

BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

OAH No. 2013120301

L.S.,

Claimant,

vs.

KERN REGIONAL CENTER,

Service Agency.

DECISION

This matter was heard by Julie Cabos-Owen, Administrative Law Judge with the Office of Administrative Hearings, on March 11, 2014, in Bakersfield, California. Claimant was represented by his mother and authorized representative.¹ Kern Regional Center (KRC or Service Agency) was represented by Jennifer Mullen, Program Manager.

Oral and documentary evidence was received, and argument was heard. The record was closed, and the matter was submitted for decision on March 11, 2014.

ISSUE

Does Claimant have a developmental disability (Autism Spectrum Disorder) entitling him to receive regional center services?

FACTUAL FINDINGS

1. Claimant is a 6-year-old male (born 6/16/07). He seeks eligibility for regional center services based on a diagnosis of Autism Spectrum Disorder.

¹ Claimant's and his mother's names are omitted to protect their privacy.

2. On November 4, 2013, KRC sent a letter and a Notice of Proposed Action to Claimant's mother, informing her that KRC had determined Claimant is not eligible for regional center services. Claimant's mother requested a fair hearing. (Exhibit A.)

3. Claimant lives with his mother and younger brother. They had resided in Arkansas, but moved to Bakersfield, California after Claimant's father committed suicide in May 2011. (Exhibit F; Exhibit 1; Testimony of Claimant's mother.)

4. On November 2, 2012, during an intake assessment at National Health Services, Inc. (NHSI), Claimant's mother reported that Claimant had been having behavioral issues since approximately 16 months prior (i.e. May 2011). His behaviors included aggression, destruction of property, and hitting and kicking people at home and at school. At that time, Claimant was attending transitional kindergarten and was performing at grade level, receiving A's and B's. Claimant was reported to have "enough friends" and to be cooperative with teachers. However, his behavioral issues were creating problems for him socially, and had resulted in him being suspended from school. Claimant's mother also reported that he: was inattentive; became easily bored or distracted; was fidgety, restless and excitable; talked excessively; had difficulty waiting his turn; was impulsive; disregarded his personal safety; and became easily frustrated. Madeleine Lorelei, PsyD, with NHSI assessed Claimant as having Attention Deficit Disorder, with hyperactivity (ADHD). (Exhibit F; Exhibit 1.)

5. On November 12, 2012, during another visit to NHSI, it was noted that the severity of Claimant's ADHD was "moderate" and occurred daily and that Claimant had been taking Clonidine. During a mental status examination, Jagdeep Garewal, M.D. noted, among other things, that: Claimant's behavior was unremarkable; his speech was appropriate; his attitude was cooperative; his reasoning and insight were fair; his attention was distracted and his concentration was poor; his impulse control and judgment were poor; and his affect and mood were "labile."² Dr. Garewal's clinical assessment was ADHD. (Exhibit F; Exhibit 1.)

6(a). On August 5, 2013, Claimant returned to NHSI with continued behavior and hyperactivity problems. Dr. Garewal noted, "[Claimant] has communication, socialization and verbal deficits, global and is not full spectrum but a Not Otherwise Specified Autistic Traits, [Mental Retardation] has to be evaluated for and ruled out in addition to [Learning Disorder], by Psychological Testing from school or KRC." He noted that Claimant had begun taking Risperdal. Dr. Garewal's clinical assessment was ADHD and Autistic Disorder. (Exhibit F; Exhibit 1.)

² "Labile" affect or mood means a pathological emotional mood expression or rapid shifts in outward emotional expressions. (E.g., an excessive but mood-congruent reaction or a mood-incongruent reaction.)

6(b). However, neither Dr. Garewal's note nor any of the NHSI records indicated that testing had been administered to obtain the diagnosis of Autistic Disorder. Consequently, that clinical assessment was given no weight.

7(a). On September 20, 2013, Claimant's mother underwent an initial interview at KRC. She noted that Claimant "makes little eye contact and has to have the same routine or he will throw a fit." He also sticks his fingers in his mouth compulsively and rubs his clothes together excessively. Claimant's mother sought evaluation through KRC to rule out autism. (Exhibit G; Exhibit 5.)

