

BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT,

and

WESTSIDE REGIONAL CENTER,

Service Agency.

OAH No. 2015110148

DECISION

This matter came on regularly for hearing on December 16, 2015, in Culver City, California, before David B. Rosenman, Administrative Law Judge, Office of Administrative Hearings, State of California.

Claimant was represented by his mother, who is also his conservator and authorized representative. (Names are not used in order to protect their privacy.)

Westside Regional Center (Service Agency) was represented by Lisa Basiri, Fair Hearing Manager.

Oral and documentary evidence was received. The record was closed on the hearing date, and the matter was submitted for decision.

ISSUE

Does Claimant continue to be eligible for regional center services?

EVIDENCE RELIED UPON

Exhibits: Service Agency's 1 through 17, and Claimant's A.
Testimony of: Service Agency witness Dr. Thompson Kelly, Claimant's mother, and Dr. Jaime Garcia.

FACTUAL FINDINGS

1. Claimant is a 22-year-old male who has received regional center services since before age three. He resides with his parents. As described in more detail below, the Service Agency claims that the initial diagnosis of the eligible developmental disability of mental retardation was clearly erroneous. Claimant contends that he is eligible based on the developmental disability of autism.

2. As described in more detail below, the Service Agency evaluated Claimant and determined he was no longer eligible for services. The Service Agency notified Claimant's mother of its decision in a letter dated September 9, 2015 (exhibit 2). Claimant's mother submitted a Fair Hearing Request form dated October 8, 2015 (exhibit 2).

3. Claimant was evaluated for eligibility for regional center services in 1996, at age two years, eight months. The evaluation was performed by Ann Walker, Ph.D., a vendor of the Service Agency. Her report is dated April 8, 1996 (exhibit 12). Various tests were administered and Claimant's father was interviewed. All test results were scored at levels below Claimant's age, in some cases significantly below (e.g., expressive language, visual-spatial integration skills, self-help skills, social skills). Dr. Walker commented that Claimant demonstrated global mild delays, and made a diagnosis of Mild Mental Retardation. She also recommended placement at age three in a special education preschool program and speech therapy.

4. According to a Los Angeles Unified School District (LAUSD) evaluation in June 2010 (exhibit 15), LAUSD created an Individualized Education Plan (IEP) for Claimant on July 10, 1996, finding him eligible for special education services based on mild retardation with autistic-like behaviors. In June 1998, Claimant was re-evaluated and found eligible for special education services based on a specific learning disability. That same basis for eligibility was listed again in June 2001. Claimant received numerous special education services and accommodations. The LAUSD evaluation in June 2010 was performed by school psychologist Linda Weiner and includes her review of records, interviews with other school personnel, Claimant's mother, and Claimant's therapist at St. John's Hospital, and administration of various tests. It is the most recent evaluation of Claimant by LAUSD that was submitted in evidence at the hearing. Weiner found that Claimant was eligible for special education services based upon an emotional disability.

5. Weiner's report contained the following points of interest. Claimant suffered from schizophrenia, including auditory hallucinations and paranoid behavior, and received treatment from a pediatrician, psychologist and psychiatrist at the St. John's Mental Health Clinic. Counseling goals over the years focused on increasing Claimant's social relationships but, due to his emotional disturbance, progress had not been made. Weiner estimated that Claimant was operating in the average range of cognitive ability, but his auditory, visual and attention deficits (including hallucinations) negatively impacted his ability to attend to instruction and perform other tasks. She noted it was not unusual for a

preschooler diagnosed with mild retardation with autistic-like behaviors to later exhibit schizophrenia.

6. Weiner determined that Claimant was eligible for special education services based on an emotional disability, specifically noting the following characteristics. Claimant had an inability to learn that could not be explained by intellectual, sensory or health factors, adding that the re-evaluation determined that Claimant had the ability to learn but could not demonstrate that ability due to his emotional issues. Claimant had an inability to build or maintain satisfactory interpersonal relationships with peers and teachers. Claimant demonstrated inappropriate types of behaviors or feelings under normal circumstances, and a general pervasive mood of unhappiness or depression. Claimant had a tendency to develop fears associated with personal or school problems, which interfered with his ability to function in all settings.

