

BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

DERICK K-D

Claimant,

vs.

NORTH LOS ANGELES COUNTY
REGIONAL CENTER,

Service Agency.

OAH No. 2012070236

DECISION

This matter came on regularly for hearing on March 19, 2013, and May 17, 2013, in Lancaster, California, before H. Stuart Waxman, Administrative Law Judge, Office of Administrative Hearings, State of California.

Derick K-D¹ (Claimant), was represented by Jeffrey D. Moffatt, Attorney at Law.

North Los Angeles County Regional Center (Service Agency) was represented by Rhonda Campbell, Contract Officer.

Oral and documentary evidence was received. The record was closed on May 17, 2013, and the matter was submitted for decision.

¹ Claimant's initials are used in lieu of his surname in order to protect his privacy. His mother's initial is used in lieu of her surname in order to further protect claimant's identity.

ISSUE

Does the Claimant have a developmental disability entitling him to Regional Center services?

EVIDENCE RELIED ON

1. Testimony of Deisy Perez
2. Testimony of Ana Garcia
3. Testimony of Pamela D.
4. Testimony of Apurva Shah, M.D.
5. Testimony of Sandi Fischer, Ph.D.
6. Exhibits 1 through 41
7. Exhibits A through G

FACTUAL FINDINGS

1. Claimant is a 15-year-old male applicant for regional center services (date of birth: April 13, 1998). He contends he is eligible for those services on the basis of autism or, in the alternative, on the basis of having a condition closely related to mental retardation or requiring treatment similar to that needed by people with mental retardation (commonly referred to as the “fifth category”). The Service Agency contends that Claimant does not meet the diagnostic criteria for either autism or fifth category.

2. Claimant resides with his grandmother and grandfather, who are also his adoptive parents. His twin sister also resides in the home. The record contains references to an older brother and an adult uncle residing there as well.

3. Claimant was born three months premature. Both of his biological parents allegedly abused substances including alcohol, cigarettes, and illicit drugs, and his mother used those substances during her pregnancy with Claimant and his twin sister. Both children were allegedly abused and neglected by their biological parents, and they were hospitalized for approximately three months upon their discovery at the age of nine months. At that time, the grandparents gained legal custody of both twins. They adopted the twins when the twins were four years old.

4. Mrs. D. is a retired special education instructor. When Claimant was nine months old, she suspected something wrong with his development. When he was 18 months old, she began what turned out to be a lengthy process of attempting to determine his diagnosis. That process has continued to the present time.

5. The evidence in this case consists of 47 exhibits, most of which are evaluation reports or other documents evidencing a diagnosis. They range from years 2001 to 2012. Many of those exhibits contain references to signs and symptoms of autism, other autism spectrum disorders, mental retardation, or fifth category, but the examiners concluded that other diagnoses better fit Claimant's constellation of symptoms. For example:

a. On June 27, 2001, Licensed Clinical Social Worker, Kathleen Cannon, wrote that Claimant was careless, acted without thinking, laid on the floor and screamed, hit and kicked others, attempted to break the fingers of his sister and family, was mean to his sister, liked to do what he wanted to do, put everything in his mouth, liked to smell everything, played by himself at school, rode his bicycle in circles looking at the ground, did not socialize well with others, hated loud noises, did not answer direct questions, hated bright colors, ran everywhere, and was very active and "hyper." Ms. Cannon gave Claimant a rule out diagnosis of Attention Deficit/Hyperactivity Disorder (ADHD). (Exhibit 3.)

b. Claimant is a long-time patient of Kaiser Permanente. On February 3, 2003, he was diagnosed with reactive attention disorder, ADHD, and intermittent explosive disorder. He subsequently received a provisional diagnosis of explosive disorder, probable post-traumatic stress disorder (PTSD), and probable reactive attention disorder. On October 10, 2003, a Kaiser Permanente physician charted RAD [reactive attention disorder] vs. autistic spectrum but added "I have doubts given extremely chaotic childhood." (Exhibit 4.)

c. In a letter dated June 28, 2001, Kathleen Cannon, LCSW, wrote that Claimant met the diagnostic criteria for ADHD, combined type, despite his young age. However, "Ms. [D.] was encouraged to follow up for an evaluation with the Regional Center due to her concerns about possible delays in gross motor development, developmental delays, and possible learning disabilities, especially as compared to his twin sibling." (Exhibit 5.)

d. A comprehensive psychological evaluation on October 1, 2003, by Gabrielle de Vergia Ph.D., which included behavioral observation, clinical interview, and objective psychometric testing, yielded a diagnosis of ADHD and borderline intellectual abilities with prenatal drug exposure and prematurity. (Exhibit 7.)

e. During a medical evaluation by the Service Agency on September 6, 2001, Claimant was found to be easy to understand. He could converse but could not tell a story. He was cooperative and put toys away. He was loving and social with his family but not with other children. However, he hit grandmother with plastic tube during the interview. (Exhibit 8.)

