *solely* psychiatric disorders or *solely* learning disabilities.

Mental Retardation

6. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revised (DSM-IV-TR) describes Mental Retardation as follows:

The essential feature of Mental Retardation is significantly sub average general intellectual functioning (Criterion A) that is accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community

resources, self-direction, functional academic skills, work, leisure, health, and safety (Criterion B). The onset must occur before age 18 years (Criterion C). Mental Retardation has many different etiologies and may be seen as a final common pathway of various pathological processes that affect the functioning of the central nervous system.

General intellectual functioning is defined by the intelligence quotient (IQ or IQ-equivalent) obtained by assessment with one or more of the standardized, individually administered intelligence tests (e.g., Wechsler Intelligence Scales for Children—Revised, Stanford-Binet, Kaufman Assessment Battery for Children). Significantly sub average intellectual functioning is defined as an IQ of about 70 or below (approximately 2 standard deviations below the mean). It should be noted that there is a measurement error of approximately 5 points in assessing IQ, although this may vary from instrument to instrument (e.g., a Wechsler IQ of 70 is considered to represent a range of 65-75). Thus, it is possible to diagnose Mental Retardation in individuals with IQs between 70 and 75 who exhibit significant deficits in adaptive behavior. Conversely, Mental Retardation would not be diagnosed in an individual with an IQ lower than 70 if there are no significant deficits or impairments in adaptive functioning. . . . When there is significant scatter in the subtest scores, the profile of strengths and weaknesses, rather than the mathematically derived full-scale IQ, will more accurately reflect the person’s learning abilities. When there is a marked discrepancy across verbal and performance scores, averaging to obtain a full-scale IQ score can be misleading.

Impairments in adaptive functioning, rather than a low IQ are usually the presenting symptoms in individuals with Mental Retardation. *Adaptive functioning* refers to how effectively individuals cope with common life demands and how well they meet the standards of personal independence expected of someone in their particular age group, sociocultural background, and community setting. Adaptive functioning may be influenced by various factors, including education, motivation, personality characteristics, social and vocational opportunities, and the mental disorders and general medical conditions that may coexist with Mental Retardation. Problems in adaptation are more likely to improve with remedial efforts than is the cognitive IQ, which tends to remain a more stable attribute.

(DSM-IV-TR at pp. 39 - 42.)

7. Regarding Mild Mental Retardation (I.Q. level of 50-55 to approximately 70), the DSM-IV-TR states:

[Persons with Mild Mental Retardation] typically develop social and communication skills during the preschool years (ages 0-5 years), have minimal impairment in sensorimotor areas, and often are not distinguishable from children without Mental Retardation until a later age. By their late teens, they can acquire academic skills up to approximately the sixth-grade level. By their adult years, they usually achieve social and vocational skills adequate for minimum self-support, but may need supervision, guidance, and assistance, especially when under unusual social or economic stress. With appropriate supports, individuals with Mild Mental Retardation can usually live successfully in the community, either independently or in supervised settings.

(Id. at pp. 42 - 43.)

8. Regarding the differential diagnosis of Borderline Intellectual Functioning (IQ level generally 71 to 84), the DSM-IV-TR states:

Borderline Intellectual Functioning describes an IQ range that is higher than that for Mental Retardation (generally 71-84). As discussed earlier, an IQ score may involve a measurement error of approximately 5 points, depending on the testing instrument. Thus, it is possible to diagnose Mental Retardation in individuals with IQ scores between 71 and 75 if they have significant deficits in adaptive behavior that meet the criteria for Mental Retardation. Differentiating Mild Mental Retardation from Borderline Intellectual Functioning requires careful consideration of all available information.

(Id. at p. 48.)

9. Claimant did not prove by a preponderance of the evidence that he suffers from mental retardation. He does not meet the criteria under the DSM-IV-TR for a diagnosis of mental retardation. Claimant's cognitive and adaptive functioning did not show significant limitations or deficiencies when tested in 2010 and 2011. Based upon the psychological evaluations performed by Dr. Sanchez and Dr. Collins-Faulkner, Claimant's cognitive functioning skills tested in the low average to average range. Claimant's WPPSI-III scores administered by Dr. Sanchez indicated that his IQ scores were 91-88, an average range of cognitive ability. Dr. Collins-Faulkner's administration of the McCarthy Scales test yielded a general cognitive score of 81 (low average range). The two psycho-educational assessments performed in July 2010 and June 2011 also placed Claimant's cognitive ability in the average range of functioning. Claimant's general cognitive index score on the

McCarthy Scales administered by Dr. Leonelli in June 2010 was 102, indicating that he had average cognitive ability. The July 2011 psycho-educational assessment performed by Dr. Starks one year later concluded that Claimant's intellectual functioning was in the average to high average range.

10. Claimant's adaptive functioning, based upon scores on the Vineland administered by Dr. Sanchez, fell within the average range (90 on communication, daily living skills score of 90, and socialization score of 100). Although Dr. Collins-Faulkner's Vineland test results yielded a significantly lower adaptive composite score, Claimant's subsequent Vineland scores by Dr. Sanchez one month later indicated that he was scoring in the average range for adaptive skills. The Vineland test administered by Dr. Leonelli, also one month later in July 2010, indicated Claimant had an adaptive composite standard score of 87 (average range) and an adaptive behavior composite age of five years, which was considered adequate at the time of the testing.

