BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

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| In the Matter of:<br><br>CLAIMANT<br><br>vs.<br><br>SOUTH CENTRAL LOS ANGELES REGIONAL CENTER,<br><br>Service Agency. | OAH No. 2017100189 |

# DECISION

Laurie R. Pearlman, Administrative Law Judge (ALJ), Office of Administrative Hearings, State of California, heard this matter on January 18, 2018 in Los Angeles, California.

South Central Los Angeles Regional Center (SCLARC or Service Agency) was represented by Karmell Walker, Fair Hearing Manager. Claimant M.V. was present and was represented by her mother.[1] A Spanish-speaking interpreter assisted at the hearing.

Oral and documentary evidence was received and argument was heard. The record was left open until February 16, 2018 to enable claimant to submit additional medical records and for SCLARC to submit a response thereto. No additional documents were submitted, the record was closed, and the matter was submitted for decision on February 16, 2018.

[1] Initials and family titles are used herein to protect privacy.

## EVIDENCE

Documentary: Service Agency exhibits 1-11; Claimant's exhibits 1C-29C.

Testimonial: Sandra Watson, Psy.D.; Claimant's mother, aunt, and sister; and R.S. and M.L.

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## ISSUE

Is claimant eligible for regional center services under the Lanterman Act as a result of a diagnosis of Autism Spectrum Disorder, intellectual disability,[2] or a condition closely related to intellectual disability or requiring treatment similar to that required for an intellectually disabled individual, which constitutes a substantial handicap (fifth category)?

## FACTUAL FINDINGS

### JURISDICTIONAL MATTERS

1. Claimant previously sought regional center services, but was found ineligible. At the urging of the Lynwood Unified School District (District), mother again sought services. On September 15, 2017, SCLARC notified claimant that she was not eligible for regional center services.

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[2] The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5), uses the term Intellectual Disability or Intellectual Developmental Disorder in place of the formerly used term, "Mental Retardation."The two terms are used interchangeably in this decision as both terms are contained in the documents.

2. Claimant's mother timely filed a fair hearing request appealing that decision and this hearing ensued.

BACKGROUND INFORMATION

3. Claimant is a twelve-year-seven-month-old female who resides in a home in Lynwood with her adoptive mother, the mother's husband, 12 year-old sister, a six-year-old nephew, and claimant's older sister, age 25. Claimant was born at eight months gestation, weighing less than three pounds at birth. Her biological mother was age 14 and had ingested alcohol and drugs, including cocaine, while pregnant with claimant. Claimant was placed in foster care with mother at ten days of age, and was adopted by mother at age two. She has no contact with her biological parents.

4. In May 2009, claimant was diagnosed with fetal alcohol syndrome (FAS) by Lyn Laboriel, M.D. at VIP Fetal Alcohol Spectrum Disorder Center. According to Dr. Laboriel, claimant has medical evidence of brain damage, CNS Rank 4,[3] static encephalopathy with findings of microcephaly and periventricular leukomalacia. (Exhibit 27C, p. 21.)

5. Claimant has an Individualized Education Program (IEP) and currently attends special education classes as a seventh-grader at Hosler Middle School in the District. Claimant functions within the average range of cognitive ability with significantly below average functioning at home and in the community and moderately low functioning at school. She demonstrates deficits in visual and auditory processing. (Exhibit 27C, p. 21.) Claimant's intellectual abilities have been described as being in the range of intellectual disability. She demonstrates relative weakness and severe deficits in word analysis skills, visual perception, attention, auditory reasoning and short-term auditory memory.

[3] Denotes definite central nervous system damage.

6. Most individuals with FAS have normal intelligence, but are not able to use the intelligence they have. In claimant's case, she suffers from brain dysfunction due to FAS, expressed in the form of inappropriate behaviors. (Exhibit 27C, p. 13.) Damage to the cingulate gyrus[4] as a result of prenatal ingestion of alcohol and cocaine contribute to severe deficits in attention and difficulty in task completion.

7. As is typical of children with FAS, claimant exhibits problem behaviors including: eloping and unfastening her seat belt while riding in a car; uneven sleep patterns; stealing items from stores; a short attention span and the need for constant stimulation and excitement, which includes frequent masturbation and the inability to remain seated for more than a short period of time. Claimant exhibits extreme difficulty in compliance and task completion at home, but responds more positively to academic tasks at school in a structured classroom with several adults and ample opportunity to earn rewards for good behavior.