7(b). Regarding his development, Claimant sat independently at six months, crawled at seven months and walked at 10 months. He was toilet trained at two years. He said "mommy" and "daddy" at an early age but mostly pointed to communicate. By age three, he was saying only two to three words. His sentence development did not improve until about five years of age. (Exhibit G; Exhibit 5.)

7(c). Regarding daily living skills, Claimant can feed and dress himself and can comb his hair and brush his teeth. Regarding socialization, although Claimant's mother reported that his eye contact was poor, the assessment coordinator who conducted the initial interview noted that his eye contact was "adequate" at the time of the initial interview. She also noted that "he enjoys interacting with assessment coordinator and with the toys in the office." Claimant's mother acknowledged that he did enjoy physical interactions as long as they were "on his own terms," and "he had to be ready for it." He enjoyed interactive games such as hide and seek and chasing. He seemed to play well with younger children but he was "rough" and "very hands on." Regarding communication, Claimant has difficulty communicating his needs and getting his point across during conversations. (Exhibit G; Exhibit 5.)

7(d). Claimant is sensitive to loud noises and frequently covers his ears and complains that things are "too loud." As noted above, he sucks his fingers constantly and rubs his clothes together excessively. (Exhibit G; Exhibit 5.)

7(e). Claimant continues to demonstrate aggression and hyperactivity. He is frequently aggressive toward his mother and brother and has problems keeping his hands to himself at school. He has been suspended for hitting another child. He has a short attention span and trouble sitting still. When out in the community, Claimant has difficulty staying with his mother and will run away. He is frequently emotional and will cry and get angry very easily. Claimant has frequent emotional outbursts at home which involve kicking, screaming, running, and throwing pillows and toys. He seems to lack empathy and "be in his own world at times." (Exhibit G; Exhibit 5.)

8(a). On September 20, 2013, Joshua Lefler, Psy.D. conducted a psychological evaluation of Claimant. Dr. Lefler noted much of the history set forth in Findings 3 through 7 above. He also noted that Claimant's father had committed suicide approximately two

years prior, which prompted the family's move to California and has "ushered in a lot of change that may be affecting them." (Exhibit D; Exhibit 1.)

8(b). To assess Claimant's cognitive functioning, Dr. Lefler administered the Wechsler Abbreviated Scale of Intelligence (WASI). He achieved a Full Scale I.Q. score of 86, placing him in the low average range of intellectual ability. (Exhibit D; Exhibit 1.)

8(c). Dr. Lefler administered the Autism Diagnostic Observation Schedule, Second Edition – Module 3 (ADOS-2), an observational assessment of Autism Spectrum Disorders. Claimant received an Overall Total score of 6, which fell below the Autism Spectrum cutoff score of 7. Dr. Lefler noted the following:

Language and Communication: [Claimant] occasionally offered information spontaneously about his own thoughts, feelings or experiences. This was slightly less than it would be expected for his age. Otherwise, [Claimant] presented no concerns in the area of language and communication in terms of problems associated with an Autism Spectrum Disorder.

Reciprocal Social Interaction: [Claimant] showed some pleasure appropriate to context during interactions with the examiner. He revealed no or minimal identification/communication of understanding of emotion in others (i.e., no empathy). He showed examples of insight into several social relationships, but not necessarily into his own role. His social overtures were slightly unusual in that they were primarily restricted to personal demands or related to his own interests. His social responsiveness was somewhat awkward or inappropriate. He revealed some reciprocal social communication, but less than it would be expected. The interaction between him and the examiner was sometimes comfortable, but not sustained.

Play: [Claimant] revealed some creative or make-believe actions, but limited in range or occurring only in response to one structured situation.

Stereotyped Behaviors and Restricted Interests: [Claimant] revealed unusual and/or repetitive mannerism to a certain degree, but they were not pronounced. These included rocking back and forth during interaction. Otherwise, [Claimant] revealed no concerns in this area, according to ADOS-2 criteria.

