

BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of the Eligibility of:

OAH No. 2012110231

M.R.,

Claimant,

and

Inland Regional Center,

Service Agency.

DECISION

Beth Faber Jacobs, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter in San Bernardino, California, on January 23, 2013, and March 19, 2013.

Jennifer Cummings, Program Manager, Fair Hearings and Legal Affairs, represented the Inland Regional Center (IRC).

Jeffrey A. Gottlieb, Esq., represented M.R. (claimant).

The matter was submitted on April 19, 2013.

ISSUE

Is M.R. eligible for regional center services under the Lanterman Act as a result of a diagnosis of autism?

FACTUAL FINDINGS

Jurisdictional Matters

1. On October 23, 2012, IRC notified claimant's mother, S.R. (Mrs. R.), that M.R. (claimant or M.) was not eligible for regional center services. It concluded that M. did

not have a substantial handicap as a result of mental retardation, cerebral palsy, epilepsy, or autism, and that he did not have disabling condition closely related to mental retardation or one that requires treatment similar to that required for individuals with mental retardation.

2. On November 1, 2012, Mrs. R. signed and timely filed a fair hearing request appealing that decision. The matter was set for hearing. Claimant requested a continuance and signed a Lanterman Act Waiver of Time. The matter proceeded to hearing. At the hearing, claimant, through his attorney, contended that M. should be eligible for regional center services on the basis of autism.

3. Oral and documentary evidence was received during the hearing in January and March, 2013. The record was closed. The parties asked to submit written closing and reply briefs and selected a briefing schedule. Claimant filed and served his "Closing Brief," which was marked as Exhibit 28. The service agency filed and served its "Closing Argument," which was marked as Exhibit 29. Claimant filed and served his "Reply Brief," which was marked as Exhibit 30. The service agency filed and served its "Response to Claimant's Brief," which attached new exhibits that were not part of the record, and was marked as Exhibit 31. Claimant filed and served objections to the introduction of new evidence and a motion to strike, which were collectively marked as Exhibit 32. Following oral argument, claimant's motion was granted. The documents attached to the service agency's response have not been received or considered, and those portions of the service agency's brief that relied on or cited new evidence were stricken. The service agency was given an opportunity to request to reopen the record, but declined to make that request.

Diagnostic Criteria for Autistic Disorder

4. The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*, (DSM-IV-TR) characterizes the essential features of an autistic disorder as "the presence of markedly abnormal or impaired development in social interaction and communication and a markedly restricted repertoire of activity and interests." With an autistic disorder, the impairment in social interaction must be "gross and sustained." The disturbance must be manifest "by delays or abnormal functioning in at least one (and often several) of specific areas before age three."

Asperger's Disorder can be distinguished from Autistic Disorder. "In contrast to Autistic Disorder, there are no clinically significant delays or deviance in early language acquisition." In addition, "there are no clinically significant delays in cognitive development."

The DSM-IV-TR also states that "symptoms of overactivity and inattention are frequent in Autistic Disorder, but a diagnosis of Attention-Deficit/Hyperactivity Disorder (ADHD) is not made if Autistic Disorder is present."

5. The DSM-IV-TR contains the diagnostic criteria used for Autistic Disorder in section 299. Under the DSM-IV-TR, a diagnosis of Autism requires the following criteria to be present:

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 impairments in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body posture, 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 to other people)
 - 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 two 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)
- d. Persistent preoccupation with parts of objects

6. The diagnostic criteria for Asperger's Disorder are at DSM-IV-TR, 299.80. A diagnosis of Asperger's Disorder does not establish eligibility for regional center services. Under the DSM-IV-TR, Asperger's Disorder is diagnosed with the following criteria:

A. Qualitative impairment in social interaction, as manifested by at least two of the following:

- (1) 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
- (2) failure to develop peer relationships appropriate to developmental level
- (3) 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 to other people)
- (4) lack of social or emotional reciprocity

B. Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

- (1) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
- (2) apparently inflexible adherence to specific, nonfunctional routines or rituals

(3) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)

(4) persistent preoccupation with parts of objects

C. The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning.

D. There is no clinically significant general delay in language (e.g., single words used by age 2 years, communicative phrases used by age 3 years).

E. There is no clinically significant delay in cognitive development or in the development of age-appropriate self-help skills, adaptive behavior (other than in social interaction), and curiosity about the environment in childhood.

F. Criteria are not met for another specific Pervasive Developmental Disorder or Schizophrenia.

Evidence Presented at the Hearing

7. Claimant M. is an 18 year old male. His father passed away in 2010. M.'s mother, Mrs. R., is his conservator. He lives with his mother and his 20 year old brother.

8. As an infant and toddler, M. met all his gross motor and language milestones; he sat at approximately 4 months, walked at approximately 10 months, spoke his first word at the appropriate time, and spoke his first phrase by about 2 years of age.

9. As a child, M.R. was not particularly social and had few friends. He sometimes paced. He began having behavioral problems in grade school at age 6. He could not sit still. He did not want to participate in class activities and had poor social skills. At age 7, in 2002, he was assessed by his local school district to determine if he was eligible for special education. The school district concluded that M. did not meet eligibility requirements.

10. M. began individual therapy in the first grade. In the second grade, M. was identified as having attention deficit hyperactivity disorder (ADHD). By the time he was in third grade, M. was also found to have a severe emotional disturbance. At age 8, he was prescribed and began taking psychotropic drugs. M. was placed in a county Emotional Disturbance (ED) classroom and has been in special education programs since then.

