BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: CLAIMANT, and WESTSIDE REGIONAL CENTER, Service Agency.	OAH No.: 2013020410

DECISION

Jennifer M. Russell, Administrative Law Judge with the Office of Administrative Hearings, heard this matter in Culver City, California on July 9 and 10, 2013.

N. Jane DuBovy, Attorney at Law, represented Claimant, who did not appear at the hearing. Lisa Basiri, M.A., Fair Hearing Coordinator, represented Westside Regional Center (WRC or service agency).

Testimonial and documentary evidence was received, the case was argued, and the matter was submitted for decision on July 10, 2013. The Administrative Law Judge makes the following Factual Findings, Legal Conclusions, and Order.

ISSUES

1. Whether Claimant is eligible for regional center services and supports under the qualifying category of autism as provided for in section 4512, subdivision (a) of the Welfare and Institutions Code.

2. Whether Claimant is eligible for regional center services and supports under the qualifying "fifth category," defined as a disabling condition "closely related to mental retardation" or requiring "treatment similar to that required for individuals with

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mental retardation" as provided for in section 4512, subdivision (a) of the Welfare and Institutions Code.

FACTUAL FINDINGS

1. Claimant is a 21-year old man residing with his adoptive parents. In December 2010 and, most recently, in September and October 2012, WRC evaluated Claimant to determine his eligibility for services and supports provided for in the Lanterman Developmental Disabilities Services Act (Lanterman Act).[1] WRC has determined that Claimant is ineligible for Lanterman Act services, and Claimant has appealed.

CLAIMANT'S ACADEMIC BACKGROUND AND RELATED EVALUATIONS

2. Claimant commenced nursery school when he was two years old and pre-school when he was three years old. Claimant enrolled in a private, religious school when he was five years old for pre-kindergarten, which grade he repeated. In November 1997, Lorie A. Humphrey, Ph.D., administered the Wechsler Preschool and Primary Scale of Intelligence-Revised (WPPSI-R) to Claimant. On the WPPSI-R, Claimant's Full Scale IQ was 95, within the average range. Dr. Humphrey reported that Claimant showed "strengths on measures of psychomotor planning and understanding of everyday events" and "relative weakness on a measure asking [him] . . . to repeat sentences and on a subtest measuring his knowledge of the kinds of information learned in school." (WRC Ex. 19.) On language functioning, Claimant reportedly was "able to use language conceptually, exhibiting strengths in his ability to express relationships and explain

[1] Welfare and Institutions Code section 4500 et seq. All statutory citations are to the Welfare and Institutions Code unless otherwise specified.

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rationales using speech. He did not require that instructions be repeated to him, and he was able to participate in a two way conversation . . . ." Dr. Humphrey noted "some relative difficulties with rapid naming," and indicated that "rapid naming has been found to be sensitive to later reading skills; low scores in this area indicate that a child would benefit from early reading training." More specifically, Dr. Humphrey observed that Claimant score "at the 35%ile for naming colors, but only the 14th percentile (low average) for naming objects. He was unable to name letters or numbers, as he said he didn't know them yet." Claimant additionally "exhibited poor phonological awareness (understanding of sound/symbol relationship)." Dr. Humphrey concluded that the results of Claimant's assessment indicate that he "is a boy of average intelligence." Dr. Humphrey additionally indicated that Claimant's "attention deficit disorder is making it difficult for him to participate effectively in his current nursery school classroom." (WRC Ex. 19.)

3. Claimant exhibited significant difficulties with reading and writing in the first grade at a private school. In November 1999, Claimant was assessed by administration of the Full Wechsler Intelligence Scale for Children-III (WISC-III). Claimant's Full Scale IQ score was assessed as 95, the 37th percentile, which is in the average range. An administration of the Woodcock-Johnson Revised Test of Achievement to Claimant indicated his significant difficulty with reading (scoring in the second percentile) and writing (scoring in the seventh percentile). Claimant's arithmetic skills scores were in the 37th percentile. Several measurements of Claimant's executive functioning—his ability to plan, monitor and strategize in order to effectively problem-solve—yielded variable results: on the WISC-III Digit Span sub-test, Claimant achieved a score at the 50th percentile; on the WISC-III Coding sub-test, he scored at the 16th percentile; on the WISC-III Mazes sub-test, he scored in the 63rd percentile; and on the Children's Category Test, he achieved a score at the 42nd percentile, which is in the

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average range, and, according to Dr. Humphrey is consistent with his IQ score at the time. (WRC Ex. 18.)