8. Claimant's inappropriate social behaviors prevent social participation. Claimant displays self-injurious behavior at least once per week and has caused property damage two to five times in the past year. Mother reports that claimant has some repetitive body movements that occur daily regardless of situation and that she does not deal well with changes in her routine. Her vocabulary is limited.

ASSESSMENTS

9. Mother initially sought a psycho-educational assessment due to concerns regarding claimant's excessive hyperactivity, language difficulties, social withdrawal and

[4] The cingulate gyrus is the part of the brain that travels longitudinally through the deep aspects of the frontal lobes.This part of the brain allows an individual to shift focus and demonstrate cognitive flexibility and to see options and adapt to change. (Exhibit 27C, p. 15.)

inappropriate behaviors. Claimant often engages in tantrums when demands are placed on her or when asked to perform non-preferred tasks or to end a preferred activity. The tantrums generally occur an average of once daily, with an average duration of 80 minutes, during which time claimant screams, hits and cries. She requires support in the community and will not cross streets independently. Claimant has had several evaluations over the years, with diagnoses of Attention Deficit Hyperactivity Disorder (ADHD), Autism, and Mild Mental Retardation.

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Dr. Leonelli's Assessments – 2008 and 2009

10a. David Roman Leonelli, Ph.D., a licensed clinical psychologist, performed psychological assessments of claimant in December 2008 and November 2009. In the first assessment in 2008, Dr. Leonelli found that Claimant was showing "early signs of attentional deficits and hyperactivity." (Exhibits 21C and 22C.)

10b. On November 19, 2009, Dr. Leonelli administered the McCarthy Scales of Children's Abilities (MSCA) to claimant. It is a multipart test made up of five scales that assesses the cognitive development and motor skills of young children. The combination of several scales yields the General Cognitive Scale, which measures a child's overall cognitive functioning in relation to other children her age. Claimant obtained a GCI score of 51, placing her in a percentile rank of less than 1, the range of someone with mental retardation. Claimant's 2009 GCI score demonstrated a mental age of two years and three months, well below the level expected of a four-year, four-month-old child. (Exhibits 21C and 22C.)

10c. Dr. Leonelli's descriptions under the heading "Behavioral Observations During Testing" in his 2009 report state that:

> She showed only minimal interest in the test materials and stimuli, and she appeared to lack verbal comprehension of many of the directives made by the examiner, whether they were related in English or Spanish. [She] was very active, impulsive and distractible during the testing session, and she had difficulty maintaining attention and concentration towards tasks. She was cooperative with the examiner throughout the testing process, but she rarely made eye contact and she did not socially engage with the examiner. [Claimant] exhibited a mild to moderate speech articulation problem throughout the testing process. (Exhibit 21C and 22C.)

10d. Dr. Leonelli wrote in 2009 that claimant was observed to have several crying spells and temper tantrums when she did not get her way. Dr. Leonelli stated that: claimant did not get along with others, and engaged in solitary play even when in the company of others; she had self-injurious behaviors, such as picking her skin and hitting herself at times; she was not fully toilet trained, and smeared feces; and, claimant rarely obeyed adult requests and directives. (Exhibits 21C and 22C.)

10e. In November 2009, Dr. Leonelli administered the Vineland Adaptive Behavior Scales (Vineland). Claimant was four years, four months old. Based on Mother's report, claimant's standard score (SS) of 78 in the Daily Living Skills domain placed her at an age equivalence of three years, three months. In the Socialization domain, claimant's SS of 74 placed her at an age equivalence of two years, seven months. (Exhibits 21C and 22C.)

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10f. Dr. Leonelli used the Conners' Parent Rating Scales, filled out by mother.

These indicated that claimant met criteria necessary for a diagnosis of ADHD, and indicated that claimant was "excitable, impulsive, restless, and distractible, and she fails to finish tasks. [She] was also reported to be oppositional and defiant, controlling, and destructive. [She] was also prone to mood swings; she is easily frustrated, and disturbs and bullies other children at times. [Claimant] was reported to be reluctant or unwilling to take responsibility for her actions." She was reportedly an unhappy child.

