BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

P.H.,

Claimant,

vs.

NORTH LOS ANGELES COUNTY REGIONAL CENTER,

Service Agency.

OAH No. 2013040844

DECISION

The hearing in the above-captioned matter was held on October 21 and 22, 2013, in Lancaster, California, by Joseph D. Montoya, Administrative Law Judge (ALJ) , Office of Administrative Hearings. Claimant P.H. was represented by Ibrahaim K. Saab, Office of Clients Rights Advocacy, Disability Rights California.[1] The Service Agency, North Los Angeles County Regional Center (NLARC or Service Agency) was represented by Rhonda Campbell, Contract Administrator.

Evidence was received, but the record was held open until December 5, 2013, for written argument and briefing. Claimant's Closing Brief was timely received, and is marked for identification as Exhibit MM. The Service Agency's Closing Argument was timely

[1] Initials are used in the place of the family surname in the interests of privacy.

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received, and that brief is marked for identification as Exhibit 28. The matter was deemed submitted for decision on December 6, 2013.

The Administrative Law Judge hereby makes his factual findings, legal conclusions, and orders.

ISSUE PRESENTED

The issue is whether Claimant P.H. is eligible for services from the Service Agency on the grounds that she suffers from autism or a condition similar to mental retardation, or which can be treated in a manner similar to mental retardation.

Determination of this issue is hampered by a number of factors, including the the fact that Claimant, now 19 years of age, has been in and out of foster homes and schools during much of her life, and has been the victim of abuse and neglect. There is a gap in her record; neither party submitted any documentation for the period between September 1998 and August 2006, although it is clear that Claimant should have been receiving, at least, special education services. Further, Claimant has received numerous diagnoses over the years, including Speech Delay, Learning Disorder, Depression, Schizoaffective Disorder, Asperger's Disorder, Amnestic Disorder (Not Otherwise Specified), Autism, and Post Traumatic Stress Disorder, and early on the question was raised as to whether she had Reactive Attachment Disorder. The Service Agency does not dispute the fact that she suffers from some of the aforementioned maladies. However, the Service Agency does not agree that Claimant suffers from an eligible condition.

FACTUAL FINDINGS

THE PARTIES AND JURISDICTION

1. Claimant is a 19-year-old woman (born May 13, 1994) who seeks services from the Service Agency under the Lanterman Developmental Disabilities Services Act

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(Lanterman Act), California Welfare and Institutions Code, section 4500 et seq.[2] based on a claim that she suffers from autism or under what is known as the fifth category.

2. On March 15, 2013, NLARC issued a Notice of Proposed Action and accompanying letter, which informed Claimant that she was not deemed eligible for services under the Lanterman Act. NLARC asserted that Claimant did not have an eligible disability that was substantially handicapping within the meaning of the Lanterman Act.

3. On April 11, 2013, Claimant filed a Fair Hearing Request, and this proceeding ensued. The matter was once continued, at Claimant's request. All jurisdictional requirements have been met.

Claimant's Family History

4. As indicated above, Claimant has not had a stable family life. She was placed in foster care (as was her older brother) a few days before her third birthday, due to her mother's substance abuse and neglect of the children. There were reports of physical, emotional, and possible sexual abuse as well. (Ex. 6, p. 1.) She was reunited with her father when still a child; one document indicated that such occurred when she was about four years old, and another indicating she was six. (Compare Ex. 5 with Ex. V.) She was removed from her father and stepmother when she was nine; according to a history contained in a later psychological assessment, her father was charged with multiple counts of sexual abuse against Claimant's half-sister. (Ex. 10, p. 2.) She was eventually reunited

[2] All statutory references are to the Welfare and Institutions Code, unless otherwise noted.

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with her mother at age 11.[3] While living with her mother, she became pregnant, at age 15, but her mother did nothing about it, not even insisting on a pregnancy test or doctor's exam, despite her suspicion that Claimant was pregnant. In part because of that parental neglect, Claimant was placed back in foster care when she was 15, and had her baby at age 16. For a time, she and the baby lived in the same foster home, but Claimant could not properly care for the infant, who was eventually placed in a separate foster home. (See summary at Ex. V, p. 1; see also Ex. O.) For a number of years, Claimant's mother was a homeless drug addict, and by the time Claimant was a teenager, her father had disappeared from her life. He had a history of drug abuse as well.

5. Various reports in the record indicate that Claimant may have been abused by her stepmother, and her mother's boyfriend was suspected of being the father of Claimant's baby.

6. Claimant has been in special education programs for much of, but not all of, her life. When she was three and one-half, her foster mother requested a speech and language assessment due to concerns about her delayed language development. (Ex. 3, p. 5.) She received speech and language services, which terminated in 2006. Other special education services were provided to Claimant. (Ex. 6, p. 3.) For example, she was put in a Special Day Class in the first grade. (Ex. 8, p. 1.) Notwithstanding years of special education, at age 19 Claimant's reading skills approximate those of a third grader, and a recent IEP goal, for math, indicated that Claimant may not understand how to make change when buying something. (See Factual Finding 31(C).) By the time she was a mother, Claimant was home schooled, in part because she could not get along with other

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[3] The psychological assessment states that she went from her father's custody to live with her emancipated half-sister for two years before reuniting with her mother. (Ex. 10, p. 2.)

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students. She may not be able to earn enough credits to graduate before she turns 22.

Assessments and Evaluations Made Prior to the Service Agency's Assessments

7. Claimant has been assessed at various times since she was a child, and prior to her request for services from the Service Agency. Those assessments typically pertained to educational needs or evaluation for foster care.

8. (A) In November 1997, when Claimant was three and one-half years old, she was deemed eligible by her school district for special education services, on the basis of a language and speech disorder. (Ex. 3, p. 1.) An Individual Education Plan (IEP) from that period stated that speech and language testing revealed a "moderate to severe expressive language delay and a moderate articulation delay." (*Id.*, p. 2.) The IEP noted that she had been removed from her parents in May of that year—at around the time of her third birthday—and that at the time of the IEP she was in her third foster home placement.

(B) According to the IEP, Claimant was using one word utterances during "play-based assessment to exclaim or label play items," and was using two word utterances on occasion. (Ex. 3, p. 5.) Receptive language was deemed age appropriate because she would get items or carry out operations as requested by the test facilitator. Her foster mother reported the occasional three word statement, such as "want my dress" or "hey you girl." (*Id.*)

(C) The IEP set some goals and objectives that were not related to language development. One was to improve self-help skills in the area of toileting, and thus a goal was set for her to independently take care of all toileting needs, including hand washing after toileting and after eating, 90 percent of the time. Goals were also put in place to improve fine and gross motor skills. (Ex. 3, p. 4.)

(D) Another goal, not clearly related to improving speech and language pertained to socialization. In that regard, a goal was set so that Claimant would play with a peer,

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sharing and taking turns for up to 10 minutes, 80 percent of the time, and another goal was set whereby she would verbally express her wants, needs, and feelings to both adults and peers, 80 per cent of the time. (*Id.*) Finally, a goal was set whereby Claimant would "verbally initiate play with another peer with adult facilitation for up to 10 minutes, 80 percent of the time, and she would initiate play with a peer for two exchanges, four out of five times." (*Id.*)

9. (A) At about the same time as the IEP was developed, the Foster Family agency that placed Claimant in a foster home wrote an "Appraisal/Needs and Services Plan." (Ex. 4, pp. 2-3.) That document, dated November 9, 1997, states, as background information, that the child was taken from her mother due to the latter's drug abuse, and that she had been exposed to physical, emotional, and sexual abuse.[4] She was described as exhibiting moodiness and inappropriate sexual behaviors. There was a question of whether she suffered from Reactive Attachment Disorder, and it was stated that she had a diagnosis of significant speech delays.

(B) The Appraisal states that Claimant then had difficulties relating to other children during play, "i.e., need [sic] to be center of attention & does not like sharing." (Ex. 4, p. 2.) The plan was for the foster mother to use behavior modification techniques to reduce such inappropriate behaviors.

10. In May 1998, the Foster Family Agency appraisal was updated. However, the document, part of exhibit 4, appears incomplete as there is only one page rather than two. However, it was reported that Claimant exhibited moodiness, tantrums, and delayed speech, and that she exhibited a lack of boundaries as well as some sexualized behaviors. It was also noted that she fought with the boys in the family. An objective was set to

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[4] A 1998 report by the Foster Family agency states that there was "possible sexual abuse" reported. (Ex. 5, p.1.)

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increase Claimant's ability to share and get along with others. (Ex. 4, p.1.)