4. On May 16, 2000, an initial Individualized Education Plan (IEP) established Claimant's eligibility for special education services in the Beverly Hills Unified School District (BHUSD) under the criteria for Specific Learning Disability and Emotional Disturbance.

5. In March 2003, Claimant enrolled in a non-public school for students with special needs. In May 2003, an adaptive behavior assessment of Claimant using the Vineland Adaptive Behavior Scales (Vineland) revealed "significant area of concern in communication and language skills as well as his behavior/social skills/emotionality." (WRC Ex. 11.) Claimant's communication skills fell in the moderately low range (SS=78); his daily living skills fell in the moderately low range (SS=77); and his socialization skills fell in the low range (SS=66). (WRC Ex. 11.) In February 2004, it was determined that the school was "not adequate for the severity of [Claimant's] . . . current deficits," and a residential treatment program was recommended for Claimant. (WRC Ex. 16.)

6. Between September 2004 and March 2005, Claimant enrolled in a non-public, residential school located outside California where he reportedly made progress. Unspecified medical concerns, however, caused Claimant to discontinue his attendance there. Claimant thereafter enrolled in another residential school located in Utah, which, after a one-month stay during June 2005, proved to be an inappropriate fit for Claimant. At the Utah school, Claimant exhibited mood lability, e.g., depressed mood and suicidality. In addition, without providing any specificity, the Utah school reported that Claimant's social skills lagged behind that of his peers.

7a. On September 6, 2005, Claimant was admitted to the UCLA Neuropsychiatric Hospital ABC Treatment Program where his attending psychologist, Dr. Mary J. O'Conner, administered, among other assessments, the Wechsler Intelligence

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Scale for Children— Fourth Edition (WISC-IV) and the Wechsler Individual Achievement Test II (WAIT-II) to him. Dr. O'Conner reported a Full Scale IQ score of 70 and noted that "this overall score does not best represent [Claimant's] . . . general cognitive functioning." According to Dr. O'Conner, "In [Claimant's] . . . case, it is more useful and appropriate to describe his abilities as lying in the Average range for Verbal Comprehension and Perceptual Reasoning, in the Borderline range for Working Memory, and in the Extremely Low range for Processing Speed." (WRC Ex. 14.) Dr. O'Conner reported that Claimant, who at the time was 13 years old, had significant deficits across a number of academic domains including reading, math, spelling, and written expression. "Although his ability to decode words appears to be intact (Pseudoword Decoding = 47th %ile), he does not appear to understand the text that he reads (Reading Comprehension = 3rd %ile). Similarly, he is unable to solve math problems or spell most words correctly and has great difficulty expressing himself in written format (Math Composite = 0.2nd %ile, Written Language Composite = 1st %ile). Considering his performance on these tasks, [Claimant's] . . . current academic skills lie well below what would be expected based on his cognitive testing results. It is likely that his impairments are related to central nervous system dysfunction related [to] the effects of fetal alcohol exposure."[2] (WRC Ex. 14.)

7b. Dr. O'Conner recommended "a contained, intensive special education program throughout the day" for Claimant. "He requires a highly structured classroom with a low student-to-teacher ratio in order to benefit from instruction, increase his independent academic skills, and continue to progress in adaptive classroom behaviors. For example, he requires explicit guidance and modeling to assist him in distinguishing

[2] See Factual Finding 16b below.

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adaptive and maladaptive behaviors, planning and approaching problematic situations, shifting attention and focus, and regulating emotions. [Claimant] . . . may benefit from meeting each morning with a school counselor to review the challenges of the day and to help him develop strategies for dealing with frustration." (WRC Ex. 13.)

7c. Dr. O'Conner additionally recommended for Claimant "a modified curriculum and remedial materials in all subject areas to address his weaknesses in reading comprehension, visual-motor integration skills, writing, and oral communication. He will also benefit from shortened assignments and a reduction in the amount of external stimuli in his immediate work space, due to his limited alertness and difficulties sustaining attention for a long period of time. For example, it is recommended that he be assigned several short assignments rather than a few longer assignments and that his desk be cleared of all but the necessary items that he may need to complete the task at hand." (WRC Ex. 13.)