11. Claimant displayed anger, social skill deficits, and aggression towards his family. At one point, the police were called five times to respond to his out-of-control behavior. He became particularly oppositional in the 4th grade when assigned to a class and

curriculum for the gifted and talented (GATE). At some point in time, M.'s father became physically abusive towards M. When M. was 9 years old, CPS intervened and M. was placed in a group home called Hillview Acres Children's Home.

12. After living in the group home for over a year, M. returned to his mother's care.

13. In 2005, when M. was 10 years old, he was evaluated for regional center services. E.N. Elmendorf, M.D. met with claimant's mother and evaluated M. Dr. Elmendorf noted that M. had already been hospitalized for psychiatric issues twice and that M.'s diagnoses included "ADHD and major depressive disorder with psychiatric features." At the time, M.'s medications were Seroquel and Guanfacine and he had previously been prescribed Adderall, Ritalin, Concerta, Risperdal, Benadryl, Depakote, and Prozac.

Dr. Elmendorf concluded that M. did not satisfy the medical criteria for regional center eligibility, but deferred eligibility pending a psychological evaluation.

14. In 2005, Rebecca Perez, Psy.D., Staff Psychologist with the Inland Regional Center, evaluated M. to determine if he was eligible for regional center services. Dr. Perez concluded that claimant did not meet the criteria for a DSM-IV-TR diagnosis of Autistic Disorder. She noted that claimant did not have a speech delay and did not demonstrate the repetitive behavior often associated with autistic children. She found that he had elements of Asperger's Disorder, complicated by mental health issues, including depression and an unstable home environment. Dr. Perez administered the Childhood Autism Rating Scale (CARS) using information provided by claimant's mother. M. received a score of 25.5, which is non-autistic. On the Autism Diagnostic Observation Schedule (ADOS), module 3, M. had a total score of 7, which the minimum cutoff for autistic spectrum, but does not meet the criteria for Autism. Dr. Perez felt that M.'s mental health issues falsely elevated his ADOS scores, which such issues are known to do.

Dr. Perez found M. to be defensive and sensitive; he denied having any problems and stated nothing was wrong. He became angry with his mother when she tried to explain the situation. M. engaged in conversation with Dr. Perez. His speech was clear. He was able to speak about his own feelings, though he did not express an understanding of the feelings of others. He showed limited eye contact and for a while had a flat affect, but then showed a greater range of emotions, depending on the topic.

15. The local school district conducted testing. In 2005 (at age 10), M.'s verbal IQ was 124; his performance IQ was 102, and his full scale IQ was placed at 102. The school district found deficits in attention and sensory motor processing, and continued to find M. qualified for special education under the category of "serious Emotional Disturbance."

16. In 2007, M. was once again placed at Hillview Acres Children's Home. In a report prepared by Hillview Acres when the claimant was 12 years old, the facility stated about M.:

[M. is] responding very well to the structure of a Level 12 group home and nonpublic school setting. His medication regiment [sic] also appears to be managing his anxiety and aggressive outbursts. Because of the history of severe acting-out behaviors with risks to his own safety and the safety of others, [M.] will need to remain on medication and closely monitored by a psychiatrist.”

According to the evaluators at Hillview, M. showed deficits in social skills, preferred to spend time alone or with one peer, and sometimes paced around the campus, but “M. does initiate conversation with multiple peers frequently. He enjoys some similar interests with boys his age. A concern is that at times he influences, or is influenced by, peers with negative behavior.” Hillview found that M. was often anxious about new settings. The evaluation noted that M. had been a danger to himself twice in the preceding 30 days, that he was refusing to follow medical advice, that he used inappropriate sexual conversation and profanity, and that he was provoking his peers daily and often argued with staff. Academically, M. was achieving at an above-average grade level.

17. On March 11, 2007, Hillview psychologist Donna Schaiterer, Ph.D., LCSW, conducted an evaluation. M.’s DSM IV diagnosis on Axis I obsessive compulsive disorder (OCD) (DSM-IV, section 300.3). Hillview Acres recommended that M. continue receiving psychotropic medications to manage his OCD symptoms, that he continue with individual and family therapy, and that he be slowly mainstreamed into a public school setting.

18. In 2008, when M. was 14 years old and in the 9th grade, the school district performed a multi-disciplinary evaluation. It noted his diagnosis of OCD and that he was being prescribed Luvox and Geodone. While his school nurse observed that M. was restless and had poor eye contact, the evaluator found that M. was “able to communicate needs and participate in spontaneous conversation at an age-appropriate level.” M. was cooperative. At times, he had few facial expressions and a flat affect; at other times, he shared strong emotions. For example, he voiced concern that he wanted to finish the math problem he was working on before he was called into the test. When he was assured he would be given time to complete the test, M. visibly relaxed. M. followed directions. His “motivation, attention, and concentration appeared satisfactory.” His full scale IQ was 108, an average score. M. also performed in the average level for verbal comprehension and performance index. M. was given the Wide Range Assessment of Memory and Learning-2 (WRAML-2) assessment, where he had above-average and average scores.

The school district conducted a Behavior Assessment System for Children-second edition (BASC-2) evaluation. The BASC-2 is given to assist in making a differential diagnosis, to classify various emotional and behavioral disorders in children, and to help determine treatment plans. The BASC-2 showed that M. had sensory motor deficits that caused the evaluator to recommend further evaluation regarding a diagnosis of ADHD. The school “suspected” that his attention processing deficits would “significantly impact educational performance.”