11. In September 1998, well into her fourth year, Claimant's status as a foster child ended, and she was reunited with her father . The Foster Family Agency prepared a "termination report," exhibit 5. At that point, Claimant was continuing to have frequent tantrums; according to her foster mother, Claimant sometimes bit herself and threw herself against objects. She kicked her foster mother and clawed at her brother; it was reported that the behaviors were worse when the child was with her natural father. She continued to exhibit sexualized behaviors, claiming that her therapist met with her without any clothes on. Apparently, her speech had not improved much, in that she was described, at the end of a visit with her father, as saying "I bad girl." (Ex. 5, p. 1.)

12. (A) In August 2006, when Claimant was 12 years old and in the sixth grade another IEP was developed, with the participation of Claimant's mother, A.M. (Mom).[5] It was reported that she had then been receiving special education services on the grounds that she suffered from a learning disability. The IEP documents specified a "discrepancy" in terms of basic reading, reading comprehension, written expression, and math calculation; this was four of the seven recognized categories, implying a rather broad problem. (Ex. I, p. 2.) The IEP also provides that Claimant had a basic psychological processing disorder in the areas of auditory processing and cognitive abilities, including association, conceptualization, and expression. Another part of the IEP document provides that there were severe deficits not only in audio processing, but in visual-motor integration; these conditions were said to support a smaller teacher-student ratio in her classes. Due to safety concerns, her school district agreed to provide transportation. (*Id.*, p. 3.)

(B) Claimant's mother told the IEP team that she was concerned with Claimant's

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[5] After several years of living with her father, Claimant was returned to her mother's custody.

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inability to communicate her needs effectively, and the fact that the child did not retain information given to her on a day-to-day basis. Mom reported that Claimant was sometimes confused about time and place, and often got side-tracked while walking to and from school. (Ex. I, p. 3.)

(C) Claimant's academic achievement was substantially impaired. Her standard scores in basic reading skills and broad reading were 58 and 53, respectively; these scores were equivalent to first grade performance at a time when she was starting the sixth grade, and they appear to be three standard deviations below the mean. Her scores for written language and written expression were similar. Her broad math and math calculation skills were slightly better: the former standard score was 72, and the latter was at 71, both being second grade performance, but placing her in the bottom two percent.

(D) The IEP stated that "[Claimant] needs to work on social cues and what is acceptable and not acceptable." (Ex. I, p. 10.) Goals were set for improvement in this area. Hence, a goal was set, for the next year, as follows: "Given a social situation, [Claimant] will respond to social initiation cues from peers, as measured by observation . . . ." (*Id.*) On the other hand, in discussing adaptive skills, the IEP document states that her adaptive skills were appropriate "for the most part," and that she was able to interact appropriately with peers "for the most part." (*Id.*, p. 13.) But, she was described as easily upset and sometimes withdrawing from others.

13. The record indicates that a school psychologist evaluated Claimant in April 2006, for emotional disturbance, but that eligibility criteria was not established, because it was not determined that the behaviors had existed for a long period of time. (Ex. 8, p. 1.) Any report that was generated was not made part of the record.

14. (A) On April 20, 2009, Claimant's school district issued a "multi-disciplinary assessment report," which followed a triennial assessment. The document provides that the purpose of the psycho-educational assessment was to discover Claimant's learning

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strengths and needs, to recommend supportive educational strategies and to assist the IEP team in determining her eligibility to receive special education services. The assessor was Michelle Burns, a school psychologist. (Ex. 8, p. 1.)

(B) In summary, the assessment showed that Claimant, then a month shy of her 15th birthday, had a low average IQ, with relative strengths in verbal and non-verbal reasoning and processing speed. Her working memory was a weak area, as was auditory memory. She demonstrated "some immaturity and difficulties coping with bullying at school." (Ex. 8, p. 5.)

(C) Ms. Burns administered the Wechsler Intelligence Scales for Children—Fourth Edition (WISC-IV). Claimant's verbal comprehension scored at 81, and her perceptual reasoning at 88. Processing speed was 91, and working memory 77. The full scale IQ score was 84. (Ex. 8, p. 6.) Administration of the Woodcock-Johnson III Tests of Achievement revealed low academic achievements. Her scores typically fell into the 60's, with a low of 46 for Academic Skills, and a high of 78 for Written Expression. However, in six categories, the scores were between 59 and 68. Age equivalent scores were concomitantly low; for Basic Reading Skills, where her score was 59, the age equivalent was seven years, seven months. Grade equivalents ran between 2.2 and 4.7, at a time when Claimant was in the eighth grade. (*Id.*, p. 8; see also Ex. 9, p.3.)

15. (A) In April 2009, an IEP was written for Claimant's transition from middle school to high school. (Ex. L.) A description of her then-current function in a special day class stated that while she brought her needed materials to school, she would not let anyone help her organize them. She completed 85 percent of her work, but needed more time. She did not get along with her peers in the classroom and had been assigned a seat near an adult. She would threaten other students, and say she wished them dead. She would get upset and cry two or three times per week. At the same time, her personal hygiene was so bad, that other students would not sit near her because of her body odor. (*Id.*, p. 5.)

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(B) She was reading at a second grade level (2.1) and was not fluent due to her stuttering. She met a basic goal from the prior school year for writing, by capitalizing the first letter in a sentence and proper pronouns in simple sentences. In terms of math, she had not met the previous goals, as she had trouble remembering skills that had previously been taught. She was estimated to be working at a third or fourth grade level.(Ex. L, pp. 5-6.)

(C) The IEP included results of the STAR tests, standardized tests administered to school children in California. For English Language Arts, her score was rated "far below basic" and no score was given for one subpart of the test. Her math results were not calculated because she did not answer a sufficient number of questions.(Ex. L, p. 13.)

(D) In various parts of the IEP, reference is made to social issues. For example, it is stated that she sometimes has "immature behaviors." (Ex. L, p. 19.) She is described as having well developed relationships with adults, and "some friends at school at grade level and younger)" but at the same time it is mentioned that her peer relationships are hampered by teasing and bullying. Cryptically, the document further states: "Teacher rating scales indicate concerns in multiple areas, however results must be interpreted with caution due to excessively negative responding." (*Id.*)

(E) Claimant's adaptive functioning was described as age appropriate, which appears to be contradicted by other parts of the IEP. (See Ex. L, p. 21.)

(F) A progress report from Claimant's physical education teacher stated that Claimant had some trouble functioning in large group activities and seemed to frustrate easily in groups and teams. In the area of social interaction with peers, the teacher stated "social interaction with her peer is not what is to be expected of an 8th grade student. She seems to have issues with other students from time to time—I must intervene in given situations." (Ex. L, p. 29.) The PE teacher, in general comments, reiterated some of the

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information, stating that Claimant had difficulty, at times, with getting along with other students, "due to misunderstanding in either rules or expectations. [Claimant's] problems, at times, may be attributed to a slight immaturity on her part." (*Id.*, p. 30.)

16. (A) In September 2009, Claimant was referred for School Based Mental Health Services, by a teacher at her high school. Claimant was then 15, in 9th grade, and living with her mother.

(B) In the referral, the teacher set out the "presenting problems" as follows:

> [Claimant] is emotionally fragile. She doesn't interact with her peers very well at all. She is an admitted cutter and has had suicidal ideations. Her home life as she reports it is difficult for her and her behavior and emotional states leaves [sic] her unable to work for long periods of time. (Ex. 7, p. 2.)

(C) Under the heading "background history," the teacher wrote:

1. [Claimant] gets upset very easily, will sometimes pull her hair & clothing. 2. She comes to school with unclean clothes/hair and feet. Her body odor is strong. Her peers tease her about her appearance. 3. She was in RSP & Speech before moving into SDC for more support. (Ex. 7, p. 2.)

(D) The record does not clearly disclose the outcome of this referral, although a later IEP document states that Claimant was receiving DIS counseling, twice per month.

17. (A) In May 2010 an annual IEP was prepared in connection with Claimant's enrollment in high school. The IEP document notes that Claimant was then receiving DIS counseling twice per month, for 30 minutes per session. (Ex. M, p. 5.) It states that Claimant had expressed a desire to work in any area that had something to do with anime, Japanese animation. (*Id.*) A goal was set for personal hygiene.

(B) The personal hygiene goal was set because Claimant was still coming to school

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unwashed, unkempt, and with significant body odor. Put another way, some eight months after the mental health referral, Claimant had not improved in the area of personal hygiene. The goal was for her to come to school with clean clothes and hair, and no body odor, 70 percent of the time. (Ex. M., p. 11.) The IEP otherwise described her adaptive skills as "adequate."[6]

(C) The May 2010 IEP relied on 2009 test scores, i.e., those showing grade equivalencies that mostly fell into the second grade level. Various educational goals were set for Claimant.