10g. On the Childhood Autism Rating Scale (CARS), claimant had an overall rating of 3.5 (total score of 50), placing her in the Severely Autistic range. Dr. Leonelli offered the following diagnostic impressions:

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| Axis I: | 299.00 | Autistic Disorder |
| | 314.01 | Attention Deficit Hyperactivity Disorder, Combined |
| Axis II: | 317 | Mild Mental Retardation |
| Axis II: | | V71.09 No diagnosis |
| Axis III: | | None, by history |
| Axis IV: | | Problems with primary support group; drug exposure at birth, removal from parent and placement in adoptive home |
| Axis V: | | Current GAF: 45 |

(Exhibits 21C, p. 8.)

Korchin Assessment - Stramski Children's Developmental Center- 2010

11a. Sharon Korchin, a licensed Occupational Therapist, assessed claimant for autism at the Stramski Children's Developmental Center of Miller Children's Hospital in Long Beach, California. In a report dated April 20, 2010, Korchin concluded that claimant met the threshold for autism, based upon administration of the Autism Diagnostic Observation Schedule (ADOS) which measures communication and social interaction skills. (Exhibits 19C and 27C, p. 9.)

11b. The ADOS is a semi-structured observation and interview measure designed to assess children and adults suspected of having an autistic spectrum disorder (ASD). The instrument is divided into four modules intended for very young children through adults. A module is chosen based on the age and language level of the individual. Tasks range from those designed to assess preverbal social/communicative behaviors in very young, nonverbal children (pretend play, joint attention) to tasks of pragmatic language, social and emotional understanding in verbally fluent adults.

11c. The ADOS is generally accepted as a high quality instrument for assessing the presence of autism. Korchin administered Module 1 of the ADOS, usually used to assess children who have not developed any language skills. In Korchin's report, she stated that Claimant's overall level of language showed "no use of words or word approximations during the evaluation. She never vocalized to her parent or the examiner during the entire session." (Exhibit 19C). Korchin, therefore, was unable to assess Claimant's intonations, use of phrase speech, or the presence of echolalia. In terms of nonverbal behaviors:

> "[Claimant] had one instance of distal pointing that was coordinated with eye gaze. She did use two different spontaneous gesture types – two conventional and two instrumental with two being used more than once. [¶] She did use appropriate eye contact to initiate and regulate social interactions. She did display a responsive social smile with her parent on the second attempt during the ADOS. She did direct some facial expressions towards her parent. . . . She used only eye contact, no vocalizations to communicate social intentions during the evaluation. She showed no

> expression of pleasure in her interactions with the examiner. She did look toward the examiner in response to hearing her name after the first attempt. She did give several times [*sic*] to another person as part of a routine during the ADOS. . . . She responded to the examiner's facial cue by looking toward a target. Social overtures were clearly inappropriate including kicking and throwing toys, smearing bubble liquid on the window, and smashing toys in to the examiner's hand." (Exhibit 19C).

11d. Korchin observed some limited spontaneous play with cause-and-effect toys, but it was quite brief. Claimant did not demonstrate any pretend play throughout the session. She was not observed to have any unusual sensory interests or unusual hand and finger mannerisms. There were no repetitive interests and behaviors observed. Korchin observed "[s]ignificant repeated negativism including behaviors which appeared both aggressive and impulsive and which were very disruptive including kicking and throwing toys. . . . She was very active and resisted being seated at the table to participate in most activities." In the communication domain, Claimant exceeded the threshold for autism, in the social-interaction domain, she met the threshold for autism, and her communication-social interaction total score indicated she met the threshold for autism. (Exhibit 19C).

Gary S. Feldman, M.D.- Stramski Children's Developmental Center

12. Gary S. Feldman, M.D., is a physician at the Stramski Children's Developmental Center, Miller Children's Hospital, in Long Beach, California. He saw claimant most recently on December 19, 2017. Under impressions, he notes that

claimant has FAS with a "typical behavioral phenotype" for that condition, as well as "autistic-like behaviors." Dr. Feldman opined that based on the ADOS administered by Korchin on April 20, 2010, claimant meets the threshold for an Autism diagnosis. (Exhibits 6C and 19C.)