7. Claimant's final IEP in May 2012 (exhibit 16) indicated varying abilities and issues, including scattered strengths and weaknesses in different academic subjects, reference to long periods of absence, difficulties interacting in classes, and progress with making friends and being less isolated. Claimant had met his graduation requirements and was expected to graduate in June 2012.

8. Claimant graduated high school and attended some classes at Santa Monica Community College. However, he expressed fears and anxiety about attending classes and stopped going. The Individual Program Plan (IPP) prepared by the Service Agency in September 2013 (exhibit 8) indicated that Claimant felt numb and stayed in bed, but planned to try college again. In a different section of the IPP, his mother indicated that Claimant did little to initiate social interactions, but that he had become a little more outgoing and enjoyed going to the store and dressing up. For the 2014 IPP (exhibit 7), mother indicated that Claimant did not have many social interactions, and repeated that he had become a little more outgoing and enjoyed going to the store and dressing up. The IPP indicated there had been no progress in the prior year relating to exhibiting anxiety issues and depressive behaviors at home or in returning to college. However, Claimant enjoyed his recreational and leisure activities and hoped that his computer time and experience would assist him in becoming a video game designer.

9. Although Claimant had been found eligible for services from the Service Agency in 1996, IPP's from 2011, 2012, 2013 and 2014 do not include any services to be provided. Although respite was offered, it was refused, as Claimant's mother did not have anyone else she felt could care for Claimant.

10. Records were sent to the Service Agency by the Venice Family Clinic and Vista Del Mar Child & Family Services. Records from Vista Del Mar (exhibit 14) indicated Claimant was referred for wraparound services by his school counselor in April 2010. Claimant had been receiving mental health services as early as the fifth grade based on a diagnosis of schizophrenia. The stated concern was that Claimant had received mental health services from St. John's and, after age 18, he would no longer qualify for this program. At

the Vista Del Mar intake, Claimant's mother reported her belief that, due to premature birth, Claimant had autism. Claimant was found eligible for services based on a diagnosis that he had a psychotic disorder, and had autism disorder according to his history. Services to be provided by Vista Del Mar were individual therapy, medication management and wraparound services. A psychiatric evaluation for medication in June 2011 again included references to these earlier diagnoses, indicated that autism was diagnosed at age five. The report contained a few references to relevant behaviors, such as having only one friend whom he did not see outside of school, and that Claimant preferred to be alone when he was not in school. Other records from Vista Del Mar (in exhibit 3) from June 2012 repeat references to diagnoses of autism, schizophrenia and depression, and indicate medication treatment of risperidone for autism and schizophrenia, and mirtazapine for insomnia, as well as other medications not relevant to this matter.

11. Medical records from the Venice Family Clinic (exhibit 17) relate primarily to treatment for asthma in January 2015, but include references to schizophrenia being diagnosed in 2009 and ongoing medication: risperidone for schizophrenia, and celexa for major depressive disorder.

12. Claimant and his mother receive services from Saint Joseph's Community Center. In January 2015, Jorge Guerreiro, who is mother's case manager at Saint Joseph's, contacted the Service Agency to gain information and seek further services. He asked if a new evaluation could be performed. Claimant's service coordinator at the Service Agency, Antonio Gonzalez, indicated he would contact the family to see if they wanted a new evaluation of Claimant. In February 2015, Dr. Jaime Garcia, who was treating Claimant at St. Joseph's, called and informed Gonzalez that Claimant was "maxed on drugs" and the staff was concerned about his future services. Gonzalez suggested that the next time the family came to St. Joseph's for services, Dr. Garcia should initiate a conference call. Dr. Garcia said he would coordinate this with Jorge Guerreiro. On March 10, 2015, Claimant's mother called service coordinator Gonzalez and requested an updated evaluation.