Overall, [Claimant] revealed a low level of Autism Spectrum related symptoms per ADOS-2 scoring criteria.

(Exhibit D; Exhibit 1.)

8(d). Dr. Lefler administered the Gilliam Autism Rating Scale, Second Edition (GARS-2), with information supplied by Claimant's mother. He noted that Claimant's mother "endorsed some signs and/or symptoms associated with Autism Spectrum Disorder." (Exhibit D; Exhibit 1.)

8(e). Dr. Lefler administered the Vineland Adaptive Behavior Scales, Second Edition (VABS-II) to assess Claimant's adaptive functioning; his mother was the respondent. Dr. Lefler noted:

[Claimant's] Adaptive Behavior Composite Standard Score of 69 classifies his general adaptive functioning as "Low;" meaning he scores higher than two percent (2%) of similarly aged individuals in the [VABS-II] Normative sample. The mother's responses indicated moderately low to low scores in all domains, save motor skills. The most striking score is in the area of communication, where the [Claimant's] score was 59. Regarding the sub-domains, this means that [Claimant's] expressive communication skills (i.e. communicating to others) are equivalent to a nine month old child and his receptive communication skills (understanding others) are equivalent to a one year, 10 month old child. Based on the description of [Claimant], this appears to be an exaggeration of [Claimant's] deficits in these areas. It can be understood from these results, however, that [Claimant] does present with deficits in adaptive behavior that are evident to the mother. However, the overall score must be interpreted in light of the behavioral observation [by Dr. Lefler].

(Exhibit D; Exhibit 1.)

8(f). Dr. Lefler diagnosed Claimant with Attention Deficit /Hyperactivity Disorder (by history) and Bereavement. (Exhibit D; Exhibit 1.)

8(g). Dr. Lefler's Summary and Recommendations included:

[T]he primary diagnosis, I referenced [Claimant's ADHD] as previously established. I saw evidence of these symptoms during the current evaluation, including hyperactivity, distractibility, being "on the go" and difficulty sustaining attention to task. This appears to be an accurate diagnosis.

I also noted bereavement as an area of clinical concern. [Claimant] has received counseling in the past in order to address this, but it is clear that the loss of his father is significant in his life and providers working

with him need to be aware of the impact this may be having in future functioning.

Regarding his intellectual and adaptive functioning, I offered no diagnosis. [Claimant's] intellectual functioning is within the low average range and likely higher. There is no indication of an intellectual disability. His adaptive behavior is likely less than it would be expected for his age, especially in view of the [VABS-II] scores. . . . However, those appear to be a slight over exaggeration of his deficits in certain areas. Nevertheless, his adaptive behavior is a concern. Nevertheless, the sum total of his intellectual and adaptive functioning do not present with symptoms significant enough to warrant an intellectual disability.

Regarding the question of an Autism Spectrum Disorder, there is insufficient evidence in the current evaluation to warrant such a significant diagnosis. [Claimant] presents with some characteristics associated with an Autism Spectrum Disorder, but based on the results of the ADOS-2 as well as the GARS-2, the symptoms are not significant and pervasive enough to be considered an Autism Spectrum Disorder. Therefore, I offer no diagnosis in this area.

Based upon the results of the current evaluation, [Claimant] does not appear to be eligible for [KRC] services. . . .

(Exhibit D; Exhibit 1.)

9(a). On October 16, 2013, Claimant's school district conducted a psycho-educational evaluation and issued a report with the same date. The evaluation included a student interview, teacher interview, observations and records review. Additionally, assessment instruments were utilized, including the Wechsler Preschool and Primary Scale of Intelligence – Third Edition (WPPSI-III), Woodcock-Johnson Tests of Achievement – Third Edition (WJ-III), the Adaptive Behavior Assessment System – Second Edition (ABAS-II), the Conners' Parent Rating Scale – Revised: Long Version (CPRS-R:L), the Conners' Teacher Rating Scale – Revised: Long Version (CTRS-R:L), and the Childhood Autism Rating Scale – Second Edition (CARS-II). (Exhibit D; Exhibit 1.)