8. After an unspecified period of home schooling, Claimant re-enrolled at the same non-public, residential school located outside California from 2006 to 2010. Claimant's academic performance during that time is summarized in a BHUSD Special Services Department February 2012 report as follows:

> During the 2006-2007 school year, [Claimant] . . . was performing around the 3rd and 4th grade instructional level in reading, language arts and math. [Claimant] . . . was frequently off task, demonstrated a very slow work pace and had a low tolerance for frustration. . . .
>
> In Spring 2007, [Claimant] . . . participated in statewide testing scoring in the Below Basic range in English Language Arts and Far Below Basic range in General Mathematics,

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History-Social Science and Science. [Claimant's] . . . services included Specialized Academic Instruction for 300 minutes daily . . . , 90 minutes per week of Speech and Language Services, 60 minutes per week of Occupational Therapy . . . and 60 minutes weekly of DMH [Department Mental Health] counseling.

During the 2007-2008 school year, [Claimant] . . . earned A's, B's and C's in all subject areas. Changing classes helped identify when [Claimant] was shutting down and prevented him from shutting down all day; he was able to recoop quicker, at times, with a new staff member. [Claimant] . . . began to self-advocate for himself when he needed help in the classroom, however he was still dependent on the teacher to recognize his signs of shutdown to help . . . [him] refocus. [Claimant] . . . utilized many of the strategies he had been given, such as the Alpha-Smart for writing in his classes. He continued to have difficulty accepting suggestions and help from the teacher.

During the 2008-2009 school year, [Claimant] . . . earned A's and B's in the fall. In the spring and summer, he earned B's and C's and an A in Work Training. [Claimant] . . . continued to benefit from the small classroom environment. He had strong verbal and decoding skills and continued to make slow but steady academic progress. He relied on teacher support and struggled with working independently.

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> [Claimant] . . . continued to have difficulty understanding the effect that his behavior had on others when discussing a conflict situation in which he was involved. [Claimant's] . . . expectation was frequently that the other person should understand what [Claimant's] . . . intentions were. He continued to need adult assistance in order to engage in a problem solving discussion, to explore alternative choices and develop more effective decision-making skills. With regard to behavior, [Claimant] . . . exhibited aggression towards staff, elopement off campus and severe property destruction. In December 2008, [Claimant] . . . participated in a Developmental Cognitive Neuroimaging Study of children and adolescents through UCLA. While no formal report was provided, cognitive scores indicate his Verbal Comprehension [SS=87] and Working Memory [SS=88] ability were within the low average range. His Perceptual Reasoning score [SS=90] was within the average range. Processing Speed [SS=85] was extremely low.[3] In February 2009, [Claimant] . . . took the California High School Exit Exam. He did not pass in either English Language Arts or Mathematics.

[3] See WRC Exs. 8 and 13. The UCLA neuro-imaging study reported a Full Scale IQ score of 78 on the WISC-IV, which placed Claimant's general cognitive status in the borderline range of intellectual functioning.

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> During the 2009-2010 school year, [Claimant] . . . earned A's, B's and C's in the fall and spring terms [.] In November 2009, [Claimant] . . . again took the California High School Exit Exam, passing English Language Arts and not passing the modified Mathematics portion. In January 2010, a behavior emergency report was filed when [Claimant] . . . refused to separate from a group of boys, caused property damage to a teacher"s car by throwing a rock at it and eloped from the campus, requiring police intervention. [Claimant] . . . received minor injuries from the police dog and was taken to a hospital for evaluation. In Spring 2010, [Claimant] . . . participated in statewide testing scoring in the Far Below Basic range in English Language Arts and U.S. History. (WRC Ex. 10.)

9. A March 11, 2010 IEP discussing Claimant's transition from secondary school notes that Claimant "continues to exhibit emotional disturbance, including depression and anxiety. [He] . . . also exhibits a significant discrepancy in the areas of reading, math, and written expression due to functional deficits in attention, auditory processing, and visual motor integration/perception. He exhibits significant difficulties in semantics and pragmatic skills. He has difficulty with impulsivity, mood regulation, frustration tolerance, and behavior." (WRC Ex. 11.) The March 11, 2010 IEP additionally indicates that in the adaptive/daily living skills milieu, Claimant "continues to benefit from "structure and consistency." (WRC Ex. 11.)

10. A BHUSD Special Services Department report corroborates that, overall, Claimant "benefitted from the structure and consistency of the [non-public, residential out of state] program."

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> He was motivated by the token economy and was generally able to meet daily expectations at a high rate. He was taking the steps needed in order to become more independent and he was also making gains in his ability to manage low-level frustrations. He made significant progress in managing stressful situations by taking, self-imposed breaks. Throughout his enrollment, [Claimant] . . . would periodically engage in higher intensity behaviors including severe property damage, aggression towards staff and off-campus elopement, usually without identified consistent antecedents. (WRC Ex. 10.)