13. Rebecca R. Dubner, Psy.D. is a psychologist who is vendored by the Service Agency. She performed a psychological assessment on June 4, 2015, and the results are summarized in her report (exhibit 5). Dr. Dubner noted that Claimant had been diagnosed with Mild Intellectual Disability (previously referred to as mental retardation), Schizophrenia and Major Depressive Disorder. Dr. Dubner was asked to clarify the diagnoses, limited to assessment of developmental disabilities, specifically mental retardation and/or autism. She was not to do a comprehensive evaluation of mental or emotional conditions or disorders. She reviewed documents collected by the Service Agency. Dr. Dubner summarized relevant information from the documents she reviewed. Dr. Dubner was aware of Dr. Walker's evaluation when Claimant was age two years, eight months; the preschool evaluation which qualified Claimant for special education services under the category of mild mental retardation with autistic-like behaviors; the autism diagnosis at age five; the LAUSD evaluation at age 13 including the determination that Claimant's cognitive ability fell within the average range but that his school performance and functioning were significantly below grade level; and the LAUSD determination that Claimant met the requirements of an

emotional disability. Record review also covered Claimant's isolative behaviors, anger and mood shifts, and his diagnosis and medication treatment for Schizophrenia, Major Depressive Disorder, asthma and inconsistent sleep.

14. Dr. Dubner interviewed Claimant, his mother and Mr. Guerreiro from St. Joseph's, and administered numerous standardized tests to Claimant, some of which are described below. The Wechsler Adult Intelligence Scale-4th Edition (WAIS-IV) is an intelligence test that measures an adult's Full Scale IQ (intelligence quotient) with reference to six areas tested. Claimant's scores resulted in a verbal comprehension score of 85, described as the low average range; a perceptual reasoning score of 77, described as the borderline range; and a general ability score of 79, described as the upper end of the borderline range.

15. During the interview and testing process, Dr. Dubner observed and reported behaviors and symptoms that are relevant to the determination of whether Claimant has an Intellectual Disability and/or Autistic Spectrum Disorder. As noted below, Dr. Dubner used the Diagnostic and Statistical Manual-fifth edition (DSM-5) as a reference. The DSM-5 is a well-known and respected compilation of diagnostic criteria and identifying factors of most known mental disorders used by psychologists and psychiatrists, and others, to standardize the diagnostic process.¹ She concluded that Claimant did not meet the diagnostic criteria for Intellectual Disability. Specifically, the DSM-5 includes a requirement of significantly subaverage intellectual functioning, defined as IQ scores of about 70 or below. Claimant's scores were notably above this level. Rather, in her opinion, efficient use of Claimant's intellectual resources was compromised by his behavioral disposition and underlying psychopathology of Schizophrenia and Major Depressive Disorder.

16. Dr. Dubner reported on behaviors and symptoms that were consistent with the criteria of Autistic Spectrum Disorder (e.g., impaired social communication, difficulty initiating and maintaining conversations and remaining on topic, stereotyped behaviors while playing with objects, does not try to make friends), as well as those that were inconsistent with the criteria of Autistic Spectrum Disorder (e.g., adequate eye contact, asking questions and engaging in some spontaneous conversation, a friendship using Facebook for communication). Dr. Dubner also administered the Gilliam Autism Rating Scale-Third Edition (GARS-3), where Claimant received an Autism Index Score of 78, which indicated the very likely probability of Autism Spectrum Disorder, as well as the Child Autism Rating Scale, Second Edition (CARS-2), where the results did not support the presence of Autistic Spectrum Disorder. Dr. Dubner determined that the majority of the issues reported on the GARS-3 seemed to stem from Claimant's emotional responses, particularly his anxiety, as well as his behaviors associated with Schizophrenia, and did not meet the criteria for a diagnosis of Autism Spectrum Disorder.

¹ The DSM is published by the American Psychiatric Association. Prior editions referred to the disability of Autistic Disorder. In 2013, a new, fifth edition was issued, referred to as DSM-5. The DSM-5 includes new diagnostic criteria and a discussion of the disability now titled Autistic Spectrum Disorder.