9(b). Claimant's teacher described him as a "sweet student" who was able to complete all or most of the tasks expected of him. His areas of greater difficulty included "taking turns, a desire for everything to be 'fair,' a perseveration on certain events that he feels were unfair." (Exhibit D; Exhibit 1.) Claimant's teacher reported that his behavior was inconsistent; some days he had good behavior and other days he became easily upset, struggled staying focused, and hit others. She noted that Claimant was very affectionate some days and not as affectionate on other days. He would show concern when others needed help or were hurt. He had friends and enjoyed social times such as work centers and

recess, but would lose interest quickly. He would often touch or push his peers and get “in their personal space.” (Exhibit D; Exhibit 1.)

9(c). On the WPPSI-III, Claimant obtained a Full Scale IQ score of 81, which was in the Low Average Range of cognitive ability. Administration of the WJ-III revealed that Claimant’s academic skills were in the average range for his grade level. On the ABAS-II, Claimant obtained a General Adaptive Composite score of 78, which was in the Borderline range. Claimant’s mother completed the CPRS-R:L, and based on her responses, virtually all of the subscale areas fell under the classification of “markedly atypical.” Claimant’s teacher completed the CTRS-R:L, and based on her observation, Claimant’s overall behavior was not consistent with ADHD. One area of concern was under Emotional Lability, in which individuals with high scores are prone to more emotional responses/behaviors (e.g. crying or anger) than is typical. (Exhibit D; Exhibit 1.)

9(d). The CARS-2, completed by Claimant’s teacher, resulted in a T-score of 36, which indicated very low levels of autism-related symptoms compared to those with a diagnosis of autism. Claimant’s teacher had reported that Claimant will occasionally display somewhat inappropriate types or degrees of emotional reaction or his reactions are sometimes unrelated to the objects or events surrounding him. She also noted that Claimant displays mild to moderate abnormality in relating to people. Claimant typically has two fingers in his mouth and licks other children. He also becomes upset with new activities or places and when the class is off schedule. (Exhibit D; Exhibit 1.)

9(e). The Psycho-Educational Evaluation report contained a Summary/Conclusions which included the following:

Based on the [the CPRS-R:L, Claimant’s] behavior is consistent with ADHD; however, the problematic behavior as [rated] by [Claimant’s mother] may be broader than ADHD. The [CPRS-R:L] did not indicate behaviors consistent with ADHD. However, an area of significant concern was identified in the Conners’ Global Index: Emotional Lability, in which individuals with high scores on this subscale are prone to more emotional [responses/behaviors]. [Claimant’s teacher] also completed the [CARS-2], which indicates “Minimal to No symptoms of Autism Spectrum Disorder.”

[¶] . . . [¶]

Autism

Due to the social, and communications concerns indicated in this assessment, special education eligibility under the classification of autism is being considered.

The qualification criterion is as follows:

A pupil exhibits any combination of the following autistic-like behaviors, to include but not limited to:

- (1) An inability to use oral language for appropriate communication. *Criterion not met. [Claimant] communicates well with adults and peers.*
- (2) A history of extreme withdrawal or relating to people inappropriately and continued impairment in social interaction from infancy through early childhood. *Criteria met: Parent reported information indicates a history of extreme withdrawal in relating to adults and peers. Current report information indicates that [Claimant] displays inappropriate social interactions.*
- (3) An obsession to maintain sameness. *Criteria met: [Claimant] has difficulty with changes in the classroom routine or unexpected changes in the schedule.*
- (4) Extreme preoccupation with objects or inappropriate use of objects or both. *Not observed or reported by parent or teacher.*
- (5) Extreme resistance to controls. *Criteria met: [Claimant] typically demonstrates appropriate compliance; however, at times, [Claimant] exhibits extreme resistance to controls when he is upset.*
- (6) Displays peculiar motoric mannerisms and motility patterns. *Not observed or reported by parent or teacher.*
- (7) Self-stimulating, ritualistic behavior. *Criteria met: [Claimant] exhibits a ritualistic self-stimulating behavior described as sucking two fingers and pulling his collar up near [his] mouth with his other hand. Parent reported ritualistic behavior with bath and bedtime routines.*

Current and previous assessment information indicates a history of social, communication, and behavior problems. Thus, [Claimant] appears to meet the eligibility criteria required to receive special education services under the classification of Autism.