18. (A) In June 2010, Claimant underwent a psychological assessment. It was conducted by Leslie B. Rosen, Ph.D., a licensed clinical psychologist, at the behest of Penny Lane, the foster care agency that had placed Claimant in foster care as a young child, and which placed her again after she was again taken from her mother. According to the report generated by Dr. Rosen, the assessment was requested by Claimant's caseworker "due to [Claimant's] being home schooled given her high anxiety and extreme difficulties relating to her peers. [Claimant] exhibits repetitive thoughts and language, academic failure, odd thinking, high distress and threats of harm to self and others. . . . Requested areas to explore include abuse, aggression, anxiety, depression, molestation, relationship skills, suicidality and thought disorder." (Ex. 10, p. 1.)

(B) Dr. Rosen reported that Claimant, then 16 years old, appeared for testing properly dressed but with dirty and tangled hair. It was noted that questions often triggered a personal story, but Dr. Rosen also noted that Claimant's statements and stories

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[6] This assessment is questionable given that Claimant has consistently shown significant impairment in adaptive skills when assessed with standardized tests. Indeed, one month later such poor test results were obtained by Dr. Rosen. (See Factual Finding 18 (F).)

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were at times bizarre.

(C) Dr. Rosen used a number of standard tests in her evaluation, including a WISC-IV, Wechsler Individual Achievement Test—Screener, Adaptive Behavior Assessment System, and ADHD Rating Scale—IV. Results on the WISC-IV were a 71 on the Verbal Comprehension Index, but a 94 on the Perceptual Reasoning Index. Subtests indicated that her ability to sustain attention, to concentrate, and to exert mental control was in the borderline range—the fourth percentile—with a working memory index of 74. Her processing speed was better, as she scored a 91 in that area. (Ex. 10, pp. 5-6.) Dr. Rosen did not specify a full scale IQ, but noted that "making sense of complex verbal information and using verbal abilities to solve novel problems are a weakness for [Claimant]." (*Id.*, p. 5.)

(D) Dr. Rosen, when discussing Claimant's strengths and weaknesses as indicated by the WISC-IV, stated as follows:

> [Claimant] achieved her weakest performance among the verbal reasoning tasks on the Comprehension subtest. Her weak performance on the Comprehension subtest was far below those of most of her peers. The Comprehension subtest required [Claimant] to provide oral solutions to everyday problems and to explain the underlying reasons for certain social rules or concepts. This subtest provides a general measure of verbal reasoning. In particular, this subtest assesses her comprehension of social situations and social judgment as well as her knowledge of conventional standards of social behavior. (Comprehension scaled score = 3.) (Ex. 10, p. 6.)

(E) When the WIAT screener was utilized, it was disclosed that Claimant's math

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skills, spelling skills, and basic reading skills were all in the first percentile. (Ex. 10, pp. 6-7.) This was equivalent to a second grader's skills.

(F) The ABAS, used to assess adaptive function, placed Claimant in the bottom 1.4 percent of people her age, due to a "General Adaptive Composite" score of 67. Not all of her subtest scores were so depressed. Her score on the social subtest, designed to assess whether she has the skills to get along with others, to have friends, to show and recognize others, was an 8, in the average range.[7] Communication was deemed low average (score of 6), and community use and health and safety subtests were at 7, deemed low average. But, self-care (1), self-direction (4), functional academics (3), and home living (3) were all deemed extremely low scores, essentially two standard deviations below the mean. (Ex. 10, pp. 7-8.) Dr. Rosen noted that the mean subtest score was 5.33, and that the subtest scores for Leisure and Social were relative strengths, as the scores in those subtests differed significantly from the mean subtest score. (*Id.*, p. 9.)

(G) Using the Beck Depression Inventory, Dr. Rosen found that Claimant was in the severe range of depression.

19. Dr. Rosen was informed that Claimant was very interested in anime, Japanese animated cartoons. She was identified as the president of an Anime Club at a local library. However, it should be noted that there is no corroboration of these claims, and on several occasions when Claimant told her mother she was at the library, her mother went there and could not find her. Her mother suspected she was seeing boys away from the library. At the time of Dr. Rosen's exam, Claimant's mother shared her suspicion that Claimant was pregnant, a matter denied by Claimant, but which was later established as true.

20. Dr. Rosen diagnosed Claimant as suffering from Schizoaffective Disorder, Depressed Type, and she made no diagnosis on Axis II. The diagnosis of a psychiatric

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[7] The subtests have a mean score of 10, with the standard deviation being 3.

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disorder was tied to Claimant's statements to Dr. Rosen that she saw and interacted with ghosts. According to Dr. Rosen's report, Claimant talked at length about the ghosts of people who had previously been alive but were now wandering souls. She claimed that she did not recall a time when she didn't see ghosts, and she had names for two of them, ascribing personality and behaviors to them. The two ghosts with names would act as protectors of Claimant; one, named Clarisse, could move things in order to annoy people who were bothering Claimant. She also claimed she could talk to animals, and could understand what they were saying as well. And, she claimed she was taught by her Cherokee grandfather, allegedly a Medicine Man, how to take on other people's pain, although she must then feel the pain. At the same time, Claimant denied that she any longer had suicidal thoughts, but admitted to having had such thoughts prior to seeing Dr. Rosen.

Assessments By the Service Agency

21. The Service Agency conducted a social assessment of Claimant and issued a report dated January 10, 2011. (Ex. 12.) According to the report, she was referred for assessment by DCFS, to rule out Mental Retardation or Fifth Category eligibility.

22. (A) Claimant came to the assessment with her foster mother, with whom she had been living with for four months. Then current functioning was described, which depicted a teenager operating well below expectations for her age, which was then 16 years and 8 months. She was at a third grade level in math, and needed reminders to perform personal hygiene tasks; she would not wash her hair or brush her teeth without prompting. Though Claimant stated she could cook entire meals, her foster mother would not allow her to do so. She claimed she was able to identify money and to combine it to pay for simple items, but she would not know how much change was due, and therefore needed help in the transaction. She only could tell time on a digital clock, would forget a message that was given to her within 10 minutes, and did not know to dial 1 before the

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area code if making a long distance call.

(B) Claimant could only use cursive writing for her name; everything else was printed. She named 10 of the 12 months of the year, and while she knew the four seasons of the year, she did not know what the season was on the day of the assessment. She was described as having a long attention span for things she enjoyed, such as TV cartoons and Anime comics, but otherwise her attention span was short, even for her baby, who was then four months old. She was described as learning new things, but then forgetting them the next day. This meant that there had to be constant repetition. It was also noted that she did best if given directions one step at a time, because she would otherwise forget the steps and have to be told again. (Ex. 12, p. 3.)

(C) Regarding social interactions, Claimant was described as sociable, but she described herself as doing best with younger children. She said she had had a best friend since middle school, that she shared feelings with. She made good eye contact, and reportedly was president of an anime club and she reported doing well in groups. She liked to be in charge, and when she couldn't she would hide in a closet or a corner and cry. She admitted to previously having suicidal thoughts, and a single effort to hurt herself. She described herself as obsessed with all things Japanese, and wished she was Japanese.

(D) The report discussed the issues pertaining to her mother and father's drug use, her stints in foster care, and special education services.

23. (A) On March 17, 2011, Claimant underwent a psychological assessment that was conducted by a Service Agency vendor, John Lamont, Ph.D. (Ex. 14.) At the time of the assessment, Claimant was 16 years and 10 months of age. She was referred for psychological evaluation to determine then-current levels of cognitive and adaptive functioning. Dr. Lamont administered four tests, using the Vineland Adaptive Behavior Scales-II (Vineland), WISC-IV, Developmental Test of Visual-Motor Integration, and the Wide Range Achievement Test-4 (WRAT-4).

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(B) The results of the IQ test showed a marked difference between Verbal Comprehension and Perceptual Reasoning, similar to what Dr. Rosen had found. In the former domain, the score was 75, while the latter domain yielded a score of 92. The score for Working Memory Index was 52, and the Processing Speed Index was an 88. Dr. Lamont declined to state a Full Scale IQ score, noting that because there was a difference exceeding 1.5 standard deviations[8] among the indices, a full scale score would not be considered a valid summary measure. He computed a "General Ability Index" by combining the Verbal Comprehension Index and the Perceptual Reasoning Index; the result was an 82. (Ex. 14, p. 6.)

(C) The subtests of the WISC-IV showed significant scatter. Those associated with the Working Memory Index were the most depressed. Claimant scored a 2 on the Digit Span test and a 1 on the Letter-Number Sequence section. The high score was Arithmetic, at 4. On the other hand, subtests in Perceptual Reasoning were close to average, as Picture Concepts and Matrix Reasoning each scored at 9, while Block Design was at 8. Processing speed subtest results were 9 for coding, and 7 for Symbol Search. Within Verbal Comprehension, Claimant scored a 6 on Similarities and Comprehension, and 5 on vocabulary.