11. In May 2010, Claimant left the non-public, residential out-of-state school. He thereafter attended a summer program where he earned a C minus in Language Arts and D's in Visual Performing Arts and Pre-Vocational Education.

12. During the 2010-2011 school year, Claimant enrolled in a local, non-public day school. On two occasions in 2010, Claimant again took the Mathematics portion of the California High School Exit Examination without success.

13a. During the 2011-2012 school year, Claimant transferred to a post-secondary school where he was eligible to receive 314 minutes daily of specialized academic instruction, 480 minutes per week of DMH individual counseling, 60 minutes per week of individual counseling, 60 minutes per week of speech and language services, and 60 minutes per month of career vocational education/career awareness.

13b. Claimant's behavior in the classroom at his post-secondary school was reported as follows:

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[Claimant] . . . has strengths in having friends and behaving appropriately in class. When interested in a topic, [Claimant] . . . will pay attention and ask questions for clarification. [Claimant] . . . can be interesting and engaging. He enjoys being social with peers throughout the day. [Claimant] . . . sometimes asks questions when he needs clarification and openly allows teachers to assist him. He is respectful to classroom teachers and most peers. [Claimant's] . . . greatest areas of difficulty include attending school and classes, following rules and listing to authority figures. [Claimant's special education teacher] . . . reports that [he] . . . does not like or want to be redirected by staff which puts him in a defensive/bad mood. He often comes to school upset due to conditions and interactions with his parents when at home, per [Claimant]. . . . [His special education teacher] . . . describes him as impulsive, forgetful, apathetic, talkative, disinterested, unhappy and preoccupied with outside events taking place in his life. [Claimant] . . . will pay attention to topics/classes that interest him and ask questions for clarification. He will often need to adjust/use music during class in order to pay attention or when not interested in topic. Academically, [Claimant] . . . is doing very poorly, as he has attended classes only a handful of times over the last two and a half months. . . . [W]hen he does come to school he rarely attends classes. His reasons for not going to class include that things happened at home, he is upset with one

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> of the classroom staff and cannot be in the same room or he is not feeling up to it. In the meantime, he is socializing with peers/friends. At this time, [Claimant] . . . is failing all his classes. (WRC Ex. 10.)

13c. In early 2012, while enrolled at his post-secondary school, Claimant's special education teacher, school psychologist, and a speech and language specialist administered to him several assessments including, the Vineland, the Woodcock-Johnson III Normative Update Tests of Achievement (Form B), the Clinical Evaluation of Language Fundamentals-Fourth Edition (CELF-4) and the Comprehensive Assessment of Spoken Language (CASL). Claimant's special education teacher reported Claimant's performance on the Woodcock-Johnson as follows:

> [Claimant] presents with achievement levels in the low range to average range as compared to peers similar in age. [Claimant's] . . . ability to apply academic skills is within the low range. When compared to others at his grade level, [Claimant's] standard scores are average in basic reading skills and low average in brief reading, broad reading, and brief achievement. His standard scores are low (compared to age peers) in brief math, brief writing, and academic skills. [He] continues to have deficits in math and writing skills. (WRC Ex. 10.)

13d. The Vineland indicated that Claimant's "communication skills fall in the moderately low range (standard score-72)." His written communication skills were in the "low range (age equivalent score-8 years, 1, month)." His expressive communication skills in the moderately low range (age equivalent-8 years, 7 months)." His receptive

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communication skills were deemed "adequate . . . (age equivalent-11 years) compared to average peers his age." The Vineland additionally indicated that Claimant's daily living skills "fall in the moderately low range in all areas (standard score-71). He was reported to demonstrate personal skills in the low range (age equivalent score-10, years, 6 month). He was also reported to have domestic skills in the moderately low range (age equivalent-13 years, 3 months) and community skills in the moderately low range (age equivalent-15 years) compared to average peers his age." Based on his assessed scores on the Vineland, Claimant's cognitive ability was deemed "within the low average range to average range" with the notation that his communication and daily living skills are significantly delayed. (WRC Ex. 10; see also Claimant Ex. 5.)

13e. Assessment of Claimant's speech and language skills indicated that his "pragmatic and expressive language, articulation, voice, and fluency skills fall within the expected range in comparison to his peers and he does not demonstrate a disability in these areas." Assessment indicated "a delay in the receptive language skills, demonstrated by weakness in memory and understanding spoken paragraphs." In addition, Claimant demonstrated low average scores in the area of non-literal language. (WRC Ex. 10.) Speech therapy with a focus on processing spoken information was recommended for Claimant.