(Exhibit D; Exhibit 1.)

9(f). Claimant also met the eligibility criteria required to receive special education services under the secondary classification of Other Health Impairment (OHI). (Exhibit D; Exhibit 1.)

10. Although his school district categorized Claimant under the category of “Autism,” this categorization was solely for the purposes of determining Claimant’s eligibility for special education services under the district’s categories and was not a formal diagnosis of Autistic Spectrum Disorder. The school district’s educational categorization was based upon different and less stringent criteria than those set forth in the recognized diagnostic manual, the Diagnostic and Statistical Manual of Mental Disorders, 5th Ed. (DSM-V), which was used by Dr. Lorelei, Dr. Lefler and other evaluators (see Finding 12 below).³

11. On January 16, 2014, Dr. Lorelei, with Omni Family Health Services, Inc. (formerly with NHSI), drafted a letter stating that she had seen Claimant whom she was treating. According to Dr. Lorelei, “Patient’s symptoms and diagnosis is consistent with: ‘Unspecified pervasive developmental disorder, current or active state (299.90).’” (Exhibit C; Exhibit 3.)

12(a). On January 23, 2014, licensed psychologists Michael Musacco, Ph.D. and Allison Little, MSW, Ph.D., conducted a psychological evaluation of Claimant to assess whether he suffers from Autistic Spectrum Disorder. The evaluation included a review of records, an interview with Claimant’s mother, a mental status examination of Claimant, and administration of diagnostic tools for measuring adaptive skills and autistic characteristics. Claimant was six years, seven months old. (Exhibit D.)

12(b). Drs. Musacco and Little noted that Claimant’s mother had become concerned for Claimant’s development based on delays in his speech and his lack of eye contact. She also reported that his anger problems highlighted her concerns about her son’s emotional development. Claimant’s mother reported that he is sensitive to clothing textures and becomes upset if his clothing is itchy or has tags. He also requires a specific routine for bed time and bathing, which includes his bathtub being filled with water to a specified height and containing a particular number of toys. Although Claimant described several friendships to the evaluators, his mother reported that he did not have any close friends. Claimant’s mother noted that he had been taking Risperdal (antipsychotic medication) and Clonidine (antianxiety medication), and that the medications were affective. Without the medications, he becomes aggressive, but with the medications, he is less impulsive and demonstrates better eye contact. Additionally, since beginning his medication regimen, Claimant has become more expressive of his feelings and more affectionate.

12(c). Claimant’s speech was organized, although he demonstrated mild articulation problems and occasionally misused words in phrases. However, he did not show stereotyped use of words or echolalia. He demonstrated inattention and over-activity consistent with ADHD. Although Claimant had a reported history of repetitive behaviors, these were not

³ The DSM-5 is published by the American Psychiatric Association. The Administrative Law Judge takes official notice of the DSM-V as a generally accepted tool for diagnosing mental and developmental disorders.

observed during the evaluation. However, he was observed sucking his fingers on several occasions.

12(d). Drs. Musacco and Little administered the ADOS-2, and Claimant received an Overall Total score of 3, which fell below the Autism Spectrum cutoff. The evaluators noted:

In terms of Language and Communication, [Claimant] was able to speak in sentences without evidence of speech abnormalities, echolalia, or stereotyped use of words or phrases. [Claimant] was able to engage in reciprocal conversation. He was able to point to objects and use gestures.

In terms of Reciprocal Social Interaction, [Claimant] showed good eye contact with a range of facial expressions directed toward the examiner. He responded to his name being called and he showed resting items to the examiner and to his mother. The quality of his social overtures was good and he often attempted to obtain and maintain the examiner's attention. He showed good rapport and good reciprocal social communication skills.