Children's Hospital Los Angeles- 2010 and 2011

13. On September 7, 2010, the Los Angeles Child Guidance Clinic (Clinic), a community partner of Children's Hospital, Los Angeles (CHLA), performed an initial assessment of claimant. The Clinic arrived at a diagnosis of AXIS I: Disruptive Behavior Disorder, NOS and Autistic Disorder and AXIS III: FAS/Toxic Effects of Alcohol. (Exhibit 15C.) In June 2011, claimant completed the Triple-P Program[5] at the Clinic.

14. On October 31, 2011, Jennifer Rafeedie, PsyD, a psychologist at CHLA, met with claimant, observed her functioning, and reviewed reports of previous assessments. In a letter of that same date, Dr. Rafeedie opined that "it is evident that [claimant] has diagnoses that make her eligible for Regional Center Services, most notably a diagnosis from . . . [the Clinic] indicating the presence of Autistic Disorder, and another report by . . . Dr. Leonelli, indicating diagnoses of Autistic Disorder and Mild Mental Retardation. . . . I urge Regional Center representatives to take seriously the eligible diagnoses that [claimant] has already been given." (Exhibit 17C.)

Munther A. Hijazin, M.D.- 2012

15. In April 2012, Munther A. Hijazin, M.D., a specialist in Psychiatry and Neurology, diagnosed claimant with Autism, Developmental Delays, ADHD, Psychosis and Learning Disabilities. (Exhibit 27C, p. 9.)

[5] The Positive Parenting Program is an evidence-based public health approach for improving parenting practices and child welfare outcomes.

Pediatric Hub, County Department of Social Services- 2012

16. A report from Pediatric Hub Medical Exam, County of Los Angeles, Department of Social Services, dated June 12, 2012, stated that in a school setting with 12 students and four teachers, claimant performed poorly, even with one-to-one assistance. (Exhibit 14C.)

Nancy Felix, BCBA, People's Care Behavioral Health- 2017

17a. Nancy Felix, M.A., Board Certified Behavior Analyst (BCBA), is the clinical manager of People's Care Behavioral Health, in Diamond Bar, California. She prepared a Functional Behavioral Assessment (FBA) and Treatment Plan for claimant, dated November 13, 2017. Felix noted that claimant had been diagnosed with ASD and had been referred by claimant's pediatrician, Emile G. Shenouda, M.D., for an eight-hour FBA to assess tantrums and deficits in communication, social skills and adaptive and community skills. (Exhibit 9C, p. 1.)

17b. In conducting the FBA and developing the treatment plan, Felix reviewed records, including a psychological evaluation by Gary Feldman, M.D., dated October 25, 2017. Felix also directly observed claimant and conducted interviews. She administered the Adaptive Behavior Assessment System, Third Edition (ABAS-3). All of claimant's scores fell into the low range, with social skill deficits in: failure to develop appropriate peer relationships; limited shared social interests and enjoyment; and lack of social reciprocity. Claimant had communication deficits in: delay in or absence of expressive language and social conversation deficits. She also had adaptive skill deficits. Based on Felix's evaluation, she recommended individual and group Applied Behavioral Analysis (ABA) therapy for claimant which was approved by her provider, Anthem Blue Cross/Medi-Cal, on December 18, 2017. At the time of hearing, claimant was on a waiting list to receive ABA services. (Exhibits 5C and 9C.)

Munther Hijazin, M.D.- 2017

18. On November 15, 2017, Munther Hijazin, M.D., a neurologist, performed a neurological examination of claimant. He noted that she has a "history of autism, ADD, and learning disability, as well as mild mental retardation and psychosis." Dr. Hijazin described claimant as "restless and confused" and that his review "is positive for behavioral problems." He suggested that claimant continue with applied behavioral analysis (ABA). (Exhibit 8C.)

Emile G. Shenouda, M.D.- 2017

19. Dr. Shenouda has provided medical care to claimant since February 2016. In a letter dated November 27, 2017, he notes that claimant "has been diagnosed with Autism, mental retardation, FAS with typical behavior and ADHD." Dr. Shenouda states that mother has provided specialist reports to him from Dr. Leonelli and Dr. Hijazin which confirm these diagnoses, as well as school reports. He opines that regional center services are "long overdue and will be of utmost benefit" to claimant. (Exhibit 7C.)