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f. On October 1, 2003, Donald Gallo, Ph.D. found that Claimant showed numerous signs of autism including poor social interactions, communications and stereotyped patterns of behaviors and interests. He had just started to draw and give things to his mother. He had stayed by himself and did not interact with others during his fifth birthday party. He did not build on conversations, and he was perseverative on topics regardless of the conversation taking place at the time. He showed stereotyped patterns of behaviors, mostly with trains, and he would be content watching TV all day. He did not engage in repetitive hand or body movements, and he did not have an intense interest in parts of objects. He did not like to be picked up as an infant or toddler. He did not like loud noises and was sensitive to texture. Dr. Gallo diagnosed Claimant with autism. However, his diagnosis was based on observation and report alone. He failed to perform any objective psychometric testing. (Exhibit 9.)

g. A comprehensive psychological evaluation by Robert Rome, Ph.D. on April 23, 2004 yielded a diagnosis of ADHD with intellectual functioning in the low average range. (Exhibit 12.)

h. On February 22, 2006, in a Department of Mental Health, Child/Adolescent Initial Assessment, Claimant was diagnosed with ADHD, mood disorder, NOS (not otherwise specified), and impulse control disorder NOS. (Exhibit 13.)

i. A psychological evaluation was conducted at BHC Alhambra Hospital on March 22, 2006 during an involuntary admission after Claimant attacked his teacher at school. Claimant was diagnosed with learning disorder, possible bipolar disorder, currently depressed; rule out ADHD; rule out conduct disorder. (Exhibit 14.) At the time of discharge approximately six days later, Wakelin McNeel, M.D. changed the diagnosis to ADHD, learning disorder, mild autism, oppositional defiant disorder, rule out bipolar disorder. No mention is made of any psychometric testing having been performed in the diagnosis of autism. (Exhibit 15.)

j. In a September 9, 2006 psychological evaluation, Leslie Rosen, Ph.D. diagnosed Pervasive Development Disorder NOS (including atypical autism), oppositional defiant disorder, and mild mental retardation. Dr. Rosen did not perform any objective testing in reaching the atypical autism diagnosis. (Exhibit 16.)

k. On December 28, 2006, Claimant was seen at Amen Clinics, Inc. with a chief complaint of explosiveness. Following extensive testing, Claimant was diagnosed with probable bipolar disorder NOS; oppositional defiant disorder; ADHD; temporal lobe dysfunction; generalized anxiety disorder; status post cranial cerebral trauma; rule out reactive attachment traits with Ring of Fire; PTSD; chronic constipation; status post septic shock; asthma; rule out prenatal exposure to alcohol and drugs. The evaluator opined that the combination of findings suggested past brain trauma. (Exhibit 17.)

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l. In a mental health assessment performed by the Los Angeles County Department of Mental Health on April 30, 2010, Claimant was found to have good eye contact. He was cooperative throughout the interview but was easily distracted. He reported a positive relationship with his father. There was no evidence of a thought disorder. His affect was in the normal range. His mood was labile, ranging from sad to angry to frustrated. His judgment and insight were impaired. (Exhibit 19.)

m. In a progress note dated August 1, 2011, Dennis James Pfanner, MFT, found that claimant was active in sports, playing baseball and bowling in Special Olympics. He had friends and loved video games. He had also been snooping in his sister's room. Claimant wanted to speak with Mr. Pfanner, but only after his mother left the room. Mr. Pfanner assessed Claimant with a behavioral problem; parent-child relational problem, and mood disorder. (Exhibit 20.)

n. In a progress note dated August 16, 2011, Claimant's child psychiatrist, Apurva Vinaykant Shah, M.D., diagnosed Claimant with mood disorder (primary encounter diagnosis) and ADHD, combined type. (Exhibit 21.)

o. An individualized education program (IEP) dated November 4, 2011, reported Claimant's primary disability as emotional disturbance and his secondary disability as a specific learning disability. (Exhibit 22.)

p. In a social assessment by the Service Agency on March 28, 2012, Claimant showed good eye contact without unusual or repetitive behaviors. He was non-echolalic. Although he did not initiate contact with peers, he had two friends from Special Olympics, and he gave spontaneous affection to his parents. He was sensitive to loud noises and disliked crowds. (Exhibit 24.)

q. In an April 4, 2012 progress note, Dr. Shah noted that Claimant's mother reported that Claimant tended to sleep in class all day, except for lunch and recess, and that he remained awake all day on non-school days. He was becoming more forgetful; he smeared feces; and he ran in the street without looking. Dr. Shah found Claimant friendly and appropriate. His speech and language were within normal limits. His mood was fine, and his affect appropriate. However, he was cognitively below average with extremely poor insight and judgment. Dr. Shah assessed Claimant with mood disorder. (Exhibit 25.)

r. A medical summary conducted by the Service Agency on April 6, 2012 found Claimant with ADHD, mood disorder, and impulse control disorder. (Exhibit 26.)