19. M.'s mother reported more depression and anxiety than was reported by either his father or the teachers. On an Asperger's diagnostic scale with information provided by his mother, father, and teacher, the answers given by his teacher and father were in the "possibly" category; the answers given by his mother were in the "very likely category."

The district reviewed the DSM IV Diagnostic criteria and identified four of the criteria on the autism spectrum: Failure to develop peer relationships appropriate to his developmental level, a lack of spontaneous seeking to share enjoyment, interests, or achievements with others, a lack of social or emotional reciprocity and a restricted repetitive and stereotyped patterns of interest as manifested by a preoccupation with a specific interest. The district concluded that "given the results of the BASC-2, Asperger's Scale, observations, and assessment, it does appear that M. is demonstrating behaviors typical of a child with Asperger's Syndrome in the educational setting."

20. In an Individual Education Plan (IEP) prepared by the school district in 2009 when M. was 15 years old, the district checked the box for "autism" and identified, as a secondary disability, emotional disturbance. Programs and agencies identified for appropriate transitional related services included the department of rehabilitation and work experience; the regional center was not included among those listed as being appropriate services for M.

In an IEP, "autism" is an administrative category for special education and is not a diagnosis. Eligibility for special education is different than eligibility for regional center services; special education eligibility under California Code of Regulations, title 5, section 3030, includes, in a broad category, children who might be on the autism spectrum. As such, a notation of "Autism" on an IEP is not definitive for regional center purposes.

21. In a 2011 multidisciplinary evaluation by the district and in the IEP created when M. was 16 years old and enrolled in the 11th grade, M.'s diagnoses were listed as "Obsessive-Compulsive Disorder and possible Asperger's Syndrome and Bipolar Disorder." The documents indicated that M. was able to communicate his needs and participate in spontaneous conversations at an age-appropriate level. His testing history was reviewed; it always placed his IQ at an either average or above-average classification.

By this point in time, M.'s father had passed away and M. was living with his mother. The IEP stated that M.'s communication skills varied "widely with his moods and the environmental setting."

According to the multidisciplinary evaluation, M. conveyed his plan to move out of state, become an oil tycoon and marry a model. M. was participating in the Special Day Class and had a GPA of 3.17.

Prior to this evaluation, M. had passed all previous classes. Now in the 11th grade, M. suddenly experienced academic difficulty; he received an F in History and Geometry, with a C in English and A's in his other classes. In the three months leading to the evaluation, M.'s

violent behavior and emotional outbursts escalated. He punched his fist through a classroom projector after he became angry with another student. Two days before the IEP meeting, he told the school he wanted to kill his teacher and six others. He also reported visual and auditory hallucinations. M. was assessed and involuntarily hospitalized under Welfare and Institutions Code, section 5150. M. was also suspended for three days for making the threat against a staff member.

The district conducted its multidisciplinary assessment to determine if M. had continuing eligibility for special education under its applicable regulations. The district concluded that M. continued to be qualified under the category of seriously emotionally disturbed. Based on its evaluation, it concluded that M. had “a number of DSM-IV-TR criteria for the diagnosis of the following disorders: Attention/Hyperactivity Disorder, Autistic Disorder/Asperger’s Disorder; Conduct Disorder; Dysthymic Disorder, Generalized Anxiety Disorder, Major Depressive Disorder, and Oppositional Defiant Disorder.”

Because the IEP meeting occurred while M. was hospitalized for his hallucinations and threats of violence, M. did not participate in the transition plan created by the interdisciplinary team. Records reflected, however, that M. had previously told his teachers that he wanted to attend Junior College, complete a two year degree program, and obtain a driver’s license.

22. Limited mental health records from Kaiser, dated March, 2012, were received during the hearing and reflected a visit with a social worker and a psychiatrist. The records indicate diagnoses of “Autistic Disorder, Obsessive-Compulsive Disorder, Mood Disorder, Not Otherwise Specified, and Bipolar Disorder,” and reflect that M. had been prescribed numerous drugs, including Geodon (an anti-psychotic medication) and Luvox (an anti-depressant), and that he has previously been prescribed Ritalin, Concerta, or Adderal (for ADHD), Prozac, Abilify, Paxil (anti-depressants), and Depakote, Seroquel and Risperdal (anti-psychotic medications).

The limited Kaiser records indicate that M.’s mother reported that M. had been seen at UCLA where he was diagnosed with autism, that OCD had been ruled out, and that UCLA recommended there be no change in his current medication regimen. Nothing in the Kaiser records submitted in this case indicate whether the diagnoses listed in the March 2012 Kaiser record contained the information that M.’s mother reported, whether they were obtained from other sources, or if the diagnoses listed had been independently determined by a Kaiser physician or psychologist.

23. M. currently lives with his mother. M. attends a regular sociology class at Chaffey College. He takes the bus, alone, to the class. At various times, he has voiced an interest in moving out of state, becoming an oil tycoon, marrying, and becoming wealthy. He has a cell phone, which he uses to call a “hot line” to talk to others when he wants to converse. He writes on his computer.

24. On June 28, 2012, claimant and his mother met with the service agency's senior intake counselor, Dalia Yaret Castrejon, as part of an initial evaluation to again determine whether M. was qualified for services from the service agency. By this point in time, M. had already graduated high school. Based on the information provided in the 2012 evaluation, M. can dress himself, cook for himself, tell time and count money. If his medications are in the correct day of the week container, he will take them correctly. Otherwise, he needs to be reminded. He advised the evaluator about his psychiatric history, including his having been involuntarily hospitalized under Welfare and Institutions Code section 5150 eleven times.