14a. Claimant's most recent IEP, which is dated February 8, 2012, summarizes Claimant's then-academic status as follows:

> [Claimant] . . . presents with significant academic deficits in the areas of math and written language. Although a discrepancy in reading was not identified on academic testing, [Claimant] . . . continues to have weaknesses in reading and reading comprehension. [Claimant] . . . presents with significant deficits in his adaptive behavior (self-

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> help/daily living skills) and continues to present with a functional deficit in the area of attention. In the area of language [Claimant] . . . exhibits a delay in the receptive language skills, demonstrated by weakness in memory and understanding spoken paragraphs. Although [Claimant] . . . my qualify for special education services under Speech and Language Impairment as well as Specific Learning Disability it is the IEP team's opinion that these are not his primary area of disability.
>
> In the area of social/emotional development, [Claimant] . . . is experiencing significant difficulties with social skills, behavior, anxiety and depression. These feelings are evidenced throughout testing, projective measures, and daily habits. These difficulties are significantly impacting his learning experience (including school attendance) and have been an area of difficulty for a long period of time and to a marked degree. Consequently, [Claimant] . . . continues to meet eligibility requirements for Special Education under Emotional Disturbance (ED) criteria. This is believed to be his primary area of disability. (Claimant Ex. 3.)

14b. The February 2, 2012 IEP elaborates that Claimant "attended 5 English classes since the beginning of October making it very difficult to work with him on improving areas of need and reaching his goals. When completing written work, [Claimant] . . . struggles with the use of basic spelling, grammar, punctuation, and word choice as well as the use of descriptive language. [Claimant] . . . has difficulty forming his

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thoughts into cohesive, well-written sentences and writes using poorly formed penmanship. [Claimant] . . . has attended approximately 7 math classes since the beginning of October. [Claimant] . . . has basic math computation deficits and has challenges answering some computations independently and/or without the use of a calculator. Since much of consumer math are word problems, [Claimant] . . . greatly benefits from information being broken down into smaller parts and written on the board for him to review and copy. (Claimant Ex. 3.)

14c. Meeting notes accompanying the February 8, 2012 IEP indicate that when his IEP team discussed his possible enrollment in a transition program focusing on life skills including money management and using public transportation, Claimant "voiced that he does not want to work on math or any academic skills anymore." According to the meeting notes, Claimant "expressed that he wants a break from school. He explained that he was away from home for a long time and now wants time to stay at home, catch up on movies and hang out. He stated that he is not interested and will not attend a transition program or do anything academically related at this time." (Claimant Ex. 3.)

15. Claimant is not currently enrolled in any academic or vocational program. He is unemployed.

CLAIMANT'S PSYCHIATRIC HISTORY AND PSYCHOLOGICAL EVALUATIONS

16a. Between 1999 and 2008, Claimant underwent no fewer than seven psychiatric or psychological assessments and evaluations, which collectively establish the following:

16b. Claimant's birth mother, who was 19 years old at the time of his birth, has a history of tobacco and alcohol consumption during pregnancy. At birth, Claimant presented with "Reactive Airways" disease (WRC Ex. 18). At age five, Claimant was diagnosed with Attention Deficit Hyperactivity Disorder (WRC Ex. 19), which upon re-evaluation, was changed to a multi-axial diagnosis of Adjustment Disorder with

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Depressed Mood and Anxiety and possible in utero alcohol exposure when Claimant was 10 years old (WRC Ex. 17). At age 11, a diagnosis of Bipolar Disorder-Not Otherwise Specified was added to Claimant's diagnostic history (WRC Ex. 16). At age 13, Claimant was additionally diagnosed with Reading Disorder, Mathematics Disorder and Disorder of Written Expression. Claimant's prior tentative diagnosis of "possible in utero alcohol exposure" was changed to the more definitive Fetal Alcohol Syndrome [FAS], Migraine Headaches (WRC Ex. 15.)

16c. Claimant has been admitted to the UCLA Neuropsychiatric Hospital ABC Treatment Program on four separate occasions: on August 29, 2002, due to unsafe behavior related to depression and anxiety; in March 2003, for reasons not established by the evidence; on February 6, 2004, due to aggressive ideation toward a peer at school and worsening psychotic symptoms including paranoid delusions along with visual and auditory hallucinations; and on September 6, 2005, due to deterioration in his mood and impaired self-esteem.