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s. An IEP dated September 27, 2012 reported Claimant's primary disability as autism and his secondary disability as emotional disturbance. (Exhibit 32.) This was a change from the earlier IEP, but it did not discuss the behaviors that caused the change. The description in the document is the Education Code description for emotional disturbance, not autism. According to Sandi Fischer, Ph.D., those behaviors that were addressed in the IEP do not support a finding of autism. Dr. Fischer speculated that the change might have been the result of a diagnosis of autism by a Kaiser Permanente interdisciplinary autism team a few months earlier. That evaluation is discussed in detail below.

t. Kaiser Permanente records show numerous diagnoses and variations including bipolar disorder, depression, ADHD, mood disorder, learning disorder, rule out ADHD, and rule out conduct disorder. On August 4, 2009, Dr. Shah wrote that Claimant was friendly and appropriate with speech and language within normal limits. His mood was fine and his affect was euthymic. He was cognitively intact with good insight but poor judgment. Dr. Shah wrote similar, but not identical notes on June 22, 2011 and June 3, 2012. (Exhibits 41 and B.)

u. An IEP dated May 9, 2013 reported Claimant's primary disability as autism and his secondary disability as emotional disturbance. As with the earlier IEP, there was no rationale for the finding of autism. (Exhibit F.)

6. Three of the most recent reports are among the most comprehensive. They are addressed separately below.

Psychological Evaluation by Larry Gaines, Ph.D. (Exhibit 28)

7. On April 16, 2012, Larry Gaines, Ph.D. conducted a psychological evaluation on Claimant. As part of the evaluation, he administered several psychometric tests including but not limited to the Weschler Intelligence Scale for Children-IV (WISC-IV), the Vineland Adaptive Behavior Scales, and the Autism Diagnostic Observation Scale, Module Three (ADOS). Based on the psychometric testing, clinical interview, and behavioral observation, Dr. Gaines found the following:

a. Although he was initially uncooperative, Claimant became more so and engaged in the evaluation process after his mother left the room, and he became more verbal over time. He was impulsive in his answers to the various tests and made numerous careless errors.

b. The WISC-IV scores were not consistent with mental retardation, but there were highly significant discrepancies between verbal and non-verbal scores, with verbal scoring far higher in problem solving skills. Nonverbal perceptual reasoning skills were within the mild range of deficiency, which was a finding consistent with all of Claimant's diagnoses. The scores reflected, among other things, impulse control problems associated with attention deficit disorder (ADD) rather than mental retardation.

c. Language skills fell within the moderate range of deficiency. Claimant spoke in sentences. He was able to describe aspects of his experiences and engage in a conversation when he wanted to. Claimant did not exhibit any odd or idiosyncratic aspects of language that would be associated with an autistic condition. However, he tended to jump from one topic to another, demonstrating poor impulse control.

d. As for sensory/motor functioning, Claimant participated in sports but only through Special Olympics. By report, he participated at the seven year, three month level.

e. Claimant was in the moderate range of deficiency in adaptive behavior functioning. His mother reported impairments in life skill activities. Claimant could feed himself but could not use a knife. He was toilet trained, and he dressed himself if clothes were chosen for him. He could wash his face and hands and brush his teeth, but he needed supervision and support in showering. He did not do household chores. He could tell time, but he did not know the day or date. He did not recognize money or cross the street safely.

f. Claimant's mother reported that Claimant functioned as an individual with moderate mental retardation. Dr. Gaines found her claims inconsistent with Claimant's presentation and other areas of demonstrated capabilities. However, claimant was extremely impulsive.

g. Claimant was in the moderate range of deficiency in social functioning. Medical evaluations suggested a mood disorder. He had only one friend. He did not want to be around others or in new settings. His mother reported repetitive behaviors such as repeatedly asking the same question. Claimant identified friends at school and their associated play activities. He had an understanding of long term relationships such as being married.

h. Regarding the ADOS, Dr. Gaines wrote: "He did not elevate Communication scores. Reciprocal/Social Interaction scores met Autism Spectrum cut-off level. Interpretation of these results reflected that these elevations indicate his lack of insight and social overtures, which are also explained by his numerous mental health conditions. [Claimant] was not observed clinically to present as a child with autistic behavior."

i. Claimant was happy playing video games and playing with friends. He was able to use some metaphors. He described in simple terms how others annoyed him by calling him names and taunting him. He reported giving "payback" by annoying them.

j. There were no idiosyncratic, repetitive or restricted behaviors in Claimant's early history to suggest an autistic condition having occurred in an early developmental period.