In terms of Play, [Claimant] did not show unusual play with toys or objects and he did not show evidence of unusual sensory interests, self-injurious behaviors, or stereotyped behaviors.

The results of the ADOS-2 are not consistent with a finding that he suffers from Autistic Spectrum Disorder.

(Exhibit D.)

12(e). The GARS-2 was administered utilizing information provided by Claimant's mother. Her responses indicated several instances of stereotyped behaviors, communication deficits, and deficits in Claimant's social interaction. However, those behaviors were not readily observed by the evaluators.

12(f). Drs. Musacco and Little administered the VABS-II to assess Claimant's adaptive functioning; his mother was the respondent. [Claimant's] Adaptive Behavior Composite Standard Score of 74 classifies his general adaptive functioning as "Moderate Low," meaning that he scores higher than four percent of similarly aged individuals in the VABS-II normative sample.

12(g). Drs. Musacco and Little diagnosed Claimant with ADHD, Combined Type.

12(h). In their Summary and Recommendations, the evaluators noted:

[Claimant] did not show symptoms typical of Autistic Spectrum Disorder. He showed good eye contact and good communication skills. He was able to play cooperatively and there was no evidence of unusual or stereotyped behaviors or a pattern of unusual speech habits. [Claimant] did not show stereotyped or repetitive interests and he quickly and easily developed rapport with the [evaluators]. However, the report from the school provides different information. . . . The school psychologist reached the conclusion that [Claimant] met the criteria for special education services based on a finding of Autism. However, . . . this report provided some inconsistencies. This is important to address in light of the difference in diagnostic conclusions. For example, in the Teacher Interview . . . , the teacher noted that [Claimant] showed inconsistent behaviors. Some days he was affectionate and other days he showed behavior problems. However, the teacher also noted that [Claimant] showed concern when other students needed help or when they were hurt. He had friends and he was accepted by others despite his overly intrusive behaviors. The school psychologist indicated that [Claimant] was friendly and cooperative and rapport was easily established. He participated and initiated conversations with the examiner. [Claimant's] teacher completed the [CTRS-R:L] indicating only mild elevations. This contrasted with scores provided by [Claimant's] mother. Furthermore, on the [CARS-II, Claimant's] teacher provided response yielding a T-score of 36 suggesting low levels of Autism-related symptoms. The school psychologist noted that these findings indicated "minimal to no symptoms of Autistic Spectrum Disorder." However, the teacher also observed mild symptoms of Autism indicating "mildly abnormal" emotional responses. [Claimant] showed "mild to moderate" abnormality in his ability to relate to people and "moderately" abnormal use of taste, smell and touch. [Claimant] frequently had two fingers in his mouth and he licked other children. Under the Conclusions section of [the district's psycho-educational] report, it was noted that [Claimant] had a history of extreme withdrawal and an impairment in his social interactions. It was also noted that [Claimant] had difficulty dealing with changes in his routine. The evaluator noted that [Claimant] exhibits ritualistic self-stimulating behavior in terms of sucking his fingers and pulling his collar towards his mouth. This data [does] not strongly suggest a finding of Autism. Furthermore, when [Claimant] was evaluated by Dr. Lefler on 9/20/13, [Claimant's] interactions were also not consistent with a finding of Autism. On the

ADOS-2, [Claimant] obtained an overall total score of 6 falling below the Autistic Spectrum cutoff score of 7. At this time, [Claimant] occasionally offered spontaneous information about his own thoughts, feeling, and experiences. The evaluator noted that these abilities were slightly below the norm, but there was [sic] no substantial deficits in his language and communication. [Claimant's] social responsiveness was described as being somewhat awkward and inappropriate, but he was able to show reciprocal social communication. Furthermore, there was no evidence of stereotyped behaviors or restricted interests. Dr. Lefler offered diagnoses of [ADHD] and Bereavement.