(D) Dr. Lamont "estimated" that Claimant's intellectual ability was in the low average range based on the General Ability Index score of 82. (Ex. 14, p. 3.)

(E) Claimant's adaptive function was significantly impaired, according to the Vineland scales. The Communication domain score was a 59, the score for Daily Living Skills was 66, and for socialization was 67. An overall or combined score was not stated, but these scores all indicate significant shortcomings, placing Claimant in the bottom two percent in terms of adaptive skills. (Ex. 14, pp. 6-7.)

[8] A standard deviation is 15, but the standard deviation for the subtests is 3.

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(F) The results of the WRAT-4 were not encouraging. The score for spelling was 69, for word reading 66, and math computation, 73. As the test has a median of 100, and a standard deviation of 15, Claimant fell into the bottom two or three percent in each area.

(G) Claimant's score on the Developmental Test of Visual-Motor Integration was in the borderline range, at 74. Dr. Lamont described the test as "a measure of graphomotor (sic) ability." (Ex. 14, p. 4.)

24. (A) In coming to a diagnosis, Dr. Lamont stated that Claimant did not qualify for a diagnosis of Mental Retardation, because her full scale IQ—which had not been stated—was not a valid measure of her intellectual ability, which was estimated from the General Ability Index at 82. Noting her significant memory problems, which were two standard deviations below her General Ability Index, Dr. Lamont reached a diagnosis of Amnestic Disorder, Not Otherwise Specified. He stated that Claimant demonstrated impaired ability to learn new information and difficulty remembering previously learned information or past events, and that such supported the diagnosis.

(B) In terms of recommendations, Dr. Lamont stated that in light of the amnestic disorder, together with Claimant's deficient adaptive functioning scores, consideration of eligibility under the fifth category should be considered. (Ex. 14, p. 4.)

25. (A) More than two years later, after having had a chance to review other assessments of Claimant, including those by Dr. Rosen and Dr. Sandra R. Kaler, Dr. Lamont modified his diagnosis. In May 2013 he noted that his diagnosis of Amnestic Disorder NOS was a product of Claimant scoring a 52 on the Working Memory Index when he gave her the WISC IQ test. Dr. Lamont noted that he had not seen the reports by Dr. Rosen, Dr. Kaler, or Michelle Burns, who had scored working memory at 74, 77, and 77, respectively. Dr. Lamont concluded that the score he obtained had to be the result of some other issue, such as inattention. Given the likelihood of a better working memory score and the 82 General Ability score he had previously derived, he changed his diagnosis to Learning

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Disorder NOS. (Ex. 18, p.1.)

(B) In a separate memorandum, written at the same time as the memorandum regarding diagnosis, Dr. Lamont withdrew his recommendation of considering fifth category eligibility. He relied on the proposed ARCA guidelines, which he states "stipulate" that when nonverbal IQ is 85 or higher, then it is difficult to find a person to be similar to a person with mental retardation. He also concluded that a learning disorder disqualified Claimant, despite her low adaptive function scores. He tended to rely on Dr. Rosen's diagnosis of Schizoaffective Disorder, saying it was "quite likely" that Respondent's low adaptive scores reflected mental illness, and that she appeared to need treatment for mental illness. (Ex. 18, p.1.)

OTHER ASSESSMENTS

26. In August 2011 Claimant was assessed at Tarzana Treatment Center's Wraparound program at the behest of her social worker. She had been residing with her current foster mother, Ms. M., for about eight months at that time.

27. (A) Claimant's symptoms were described as isolation, suicidal ideation, poor hygiene, difficulties in maintaining and initiating friendships, inappropriate sexual conversations with older men, and scattered train of thought. She had difficulty organizing her thoughts, and retaining information; her foster mother stated that Claimant did not know information such as her boyfriend's name or her foster sister's name. She presented with a stutter. By history, she had had symptoms for years. "Ct's [Claimant's] social skill deficits and topic preservations limit Ct's abilities to effectively communicate her wants and needs." (Ex. V, p. 1.)

(B) According to the assessment report, "Ct presents with marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction, failure to develop peer relationships appropriate to developmental level, encompassing preoccupation with one or more

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stereotyped and restricted patterns of interest that is abnormal in either intensity or focus." (Ex. V, p. 2.)

(C) The Admission Diagnosis was Asperger's Disorder, along with Depressive Disorder, Stuttering, and Parent-Child Relational Problem. (Ex. v. p. 7.)

28. In January 2012, it was reported that Claimant had been diagnosed with Post Traumatic Stress Disorder and ADHD, Inattentive Type, by a Dr. M. Spidel, who was associated with Penny Lane Centers. That information was part of a summary of needs and services that was set out in a Los Angeles County Provider Needs and Services Plan/Quarterly Report. (Ex. Z, p. 5.) If Dr. Spidel wrote an assessment report, it did not make its way into the record.

29. (A) Claimant was assessed by Sandra R. Kaler, R.N, Ph.D., an Assistant Clinical Professor at the UCLA Neuropsychiatric Institute, in late 2012. Claimant was then 18 years and 4 months old. Dr. Kaler reviewed many of the reports and IEP's discussed above. She also used a battery of tests in her assessment, including the Wechsler Adult Intelligence Scales—IV (WAIS), portions of the WIAT—III, the ABAS—II, and two instruments designed to assess for autism, the ADOS—2 (Autism Diagnostic Observation Schedule) and the ADI—R (Autism Diagnostic Interview). Dr. Kaler issued her report on November 15, 2012. (Ex. A or 16.)

(B) At hearing, Dr. Kaler explained that she used the WAIS instead of the WISC because the latter is normed for young people, to be used until a person turns 17. The WAIS is used to test adults, and Claimant qualified as such given her age. Claimant's full scale IQ score was 75. Her Verbal Comprehension score was 74, her perceptual reasoning score was 81, her working memory score 77, and processing speed was 86. (Ex. A, pp. 6-7.) Dr. Kaler testified that the WISC leans more toward concrete problems and solutions, whereas the WAIS is more demanding on abstract function.

(C) Dr. Kaler utilized the ABAS to assess adaptive function. As other examiners

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found, Claimant's adaptive function is substantially impaired. The composite score of 57 placed Claimant in the .02 percentile. Her score pertaining to social behavior was 70, and the highest of the three domain scores, but as compared to peers, she was in the second percentile. The score for conceptual was 55, and for practical, a 52. (Ex. A, p. 5.)

(D) Dr. Kaler interviewed Claimant's foster mother, Ms. M., and she utilized the ADI-R. However, she could not complete the diagnostic algorithm because Claimant has not lived with Ms. M. and her family long enough. Ms. M. did state that Claimant is having difficulty with the other children in the family because Claimant is immature socially. Ms. M. stated Claimant has two acquaintances who she rarely sees. She described a young adult with limited social skills, and who spends most of her time talking about anime characters and drawing pictures of them. (Ex. 16, p. 6.)

(E) Dr. Kaler utilized the ADOS-2, finding that Claimant met all the criteria for all three of the autism cut-off scores. Ultimately, she concluded that Claimant is functioning cognitively in the borderline range, at least as of the time of the test, and she diagnosed Claimant as suffering from autism. She did not agree with the theory that Claimant suffers from a thought disorder, i.e., she does not believe Claimant has schizoaffective disorder. She noted that while Claimant has demonstrated significant environmental stressors, and that she has "psychiatric sequelae as a result," she has always demonstrated developmental delays, and her adaptive function is clearly delayed. (Ex. 16, p. 9.)

30. (A) At hearing, Dr. Kaler gave her opinion that the available record shows that Claimant has been delayed in social reciprocity for a period of years, and back into her childhood. She noted that the Claimant's language delay was quite substantial; at age three she was barely using two-word utterances, when average children her age would have a vocabulary of hundreds of words. When she examined Claimant, she found her language to be stereotypical, with Claimant using rote phrases that she has learned. Claimant's eye contact was of poor quality, as Claimant would stare at Dr. Kaler, but then

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look elsewhere.

(B) During her testimony, Dr. Kaler made it clear she believes that Claimant is autistic within the critereia of the DSM IV, or the new DSM 5. Alternatively, she would meet fifth category eligibility in light of her significantly low adaptive function, and low IQ score obtained by Dr. Kaler.