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k. In summary, Claimant showed average intellectual potential. There were significant deficiencies in nonverbal processing areas that were consistent with mental health diagnoses of mood disorder and ADD. Claimant did not have mental retardation or autism. Dr. Gaines diagnosed ADHD, combined type by history and cognitive disorder NOS by report.

Kaiser Permanente Interdisciplinary Report (Exhibit 30)

8. As referenced above, Dr. Shah is Claimant's child psychiatrist. He is also a member of an autism interdisciplinary team at Kaiser Permanente, which is charged with the task of determining whether certain patients meet the diagnostic criteria for autism. On July 12 and 18, 2012, the team, consisting of Dr. Shah and Katherine Donahue, Ph.D., conducted such an evaluation on Claimant. The psychometric tests administered in the evaluation included the ADOS, the Childhood Autism Rating Scale, Second Edition, the Social Communication Questionnaire, and the WISC-IV. Dr. Shah authored the report and made the following findings:

a. Claimant was 14 years old and in the ninth grade at the time of the evaluation. He was "self-referred" to the interdisciplinary team. (Presumably, the referral was by his mother. It was not made by Dr. Shah.)

b. The maternal side of Claimant's family was noteworthy for ADHD. His biological father was diagnosed with Bipolar Disorder.

c. Claimant showed poor eye contact, but he did not display any repetitive or stereotyped behaviors. He tended to perseverate on dying and things that could hurt him. He was sensitive to light and touch. He feared using the toilet and preferred to defecate in the yard. He had flat affect and limited facial expressions. He was resistant to tasks and had low frustration tolerance. He had a longstanding history of echolalia, but he had never undergone a speech and language evaluation.

d. Claimant's most recent IEP, dated 4/24/12, showed he was performing below grade level across all academic areas. However, he could understand the curriculum when it was scaffolded and modified. Claimant tended to sleep in class.

e. Claimant reported to be making friends. His overall social skills seemed to be improving.

f. Claimant struggled with two-step directions. He needed many reminders and prompting.

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g. On the ADOS, “[t]he overall quality of his language was largely correct, but there was little variation in pitch and tone. No immediate echolalia or idiosyncratic language was observed.” Claimant engaged in little reciprocal conversation. Eye contact was poor and affect was flat. He did not make or respond to social overtones with the examiner, and he demonstrated no interactive or creative play skills. There were no unusual sensory interests or behavioral stereotypes, and no self-injurious behavior, compulsions or rituals. Claimant stayed appropriately seated during the evaluation, but he showed marked anxiety throughout the evaluation. The ADOS Classification showed evidence of autism.

h. On the Childhood Autism Rating Scale, Dr. Shah reported that “[Claimant] earned a raw score of 35, giving him a *t*-score of 49 and placing him at the 46th percentile compared to other individuals with Autism Spectrum diagnoses in his age group. This score places him in the Severe Symptoms of Autism Spectrum Disorder group.”

i. Claimant’s mother was given the Social Communication Questionnaire. Dr. Shah wrote: “According to parental report, [Claimant’s] score was 27, strongly indicating the presence of a possible Autism Spectrum Disorder (Scores over 15 are suggestive of a possible Autism Spectrum Disorder).”

j. Claimant’s mother was also the reporter on the Vineland Adaptive Behavior Scales, Second Edition. Dr. Shah wrote: “Overall, [Claimant’s] general level of adaptive functioning is in the profoundly impaired range, at the <1st percentile (Standard Score = 42).”

k. Dr. Shah reported: “With respect to [Claimant’s] overall functioning in the communication domain, his skills fall in the profoundly impaired range, with skills at <1st percentile (Standard Score = 45). Regarding his acquisition of the skills of daily living, [Claimant’s] overall level of functioning was rated to be in the profoundly impaired domain (Standard Score = 43; <1st percentile). [Claimant’s] social skills development was also rated to be in the profoundly impaired range (Standard Score = 43; <1st percentile). [Claimant] exhibits clinically-significant internalizing behaviors including: avoids others, and prefers to be alone, refuses to go to school for fear of rejection, poor eye contact, sleep difficulties, and avoid social interaction. Mrs. [D.] also reported clinically elevated externalizing and maladaptive behaviors including impulsivity, temper tantrums, aggression, stubbornness, bedwetting, difficulties with paying attention, swearing, and acts overly familiar with strangers at times.”