16d. In correspondence and an evaluative report in connection with Claimant's September 2005 hospitalization, Dr. O'Conner, his treating psychologist, noted that during his early childhood, Claimant's family struggled with considerable upheaval and financial difficulties. For several years, the family resided in a motel. Claimant's parent"s marital discord has been a continuing source of anxiety and frustration for Claimant. Dr. O'Conner observed that Claimant's problems maintaining attention and controlling his anxieties and frustrations "seem related to his experience in the home environment, which seems to be stressful for him at times." Dr. O'Conner observed, "It is likely that [Claimant's parents] . . . often experience interpersonal distress that exacerbates the emotional and behavioral setbacks seen in [Claimant's] . . . behavior." (WRC Ex. 14.)

16e. Dr. O'Conner regarded Claimant as having "significant brain damage and should be viewed as having a medical disability." (WRC Ex. 15.) According to Dr.

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O'Conner, "those working with [Claimant] . . . should understand that because of his prenatal alcohol exposure, he should be viewed as a child with brain damage and his teachers should become familiar with the behavioral phenotype associated with alcohol exposure and methods of working with these children." (WRC Exs. 13 and 15.) Dr. O'Conner noted in general that "[t]he FAS diagnosis has implications for education planning, societal expectations, and health" and that in particular, Claimant has "ongoing adaptive functioning deficits" that are reflected on the Vineland with an Adaptive Behavior Composite scaled sore of 70, which is in the second percentile (WRC Ex. 15.) Dr. O'Conner further noted that delays in Claimant's adaptive behaviors "do not suggest . . . [an] autistic disorder." (WRC Ex. 14.)

17. Most recently, by correspondence dated June 11, 2013, Dr. O'' Conner states that Claimant's fetal alcohol syndrome has multiple consequences:

> In the context of an average IQ, [Claimant] . . . had problems in self-regulation, executive function, working memory, and adaptive functioning meeting the criteria for [central nervous system] CNS dysfunction. Regarding alcohol exposure, there is a clear history of heavy prenatal alcohol exposure. In [Claimant's] . . . case, he received a diagnosis of Partial Fetal Alcohol Syndrome (PFAS). An individual with PFAS and CNS dysfunction should be viewed as a person with a disability, which has implications for educational planning, societal expectations, and health. With the newest edition of the DSM-5, these individuals meet criteria for :315.8 Other Specified Neurodevelopmental Disorder— Neurodevelopmental Disorder Associated with Prenatal Alcohol Exposure.

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Extensive research has documented the teratogenic effects of alcohol in both animal and human studies, and such research has highlighted a range of cognitive, behavioral, and adaptive impairments associated with it.

Intellectual and learning disabilities, adaptive and executive dysfunction, speech and language delays, behavioral and emotional difficulties, poor social skills, and motor deficits have all been reported among people with FASD. People with FASD are at greatly increased risk for a host of secondary disabilities, including school failure, delinquency, and alcohol and substance abuse problems. . . .

It is critical to understand the neurological aspects of FASD in order to implement effective treatment strategies. Because of the nature of FASD and the brain damage caused by it, many affected individuals have difficulty controlling their impulses and have poor judgment, so that most will require close supervision and frequent monitoring during and well past their teen years. The ultimate success of affected individuals will be fragile and will depend on continued guidance and close monitoring that might require a one-one-one mentor or job coach and the presence of an adult in social and community situations. In adolescence and adulthood, prenatal alcohol exposure is related to high risk situations such as getting into trouble with the law, alcohol and substance abuse, exhibiting inappropriate sexual

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behavior, having clinical depression, and suicide ideation and attempts. Because of their multiple developmental challenges, individuals with FASD need ongoing educational opportunities adapted to address their neurocognitive deficits, medication management, supportive psychotherapy, vocational and job training. Without these supports, the individual with an FASD will become a nonproductive member of society and possibly a liability. (Claimant's Ex. 7.)[4]

18. Dr. O'Conner did not testify.

WRC'S EVALUATION OF CLAIMANT

19a. Concerned about Claimant's ability to live independently as an adult, when Claimant was 18 years old, his parents sought to establish his eligibility for supports and services under the Lanterman Act. A WRC multi-disciplinary team assessed Claimant using among other methods, the Kaufman Brief Intelligence-Second Edition (KBIT-2) for assessment of cognitive functioning and the Wide range Achievement Test-Fourth Edition (WRAT-4) for assessment of academic achievement. The KBIT-2 revealed average

[4] The American Psychiatric Association has only articulated "proposed criteria" for Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure. These criteria are published only to encourage future research. (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (2013) (DSM-5) at pp. 783 and 798.) The proposed criteria are not intended for clinical use. Consequently, testimony or documentary evidence premised on the proposed criteria for Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure in the presentation of Claimant's case is accorded diminished weight.