OTHER REPORTS

31. (A) In June 2011, an IEP was prepared under the aegis of the Antelope Valley SELPA. That document indicates that at that time, Claimant was reading at a mid-second grade level. (Ex. T, p. pp. 31-32.) Her math skills were in the high third grade level. (*Id.*, pp. 29-30.) She was then 17 years old and in the 11th grade.[9]

(B) The 2011 IEP states that Claimant shows "fragile emotional behaviors when she becomes overwhelmed by her schoolwork because she also has to take [care] of her baby at home." (Ex. T, p. 5.)

(C) A math goal was set, pertaining to the value of coins. By June 2012, Claimant was to be able to "identify/state the value/show different combinations of coins with the same value with 80% accuracy in 3 consecutive trials as measured by teacher-charted records." (Ex. T, p. 12.) As a short term goal—within three months of the June 2011 IEP—when given 10 coins, Claimant was to be able to show different combinations of coins with the same value up to 25 cents with 80 percent accuracy in three consecutive trials. Intermediate goals—for six and nine months out—amounted to Claimant being able to state the value of pennies, nickels, dimes, and quarters with 100 percent accuracy in three

[9] To be sure, another part of the IEP document states that the results of "Edperformance Tests" indicated Claimant was reading at a fourth grade level, and that her math was at the 3.1 grade level. (Ex. T, p. 5.) The information cited in the text, above, seems to have come from the teachers or the IEP team, and is given precedence here.

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consecutive trials. (*Id.*)

(D) Other math goals indicted that she lacked a basic understanding of fractions, as a one-year goal was set for her to be able to look at drawings or concrete materials representing fractions, and for her to be able to show fractional equivalents and to add and subtract with 75 percent accuracy. (Ex. T, p. 13.)

(E) A goal was set for Claimant to improve personal hygiene, 100 percent of the time. That same part of the IEP stated that Claimant could communicate her needs appropriately. (Ex. T, p. 16.)

(F) The IEP team noted that Claimant had not completed nearly enough credits to graduate, and that she was then completing credits at the rate of .3 per week, which had her on track for high school graduation in 2022, when she would be 30 years old. (Ex. T, p. 20.)[10]

32. (A) In September 2011, a "Plan of Care" was generated for Claimant by her Wraparound Child and Family Team. According to that plan, Claimant's schooling was provided by independent study, seemingly because she had difficulty in large settings and because of her academic challenges. It was also reported that "[Claimant] is unable to effectively communicate her needs and concerns as well as comprehend. [Claimant] gets easily overwhelmed and anxious resulting in [Claimant] to shut down. Majority of information was reported by caregiver due to [Claimant's] inability and difficulties with being able to communicate effectively and comprehend." (Ex. X, p. 7.)

(B) Some of the observations from the Plan of Care are consistent with the Child/Adolescent Initial Assessment report generated in August 2011 by the Los Angeles

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[10] By August 2013, things had improved somewhat, as she was obtaining one credit per week, still below the optimal level, and insufficient to lead to graduation in 2013. (Ex. CC, p. 9.)

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County Department of Mental Health, cited in Factual Finding 27, above. (I.e., "difficulties maintaining and initiating friendships," and "social skills deficits and topic preservations [that] limit [Claimant's] abilities to effectively communicate her wants and needs." [Ex. V, p. 1.].)

33. A Los Angeles County Provider Needs and Services Plan/Quarterly Report dated January 13, 2012, refers to an aspect of Claimant's adaptive function. Claimant's foster mother reported that Claimant did not have good judgment in dealing with money, in that she had earned $100 through her ILP class, and then gave it to a girl at a store for a puppy. "She needs to be supervise [sic] if handling more than $20." (Ex. Z, p. 14.) Meanwhile, hygiene and basic cleanliness remained an ongoing issue in the foster home; goals were set in this area, so that she would shower three times per week, with the foster mother's prompting. (*Id.*, p. 16.)

TESTIMONY REGARDING CURRENT FUNCTION

34. (A) Claimant's current foster mother, Ms. M., testified. She described how Claimant has lived with her and her family for three years, and that she is in the ninth grade though 19 years old. She described Claimant as presenting boundary issues to others, demanding that you be her friend "24-7," but tending to get right in your face, and tending to have one-way conversations, which prevents others from being heard. If Ms. M. tries to redirect the conversation, Claimant acts out. She only wants to hear Japanese music, and insists on playing it loudly, and won't listen to what the other kids want to hear. She sometimes wants to make a video with the other children, but insists on rehearsing it over and over, and when the other children don't want to, Claimant becomes angry. Ms. M. attested that the only social cue Claimant understands is tears, and only rarely engages in a reciprocal conversation.

(B) Older than the other girls, in the house, she is youngest mentally. She makes friends with the young children at the church the family attends, but she could not parent

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her baby, because of her inability to learn from experience.[11] Although good hearted, she is gullible to a point of vulnerability, and cannot manage money. She dresses eccentrically, sleeps in her clothes, and her hygiene remains a constant issue. She needs much repetition and redirection to accomplish things. She isn't allowed to operate the washing machine, because she will put trash in it, though she can use the microwave.

DIAGNOSTIC CRITERIA FOR AUTISM:

35. (A) Two main sources of assessment criteria are available to determine whether or not Claimant is autistic. The primary source is the Diagnostic and Statistical Manual of Mental Disorders (generally, the DSM), which is published by the American Psychiatric Association (APA). The other main source of assessment criteria is the Best Practices Guidelines published by the Department of Developmental Services in 2002.[12] However, because the DSM was substantially revised in May 2013, there are two versions of that tome relevant to this case, and both were referenced during this proceeding.

(B) For many years, the DSM's Fourth Edition, Text Revision, also known as the DSM-IV-TR (hereafter DSM IV), was the standard tool for diagnosing autism. It should be noted that Dr. Lamont had relied upon the DSM IV, and Dr. Langer utilized it in writing her

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[11] Written reports indicated that she would not pay attention to the child, and instead would pay attention to her cell phone. At one point she told a social worker she would want to take the child swimming, but the social worker, after observing the interaction (or lack thereof) between the child and Claimant, quietly advised the foster mother to never leave Claimant and her baby unattended near water.

[12] Properly, Autistic Spectrum Disorders, Best Practices Guidelines for Screening, Diagnosis, and Assessment, hereafter “the Guidelines.”

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report. That version of the DSM has been superseded by the DSM-5.[13]

(C) The Guidelines pertain to the assessment of autism and related disorders, while the DSM provides the diagnostic criteria for those conditions. The Guidelines state that the DSM IV was to be used for diagnosis, but it should be noted that the Guidelines have not been revised since the DSM evolved into the DSM 5. And, the Guidelines reference the autism "spectrum" analysis that was adopted with the publication of the DSM-5.

THE DSM IV

36. The DSM IV set out five separate disorders under the heading "Pervasive Developmental Disorders." They were Autistic Disorder, PDD-NOS, Asperger's Disorder or Syndrome, Rhett's Disorder, and Childhood Disintegrative Disorder. Different diagnostic criteria are set forth for each within the DSM. Under the DSM IV, Autistic Disorder is not Asperger's Disorder or PDD-NOS, even though the conditions have similarities.

37. (A) Under the DSM IV, to find that a person suffered from Autistic Disorder, it had to be established that the person in question suffered from impairments in social interaction and communication, through examination of certain criteria, and there must also have been evidence of restricted repetitive and stereotyped patterns of behavior, interests, and activities. Further, there had to be delays or abnormal functioning in social interaction, or language as used in social communication, or symbolic or imaginative play, before the person was three years of age. Further, the disturbance could not be better accounted for by Rhett's Disorder or Childhood Disintegrative Disorder. The diagnostic criteria laid out certain touchstones within each of the aforementioned areas, and the person in question had to meet a number of the criteria. And, the symptoms must be

[13] Why the APA designated this fifth edition of the DSM with an Arabic numeral, rather than the Roman numerals used in prior versions, is not revealed by the new edition.

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clinically significant.

(B) The diagnostic criteria for Asperger's Disorder had some similarities to those set forth for autism, but concentrated on impairment in social interaction and restricted repetitive and stereotyped behaviors.[14] Typically, language development in a person with Aspergers had been adequate, and thus there could not be a clinically significant general delay in language, such as the use of single words by age two, and communicative phrases by age three. Nor could there be clinically significant delay in cognitive development, or in the development of age-appropriate self-help skills, nor in adaptive behavior other than social interaction, and curiosity about the environment. Finally, it had to be determined that criteria are not met for another pervasive developmental disorder or schizophrenia.