Finally, there was a diagnosis of Autism offered by the [NHSI]. However, the records describe [Claimant's] mental status [and] these records do not include objective data describing symptoms of an Autistic Spectrum Disorder. It is my opinion that [Claimant's] symptom presentation supports a diagnosis of [ADHD]. [Claimant] shows over activity, poor social boundaries, and inattention. He is prone to tantrums [when] he does not get what he wants. Thus, I offered the diagnosis of [ADHD], Combined Type.

(Exhibit D.)

13. Claimant's teacher submitted a letter, dated December 16, 2013, describing Claimant's behaviors at school. She noted:

[A]reas of concern include:

- 1) Oral fixations (sucking on 2 fingers and pulling his collar up to his mouth, licking and kissing classmates)
- 2) Inability to sit nicely on his bottom. He wants to have his hands on others, lay his head in their laps, make noises or talk to his peers.
- 3) Easily distracted
- 4) Usually melts down if he is not chosen after raising his hand or name is not drawn out etc. It is very difficult for him to lose or not be the winner.
- 5) Line-up time is difficult because he is usually putting his hands on the people around him or licking etc.
- 6) If a task is difficult for [Claimant] he refuses to give it a try.

[Claimant] is affectionate and loving. Most of the children are fond of him and refer to him as their friend. They sometimes run out of patience with him.

(Exhibit 3.)

14(a). At the fair hearing, Claimant's mother testified credibly on his behalf. She reported that he demonstrated a delay in spoken language and did not start speaking in sentences until he was about four years old; she noted that he is currently receiving speech therapy through his school district. Additionally, Claimant often "goes off on tangents" during conversations. According to Claimant's mother, when speaking to him, he does not maintain eye contact but will look down or to the side.

14(b). As noted previously, he frequently sucks his fingers and rubs his shirt or a soft object (e.g. blanket or sheet). He is very sensitive to noises. Claimant's mother reported that it is difficult for him to develop relationships with his peers because he is always in their "personal space" and because he "does not understand the thinking and feeling of others." She noted that he will have "outbursts" of crying or violence (e.g. head banging, hitting furniture, hitting others). When they are out in public, he often runs away from her. She recounted the time he was outside riding his bicycle and began "racing" alongside a moving vehicle before turning into its path. Fortunately, the driver was able to stop the vehicle, so Claimant was not injured. When Claimant's mother attempted to discuss the incident with him, he did not appear to understand that he could have gotten hurt but instead repeatedly told her that he was "racing."

14(c). Claimant's mother agreed that he suffers from ADHD and that he is "obsessive compulsive." However, she believes that he has "autistic behaviors," which may not be severe but she wants to obtain help for him now before it is "too late."

15. The totality of the evidence did not establish that Claimant suffers from Autism Spectrum Disorder.

LEGAL CONCLUSIONS

1. Claimant did not establish that he suffers from Autistic Spectrum Disorder which would entitle him to regional center services. (Factual Findings 1 through 15.)

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

3. In order to be eligible for regional center services, a claimant must have a qualifying developmental disability. 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, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. . . . This [includes] mental retardation, cerebral palsy, epilepsy and autism. [It also includes] 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.

4(a). To prove the existence of a developmental disability within the meaning of Welfare and Institutions Code section 4512, a claimant must show that he has a “substantial disability.” Pursuant to Welfare and Institutions Code section 4512, subdivision (1):

“Substantial disability” means the existence of significant functional limitations in three or more of the following areas of major life activity, as determined by a regional center, and as appropriate to the age of the person:

- (1) Self-care.
- (2) Receptive and expressive language.
- (3) Learning.
- (4) Mobility.
- (5) Self-direction.
- (6) Capacity for independent living.
- (7) Economic self-sufficiency.

4(b). Additionally, California Code of Regulations, title 17, section 54001 states, in pertinent part:

(a) “Substantial disability” means:

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

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

- (A) Receptive and expressive language;
- (B) Learning;
- (C) Self-care;

- (D) Mobility;
- (E) Self-direction;
- (F) Capacity for independent living;
- (G) Economic self-sufficiency.