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l. Regarding the WISC-IV, Dr. Shah wrote: “Overall level of cognitive functioning was in the extremely low range (FSIQ=54; <1st percentile) indicates mild mental retardation which is consistent with his severely impaired adaptive scores and teacher reports. WISC-IV profile is flat which predicts that “he will experience a great deal of difficulty with learning, memory, attention, and classroom academics.” The team found that Claimant’s verbal concept formation, word knowledge and social judgment were in the extremely low range, under the first percentile. However, there was some discrepancy among the subtest scores from the low average to profoundly impaired range. Nonverbal reasoning, organization and spatial abilities scores were in the extremely low range, under the first percentile, but there was a high degree of scatter among the subtest scores ranging from the low average to profoundly impaired range. Working memory scores were in the extremely low range, under the first percentile with some discrepancy among the subtest scores. Speed of processing visual information and required rapid decision-making, and motor response scores were in the borderline range with a high degree of discrepancy among the subtest scores.

m. The team rendered a diagnosis of autism disorder (primary encounter diagnosis) and developmental delay.

9. The Kaiser Permanente Interdisciplinary Team’s report is not convincing for several reasons:

a. Claimant’s evaluation was “self-referred” even though Dr. Shah had been his psychiatrist for several years. As a member of the interdisciplinary team, one would expect him to recognize signs of autism in his patient and refer the patient for an autism evaluation. Because of his failure to make the referral, a reasonable inference is drawn that he did not believe Claimant suffered from autism.

b. The team’s record review was incomplete. Among others, they failed to review the report of Dr. Gaines’s evaluation which had been completed only approximately two months before. As a result, their use of the WISC-IV, so soon after another one had been administered, rendered the interdisciplinary team’s WISC-IV invalid. (Testimony of Sandi Fischer, Ph.D.)

c. Exhibit 41 contains a note by Dr. Donahue to the effect that Claimant “shut down” during the evaluation after she conducted the WISC-IV, and that he refused to participate further. She also wrote that Claimant demonstrated a low frustration tolerance, and gave up easily when tasks became challenging. Dr. Fischer explained that Dr. Donahue assigned scores of “3” on several of the ADOS criteria because Claimant was “shut down.” Those scores meant that Dr. Donahue lacked sufficient data to evaluate Claimant in those areas. The scores converted to scores of “2” in the final calculation, the highest score possible for each criterion. As a result, Claimant’s ADOS scores were artificially high, putting him in the range for autistic disorder. In addition, Dr. Donahue did not address that situation in the interdisciplinary team’s report.

d. The interdisciplinary team did not find any restricted or stereotyped behaviors. Although there is a positive finding in that regard at Exhibit 30, page 57, Dr. Shah testified that the finding was made in error.

e. The mention of a longstanding history of echolalia is not supported by the weight of the other evidence which lacks mention of such a history except for one or two reports by Claimant's mother that Claimant tended to repeat questions. If there were a history of echolalia, one would expect to see speech and language evaluations among the voluminous other reports.

f. Dr. Shah's progress notes provide a dramatically different presentation of Claimant. In none of his notes, does he declare any suspicion of autism. On the contrary, in several notes, he found Claimant friendly and appropriate with speech and language within normal limits and cognitively intact. Mood, affect, insight and judgment varied. In each of the notes, Dr. Shah endorsed diagnoses of mood disorder and ADHD.

g. Dr. Shah testified at the hearing that he has never personally evaluated Claimant for autism. However, that testimony is belied by the first page of the report (Exhibit 30) which reads in part: "Examiners: Apurva Shah, M.D. and Katherine A. Donahue, Ph.D.," and the last page of the report which bears his signature. Nowhere in the report is it disclosed that Dr. Shah, the author of the report, did not participate in the evaluation.

10. During Dr. Shah's hearing testimony, when confronted with the facts that he did not refer Claimant for an autism evaluation, and that his notes did not reflect a patient with autism, he explained that, at Kaiser Permanente, he wore "two hats." He was Claimant's child psychiatrist who saw him for the purpose of prescribing medication, and he was a member of the autism interdisciplinary team, and thus an individual who focused on determining whether a patient had autism. Because of those "two hats," as Claimant's child psychiatrist, Dr. Shah did not view Claimant as autistic because he was not "looking for autism." (Dr. Shah's term.) Further, the Kaiser Permanente record-keeping system was electronic, and it would auto-complete a note after the physician typed a few characters. The physician could then edit the note to correct inaccuracies in the auto-completed text. However, Dr. Shah testified that he was busy, and he sometimes forgot to make the edits. Therefore, his progress notes did not accurately reflect Claimant's condition, which was actually worse than the notes indicate.