Thomas L. Carrillo, Ph.D.- June 8, 2017 Assessment

20a. On June 8, 2017, Thomas L. Carrillo, Ph.D., a clinical psychologist, performed a psychological evaluation of claimant at the request of SCLARC for the purpose of assessing ID and ASD.[6] He interviewed mother, aunt and claimant; performed clinical observations; and administered the Wechsler Intelligence Scale for Children (WISC-V); the Vineland II; the Gilliam Autism Rating Scale; and the CARS. Dr.

[6] The Service Agency did not initially include Dr. Carrillo's report as an exhibit, but produced it during the hearing at the ALJ's request.

Carrillo also reviewed claimant's November 10, 2016 IEP. He noted that claimant had been diagnosed with FAS and related microcephaly in 2009. (Exhibit 11, p. 1.)

20b. Dr. Carrillo described claimant as a passive-resistant child, with fleeting eye contact. He opined that she "tended to fake bad." By this, Dr. Carrillo meant that she "intentionally answered questions inappropriately or incorrectly, even in questions that a 2 to 3-year-old would be able to respond appropriately." *He then stated that once she acclimated to the unfamiliar environment, claimant "eventually began to respond to the best of her ability." Dr. Carrillo opined that claimant "made a reasonable effort to respond . . . to the best of her ability" and the results are "a reasonable estimate of her overall intellectual and adaptive functioning."* (emphasis added.) (Exhibit 11, p. 3.)

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20c. Cognitive and Intellectual Functioning: The WISC-V, claimant demonstrated a scattering of abilities ranging from the mild range of delay to the borderline range of delay. Her overall results suggested that claimant's cognitive abilities are within the mild range of delay. (Exhibit 11.)

20d. Adaptive Functioning (Communication): Claimant showed delays in receptive, expressive and written language. Her conversational content was "impoverished" and that of an individual younger than claimant's chronological age based upon her Vineland-II scores. (Exhibit 11.)

20e. Adaptive Functioning (Adaptive/Social Skills): Her Vineland-II scores indicated that Claimant showed borderline delays in Daily Living Skills, mild delay in Socialization, and Overall Adaptive Abilities within the mild range of delay. (Exhibit 11.)

20f. Dr. Carrillo opined that neither the Gilliam-II nor the CARS suggested that claimant has ASD. In the area of social communication and social interaction, claimant did not demonstrate the required symptomatology in any of the three required subcategories (reciprocity, nonverbal communication for social interactions, and relationships.) In the category of restricted, repetitive patterns of behavior, interests or

activities, claimant met only one subcategory in that she is hypersensitive to sound. Therefore, she did not meet at least two of the four subcategories of restricted, repetitive patterns of behavior, interests or activities, as required. (Exhibit 11.)

20g. At the completion of the testing, Dr. Carrillo diagnosed claimant as having mild ID. (Exhibit 11, p. 7.)

Jennie M. Mathess, Psy.D., August 3, 2017 Assessment

21a. On August 3, 2017, an additional psychological assessment of claimant was conducted for the Service Agency by Jennie M. Mathess, Psy.D., a clinical psychologist. The purpose was the same as the assessment conducted just two months earlier by Dr. Carrillo. Dr. Mathess reviewed the same documents and administered the ADI-R, with mother as the respondent, the Vineland-3, and the Wechsler Nonverbal Scale of Ability.

21b. Based upon the ADI-R, Dr. Mathess found that in the adaptive functioning/communication domain, claimant scored in the low range. On the daily living skills domain and socialization domain of the Vineland-3, she scored on the low range. Claimant's adaptive functioning was in the low range in all areas.

21c. Dr. Mathess determined that claimant's cognitive functioning was in the low average range, indicating that her cognitive abilities are somewhat undeveloped for her age.

21d. Dr. Mathess did not diagnose claimant as having either ID or ASD. She stated that a diagnosis of ID requires significant deficits in intellectual functioning with concurrent deficits in adaptive functioning and that ASD requires persistent deficits in social communication and social interaction, as well as restricted, repetitive patterns of behavior, interests and activities. (Exhibit 3, p. 5.)

WITNESS TESTIMONY

22a. Sandra Watson, Psy.D., a clinical psychologist, was the Service Agency's sole witness. Dr. Watson is a consulting psychologist at SCLARC and is a member of the team that determines eligibility.