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perceptual abilities, borderline verbal abilities, and an overall low average IQ in the 23rd percentile for Claimant. Claimant's performance on the WRAT-4 was in the 39th percentile for sentence comprehension and first percentile for math computation. (WRC Ex. 8.)

19b. Employing the definition of "autism" contained in the Diagnostic and Statistical Manual of Mental Disorders, 4th ed., Text Revised (DSM-IV-TR), the multi-disciplinary team determined that Claimant did not present with autism.

> Although [Claimant] . . . did show some atypical behaviors prior to age 3 years (i.e. head-banging and hyperactivity), early records (and multiple evaluations by experts in the field) do not support full spectrum symptomatology prior to age three years. Therefore, [Claimant's] . . . current symptomatology can be considered with respect to possible diagnosis of PDD-NOS [Pervasive Developmental Disorder-Not Otherwise Specified], but not to the full spectrum disorder. . . . [Claimant's] . . . symptoms are confounded by his history of family conflict and instability as well as early-onset bipolar disorder treated with multiple medications. Thus, even though he does at present appear to meet the criteria for PDD-NOS, it cannot be stated with certainty that his symptoms may possibly be better attributed to his mental illness. (WRC Ex.8.)

19c. The multi-disciplinary team interviewed Claimant about his ability to engage in appropriate activities of daily living and determined that Claimant was fully independent for toileting and hygiene. Claimant kept his room clean. Claimant

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performed no regular chores at home. Claimant had no experience budgeting money or acquiring groceries. Claimant did not have a driver‟s license and did not express a desire to acquire one because there were few places to which he wanted to drive. Claimant expressed a willingness to walk to his desired destinations. Claimant exhibited no awareness of how to use public motorized transportation. Claimant expressed an interest in working in fast-food restaurants.

19d. The multi-disciplinary team's concluding impressions of Claimant are set forth in a December 21, 2010 report prepared by Valerie Benveniste, Ph.D, as follows:

> Current assessment reveals a young adult who in spite of his overall average I.Q. does not appear equipped to cope with typical daily activities. His impairments manifest in extremely poor arithmetic skills with limited ability to budget, slow processing speed, very poor writing skills, impaired memory, impaired judgment, limited ability for self-direction or goal setting for his future, obsessive-compulsive thoughts and behaviors. History supports that etiology of his disabilities appears to have a neurological/developmental component (e.g. head-banging at age 18 months with ADHD and behavioral challenges) that have been exacerbated by significant psychosocial/family stressors, and subsequent mental illness (early onset bipolar disorder). [Claimant] . . . had undergone many assessments beginning at a young age and developmental disability was not discussed until relatively recently. Due to his extremely complex history, it appears unlikely that it will be possible to tease apart the relative contribution of developmental issues versus mental

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> health/psychosocial issues. Given his current psychosocial environment, his future prognosis is fair to guarded regarding his future ability for self-care, learning, self-direction, capacity for independent living, and capacity for economic self-sufficiency. (WRC Ex. 8.)

19e. Dr. Benveniste reported DSM-IV diagnoses of PDD-NOS, Bipolar Disorder (by history), Dyssomnia-Not Otherwise Specified, Eating Disorder-Not Otherwise Specified, and Parent Child Relational Problem. WRC thereafter notified Claimant by letter and Notice of Proposed Action dated January 13, 2011 that he was ineligible for services and supports under the Lanterman Act. (WRC Ex. 8.)

20. Claimant's mother, acting on his behalf, submitted updated information to the WRC on June 27, 2012, and she requested WRC"s reconsideration of Claimant's eligibility for Lanterman Act supports and services.

21. On August 23, 2012, Rafael Garcia, M.A., the WRC intake counselor, conducted an interview of Claimant's parents who expressed to him a concern about Claimant "maintaining steady employment," "improving [his] . . . independent living skills," and "being able to live independently." Mr. Garcia prepared a psychosocial assessment indicating that Claimant's parents reported his "current functioning" as follows:

> ***INDEPENDENT:*** Parents state the [Claimant] is able to do most self[-]care tasks but with prompting. [Claimant] . . . completes toileting tasks independently. . . . With prompts [Claimant] . . . is able to wash his hands and face, brush his teeth, and bathe, he frequently bathes two to three times in a day. [Claimant] . . .is able to dress himself but not