11. Dr. Shah's testimony was devoid of credibility. First, regardless of which "hat" he was wearing, Dr. Shah was and is a physician. As a child psychiatrist, he well knew the signs and symptoms of autism. He was responsible for prescribing and titrating Claimant's medications. It defies both logic and reason that he would ignore, or even worse, not look for, those signs and symptoms in his long-time patient while writing prescriptions for what could be disorders Claimant did not have, or for medications contraindicated for a patient with autism.

12. Secondly, Dr. Shah admitted that he was aware that, as a physician, he was mandated to maintain adequate and accurate records. (Bus. & Prof. Code, §2266.) Yet, he also admitted that this is exactly what he failed to do. If one were to accept his testimony as true, then by indicating in his notes that there were no signs of autism, while participating in an evaluation that resulted in an autism diagnosis, Dr. Shah demonstrated the very reason why adequate and accurate medical documentation is so important. It provides others involved in the care and treatment of the patient a correct history of what has occurred, why it has occurred, what has been done, and the results of the treatment, so that correct decisions can be made regarding future treatment.

13. However, although it initially appears that Dr. Shah failed to keep adequate and accurate records, closer examination reveals that such is not the case. Although his progress notes contain the same auto-completed text, they are not identical. Dr. Shah changed several of the notes to indicate changes in Claimant's mood, affect, insight and judgment over time. Therefore, he accurately edited the notes to reflect Claimant's condition on each office visit. Accordingly, the inference drawn from those notes and Dr. Shah's testimony is that Dr. Shah attempted to rationalize his testimony by saying his accurate office notes are inaccurate in order to justify the finding of autism made by the interdisciplinary team.

14. Dr. Shah's testimony is given no weight. Because he falsely admitted he kept inaccurate records, and that he did not participate in the evaluation, his willingness to be untruthful is established. Therefore, the interdisciplinary team report he authored must also be viewed with distrust. Expert witness testimony is of no value if it is based on inaccurate facts. "[W]here the *facts* underlying the expert's opinion are proved to be false or nonexistent, not only is the expert's opinion destroyed but the falsity permeates his entire testimony; it tends to prove his untruthfulness as a witness." (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 923-924.) (Emphasis in text.)

Record Review by Sandi Fischer, P.D. (Exhibit 38)

15. On December 3, 2012, Sandi Fischer, Ph.D. issued a comprehensive record review of the reports germane to this matter and opined that Claimant does not suffer from either an autistic disorder or mental retardation. Her rationale supporting those opinions follows:

16. Regarding her opinion that Claimant does not suffer from an autistic disorder, Dr. Fischer wrote:

[Claimant] does not meet the DSM-IV TR eligibility criteria for Autistic Disorder. In order to meet the eligibility criteria one must have at least six symptoms of Autistic Disorder including at least two in the area of Social Interaction and at least one each in the areas of Communication and Restricted Repetitive and Stereotyped Patterns of Behavior, interests and activities.

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Information from [Claimant's] records suggests variability in his use of eye contact. As a young child when lack of eye contact is particularly compelling, [Claimant] made good eye contact during an interview with Carlo De Antonio, M.D. (September 2001.) It appears that he sometimes makes facial expressions although these are more limited than would be expected although this could be related to his history of depression. Lack of facial expression was particularly commented upon by Wakelin McNeel, M.D. when [Claimant] was psychiatrically hospitalized in 2006. He may have difficulty integrating facial expression with verbalizations. There appears to be problems with [Claimant's] in [*sic*] his use of nonverbal communication to regulate social interactions; however, this began to manifest after significant mental health problems developed.

[Claimant] has failed to develop peer relationships appropriate to his developmental level. As a young child [Claimant] had on-going problems with attention, and distractibility. He was diagnosed with ADHD as a three year old which is highly unusual and even his therapist at the time, Ms. Cannon commented about this. It is likely that [Claimant's] difficulty developing appropriate peer relationships was related to long-standing mental health problems.

As a young child, [Claimant] showed toys to his mother during a Social Assessment (July 2001.) He was also reported to share interests with Dr. Gaines during his May 2012 Psychological Assessment. School records from when he was younger indicated that [Claimant] responded well to praise. It appears that [Claimant] has some capacity for spontaneous seeking to share enjoyment, interests, and achievement. There does not appear to be qualitative impairment in this area.