17. Thompson Kelly, Ph.D., is the Manager of intake services at the Service Agency. He has many years of experience in the field of developmental disabilities, both as to diagnosis and services provided by the Service Agency. He reviewed documentation relating to Claimant's continued eligibility for regional center services and was part of the eligibility team reviewing Claimant's case. Dr. Kelly wrote a letter dated September 9, 2015 (exhibit 2), indicating that the current assessment concluded that Claimant did not exhibit characteristics of Mild Intellectual Disability. Rather, the indication was of a mental health condition, which was not a basis for continued eligibility for regional center services. Dr. Kelly also stated that the eligibility team considered whether Claimant met the "fifth category" of eligibility and determined he did not. (The "fifth category" is a reference to the eligible conditions noted in Legal Conclusion 9, specifically "disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability.")

18. Dr. Kelly noted that, usually when a diagnosis of mental retardation/ intellectual disability is made before age three, the child will be tested again at around ages six and before age 18. He referred to the neuroplasticity of brain development and that, with increasing age, diagnosis of this disability becomes more reliable.

19. Dr. Kelly testified about aspects of Dr. Dubner's testing and report. He explained that the GARS-3 is based primarily on parental input, which indicated here the "very likely probability" of Autism Spectrum Disorder. The CARS-2 combines the clinician's observations of the Claimant's behaviors and responses with information from the parents, producing a qualitative rating of the symptoms and behaviors. In Dr. Kelly's comparison, although Claimant's parents reported behaviors and symptoms that indicated the likelihood of Autism Spectrum Disorder, Dr. Dubner did not observe the behaviors and characteristics that would support such a diagnosis.

20. Dr. Kelly is familiar with the legal requirements for a school district to find a student eligible for special education services as a child with autism. (In addition to his many years of experience in the fields of mental health and developmental disabilities, he was a special education teacher for 12 years.) The process of determining eligibility for special education services encompasses broader categories than the process related to regional center services, which requires diagnoses under the criteria in the DSM-5. School district resources address the conditions that make a student eligible for special education services. Dr. Kelly noted that, by virtue of their licensure, school psychologists do not make diagnoses using DSM-5 criteria. In his experience, he often sees applicants for regional center services who have been found eligible for special education services as a child with autism, however they do not meet the more exacting criteria for a diagnosis of Autistic Spectrum Disorder under the DSM-5.

21. The Preface to the DSM-5 notes that it was developed for use in clinical, educational and research settings and is designed for use by those with appropriate training and experience, including a specialized body of knowledge and clinical skills. The Introduction (DSM-5, p. 6) states: "Clinical training and experience are needed to use DSM

for determining a diagnosis.” The section titled “Use of the Manual” (DSM-5, p. 19) refers to the use of clinical judgment to determine the presence and severity of the criteria necessary to make a diagnosis, as well as to determine the valence of symptoms; i.e., how symptoms react or interact with other symptoms. “Diagnostic criteria are offered as guidelines for making diagnoses, and their use should be informed by clinical judgment.” (DSM-5, p. 21.) It should not be applied mechanically or in a cookbook fashion. Therefore, behaviors and characteristics must rise to a level such that a trained clinician would find them to be significant.

22. The DSM-5 article on Autistic Spectrum Disorder notes that the diagnosis is made “only when the characteristic deficits of social communication are accompanied by excessively repetitive behaviors, restricted interests, and insistence on sameness. [¶] Autism spectrum disorder is characterized by persistent deficits in social communication and social interaction across multiple contexts, including deficits in social reciprocity, nonverbal communicative behaviors used for social interaction, and skills in developing, maintaining, and understanding relationships. In addition to the social communication deficits, the diagnosis of autism spectrum disorder requires the presence of restricted, repetitive patterns of behavior, interests, or activities. Because symptoms change with development and may be masked by compensatory mechanisms, the diagnostic criteria may be met based on historical information, although the current presentation must cause significant impairment.” (DSM-5, pp. 31-32.)

23. The DSM-5 lists the many specific factors and behaviors necessary to support the diagnosis of Autistic Spectrum Disorder. Of significance here are the following:

“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 the 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 interest).

“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 of 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 developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.”