5. In addition to proving a “substantial disability,” a claimant must show that his disability fits into one of the five categories of eligibility set forth in Welfare and Institutions Code section 4512. The first four categories are specified as: mental retardation, epilepsy, autism and cerebral palsy. The fifth and last category of eligibility, also known as the “fifth category,” is listed as “disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation.” (Welf. & Inst. Code, § 4512, subd. (a).)

6. In order to establish eligibility, a claimant’s substantial disability must not be solely caused by an excluded condition. The statutory and regulatory definitions of “developmental disability” (Welf. & Inst. Code, § 4512 and Cal. Code. Regs., tit. 17, § 54000) exclude conditions that are *solely* physical in nature. California Code of Regulations, title 17, section 54000, also excludes conditions that are *solely* psychiatric disorders or *solely* learning disabilities. Therefore, a person with a “dual diagnosis,” that is, a developmental disability coupled with either a psychiatric disorder, a physical disorder, or a learning disability, could still be eligible for services. However, someone whose conditions originate from just the excluded categories (psychiatric disorder, physical disorder, or learning disability, alone or in some combination) and who does *not* have a developmental disability would not be eligible.

7. The DSM-V, section 299.00 discusses the diagnostic criteria which must be met to provide a specific diagnosis of Autism Spectrum Disorder, as follows:

- A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive; see text):
 - 1. Deficits in social-emotional reciprocity, ranging, for example from abnormal social approach and failure of normal back –and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
 - 2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.

3. Deficits in developing, maintaining, and understanding relationships, ranging, for example from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

[¶] . . . [¶]

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

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).
3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).
4. Hyper- or hyporeactivity to sensory input or unusual interests in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching objects, visual fascination with lights or movement).

[¶] . . . [¶]

C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).

D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

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

(DSM-V at pp. 50-51.)

8(a). Although Claimant maintains that he is eligible for regional center services under a diagnosis of Autism Spectrum Disorder, this diagnosis was not established by the totality of the evidence.

8(b). While Dr. Garewal's assessment of Claimant included "Autistic Disorder," this assessment was based on communication and verbal deficits which Dr. Garewal found to be "not full spectrum but a Not Otherwise Specified Autistic Traits." It was unclear what Dr. Garewal meant by this note. Furthermore, neither Dr. Garewal's note nor any of the NHSI records indicated that testing had been administered to obtain the diagnosis of Autistic Disorder. Consequently, Dr. Garewal's assessment of Autistic Disorder was viewed with skepticism and was given no weight. Additionally, Claimant's treating psychologist Dr. Lorelei did not diagnose Claimant with Autism Spectrum Disorder, but instead found that his symptoms were consistent with "Unspecified pervasive developmental disorder, current or active state (299.90)."

8(c). As noted above, although Claimant qualified for special education services under the category of "Autism," this categorization was solely for the purposes of determining Claimant's eligibility for special education services under the district's categories and was not a formal diagnosis of Autism Spectrum Disorder. The school district's educational categorization is based on different criteria than those set forth in the DSM-V.

8(d). The diagnosis that evaluators agreed on was that Claimant suffered from ADHD. The psychologists who conducted testing and applied the criteria of the DSM-V opined that Claimant does not meet the requisite clinical criteria to diagnose him with Autistic Spectrum Disorder. While Claimant may manifest some deficits in his communication and social skills, his symptoms do not cause clinically significant impairment which would satisfy the required DSM-V criteria for a diagnosis of Autistic Spectrum Disorder. Consequently, Claimant has not established that he is eligible for regional center services under the diagnosis of autism.

9. The preponderance of the evidence does not support a finding that Claimant is eligible to receive regional center services.

ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

Claimant's appeal is denied. The Service Agency's determination that he is not eligible for regional center services is upheld.

DATED: March 25, 2014

A handwritten signature in black ink, appearing to read 'JCO', is written over a horizontal line.

JULIE CABOS-OWEN
Administrative Law Judge
Office of Administrative Hearings

NOTICE

This is the final administrative decision; both parties are bound by this decision. Either party may appeal this decision to a court of competent jurisdiction within 90 days.