[Claimant] is frequently avoidant of interactions with others and school records indicate that he has been aggressive with peers. He has a history of being mean to animals. This would suggest problems with social and emotional reciprocity although this is likely related to his mental health issues (e.g. Mood Disorder, and Oppositional Defiant Disorder.)

Records do not clearly suggest a history of language delay although it is possible that there was a delay in his use of complete sentences. [Claimant] is able to hold brief conversations although it appears that his ability to initiate and sustain conversations with others is significantly impaired.

Records do not support the use of repetitive or idiosyncratic language. There is not qualitative impairment in this area.

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[Claimant's] use of make-believe play and social initiative play seemed to have been limited and less well developed than would have been expected when he was a younger child. There appears to be qualitative impairment in this area.

As a younger child, [Claimant] was reportedly interested in Thomas the Tank Engine. A recent report indicated that he has an interest in fighter jets. Therapy and School records do not mention these interests or any other in a way that would suggest that this reached the level of an encompassing preoccupation. There was not significant impairment in this area.

Parents sometimes reported that [Claimant] lined up his trains when he was a younger child; however, this behavior was never directly observed by any of the assessors, therapists, and other reporters (e.g. teachers) who provided input through the records reviewed. [Claimant's] therapist, Ms. Cannon, who worked with him for approximately three years when he was young and a later Kaiser-Permanente therapist who worked with [Claimant] as well as his psychiatrist never reported this type of behavior and did not report that parents were expressing concerns about this. [Claimant] did not have qualitative impairment in his inflexible adherence to specific, nonfunctional routines or rituals.

Records and parent report do not support the presence of stereotyped and repetitive motor mannerisms. There is not significant impairment in this area.

Records and parent report do not support a persistent preoccupation with parts of objects. There is not significant impairment in this area.

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17. Regarding her opinion that Claimant does not have mental retardation, Dr. Fischer wrote:

The DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, Washington DC; American Psychiatric Association 2000) diagnosis of mental retardation requires significantly sub-average intellectual functioning with concurrent deficits in adaptive functioning. Testing by Dr. Rosen, and Dr. Gaines suggested significant variability in [Claimant's] skills with significantly stronger language skills than skills in other areas. [Claimant's] Verbal Comprehension Index during Dr. Gaines's testing was in the average range which is consistent with Dr. Rome's findings that his receptive vocabulary as measured by the PPVT was in the average range. Dr. Donahue's testing was lower; however, she noted problems with [Claimant's] motivation. Additionally, she administered the same test as Dr. Gaines did two months later which calls into question the validity. Additionally, while [Claimant's] math skills consistently test low, his academic achievement scores in other areas are stronger falling in the low average to borderline range of functioning. Parent report of [Claimant's] adaptive functioning have consistently been exceedingly low despite a recent school report (September 2012) that they have no current concerns about [Claimant's] adaptive functioning or daily living skills in the school environment.

LEGAL CONCLUSIONS

1. Claimant does not have a developmental disability entitling him to regional center services.

2. Throughout the applicable statutes and regulations (Welf. & Inst. Code §§ 4700 - 4716, and California Code of Regulations, Title 17 (CCR), §§ 50900 - 50964), the state level fair hearing is considered an appeal of the service agency's decision. In this instance, where 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 failed to sustain his burden in that regard.

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3. Various statutes and regulations relating to eligibility apply to Claimant's request for services. As applicable to this case, Welfare and Institutions Code section 4512, subdivision (a) defines "developmental disability" as:

a disability which originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. . . . This term shall include 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 individuals with mental retardation, but shall not include other handicapping conditions that are solely physical in nature.

4. As relevant here, CCR section 54000 defines "developmental disability" as a disability attributable to mental retardation, cerebral palsy, epilepsy, autism, or other conditions similar to mental retardation that require treatment similar to that required for mentally retarded individuals. The disability must originate before age 18, be likely to continue indefinitely, and constitute a substantial handicap. Excluded are handicapping conditions that are solely psychiatric disorders, solely learning disabilities, or solely physical in nature.

5. The three exclusions from the definition of "developmental disability" under CCR section 54000 are further defined therein. Impaired intellectual or social functioning which originated as a result of a psychiatric disorder, if it was the individual's sole disorder, would not be considered a developmental disability. "Such psychiatric disorders include psycho-social deprivation and/or psychosis, severe neurosis or personality disorders even where social and intellectual functioning have been seriously impaired as an integral manifestation of the disorder." (CCR, §54000, subd. (c)(1).)