24. Jaime Garcia, M.D., is a board certified psychiatrist licensed in California in 2007. He is on staff at the St. Joseph’s Center and began treating Claimant in June 2013, when Claimant’s care was transferred from the Edelman Clinic. Dr. Garcia was aware of prior diagnoses of schizophrenia and autism and, in his opinion Claimant has exhibited symptoms and behaviors consistent with paranoid schizophrenia and autism or Asperger’s Disorder. Dr. Garcia is aware that, under the DSM-5, autism and Asperger’s Disorder are now included within a diagnosis of Autism Spectrum Disorder. Dr. Garcia has had about 15 to 20 therapy sessions with Claimant and has prescribed medications which, as of about eight months ago, have largely controlled the symptoms of schizophrenia. However Claimant is still withdrawn, has a fear of leaving home, and exhibits a social phobia. Dr. Garcia believes

the fear is no longer related to schizophrenia but, rather, is due to too much sensory input. Other behaviors reported to Dr. Garcia by Claimant's mother included that Claimant was unable to shower unless he wore clothes, which Dr. Garcia interpreted as a hypersensitivity to water on his skin, as well as hypersensitivity to the noise. Dr. Garcia also commented on rigidity in Claimant's behaviors and rituals relating to where he eats, sleeps, and the art that Claimant creates. Claimant's mother also reported that he rocks in a chair and/or touches his knees when he is nervous. Dr. Garcia found these to be repetitive, stereotypical behaviors. He noted in his treatment plan the possibility that Claimant had autism and brought up the matter to a team meeting in May 2015, where the topic of referral to the Service Agency was also discussed. However, Dr. Garcia also noted that there had never been an authorization for his treatment notes and other records to be released to the Service Agency. Dr. Garcia added that psychiatrists do not usually administer the types of testing as do psychologists such as Dr. Dubner or Dr. Kelly, and that the diagnosis of Autism Spectrum Disorder is extremely complicated. Only one to two percent of his patients have been diagnosed with autism, and some others have a diagnosis of Asperger's Syndrome. He agreed that Claimant's schizophrenia was significant; however, now that those symptoms are better controlled, these other behaviors persist.

25. Claimant's mother testified about various behaviors of Claimant that are troubling to her, specifically his isolation and sensitivity to water. She is very concerned that Claimant cannot care for himself and cannot explain his behaviors. She has worked with the St. Joseph's staff to obtain treatment for Claimant and in the process of requesting the Service Agency to perform a new evaluation to see if further services are available.

LEGAL CONCLUSIONS

1. Claimant did not prove that he is entitled to continued regional center services.
2. There is a two-step analysis needed for this matter. First, did the Service Agency establish that the initial diagnosis that Claimant suffered from Mental Retardation was clearly erroneous? If so, did Claimant establish that he is eligible for services because he suffers from autism?
3. Eligibility for services can be terminated in certain circumstances. As stated in Welfare and Institutions Code Section 4643.5, subdivision (b), "An individual who is determined by any regional center to have a developmental disability shall remain eligible for services from regional centers unless a regional center, following a comprehensive reassessment, concludes that the original determination that the individual has a developmental disability is clearly erroneous."
4. Therefore, before an individual who has been found eligible can be denied that status, the regional center challenging eligibility must show by clear and convincing evidence that, at the time the original eligibility determination was made, it was clearly wrong. Evidence of a consumer's current intellectual functioning and adaptive abilities is

relevant only to the extent that it demonstrates the correctness/ incorrectness of that initial determination.

5. The basis of Claimant's original diagnosis of Mild Mental Retardation is explained in Dr. Walker's report of the evaluation in 1996 when Claimant was age two years, eight months (see Finding 3). Although the usual process, per Dr. Kelly, would have Claimant re-evaluated at age six and again before age 18, that did not occur. The re-evaluation occurred at the request of Claimant's mother in 2015. Records for the intervening period are largely from LAUSD, which found Claimant eligible for special education services for various reasons over the years, but due to mental retardation only in 1996, shortly after Dr. Walker's evaluation.

6. Dr. Dubner's assessment on June 4, 2015, included the results of numerous tests and interviews, including gathering information from Claimant's mother. (See Findings 13-16, and 18.) Dr. Dubner did not find support for the diagnosis of Mental Retardation (now referred to as Intellectual Disability), and specifically found that Claimant's IQ scores tested at above the range necessary for a diagnosis of Intellectual Disability.