(C) The diagnostic criteria for PDD-NOS were the most abbreviated of the three maladies that came under the general rubric of Pervasive Developmental Disorder. There was no "checklist" of criteria as was developed for autism and Asperger's. A short paragraph set forth the diagnostic criteria, as follows:

> This category should be used when there is a severe and pervasive impairment in the development of reciprocal social interaction associated with impairment in either verbal or nonverbal communication skills or with the presence of stereotyped behavior, interests, and activities, but the criteria are not met for a specific Pervasive Developmental Disorder, Schizophrenia, Schizotypal Personality Disorder, or Avoidant

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[14] Discussion of the diagnostic criteria for Aspergers and PDD-NOS under the DSM IV may further the analysis necessary in this case, and, in any event, the DSM 5 treats persons previously diagnosed with those conditions as falling into the new spectrum definition. (See Factual Finding 41.)

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> Personality Disorder. For example, this category includes "atypical autism"—presentations that do not meet the criteria for Autistic Disorder because of late age at onset, atypical symptomatology, or subthreshold symptomatology, or all of these.

(DSM IV, p. 84.)

38. Under the DSM IV, Autistic Disorder was a malady that occurred by age three, but Asperger's or PDD-NOS could be diagnosed with a later onset. Regarding Autistic Disorder, the DSM states that "by definition, if there is a period of normal development, it cannot extend past age 3 years." (DSM IV, p. 71.)

THE GUIDELINES

39. The Department of Development Services (DDS) published the Guidelines in 2002, after extensive study and with the assistance and participation of numerous experts. The book is not a diagnostic manual per se, but gives guidance in the areas of screening, evaluation, and assessment of those who may suffer from what it labels an "autistic spectrum disorder" (ASD), a reference to the concept that at least some of the maladies categorized as separate pervasive developmental disorders in the DSM IV might be seen as a singular condition, on a continuum of related disorders. The Guidelines provide information that may assist the diagnostic analysis. However, the Guidelines do not have the force of law, and are not established as regulations adopted by DDS.

40. (A) Some important concepts may be gleaned from the Guidelines. First, when determining whether or not a person suffers from an ASD, there is no substitute for sound clinical judgment based on experience, familiarity with the population, and familiarity with the research. (Guidelines, p. 4.) Professionals with such experience and expertise are not just found in the regional centers, but also in private health systems and

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university settings. (*Id.*)

(B) Information obtained from parents is quite valuable. "Because parents are the experts regarding their children, eliciting and valuing parental concerns is imperative." (Guidelines, p. 14.) The Guidelines make this general statement in the context of screening, but the concept cannot be ignored in any case where the parent can provide information pertaining to the child's development. While potential reporter bias is an issue that should not be ignored, the *possibility* of reporter bias should not be allowed to swallow up a parent's report.

(C) A substantial number of children with an ASD have normal to superior cognitive function; 20 to 25 percent demonstrate such in at least one of the two major cognitive domains, verbal and non-verbal.[15] (Guidelines, p. 49.)

(D) Impairment in communication, rather than in language, is a key issue, as children with ASD have a vast range of language skills. As taught by the Guidelines, ". . . it is clear that the fundamental difficulty is with communication, of which speech and language are components." Further, "Delays in speech and language alone are not specific to autism, nor are the presence of intact language skills contraindicative of an ASD." (Guidelines, p. 60, citations omitted.)

(E) ASDs are associated with a tremendous range in syndrome expression, and symptoms change over the course of development.

(F) Diagnosis of ASDs, and especially PDD-NOS in children and adolescents, must

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[15] But, such percentages may not apply to Autistic Disorder. As noted by the DSM IV, "in most cases, there is an associated diagnosis of Mental Retardation, which can range from mild to profound. The profile of cognitive skills is usually uneven, regardless of general level of intelligence, with verbal skills typically weaker than non-verbal skills." (DSM IV, pp. 71-72. Emphasis added.)

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be differentiated from other problems, such as language and sensory impairments. "Since comorbidity and differentiation of psychiatric diagnoses are so vital in this age group [children and adolescents], knowledge and/or consultation with specialists in child psychiatry is required." (Guidelines, p. 115.) "Depression is one of the most common coexisting syndromes found in children and adolescents with an ASD. This is particularly true for 'higher functioning' children who have an awareness of their difficulties. [Citation omitted]." (*Id.*, p. 119.) Anxiety disorders are also common in children with an ASD. (*Id.*, p. 120.) And, differentiating ADD or ADHD from an autism spectrum disorder can be especially difficult. (*Id*, pp. 120-121.)

THE DSM-5 AND AUTISM

41. The definition of autism, and indeed, the name for that malady was substantially revised with the May 2013 publication of the DSM-5. "Autism Spectrum Disorder" is the APA's new diagnostic nomenclature encompassing the DSM-IV-TR's general category "Pervasive Developmental Disorder," which included autistic disorder, Asperger's disorder, childhood disintegrative disorder, Rett's syndrome, and PDD-NOS. (DSM-5 at p. 809.) Thus, individuals with a diagnosis of the DSM-IV-TR disorders of autistic disorder, Asperger's disorder, or PDD-NOS, are now given the diagnosis of Autism Spectrum Disorder. (*Id.* at 51.)

42. The DMS-5 diagnostic criteria for Autism Spectrum Disorder are as follows:

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history:

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.

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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:

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 interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sound or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

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C. Symptoms must be present in 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.

43. These essential diagnostic features of Autism Spectrum Disorder—deficits in social communication and social interaction (Criterion A) and restricted repetitive patterns of behavior, interests and activities (Criterion B)—must be present from early childhood and limit or impair everyday functioning (Criteria C and D).

44. The DSM-5 provides that, with respect to individuals presenting for diagnosis in adulthood, "where clinical observation suggests criteria are currently met, autism spectrum disorder may be diagnosed, provided there is no evidence of good social communication skills in childhood." (*Id.* at 56.) In the case of the adult individual, the DSM-5 provides that "the report (by parents or another relative) that the individual had ordinary and sustained reciprocal friendships and good nonverbal communication skills throughout childhood would rule out a diagnosis of autism spectrum disorder; however, the absence of developmental information in itself should not do so." (*Id.*)

45. In adults, deficits in social-emotional reciprocity may be most apparent in difficulties processing and responding to complex social cues. The DSM-5 lists, by way of example, "when and how to join a conversation, what not to say." (*Id.* at 53.) Deficits in nonverbal communication are manifested through "odd, wooden, or exaggerated 'body language' during interactions. Impairment may be relatively subtle within individual modes (e.g., someone may have relatively good eye contact when speaking) but noticeable in poor integration of eye contact, gesture, body posture, prosody, and facial expression for social communication." (*Id.* at 54.) Adult individuals with deficits in developing, maintaining, and understanding relationships "struggle to understand what

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behavior is considered appropriate in one situation but not another (e.g., casual behavior during a job interview), or the different ways that language may be used to communicate (e.g., irony, white lies)." (*Id.*) According to the DSM-5, these individuals "may desire to establish friendships without a complete or realistic idea of what friendship entails (e.g., one-sided friendships or friendships based solely on shared special interests)." (*Id.*)

46. The DSM-5 indicates that adults with Autism Spectrum Disorder suppress repetitive behaviors in public. (*Id.* at 54.) Criterion B may be met "when restricted, repetitive patterns of behavior, interests or activities were clearly present during childhood or at some time in the past, even if symptoms are no longer present. (*Id.*) Those symptoms include the following: "simple motor stereotypies (e.g., hand flapping, finger flicking), repetitive use of objects (e.g., spinning coins, lining up toys), and repetitive speech (e.g., echolalia, the delayed or immediate parroting of heard words; use of "you" when referring to self; stereotyped use or words, phrases, or prosodic patterns). Excessive adherence to routines and restricted patterns of behavior may be manifest in resistance to change (e.g., distress at apparently small changes, such as in packaging of a favorite food; insistence on adherence to rules; rigidity of thinking) or ritualized patterns of verbal or nonverbal behavior (e.g., repetitive questioning, pacing a perimeter)." (*Id.*) According to DSM-5, "[h]ighly restricted, fixated interests in autism spectrum disorder tend to be abnormal in intensity or focus (e.g., a toddler strongly attached to a pan; a child preoccupied with vacuum cleaners; an adult spending hours writing out the timetables). Some fascinations and routines may relate to apparent hyper- or hyporeactivity to sensory input, manifested through extreme responses to specific sounds or textures, excessive smelling or touching of objects, fascination with lights or spinning objects, and sometime apparent indifference to pain, heat, or cold. Extreme reaction to or rituals involving taste, smell, texture, or appearance of food or excessive food restrictions are common and may be a presenting feature of autism spectrum disorder." (*Id.*)

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Diagnostic Criteria for Mental Retardation or Intellectual Disability

47. In this case, Claimant asserts she is eligible because she has a condition similar to mental retardation, or that can be treated in a manner similar to how mental retardation is treated. In order to determine if her condition is similar to mental retardation, that developmental disorder must be examined.