Expert Testimony

PEGEEEN CRONIN, PH.D.

25. Pegeen Cronin, Ph.D., an Assistant Clinical Professor at UCLA, conducts research at UCLA's Semel Institute for Neuroscience and Human Behavior and serves as a clinical director of UCLA's Autism Evaluation Clinic. Dr. Cronin received her bachelor's degree from U.C. Berkeley. She received her masters in 1992 and her doctorate in clinical psychology in 1995, both from Pacific Graduate School of Psychology. In 1998 Dr. Cronin received training in the Autistic Diagnostic Observation Schedule (ADOS). She has consulted with various service agencies and school districts regarding the diagnoses and evaluation of individuals who might be Autistic. Dr. Cronin has conducted or supervised approximately 200 evaluations each year for 12 years. Dr. Cronin is well qualified to evaluate and diagnose individuals with Autism Disorder.

26. Dr. Cronin conducted an evaluation of M. and prepared a lengthy report dated March 15, 2012. Dr. Cronin relied on multiple sources of information, assessment tools including the ADOS, school records, parent input and her personal evaluation of M. According to Dr. Cronin, M. has a diagnosis of Autistic Disorder.

Dr. Cronin disagreed with the service agency's 2005 assessment by Dr. Perez and felt that Dr. Perez failed to reconcile what Dr. Cronin considered were M.'s considerable delays in adaptive functioning.

Dr. Cronin also disagreed with the service agency's conclusion that M. has Asperger's Syndrome. According to Dr. Cronin, "we don't know the difference between Autism and Asperger's." Dr. Cronin is aware of the distinctions the DSM-IV-TR makes between Autism Disorder and Asperger's, but disagrees with the existence of those distinctions; she testified that subsequent research does not support the distinctions the DSM-IV-TR makes between Autism and Asperger's Disorder. Dr. Cronin does not believe the DSM-IV-TR covers enough; while Dr. Cronin acknowledged it is the standard of care to rely on the DSM-IV-TR, and she uses it in making an evaluation, she believes it is appropriate to make a diagnosis of Autism without using the DSM-IV-TR.

Dr. Cronin focused on what she characterized as adaptive functioning, which is not addressed in the DSM-IV-TR. Even though M. has the ability to be self-directed, to follow his own routine and make his own choices, Dr. Cronin opined that he was significantly impaired and was not capable of living independently.

Dr. Cronin opined that M.'s Autism is severe, though she did not feel his case was complex. She opined that his communication deficits were severe and profound. She found repetitive behaviors that were disabling, significant disorganization in his language and a lack of social skills. She concluded that he is substantially disabled. Dr. Cronin acknowledged that M. speaks in complete sentences, but her assessment focused on other deficiencies that she felt were more important in the diagnostic arena. Dr. Cronin recognized that M. has significant cognitive abilities, but opined that cognitive abilities are not predictive of adaptive functioning. She felt that M.'s "own self direction interfered with his ability" because he wants to do things "his way" and "only does what he wants to do." Dr. Cronin was aware that with some evaluators, M. would make eye contact and be conversant. With her, and with some others, he did not make eye contact and was not particularly conversant. Dr. Cronin felt this inconsistency was a "hallmark" of Autism.

Dr. Cronin explained that Autism is a psychiatric disorder that is neurologically based. Dr. Cronin opined that Autism is in the psychiatric domain because there is no other place to put it and authorities do not know its cause. In her opinion, M. did not have ADHD and did not have any psychiatric diagnoses other than Autism; she does not believe he has a mood disorder or that he is or has been bipolar or schizophrenic. She felt that all of M.'s issues stemmed from his need to adhere to his own way. Dr. Cronin did not recommend a psychiatric evaluation or that his medication be stopped. She felt "he probably needs his medication for agitation."

In Dr. Cronin's opinion, M. has been misdiagnosed for most of his life and that as a result, has not had appropriate treatment. She did not think he should have been placed with emotionally disturbed children and that doing so was inappropriate. She believes M. should have received Applied Behavioral Analysis (ABA) treatment for Autism and that he requires and is qualified to receive regional center services.

27. Dr. Cronin participated in a four day training conducted by the authors of ADOS at the University of Chicago. Dr. Cronin used ADOS module 3 for assessing M. and used a new algorithm for her ADOS assessment. Because UCLA is a research facility, Dr. Cronin had access to the newest ADOS algorithm, which was not yet available to the public when the regional center conducted its evaluation.

28. Regardless of the ADOS version or algorithm she used, Dr. Cronin would still have concluded that M. is Autistic. Dr. Cronin opined that with the sole exception of language delays, M. meets all the Autistic Disorder diagnostic criteria under the DSM-IV-TR, section 299.

PAUL GREENWALD, PH.D.