22b. Dr. Watson did not conduct any of claimant's assessments. She was not present at the assessment and could not say how much time Dr. Mathess had spent with claimant in conducting the assessment.

22c. Dr. Watson relied on the assessment conducted by Dr. Mathess in stating that claimant is ineligible for regional center services because Dr. Mathess found that she did not meet the criteria for ASD. Dr. Watson opined that claimant does not meet the criteria for ID or Fifth Category because her IQ is in the low-average range, according to Dr. Mathess.

22d. Dr. Watson discounted the assessment carried out by Felix (Exhibit 9C), stating that a FBA is a behavioral treatment plan, rather than a diagnostic tool. She discounted the assessment carried out by Dr. Leonelli (Exhibit 21C), opining that it was not sufficient for a diagnosis of ASD in that he "should have taken it further." Dr. Watson discounted the assessment conducted by Korchin, because it was administered by an Occupational Therapist and no scores were provided. (Exhibit 19C).

22e. When Dr. Watson was asked why the regional center ordered a second assessment to be conducted by Dr. Mathess only two months after Dr. Carrillo's assessment she stated that his results were inaccurate because claimant had not made a reasonable effort to respond to the best of her ability. However, this was not persuasive in that Dr. Carrillo specifically stated in his report that once claimant became acclimated to the setting, claimant did answer to the best of her ability and the results are "a reasonable estimate of her overall intellectual and adaptive functioning." (Factual Findings 20a-20g.) It is of concern that the regional center ignored the test results it had

sought, "forum shopped" for a result more to its liking, and then attempted to hide Dr. Carrillo's report by failing to include it in its exhibits until asked to do so by the ALJ.

22f. Dr. Watson opined that one cannot make a diagnosis based on a single test and that a full psychological battery should have been conducted. She also stated that she would conduct both an ADOS (an interactive test in which the client's responses are scored) and an ADI- R (in which a parent is asked questions.) However, Dr. Watson admitted that the ADI-R results could "be skewed" due to a parent's limited education level if the "questioner is not adept." She opined that a psychologist "should take everything into consideration. A child can interact better one day than another."

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23a. Mother testified at hearing. She stated that claimant "behaves like a baby outside of the home and is worse at home." Claimant is unable to follow a regular routine, has limited language skills, and "has noticeable behavior problems." Mother would like to obtain regional center services to help her daughter who needs socialization, behavioral therapy, more speech and language services than the District can provide, and autism services. She stated that Medi-Cal has approved ABA services for claimant, but there is a four to six month waiting list.

23b. Mother previously sought regional center services for claimant in 2009 and in 2011. In November 2011, an ALJ upheld the Service Agency's denial of services to claimant, finding that the evidence presented did not establish eligibility for regional center services. The principal at claimant's school told mother "to reopen the case" when he became aware that claimant is not receiving regional center services.

24. M.L. and R.S. testified on claimant's behalf. Both are mothers of children with ASD and are active with mother in an organization called "Latino Strong Voice Families." They have known mother for many years and have observed claimant's behavior which mirrors that of their children with ASD. They noted that during the

hearing, claimant has thrown herself on the floor repeatedly and has not shown any interest in the proceedings despite the fact that "we are here talking about her."

25. Claimant's adult sister testified that her mother has taken claimant to many doctors "on her own" and her sister has undergone many evaluations over the years in which she was determined to be developmentally disabled.

26. Claimant's aunt testified that her neuro-typical son and claimant were born a week apart. Claimant's development is substantially delayed compared to that of her son. Their families are very close. The other children in the family help claimant by "telling her what to do" because she is unable to function independently.

## LEGAL CONCLUSIONS

### BURDEN OF PROOF

1. In a proceeding to determine eligibility, the burden of proof is on the claimant to establish he or she meets the proper criteria. The standard is a preponderance of the evidence. (Evid. Code, § 115.)

### STATUTORY AUTHORITY

2. The Lanterman Act is set forth at Welfare and Institutions Code section 4500 et seq.

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3. Welfare and Institutions Code section 4501 states:

> The State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge. Affecting hundreds of thousands of children and adults directly, and having an important impact on the lives of their families, neighbors and whole

communities, developmental disabilities present social, medical, economic, and legal problems of extreme importance . . .