11. Claimant's evaluations and assessments did not indicate that there were significant deficiencies in cognitive and adaptive functioning. In fact, Claimant's IQ scores were consistently in the average to low average range (81 to 91) and his adaptive functioning scores were in the average range (84 to 100) with the exception of the Vineland reported by Dr. Collins-Faulkner. The DSM-IV-TR provides that intellectual functioning should be in the 70 to 55 IQ range to establish mental retardation. Higher IQ scores (71 to 84) are sometimes considered where there exist significant deficiencies in adaptive functioning. Claimant's adaptive functioning scores were generally in the 84 to 100 standard score range. Thus, even if Claimant's lowest IQ score were considered, his adaptive functioning scores are too high to conclude that he suffers from mental retardation. On this record, Claimant's test scores are significantly above the threshold cognitive and adaptive functioning levels required to establish a developmental disability based upon mental retardation.

Fifth Category

12. As stated above, there must be a significant degree of cognitive and adaptive deficits to establish mental retardation. Under the fifth category, to be "closely related" or "similar" to mental retardation, there must also be evidence of cognitive and adaptive deficits such that an individual can be said to have a disability like that of a person with mental retardation. Although this does not require strict application of all of the cognitive and adaptive criteria utilized in establishing mental retardation, there must be some evidence of significant deficiencies in cognitive and adaptive functioning. That is not the case here. Claimant's test scores indicated that he was scoring generally in the average range for cognitive functioning and in the average to low average range for adaptive functioning. Eligibility under the fifth category requires a showing that the cognitive and adaptive functioning has an effect or impact on Claimant that renders him like a person with mental retardation. The evidence does not support this conclusion.

13. Claimant's evaluations and assessments did not make recommendations that would typically be considered "treatment similar" to persons with mental retardation. In

fact, the recommendations from Dr. Sanchez, Dr. Collins-Faulkner, and Dr. Leonelli, all included interventions that focused on developmental delays that were negatively impacting Claimant's learning ability. Dr. Stark's assessment also emphasized deficiencies that were related to a learning disability rather than a developmental disability associated with mental retardation.

14. Claimant did not establish that he has significant deficits in cognitive and adaptive functioning such that he suffers from a condition similar to mental retardation. The evidence also did not establish that Claimant requires treatment similar to that required for a person with mental retardation. Thus, Claimant has not met his burden of proof that he falls under the fifth category of eligibility.

Autism

15. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revised (DSM-IV-TR) states that "the essential features of Autistic Disorder are the presence of markedly abnormal or impaired development in social interaction and communication and a markedly restricted repertoire of activity and interests." The DSM-IV-TR describes the diagnostic criteria for autism to include the following:

- A. A total of six (or more) items from (1), (2), and (3), with at least two from (1), and one each from (2) and (3):
 - (1) qualitative impairment in social interaction, as manifested by at least two of the following:
 - (a) marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction;
 - (b) failure to develop peer relationships appropriate to developmental level;
 - (c) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest);
 - (d) lack of social or emotional reciprocity;
 - (2) qualitative impairments in communication as manifested by at least one of the following:
 - (a) delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime);
 - (b) in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others;

- (c) stereotyped and repetitive use of language or idiosyncratic language;
 - (d) lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level;
- (3) restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:
- (a) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus;
 - (b) apparently inflexible adherence to specific, nonfunctional routines or rituals;
 - (c) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements) persistent preoccupation with parts of objects;
- B. Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years: (1) social interaction, (2) language as used in social communication, or (3) symbolic or imaginative play.
- C. The disturbance is not better accounted for by Rett's Disorder or Childhood Disintegrative Disorder.

(DSM-IV-TR at pp. 70-71, and 75.)

16. Claimant did not prove by a preponderance of the evidence that he suffers from an autistic disorder. Dr. Sanchez evaluated Claimant specifically for autism. Dr. Sanchez administered the GARS to Claimant in July 2010. Claimant score on the GARS was an Autism Index score of 46, well below the level that would typically indicate the presence of autism. The Autism Diagnostic Interview conducted by Dr. Sanchez also produced scores below the level typically found with full syndrome autism. During his evaluation, Dr. Sanchez observed that Claimant established and maintained good levels of eye contact, communicated using sentences which were reasonably clear, was very friendly and cooperative, seemed interested in the assessment materials and gave good effort, and he did not exhibit significant problems with overactivity, distractibility, or impulsivity. Claimant was observed smiling readily and responding positively to praise. He played with toys presented to him, and displayed no unusual or typical behaviors associated with a child suffering from autism, i.e., no self-stimulatory, ritualistic, or perseverative behaviors.

17. Although the evaluations performed by Dr. Collins-Faulkner and Dr. Leonelli did not specifically test for autism, both noted observations that appear to support a determination that Claimant does not suffer from autism. Dr. Collins-Faulkner observed that Claimant was outgoing, attentive, able to imitate, and displayed exploratory traits during her evaluation. Dr. Leonelli indicated that Claimant “showed interest in the test material and

stimuli, and that he appeared to give adequate effort in his attempts to complete the tasks that were presented to him.” Although he noted Claimant was “fidgety and distractible” and had “some difficulty maintaining attention and concentration towards tasks,” Claimant was “friendly and cooperative with the examiner throughout the testing process.”

18. Claimant presented insufficient evidence to support a finding that he suffers from autism. The evidence presented did not show qualitative impairment in social interaction, communication, or manifestations of restricted repetitive and stereotyped patterns of behavior. To the contrary, Claimant was engaging, talkative, inquisitive, friendly and motivated during the psychological evaluations and psycho-educational assessments offered as evidence in this proceeding.

19. Accordingly, the weight of the evidence does not support a finding that Claimant is eligible to receive regional center services at this time.

ORDER

The Service Agency’s determination that Claimant Andrew A. is not eligible for regional center services is upheld. Claimant’s appeal is denied.

DATED: April 11, 2012

MICHAEL A. SCARLETT
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 90 days.