29. Paul Greenwald, Ph.D., staff psychologist with the Inland Regional Center, conducted an evaluation of M. in response to Mrs. R.'s request for regional center services. Dr. Greenwald is a licensed clinical psychologist. He obtained his bachelor's degree in 1974 from the University of Miami and in 1987, received a doctorate in clinical psychology from the California School of Professional Psychology. Dr. Greenwald has spent seven years evaluating children and adults for eligibility under the Lanterman Act and has served as a clinical psychologist with the service agency since 2008. From 2006 through 2008, Dr. Greenwald provided psychological services for individuals with developmental disabilities, including those on the Autism spectrum. Dr. Greenwald has extensive experience in identifying, evaluating, and developing treatment plans for those diagnosed with or identified as being at risk for Autism and has conducted approximately 600 assessments for Autism. Dr. Greenwald is well qualified to evaluate and diagnose individuals with Autism Disorder.

30. Dr. Greenwald explained that in order to become eligible for services under the Lanterman Act and the applicable regulations, an individual must first have one of five disabling conditions (mental retardation, autism, cerebral palsy, epilepsy, or one that is closely related to mental retardation or requiring treatment similar to that required for mentally retarded individuals [the "fifth category"].) (Welf. & Inst. Code, §§ 4501, 4502, subd. (a).) Developmental disabilities that are eligible for services are neurologically and genetically driven delays that usually appear within the first three years of a child's life.

31. Dr. Greenwald explained that in order for a person to qualify for services based on a diagnosis of Autism, an individual must fall within the diagnostic criteria for Autism established by the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, (DSM-IV-TR)* (also called the "DSM-IV"). (See pp. 2-4, *infra*.)

32. Dr. Greenwald conducted an assessment of M. on October 23, 2012. He reviewed the materials provided to the service agency, including prior assessment records, the available Kaiser records, prior regional center evaluations, available school district evaluations, and parent and teacher reports, and Dr. Cronin's March 15, 2012 report.

33. Dr. Greenwald initially met M. while M. was in the waiting room using an iPad. M. acknowledged Dr. Greenwald. M. made eye contact, he gave a reciprocating smile, shook hands with Dr. Greenwald, and said hello. They went to Dr. Greenwald's office.

34. M. initially had a flat tone and spoke softly with Dr. Greenwald, but as their interaction continued, he spoke louder, began gesturing, and he conversed spontaneously. He consistently made eye contact. M. had a superior use of words, albeit peppered with arcane and pedantic language. M. carried on a complete conversation with Dr. Greenwald and responded appropriately.

At one point, M. had a disagreement with his mother and wanted her to leave. His mother reminded him that she was his conservator and had a right to be present. She remained present for half the assessment. After M.'s mother left, M. told Dr. Greenwald there were some things he wanted to tell Dr. Greenwald confidentially. M.'s level and depth of conversation and his consistent eye contact with Dr. Greenwald was not consistent with a diagnosis of Autism.

35. Dr. Greenwald used the Autism Diagnostic Observation Schedule (ADOS), Module 3 and Module 4, which is used for young adults and adults with language fluency, and conducted a mental status examination and cognitive assessment. Dr. Greenwald characterized the ADOS as the "gold standard" diagnostic tool for assessing autism. Used throughout the world and translated into 17 languages, the ADOS is a research driven observation tool that allows a clinician to interact with the individual as part of the assessment. It is useful in differentiating between Autism and Asperger's Disorder. Dr. Greenwald opined that there is no one perfect tool, nor one tool that should be solely relied upon in making a diagnosis, but he felt the ADOS was the best, most refined, and most objective tool for diagnosing Autism.

Dr. Greenwald relied on other tools as well, but he did not consider the others as valuable as the ADOS. Many of the other tools, such as the Childhood Autism Rating Scales (CARS) or Gilliam Autism Rating Scales (GARS) are based on parent or teacher descriptions of behavior, are written in recollection and are subjective.

Dr. Greenwald reviewed self-reports prepared by M. M.'s scores were atypical for "endorsing unusual thoughts and perceptions." Dr. Greenwald found this instructive; autistic individuals have deficits in "theory of mind;" they do not recognize their own thoughts. M. had a high score in the self-reporting. According to Dr. Greenwald, an autistic individual would not be able to self-report at all.

36. Based on his all the information provided and his clinical observations, Dr. Greenwald concluded that M. did not meet the DSM-IV-TR 299 diagnosis of Autism. In Dr. Greenwald's opinion, M. showed behaviors and had testing results consistent with an Asperger's Disorder on the autistic spectrum under the DSM-IV-TR section 299.80, but not Autistic Disorder. Having a diagnosis of Asperger's Disorder is not a qualifying developmental disability for regional center services.

37. Dr. Greenwald testified about some of the ways in which individuals with Asperger's Disorder present differently from those with Autism. For individuals with Asperger's, there is no clinical delay in the onset of language or cognitive skills. There is a greater likelihood of having a lower IQ for individuals with Autism; individuals with Asperger's do not have a reduced IQ.

38. It is not typical for a child with Autism to be prescribed neuroleptics or drugs for people with psychosis, such as Seroquel, which was often prescribed for M.

39. Dr. Greenwald explained that the presence of certain co-morbid psychiatric disorders (such as bipolar, schizophrenia, schizophrenic/affective disorder, conduct disorder, oppositional disorder and hyperactivity) can present and look like Autism, but because they have different roots and causes, are not dispositive of a developmental disability or Autism. M. had a history of psychiatric illnesses such as severe depression, OCD, being bipolar, hyperactive, and oppositional. These conditions can cause an ADOS score to elevate, but the ADOS assessment has been refined to weed out false positives. Dr. Greenwald anticipated, in light of M.'s history, that M.'s ADOS score would be higher than expected because of his co-morbidities, but even with the increased scores, M. still did not make the Autism cutoff.