An array of services and supports should be established which is sufficiently complete to meet the needs and choices of each person with developmental disabilities, regardless of age or degree of disability, and at each stage of life and to support their integration into the mainstream life of the community. To the maximum extent feasible, services and supports should be available throughout the state to prevent the dislocation of persons with developmental disabilities from their home communities.

4. Welfare and Institutions Code section 4512, subdivision (a), defines "developmental disability" as follows:

'Developmental disability' means a disability which originates before an individual attains age 18, continues, or can be expected to continue indefinitely, and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disablin*g* conditions found to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals, but

shall not include other handicapping conditions that are solely physical in nature.

5. California Code of Regulations, title 17, section 54000, provides:

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

(b) The Developmental Disability shall:

(1) Originate before age eighteen;

(2) Be likely to continue indefinitely;

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

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

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

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

(3) Solely physical in nature. These conditions include congenital anomalies or conditions acquired through disease, accident, or faulty development which

are not associated with a neurological impairment that results in a need for treatment similar to that required for mental retardation.

6. California Code of Regulations, title 17, section 54001, provides:

(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

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(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.

(b) The assessment of substantial disability shall be made by a group of Regional Center professionals of differing disciplines and shall include consideration of similar qualification appraisals performed by other interdisciplinary bodies of the Department serving the potential client. The group shall include as a minimum a program coordinator, a physician, and a psychologist.

(c) The Regional Center professional group shall consult the potential client, parents, guardians/conservators, educators, advocates, and other client representatives to the extent that they are willing and available to participate in its deliberations and to the extent that the appropriate consent is obtained.

(d) Any reassessment of substantial disability for purposes of continuing eligibility shall utilize the same criteria under which the individual was originally made eligible.

AUTISM SPECTRUM DISORDER

7. The DSM-5 criteria for ASD are 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.

Specify Current Severity

**Severity is based on social communication impairments and restricted repetitive patterns of behavior** . . . . [Italics and bolding in original.]

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 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).

Specify current severity

**Severity is based on social communication impairments and restricted, repetitive patterns of behavior** . . . . [Italics and bolding in original.]

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.

(DSM-5, pp. 50-51.)

DIAGNOSTIC CRITERIA FOR INTELLECTUAL DISABILITY

8. The DSM-5 contains the diagnostic criteria used for intellectual disability. Three diagnostic criteria must be met: deficits in intellectual functions; deficits in adaptive functioning; and the onset of these deficits during the developmental period. An individual must have a *DSM-5* diagnosis of intellectual disability to qualify for regional center services. Intellectual functioning is typically measured using intelligence tests. Individuals with intellectual disability typically have IQ scores in the 65-75 range.

THE "FIFTH CATEGORY"

9. Under the "fifth category" the Lanterman Act provides assistance to individuals with "disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals" but

does "not include other handicapping conditions that are solely physical in nature."[7] Along with the other four qualifying conditions (cerebral palsy, epilepsy, autism spectrum disorder, and intellectual disability), a disability involving the fifth category must originate before an individual attains age 18 years of age, must continue or be expected to continue indefinitely, and must constitute a substantial disability.

10. The fifth category is not defined in the *DSM-5*. In *Mason v. Office of Administrative Hearings* (2001) 89 CalApp.4th 1119, 1129, the California Court of Appeal held that the fifth category was not unconstitutionally vague and set down a general standard: "The fifth category condition must be very similar to mental retardation, with many of the same, or close to the same, factors required in classifying a person as mentally retarded. Furthermore, the various additional factors required in designating an individual developmentally disabled and substantially handicapped must apply as well."

11. On March 16, 2002, in response to the *Mason* case, the Association of Regional Center Agencies (ARCA) approved the *Guidelines for Determining 5th Category Eligibility for the California Regional Centers* (Guidelines).[8] In those Guidelines, ARCA noted that eligibility for Regional Center services under the fifth category required a "determination as to whether an individual functions in a manner that is similar to that of a person with mental retardation **OR** requires treatment similar to that required by individuals with mental retardation." (Emphasis in original.) The Guidelines stated that *Mason* clarified that the Legislative intent was to defer to the professionals of the Regional Center Eligibility Team to make the decision on eligibility after considering

[7] Welfare and Institutions Code section 4512, subdivision (a).