7. There was no evidence from or contention by Claimant that the diagnosis on Mental Retardation was correct or that he should remain eligible for services under the current diagnostic language of Intellectual Disability. Rather, Claimant contends that he remains eligible for services under the condition of autism.

8. Claimant bore the burden to prove he has a developmental disability that makes him eligible for services. The standard of proof is a preponderance of the evidence. Claimant failed to sustain his burden of proof.

9. Welfare and Institutions Code section 4512, subdivision (a) states:

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

10. California Code of Regulations (CCR), title 17, section 54000 also defines a developmental disability, contains the same criteria as Welfare and Institutions Code section 4512, but also excludes conditions that are:

(c)(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. . . .

11. The three exclusions from the definition of “developmental disability” under CCR, title 17, 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, tit. 17, § 54000, subd. (c)(1).) 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, tit. 17, § 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.

12. The earliest reference to autism is in 1996 when LAUSD found Claimant eligible for special education services due to mental retardation and autistic-like behaviors. The back-up documentation supporting these conclusions was not in evidence; however, Weiner summarized prior events in 2010 (see Findings 4-6). Of note, LAUSD’s later records for Claimant no longer referred to autistic-like behaviors. Further, the requirements to find autistic-like behaviors to make a student eligible for special education services, found in CCR, title 5, section 3030, subdivision (g),² were substantially less than the requirements for a diagnosis of Autism (under the DSM-IV-TR) or Autism Spectrum Disorder (under the DSM-5) such that a regional center would find eligibility. Therefore, the early references to Claimant’s autistic-like behaviors do not establish his present eligibility for services.

² This regulation of special education eligibility was changed as of July 1, 2014, and no longer refers to “autistic-like behaviors.”

13. It is Claimant’s burden to establish his eligibility. More significant to the question of Claimant’s current eligibility under a diagnosis of Autism Spectrum Disorder is consideration of the opinions of Dr. Dubner (Claimant does not suffer from Autism Spectrum Disorder) and Dr. Garcia (Claimant suffers from Autism Spectrum Disorder). Dr. Dubner explained her testing and interview results in support of her conclusion. Dr. Garcia explained his treatment and observations of Claimant and information gathered from Claimant’s mother. On balance, Dr. Dubner’s reasoning in support of her opinion was more persuasive than Dr. Garcia’s opinion.

14. More specifically, the general requirements for the diagnosis of Autism Spectrum Disorder from the DSM-5 are described in Findings 22 and 23. Dr. Garcia has mentioned some of the necessary elements, but not all, and did not describe them in a way that meets all of the DSM-5 criteria. For example, Dr. Garcia did not mention “excessive” repetitive behaviors or persistent deficits in social communication and social interaction across multiple contexts. Dr. Garcia made no reference to deficits in social reciprocity, and scant reference to restrictive, repetitive patterns of behavior, interests or activities. There is not enough specificity in the behaviors and conclusions cited by Dr. Garcia to support the diagnosis. Further, Dr. Garcia does not have a significant basis of experience with autistic clients, which is understandable as there is no medication regimen for psychiatric treatment of Autism Spectrum Disorder.

15. Although the Service Agency does not have to “disprove” that Claimant has an Autism Spectrum Disorder, Dr. Dubner’s assessment and report include sufficient information to support her opinion that Claimant does not have Autism Spectrum Disorder. Of significance, and as explained by Dr. Kelly, although Claimant’s mother reported certain behaviors to Dr. Dubner, thus the “very likely probability” of Autism Spectrum Disorder based on the GARS-3, the observations by Dr. Dubner in administering the CARS-2 did not support a diagnosis of Autism Spectrum Disorder. Therefore, where Dr. Garcia relied on the reports of Claimant’s mother in making his determination, Dr. Dubner had the additional input of her direct observations and analysis of Claimant’s behaviors as she administered the various tests to him. She did not confirm the type of excessively repetitive behaviors or persistent deficits required to meet the DSM-5 diagnostic criteria.

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