40. Self-reporting visual hallucinations or having delusional thoughts are not autistic characteristics. They are solely psychiatric symptoms. Psychotropic drugs are not prescribed for developmental disabilities.

41. Dr. Greenwald commented on the significant inconsistencies between M.'s self-report and his mother's report on certain issues such as socialization and daily living skills. The scores were inconsistent by more than one standard deviation, which discrepancy would not be expected for an individual with Autism. To Dr. Greenwald, these significant discrepancies showed that M.'s condition was neither pervasive nor severe.

42. Dr. Greenwald explained that autism is a steady state that does not "escalate." It would maintain or diminish because of interventions, but it would not get worse. In 2008 and 2011, M. had acute onsets of manic and disruptive behavior, and was hospitalized. To Dr. Greenwald, these changes were consistent with an affective disorder and being bipolar; and were not consistent with Autism.

43. On cross examination, Dr. Greenwald was asked about M.'s pacing, as some observers have seen M. pace extensively. Dr. Greenwald did not consider this a "repetitive behavior" indicative of autism. He found it a generic behavior that could be also reflective of anxiety, mania, or ADHD, all of which have been ascribed to M. In addition, pacing is not necessarily a classic autism repetitive behavior. More classical would be flapping of fingers or hands, tip toe walking, putting hands in front of eyes. Dr. Greenwald did not see any of this type of classically autistic repetitive motions during his three hour evaluation.

44. Dr. Greenwald opined that M. presented a complicated clinical picture, as some of his behaviors were on the autistic spectrum. His extreme resistance to controls can be characteristic of Autism. However, his inconsistencies – with eye contact, with motions, lean away from Autism. To Dr. Greenwald, M.'s sudden and acute onset of behavioral outbursts that were noted last year before he was hospitalized reflects the cycling nature of a bipolar condition. In contrast, Autism is chronic and it does not come on acutely.

45. Dr. Greenwald also observed that autistic individuals are less likely to engage in violence than the general population; M. has been violent, he has threatened people's lives, and, exemplifying interactive behavior, which is not consistent with Autism, has had verbal altercations with his peers. Visual hallucinations and delusional thoughts are not

consistent with Autism. An autistic person cannot articulate having hallucinations. A thought disorder is more consistent with Asperger's than autism, just as is the ability to self-report is more consistent with Asperger's. An average to high IQ is more consistent with Asperger's than autism, and M.'s average and above-average IQ scores support, to Dr. Greenwald, a diagnosis of Asperger's.

46. Dr. Greenwald disagreed with Dr. Cronin's report and testimony. He opined that her assessment and report ignored the significance of M.'s co-morbidities and psychiatric medications. He called this the "500 pound gorilla in the room." According to Dr. Greenwald, M. was prescribed medications for specific psychiatric conditions that modified and contributed to his problematic behaviors. He also disagreed with Dr. Cronin's conclusion that M. has adaptive functioning "well within the range of mental retardation."

The Testimony From Claimant's Mother

47. M.'s mother, Mrs. R., testified that M. has had social problems his whole life. She has always felt that his communication skills have been poor; she felt his conversations are only one way and he only speaks about things he wants to talk about. He has no friends. His favorite topics are movies and historical events. He will make eye contact, but only when he wants to.

According to M.'s mother, M. has no interest in getting a job. He has a cell phone but uses it privately so Mrs. R. does not know what he uses it for or how he uses it.

M. is prescribed Geodone, 40 mg/day and Luvox, 100 mg. at night to "calm him down." The drugs take the "edge" off his anxiety. He has been on both drugs for four to five years; she does not know how he is without the drugs. The last time he was admitted to a psychiatric hospital was two years ago, when he was in 11th grade. He sees a Kaiser counselor about once a month and likes to go. Mrs. R. felt M. is benefitting from the counseling.

M. is taking a sociology class at Chaffey College. He takes the bus alone to school. It was his idea to take the class. Mrs. R. believes her son has Autism.

Written Closing Arguments

48. Claimant argued that he was eligible for regional center services as a result of a diagnosis of Autism and that his Autism constitutes a substantial disability. He asserted that he meets virtually every diagnostic criterion for Autism. He denies having any other psychiatric condition that would explain his behaviors. Claimant contends his adaptive functioning is so poor and his needs for services so great that he is eligible for regional center services. Claimant also argued that Dr. Greenwald's evaluation was fatally flawed because he did not consider M.'s entire historical record and relied too greatly on the ADOS.

49. The regional center argued that the evidence established that M. does not have Autism, but has an appropriate diagnosis of Asperger’s Disorder with mental health co-morbidities that impact his presentation. The service agency disagreed with Dr. Cronin’s assessment, emphasizing that Dr. Cronin disagrees with the distinction in the DSM-IV-TR between Autism and Asperger’s and that there are meaningful distinctions between the two disorders. The service agency asserted that M. is not eligible for regional center services under the Lanterman Act.

LEGAL CONCLUSIONS

The Burden and Standard of Proof

1. In a proceeding to determine if an individual is eligible for services, the burden of proof is on the claimant to establish that he or she has a qualifying diagnosis. (Evid. Code, § 500.) The standard of proof required is preponderance of the evidence. (Evid. Code, § 115.)

2. A preponderance of the evidence means that the evidence on one side outweighs or is more than the evidence on the other side, not necessarily in number of witnesses or quantity, but in its persuasive effect on those to whom it is addressed. (*People ex rel. Brown v. Tri-Union Seafoods, LLC* (2009) 171 Cal.App.4th 1549, 1567.)