[8] The ARCA guidelines have not gone through the formal scrutiny required to become a regulation and were written before the DSM-5 was in effect.

information obtained through the assessment process. The Guidelines listed the factors to be considered when determining eligibility under the fifth category.

12. Another appellate decision, *Samantha C. v. State Department of Developmental Services* (2010) 185 Cal.App.4th 1462, has suggested that when considering whether an individual is eligible for regional center services under the fifth category, that eligibility may be based largely on the established need for treatment similar to that provided for individuals with mental retardation, and notwithstanding an individual's relatively high level of intellectual functioning. In *Samantha C.*, the individual applying for regional center services did not meet the criteria for mental retardation. Her cognitive test results scored her above average in the areas of abstract reasoning and conceptual development and she had good scores in vocabulary and comprehension. She did perform poorly on subtests involving working memory and processing speed, but her scores were still higher than persons with mental retardation. The court understood and noted that the ARCA Guidelines recommended consideration of fifth category for those individuals whose "general intellectual functioning is in the low borderline range of intelligence (I.Q. scores ranging from 70-74)." (*Id.* at p. 1477.) However, the court confirmed that individuals may qualify for regional center services under the fifth category on either of two independent bases, with one basis requiring only that an individual require treatment similar to that required for individuals with mental retardation. Thus, an individual can qualify for regional center services under the fifth category if he or she satisfies either prong: (1) a condition closely related to intellectual disability or (2) a condition requiring treatment similar to that required for an intellectually disabled individual.

ANALYSIS

13. The Lanterman Act and the applicable regulations set forth criteria that a claimant must meet in order to qualify for regional center services. (Legal Conclusions 4-

6). In this case, the records overwhelmingly demonstrated that claimant has ASD and an intellectual disability. There is no dispute that claimant has FAS, which can cause intellectual disability. Numerous evaluations have been performed over the years establishing that claimant's FAS has caused her to suffer impaired cognitive abilities and adaptive functioning. (Factual Findings 4, 6, 7, 12, 13, 19 and 20). As Dr. Carrillo opined, claimant's scores on cognitive and adaptive functioning tests supported a diagnosis of intellectual disability. (Factual Findings 20a-20g). Alternatively, the documents supported a finding of eligibility based upon ASD and the fifth category. Aside from the report of Dr. Mathess, a careful and detailed review of the testimony and records presented established that claimant is eligible for regional center services based upon a diagnosis of intellectual disability and ASD. (Factual Findings 3-20g and 23a-26).

14. Additionally, claimant is also eligible under the fifth category because she presented as one who had a disabling condition, FAS, found to be closely related to intellectual disability or to require treatment similar to that required for individuals with intellectual disabilities. The effects of claimant's FAS cause her to have a condition that is closely related to intellectual disability that requires treatment similar to that required for intellectual disability. (Factual Findings 4, 6, 7, 12, 13, 19 and 20).

15. There were ample records supplied and multiple assessments performed on this child over the course of many years, all of which (aside from that of Dr. Mathess) supported claimant's request for eligibility. (Factual Findings 3-20g.) The abundance of information that the regional center downplayed or disregarded (including Dr. Carrillo's evaluation performed at SCLARC's request only two months prior to that of Dr. Mathess) call Dr. Mathess' conclusions, and the regional center's reliance on them, into question.

16. There is more than enough evidence available to determine that claimant is eligible for regional center services and supports under the Lanterman Developmental Disabilities Services Act. Her eligibility is based upon diagnoses of intellectual disability and autism spectrum disorder which poses a substantial disability for claimant. Claimant

is also eligible under either prong of the fifth category. Claimant has a disabling condition found to be closely related to intellectual disability or that requires treatment similar to that required for individuals with an intellectual disability. (Legal Conclusions 3-12 and Factual Findings 3-20g and 23a-26.)

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## ORDER

1. Claimant's appeal from South Central Los Angeles Regional Center's determination that she is not eligible for regional center services and supports is granted.

2. South Central Los Angeles Regional Center shall immediately make claimant eligible for services and supports.

DATED:

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LAURIE R. PEARLMAN

Administrative Law Judge

Office of Administrative Hearings

## NOTICE

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