6. Similarly, an individual would not be considered developmentally disabled if his/her only condition was a learning disability (a significant discrepancy between estimated cognitive potential and actual level of educational performance) which is not "the result of generalized mental retardation, educational or psycho-social deprivation, [or] psychiatric disorder . . ." (CCR §54000, subd. (c)(2).) Also excluded are solely physical conditions such as faulty development, not associated with a neurological impairment, that result in a need for treatment similar to that required for mental retardation. (CCR § 54000, subd. (c)(3).)

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7. DSM-IV-TR defines Autistic Disorder as follows:

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

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(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)
- (d) 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.

8. In closing argument, Claimant's counsel asserted that the record was replete with references to autism and other autistic spectrum disorders. Although that may be true, those references do not constitute a finding of autism for the purpose of attaining regional center supports and services. As shown above, both "autistic disorder" and "developmental disability" are distinctly and sharply defined. A claimant must satisfy those definitions in order to qualify for services by a regional center. All autism spectrum disorders, except for autistic disorder, are excluded from consideration.

9. In this case, the weight of the evidence does not support a finding of autism. Except for the flawed evaluation by the Kaiser Permanente interdisciplinary team, each of the few diagnoses of autism in the record was made without the benefit of objective psychometric testing. Further, there was no convincing finding to satisfy section (A)(3) of the DSM-IV-TR criteria for autistic disorder (restricted repetitive and stereotyped patterns of behavior). Finally, Dr. Fischer's record review and testimony were credible and convincing. Dr. Shah's report and testimony were not.

10. In the alternative, Claimant argues that his condition satisfies the criteria for the fifth category.

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11. “Disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation,” as referenced in Welfare and Institutions Code section 4512, subdivision (a), is not defined by statute or regulation. Whereas the first four categories of eligibility are very specific (e.g., mental retardation, epilepsy, autism and cerebral palsy), the disabling conditions under this residual, fifth category are intentionally broad to encompass unspecified conditions and disorders. There are many persons with sub-average functioning and impaired adaptive behavior. However, the service agency does not have a duty to serve all of them. The fifth category does not provide unlimited access to all persons with some form of learning or behavioral disability.

12. Although the Legislature did not define the fifth category, it did require that the condition be “closely related” (Welf. & Inst. Code §4512, subd. (a)) or “similar” (CCR §54000) to mental retardation. The definitive characteristics of mental retardation include a significant degree of cognitive and adaptive deficits. Thus, to be closely related or similar to mental retardation, there must be a manifestation of qualitative or functional cognitive and/or adaptive deficits which render that individual’s disability like that of a person with mental retardation. This, however, is not a simple and strict replication of all of the cognitive and adaptive qualities or criteria to find eligibility due to mental retardation (e.g., reliance on I.Q. scores). If it were, the fifth category would be redundant. Eligibility under this category requires analysis of the quality of Claimant’s cognitive and adaptive functioning and whether the effect on his performance renders him like a person with mental retardation.

13. To have a condition which requires treatment similar to that provided to mentally retarded persons is not a simple exercise of enumerating the services provided to such persons and seeing if claimant would benefit. Many people could benefit from the types of services offered by regional centers, such as counseling, vocational training or living skills training. The criterion is not whether someone would benefit. Rather, it is whether someone’s condition requires such treatment.

14. In this case, there were few references to positive findings of mental retardation, and no evidence was offered to show that, or how, Claimant’s condition is similar to mental retardation, or requires treatment similar to that required by an individual with mental retardation. Given that Claimant had the burden of proof on the issue, the lack of such evidence constitutes a failure of proof.

15. The evidence was overwhelmingly clear that Claimant suffers from a number of severe problems. However, the evidence was also clear that those problems are not developmental such that they would qualify for regional center supports and services.

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16. On the day he testified, Dr. Shah stated that the new DSM-V was being released that day, and that the autistic spectrum disorders referenced in DSM-IV-TR had been synthesized under one diagnostic name. Dr. Fischer later stated that the DSM-V had been called back for additional editing. Regardless of the status of DSM-V, the parties agreed that all evaluations had been made using the criteria in DSM-IV-TR, and all witnesses testified using those criteria. Accordingly, this decision is made using the DSM-IV-TR criteria. No finding is made as to whether the outcome would be different under DSM-V.

ORDER

Claimant has not established his eligibility for services. Claimant's appeal of the service agency's determination that he is not eligible for services from the service agency is denied.

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.

Dated: May 22, 2013

_____/s/_____
H. STUART WAXMAN
Administrative Law Judge
Office of Administrative Hearings