The Lanterman Act

3. The State of California accepts responsibility for persons with developmental disabilities under the Lanterman Developmental Disabilities Services Act (the Act). (Welf. & Inst. Code, § 4500, et seq.) The purpose of the Act is to rectify the problem of inadequate treatment and services for the developmentally disabled, and to enable developmentally disabled individuals to lead independent and productive lives in the least restrictive setting possible. (Welf. & Inst. Code, §§ 4501, 4502; *Association for Retarded Citizens v. Department of Developmental Services* (1985) 38 Cal.3d 384.) The Act is a remedial statute; as such it must be interpreted broadly. (*California State Restaurant Association v. Whitlow* (1976) 58 Cal.App.3d 340, 347.)

4. In order to be eligible for services under the Lanterman Act, an individual must first have a developmental disability. Welfare and Institutions Code section 4512, subdivision (a), defines “developmental disability” as follows:

“Developmental disability” means 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. . . . [T]his term shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include 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.

5. The California Code of Regulations, title 17, section 54000, also defines “developmental disability” and the nature of the disability that must be present before an individual is found eligible for regional center services. It states:

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

(b) The Developmental Disability shall:

(1) Originate before age eighteen;

(2) Be likely to continue indefinitely;

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

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

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

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

(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.

6. When an individual is found to have a developmental disability as defined under the Lanterman Act, the State of California, through the regional center, accepts responsibility for providing services to those persons to support their integration into the mainstream life of the community. (Welf. & Inst. Code, § 4501.)

Evaluation

7. The Lanterman Act and the applicable regulations identify criteria that a claimant must meet to establish a developmental disability that qualifies for regional center services. The issue in this matter is whether M. has a diagnosis of Autism, in which case he would be eligible for regional center services; if M has a diagnosis of Asperger's Disorder and no other developmental disability articulated under the Lanterman Act, he would not be eligible for regional center services.

The determination of whether an individual has Autistic Disorder or has Asperger's Disorder cannot be based on a single test. The most accurate diagnosis will be made by a skilled and qualified professional based on accumulated evidence from multiple sources. In this case, both experts based their opinions on multiple sources of evidence and both were well qualified to render their expert opinions. In determining the weight of each expert's testimony, the expert's qualifications, credibility and basis for his or her opinions was considered. Based on the totality of the evidence presented, the testimony of Dr. Greenwald was more reasonable and more credible. Several factors support this conclusion.

The standard of care is to rely on the DSM-IV-TR criteria for diagnosis. Dr. Cronin, however, disagrees with the DSM-IV-TR distinctions between diagnosing Autism and Asperger's Disorder and does not believe there really is a difference between the two. The Lanterman Act, however, recognizes Autism as a developmental disability, but does not recognize Asperger's. The distinctions between the two disorders exist and are relevant in this case.

With Autism, the disorder is characterized by severe and sustained impairments in social interaction and the development of restricted, repetitive patterns of behavior that exist before the age of three. Though necessary for a diagnosis of Autistic Disorder, there was no evidence that M. had any significantly abnormal functioning prior to the age of three.

M. had no delay in his development of language and has consistently shown average to above average intelligence. These characteristics are more consistent with Asperger's Disorder. (DSM-IV-TR 299.80.)

In the school arena, when M. was age seven and in second grade, he was assessed by the school district, and was not found eligible for special education classes. His behavioral and emotional outbursts increased. A severe emotional disturbance was identified, and by

age eight, M. was prescribed psychotropic medications and was placed in special education on the basis of his emotional disturbance.

A hallmark of Autism is that the deficiencies are both severe and pervasive; they are consistent. M.'s deficiencies have not been consistent or pervasive. Numerous records reflect that M. is fully conversant "when he wants to be." The same can be said about his use of eye contact. At times, M. makes little eye contact when communicating; other times, he shows a reciprocating smile and gives good eye contact. Several school records indicate that his level of conversation and engagement was dependent on his mood. In 2008, at age 14 and in the 9th grade, his school district noted that M. communicated his needs and participated in spontaneous conversation at an age-appropriate level. M. regularly meets with a Kaiser therapist (a licensed social worker) and calls the Kaiser hot line when he wants to talk in between sessions. He has a cell phone that he uses. He had an engaging conversation with Dr. Greenwald about his goals, about school, and about one girl in particular. His inconsistencies in the level and depth of conversation and eye contact he makes are more indicative of an individual with Asperger's than that of an individual having a diagnosis of Autism. While his conversations are sometimes odd, one-sided or seemingly insensitive to others, such conversation style is, under the DSM-IV-TR, indicative of an individual with Asperger's.

Another distinction that the DSM-TR-IV makes between Asperger's and Autism relates to cognitive development. Autistic individuals have significant cognitive impairments that can be consistent with mental retardation. In contrast, and more in keeping with Asperger's Disorder, M. has consistently had IQ scores that are average or above average. In grade school, he was identified and placed in the GATE ("gifted and talented education" program) for children with higher intellectual functioning. In 2011, at age 16, he was maintaining a 3.17 GPA. He is currently taking a regular college course in Sociology at Chaffee College. M.'s cognitive abilities are consistent with an individual with Asperger's Disorder and not with a diagnosis of Autism.