48. The DSM-IV defined Mental Retardation, one of the developmental disabilities that make one eligible for services under the Lanterman Act. The DSM-5 has retitled the condition as Intellectual Disability or Intellectual Disability Disorder.[16] To be sure, the newest edition of the DSM sets forth somewhat different diagnostic criteria. However, it can be said that in either model, there is a developmental disability where the person in question has significantly low intelligence, coupled with significantly low adaptive functioning, and where adaptive function is the key to the analysis.

Mental Retardation as Defined in the DSM-IV

49. (A) Under the DSM-IV, Mental Retardation was defined, generally, as significantly subaverage general intellectual functioning that is accompanied by significant limitations in adaptive functioning, in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety. (DSM-IV, p. 41.) "Significantly subaverage intelligence" in turn was defined as an IQ of about 70 or below; there is a possible error of measurement of approximately five points, depending on the IQ test used. (*Id.*) Put another way, "significantly subaverage" translates to IQ scores falling in the second percentile, two standard deviations below the mean in most

[16] As noted in the DSM-5, this follows the trend in research journals, and a Federal law that renamed the condition. (DSM-5, p. 33.)

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standardized tests. It must also be noted that for a person to receive a diagnosis of mental retardation, the onset must occur before age 18.

(B) As noted in the DSM-IV, "when there is a marked discrepancy across verbal and performance scores, averaging to obtain a full-scale IQ can be misleading." (DSM, p. 42.)

(C) The DSM-IV also provided that:

> Impairments in adaptive functioning, rather than a low IQ, are usually the presenting symptoms in individuals with Mental Retardation. *Adaptive functioning* refers to how effectively individuals cope with common life demands and how well they meet the standards of personal independence expected of someone in their particular age group, sociocultural background, and community setting. Adaptive functioning may be influenced by various factors, including education, motivation, personality characteristics, social and vocational opportunities, and the mental disorders and general medical conditions that may coexist with Mental Retardation. Problems in adaptation are more likely to improve with remedial efforts than is the cognitive IQ, which tends to remain a more stable attribute. (DSM-IV, p. 42. Emphasis in the original.)

Intellectual Disability Under the DSM-5

50. (A) DSM-5 defines intellectual disability as "a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains." (DSM-5, p. 33.) The following three criteria must be met:

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A. Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing.

B. Deficits in adaptive functioning that result in failure to meet developmental and socio-cultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.

C. Onset of intellectual and adaptive deficits during the developmental period.

(B) Thus, the definitive characteristics of intellectual disability include deficits in general mental abilities (Criterion A) and impairment in everyday adaptive functioning, in comparison to an individual's age, gender, and socio-culturally matched peers (Criterion B). To meet the diagnostic criteria for intellectual disability, the deficits in adaptive functioning must be directly related to the intellectual impairments described in Criterion A. Onset is during the developmental period (Criterion C). A diagnosis of intellectual disability should not be assumed because of a particular genetic or medical condition. Any genetic or medical diagnosis is a concurrent diagnosis when Intellectual Disability is present. (DSM-5, pp. 39-40.)

51. The APA notes that the most significant change in diagnostic categorization accompanying the change from DSM-IV-TR to DSM-5 nomenclature of intellectual disability is emphasis on the need for an assessment of both cognitive capacity and adaptive functioning, and that the severity of intellectual disability is determined by adaptive functioning rather than IQ score. (*Id.* at 37.) The APA notes no other significant changes.

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52. The authors of the DSM-5 have indicated that "[i]ntellectual functioning is typically measured with individually administered and psychometrically valid, comprehensive, culturally appropriate, psychometrically sound tests of intelligence. Individuals with intellectual disability have scores of approximately two standard deviations or more below the general population mean, including a margin for measurement error (generally +5 points). On tests with a standard deviation of 15 and a mean of 100, this involves a score of 65-75 (70 ± 5)." (DSM-5. p. 37.) At the same time, the APA recognizes that "IQ test scores are approximations of conceptual functioning but may be insufficient to assess reasoning in real-life situations and mastery of practical tasks." Thus, "a person with an IQ score above 70 may have such severe adaptive behavior problems in social judgment, social understanding, and other areas of adaptive functioning that the person's actual functioning is comparable to that of individuals with a lower IQ score." (*Id.*)

53. According to DSM-5, "[a]daptive functioning is assessed using both clinical evaluation and individualized, culturally appropriate, psychometrically sound measures. Standardized measures are used with knowledgeable informants (e.g., parent or other family member; teacher; counselor; care provider) and the individual to the extent possible. Additional sources of information include educational, developmental, medical, and mental health evaluations." (*Id.*) Whether it is intellectual functioning or adaptive functioning, clinical training and judgment are required to interpret standardized measures, test results and assessments, and interview sources.

54. The DSM-5 revisions do not appear to have altered the Lanterman Act's fifth category eligibility analysis. A claimant asserting fifth category eligibility is required to establish by a preponderance of evidence significant deficits in intellectual functions or deficits in adaptive functioning, or both. Fifth category eligibility does not require strict replication of all of the diagnostic features of intellectual disability. If this were so, the fifth

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category would be redundant.

Ultimate Findings of Fact

55. Claimant is substantially handicapped in a number of areas, including learning, receptive language, economic self-sufficiency, capacity for independent living, self-direction, and self-care. (See Factual Findings 17 (B) & (C), 18 (E) & (F), 22 (A)-(C), 23 (E) & (F), 29 (C), 31 through 34.)

56. Claimant suffers from a condition similar to mental retardation, or a condition which can be treated in a manner similar to the manner similar to the treatment of mentally retarded people. This is based on her substantially impaired adaptive function, and her IQ scores, which most recently were found in the borderline range.

57. Claimant's condition is not solely the result of a psychiatric condition, solely the result of a learning disorder, or solely the result of a physical injury.

58. Claimant's condition arose before she was 18 years of age, and can be expected to continue indefinitely.

LEGAL CONCLUSIONS

Jurisdiction

1. Jurisdiction exists to conduct a fair hearing in the above-captioned matter, pursuant to Code section 4710 et seq., based on Factual Findings 1 through 3.

Legal Conclusions Pertaining to Eligibility Generally

2. The Lanterman Act, at section 4512, subdivision (a), defines developmental disabilities as follows:

> “Developmental disability” means a disability which originates before an individual attains age 18, continues, or

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can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. . . . this term shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation, but shall not include other handicapping conditions that are solely physical in nature."

This latter category is commonly known as "the fifth category."

3. (A) Regulations developed by the Department of Developmental Services, pertinent to this case, are found in Title 17 of the California Code of Regulations (CCR).[17] At section 54000 a further definition of "developmental disability" is found which mirrors section 4512, subdivision (a).

(B) Under CCR section 54000, subdivision (c), some conditions are excluded. The excluded conditions 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

[17] All references to the CCR are to title 17.

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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.

4. Section 4512, subdivision (l), provides that,

> "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.

LEGAL CONCLUSIONS PERTAINING TO CREDIBILITY

5. (A) It is settled that the trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke Davis & Co*. (1973) 9 Cal.3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected material." (*Id.*, at pp. 67-68, quoting from *Neverov*

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v. Caldwell (1958) 161 Cal.App.2d 762, 767.) Further, the fact finder may reject the testimony of a witness, even an expert, although not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.) And, the testimony of "one credible witness may constitute substantial evidence", including a single expert witness. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, at 1052.)

(B) The rejection of testimony does not create evidence contrary to that which is deemed untrustworthy. That is, disbelief does not create affirmative evidence to the contrary of that which is discarded. That the trier of fact may disbelieve the testimony of a witness who testifies to the negative of an issue does not of itself furnish any evidence in support of the affirmative of that issue, and does not warrant a finding in the affirmative thereof unless there is other evidence in the case to support such affirmative. (*Hutchinson v. Contractors' State License Bd.* (1956) 143 Cal.App.2d 628, 632-633, quoting *Marovich v. Central California Traction Co*. (1923) 191 Cal. 295, 304.)

(C) An expert's credibility may be evaluated by looking to his or her qualifications (*Grimshaw v. Ford Motor Co*. (1981) 119 Cal.App.3d 757, 786.) It may also be evaluated by examining the reasons and factual data upon which the expert's opinions are based. (*Griffith v. County of Los Angeles* (1968) 267 Cal.App.2d 837, 847.)

(D) The trier of fact may reject the testimony of a witness, including an expert witness, even if it is uncontradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.) The expert's opinion is no better than the facts on which it is based and, "where the facts underlying the expert's opinion are proved to be false or nonexistent, not only is the expert's opinion destroyed but the falsity permeates his entire testimony; it tends to prove his untruthfulness as a witness." (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 923-924.)

(E) "[E]ven when the witness qualifies as an expert, he or she does not possess a carte blanche to express any opinion within the area of expertise. For example, an expert's

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opinion based on assumptions of fact without evidentiary support, or on speculative or conjectural factors, has no evidentiary value and may be excluded from evidence. Similarly, when an expert's opinion is purely conclusory because unaccompanied by a reasoned explanation connecting the factual predicates to the ultimate conclusion, that opinion has no evidentiary value because an "expert opinion is worth no more than the reasons upon which it rests." (Citations omitted.) (*Jennings v. Palomar Pomerado Health Systems, Inc.* (2003) 114 Cal.App.4th 1108, 1116.)

LEGAL CONCLUSIONS SPECIFIC TO RESOLUTION OF THE CASE

6. (A) To establish eligibility, Claimant must prove, by a preponderance of the evidence, that she suffers from an eligible condition, i.e., autism, mental retardation, intellectual disability, or that she falls into the fifth category. This Conclusion is based on section 4512, subdivision (a).

(B) For many years, the undersigned and other ALJ's have considered that since the governing statute uses the term autism, and did not use the term autism spectrum disorder, Asperger's Disorder, or PDD-NOS, then only the former condition was an eligible one. However, since the DSM-5 has been published, the term Autistic Disorder has been abandoned. When used in a statute, technical words are given their peculiar and appropriate meaning. (*Handlery v. Franchise Tax Bd.* (1972) 26 Cal.App.3d 970, 981; Civ. Code § 13.) Because that technical definition has changed, it appears appropriate to use the provisions of the DSM-5 to determine eligibility in this area. Otherwise, an absurd result could follow; that nobody could obtain services under the statutory rubric of autism. And, while it might be argued that the DSM-IV definition should continue to bind the definition of the condition, it has to be noted that the definition of autism was substantially different under the DSM IV than it had been in prior editions of the DSM. Since the Lanterman Act was enacted in the mid-1970's, the definition of autism has changed more than once, without barring services to those deemed autistic within the technical definition

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then in place. The definition has changed again, and the latest definition should be utilized.

(C) A similar analysis applies to finding eligibility for "mental retardation," a statutory term that has been superseded by the DSM-5. To be sure, the change in the diagnostic criteria does not appear to be as significant as that which took place in regards to autism.

7. (A) Claimant is eligible under the fifth category, based on all the foregoing, and especially Factual Findings 17 (B) & (C), 18 (E) & (F), 22 (A)-(C), 23 (E) & (F), 29 (C), 31 through 34, and 49-58. Eligibility under the fifth category requires an analysis of the quality of a claimant's cognitive and adaptive functioning and a determination of how well that claimant meets community standards of personal independence and social responsibility in comparison to others of similar age and sociocultural background. The evidence must establish that a claimant has a disabling condition that does not fall within CCR section 54000, subdivision (c), exclusions set forth in Legal Conclusion 3(B). Alternatively, the evidence must establish that the claimant's disabling condition requires treatment similar to the treatment needs of an individual with intellectual disability.

(B) At bottom, Claimant's adaptive function is substantially impaired, essentially mimicking mental retardation/intellectual disability. This has been established in a series of standardized tests, administered over a period of years, all placing her in the first or second percentile. (Factual Finding 29 (C) [Kaler's ABAS composite of 57]; 23 (E) [Lamont Vineland domains all less than 70]; 18 (F) [Rosen ABAS composite 67].) Those test scores are supported throughout the record. At 19, it appears that Claimant needs instruction about the value of the coins we use, and she gave someone $100 for a puppy. She could not attend to her child, one of the reasons it was taken from her, another being her inability to maintain her personal hygiene.[18]

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[18] Initially, the baby was taken from her room, and was placed in the foster mother's

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(C) Claimant's full scale IQ was 75 when she was assessed by Dr. Kaler with adult scales. While she had higher scores as a child, the verbal side of the equation was always impaired compared to the perceptual side. Hence, Dr. Rosen found a PIR of 71. As Dr. Kaler explained, those verbal scores give a better indicator of intelligence and adaptive ability than do the perceptual reasoning scores, which tend to be concrete in nature. Her opinion has support in the literature, as follows:

"Individuals with retardation tend to perform at a higher level on tasks that involve the use of 'visual' understanding . . . Best-known examples are reproducing block designs and putting pieces together to form a picture. . . . In contrast, test items demanding *both* an understanding of what is presented through language ('questions') and the ability to articulate a reply present greater difficulty. . . . The relative strength in the visual mode translates into a better performance on task that are 'practical' and 'concrete' in contrast to those that are primarily verbal or 'conceptual.' This pattern is seen more often in persons with mild retardation and in whom the impairment is not associated with clear organic brain abnormality. . . ." (Barroff & Olley, Mental Retardation, Nature, Cause, and Management (3rd Ed. 1999) p.31.)

(D) As reported by Dr. Rosen, Claimant was weakest in terms of making sense of complex verbal information and using verbal abilities to problem solve. (Factual Finding 18(C).) Her weakest performance on the WISC was in the Comprehension subtest, which required oral solutions to everyday problems. The score on that subtest was substantially

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room because Claimant could not keep her room clean. Then the baby was removed entirely from Claimant's custody because it was hurt, while in the same room with her, because she was paying all her attention to her cell phone. She became angry when the cell phone was taken, seeming more concerned about it than the infant. (See Exhibits V and Y.)

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depressed, as she scored a three. (Factual Finding 18 (D).) On the other hand, Claimant scored an 11 on the Block Design subtest. (Ex. N, p. 6.) This is consistent with the pattern noted by Barroff & Olley, above.

(E) While it can be found that Claimant has a condition closely related to mental retardation, she requires treatment similar to those who suffer from that condition. It has been observed that she needs repetition in order to understand what to do, and it is plain that tasks have to be broken down into discrete components, and this is similar to the sort of treatment that mentally retarded persons need. (See Factual Finding 34(B). (See also *Samantha C. v. State Dept. of Developmental Services* (2010) 185 Cal.App.4th 1462.)[19]

8. Claimant's condition is not solely the result of a learning disorder or a psychiatric disorder, though there is evidence that she suffers from both conditions. While the schools that have served her have continually diagnosed a learning disorder, her impairment appears more global than that. Likewise, she has been diagnosed with psychiatric disorders, but they are not the sole source of her condition, and thus she is not

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[19] Welfare and Institutions Code, section 4712, subdivision (b), which mandates DDS training of hearing officers. Government Code section 11425.50, subdivision (c), provides that the hearing officer may evaluate evidence based on his or her experience, technical competence, and specialized knowledge. DDS training in November 2005 provided examples of procedures to be used in treating the mentally retarded, including highly structured learning environments, breakdown of tasks into smaller steps, immediate reinforcement, modeling of behavior, constant or near constant one-to-one supervision, prompting and redirection when an error, repetition of learning opportunities to achieve an outcome. Such is consistent with Dr. Kaler's testimony of the steps that might be taken to treat Claimant.

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barred from eligibility.[20]

9. Dr. Kaler's diagnosis of autism spectrum disorder was carefully considered, and she was persuasive during her testimony. However, Claimant's somewhat spotty history, and the ambiguous nature of parts of the record left questions about that analysis. For example, Claimant's language was severely impaired as a child, but three word utterances such as "want my dress" and "hey you girl" (Factual Finding 8(B)) may have been efforts to *communicate*; it is the lack of communication, and not language, that tends to define autism . Likewise, while there is evidence of inability to initiate play with peers as a child (Factual Finding 8 (D)), or to interact appropriately with peers at a later age, there are some reports of an ability to share and communicate with others; her teachers seemed to be able to communicate with her, at least at times. While she appears to have a rather strong interest in anime and things Japanese, that did not arise until she was in adolescence. In all the circumstances, the fifth category appears as a better fit at this time.

ORDER

Claimant's appeal is granted, and she is hereby made eligible for services under the Lanterman Act.

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[20] The ALJ credited Dr. Kaler's analysis of whether Claimant has a schizoaffective disorder. Not only are the percentages against that diagnosis—not itself dispositive, as the Service Agency points out—there has been no indication of any hallucinations before or after that period of time, and she has been medicated for depression, not for psychosis of some type. The ghosts she talked about seem to have vanished into the ether, not to be heard from again.

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January , 2014

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Joseph D. Montoya

Administrative Law Judge

Office of Administrative Hearings

NOTICE

THIS IS THE FINAL ADMINISTRATIVE DECISION IN THIS MATTER, AND BOTH PARTIES ARE BOUND BY IT. EITHER PARTY MAY APPEAL THIS DECISION TO A COURT OF COMPETENT JURISDICTION WITHIN NINETY (90) DAYS OF THIS DECISION.

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