Dr. Cronin completely rejected any suggestion that M. had co-morbidities in the psychiatric arena – that he was bipolar, had OCD, depression, or a mood disorder. Even through the school district identified M. as emotionally disturbed from the age of eight, despite M.'s aggressive outbursts and being on psychotropic drugs for years, having a history of eleven psychiatric hospitalizations, and having had hallucinations and delusions, Dr. Cronin disagreed that M. had any psychiatric condition other than "anxiety." She had little explanation for rejecting these well-documented psychiatric conditions and diagnoses. It is interesting that Dr. Cronin, who rejected the very suggestion that M. has psychiatric co-morbidities, did not recommend that M. should be medically evaluated to determine if he should be off his psychotropic medications that he has taken regularly for the past five years. This inconsistency detracts from the reasonableness and credibility of Dr. Cronin's opinion. Dr. Greenwald's discussion of the impact of M.'s co-morbidities on M.'s behavior and adaptation was more reasonable and more credible.

Dr. Greenwald's opinion is additionally found to be more credible because he considered aspects of M.'s behavior that Dr. Cronin appeared to ignore. M. engaged in a sustained dialogue with Dr. Greenwald. M. shared hopes and dreams, albeit unrealistic, such as showing an interest in marketing a revolutionary form of energy production and becoming rich. He spoke of having a relationship with a young woman (and asked Dr. Greenwald not to share this information with his mother or others). He spoke about conflicts in high school as a "pissing contest," reflecting an introspection that Autistic individuals do not display. In addition, M. sometimes used inappropriate sexual conversation and when he is angry, used profanity and argued with people. Dr. Cronin gave this little significance; she opined that Autistic individuals can use profanity even if they don't know what it means. However, M. used profanity and threats as a weapon, reflecting an understanding of the language he was using and a purposeful intent to use it. This behavior is not consistent with having a qualitative impairment in communication expected with an Autistic individual.

M. does present a complicated picture. He does have some behavioral elements and characteristics that can be found in individuals with Autism. But that is the nature of Asperger's. Both diagnoses can exist for individuals who demonstrate deficits in social interaction, which M. displays. There was evidence that M. often shows extreme resistance to control; such resistance is consistent with Autism, Asperger's and even with adolescence in general. An individual, such as M., can show some characteristics of a person with Autism but not meet the full criteria. The weight of the evidence supports the conclusion that M. does not meet the full criteria for Autism, and on balance, a more accurate diagnosis is Asperger's.

Both experts utilized the Autism Diagnostic Observation Schedule (ADOS) in forming their opinions. The manufacturer of ADOS cautions against strict reading of the ADOS scores when an individual has a co-morbidity. It states:

The ADOS is quite good at identifying individuals with autism and autism spectrum disorders (ASDs), but simply meeting cutoffs on the ADOS does not necessarily mean that person has autism or an ASD. Overall ADOS totals and scores in individual items may be elevated for various reasons. Individuals with other disorders, such as mental retardation and/or severe behavior problems, may have elevated scores on the ADOS due to comorbid conditions that affect social-communication behaviors that we see in ASD. To provide an accurate diagnosis, your evaluation must include more than just the ADOS.

M.'s co-morbidities likely elevated his ADOS scores. Dr. Cronin disagreed that M. had any psychiatric co-morbidities and thus did not address the issue. Dr. Greenwald discussed the issue. In his assessment, however, even considering an elevation one would expect for an individual with the psychiatric co-morbidities that M. has, in Dr. Greenwald's assessment under ADOS, M. did not meet the cut off for Autism. Dr. Cronin criticized Dr.

Greenwald's evaluation because she opined that Dr. Greenwald did not utilize enough resources to obtain a full picture of M. Dr. Greenwald had the benefit of Dr. Cronin's report which summarized any records related to M. that had not been provided to the regional center. On balance, Dr. Greenwald's use of ADOS as an objective evaluative tool was appropriate and the conclusions he reached were more reasonable than Dr. Cronin's.

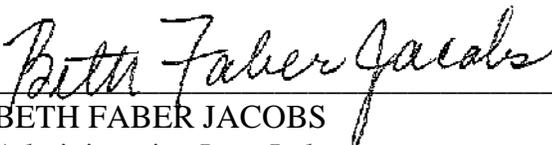
Dr. Cronin's opinion focused on M.'s adaptive disabilities, opining that M. was eligible because he needs the services that the regional center can provide. To a certain degree, this opinion placed the cart before the horse. Most everyone, even those who do not suffer from a developmental disability, would benefit from the broad array of services and supports provided by the regional center. Given M.'s history, it is understandable that his adaptive skills might be lower: M. suffered abuse from his father. He has had numerous manic, psychotic, depressive, and other psychiatrically based episodes on top of his Asperger's. All of these can affect adaptive functioning. But regardless of his level of adaption, to be eligible for regional center services, M. must first have an eligible disability under the Lanterman Act. The weight supports the conclusion that M. does not have an eligible developmental disability.

The burden was on claimant to establish his eligibility for regional center services. He did not meet that burden. The weight of the evidence supports the conclusion that M. has a diagnosis of Asperger's Disorder with a psychiatric overlay, and that he does not have a diagnosis of Autism. As such, M. is not eligible to receive regional center services.

ORDER

Claimant M.'s appeal from the service center's determination that he is not eligible for regional center services and supports is denied. Claimant is ineligible for regional center services and supports under the Lanterman Developmental Disabilities Services Act.

DATED: May 6, 2013


BETH FABER JACOBS
Administrative Law Judge
Office of Administrative Hearings

NOTICE

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