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appropriately to the weather or occasion and will not care to match his clothes. He is able to manipulate buttons and zippers but has difficulty with buttons. He is able to tie his shoes at 14 or 15 years of age. [Claimant] . . . is able to eat with a spoon and fork with little spillage and can drink from an open cup. [Claimant] . . . is able to make simple purchases and can count simple change. However, he has difficulty managing and budgeting his money and going grocery shopping. He has difficulty understanding the value of things and will easily pay much more than something is worth. In this regard he can easily be taken advantage of. He is willing to order food in public. He is able to use a phone to make and receive routine calls. He has not learned, despite frequently being taught, to check voicemail on [his] mobile phone. He has not learned to use public transportation. He has not obtained a drivers‟ license. He will not do routine chores around the house and his room is described as "a mess." He is said to hoard many things. He is not able to do laundry. He is able to go [to] the refrigerator and take out simple cold snacks for himself. He has learned to cook simple eggs on the stove. He is able to use the microwave to warm up precooked frozen burgers.

COMMUNICATION: [Claimant] speaks in complete sentences that are easy to understand and is described as being articulate. However he has difficulty expressing himself and his feelings when upset. He is able to relay a story but

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may require prompting for details. He has difficulty engaging in ongoing conversation. [Claimant] is a said to rarely exhibit echolalia.

SOCIAL: [Claimant's] eye contact is said to vary and is described as not being typical. He shows affection but does not like to receive it. Claimant will not attempt to initiate social contact. [Claimant] does not engage with typical peers and has difficulty establishing and maintaining reciprocal relationships. He is said to have two "friends" whom he sees regularly but only when the parents arrange visits and activities. Otherwise they will not make arrangements to meet. . . . He has difficulty sharing and taking turns.

EMOTIONAL: Parents describe [Claimant] as being frustrated, impulsive, rigid, and resistive to transitions, changes in routines or changes in plans. He also has difficulty with new environments. Parents state that he always needs to be forewarned of any possible changes. He is no longer aggressive but this was an issue in the past. He will leave an environment without notice or permission but does not necessarily wander away. He might require supervision in unfamiliar settings. Parents state that [Claimant] is generally calm and never hyperactive. He has no difficulty concentrating on a preferred activity such as video games. However, with non[-]preferred activities he will only focus from 2-10 minutes and is easily distracted.

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[Claimant] . . . is very obsessed with anime and will view the same video repeatedly. He is also obsessed with video games and will play them for hours. He enjoys working with puzzle-like bionacles. He is sensitive to loud vibrating sounds. [Claimant] . . . is also said to be sensitive to being touched and will react impulsively if touched without notice. He is said to have sensory issues and has a liking for certain textures. He will wear a heavy thick jacket regardless of how warm it is. He is said to dislike being spoken about. He has a phobia for heights. He has talent of making things out of duct tape. Parents stated that they have not noticed [Claimant] . . . rocking or hand flapping.

COGNITIVE: [Claimant] . . . knows his name and age. He does not know his address and phone number. He can tell time on a digital but not an analog clock. [Claimant] . . . can name the major parts of his body. He can recognize and identify colors and shapes. Parents were not sure up to what number he can count to and were not sure if he could count to 100. He is able to add and subtract single digit numbers with difficulty. He can read and write simple sentence. He has difficulty with comprehension. He is said to have taken a special program . . . to help with his language, reading and writing. He has difficulty with spelling. [Claimant] . . . follows basic one-step instructions but cannot be easily remember instructions.

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> ***MOTOR:*** [Claimant] . . . has functional use of his upper and lower extremities. He can walk typical distances. [Claimant] . . . can go up and down stairs without using a hand rail. He can draw and trace objects. He can write but with difficulty. He has difficulty using scissors. He has difficulty with buttons and shoe laces. He can ride a bicycle. He can open and close containers. . . . (WRC Ex. 6.)

22. Mr. Garcia, who did not testify, referred Claimant for evaluation of his cognitive and adaptive levels of functioning, which Gabrielle du Verglas, Ph.D conducted in September and October 2012.

23a. During multiple sessions, Dr. du Verglas, along with a multidisciplinary team from WRC, interviewed Claimant and his parents and reviewed Claimant's records including background and diagnostic information contained in Claimant's academic records and the several psychiatric and psychological reports set forth above. Dr. du Verglas administered the WAIS-IV, WRAT-4, the Adaptive Behavior Assessment System-II (ABAS-II), the Vineland, and the Autism Diagnostic Observation Schedule (ADOS) Module 4 to Claimant. Dr. du Verglas reported that the overall test results obtained from Claimant validly reflect his current level of cognitive abilities.

> Throughout the three sessions [Claimant] . . . displayed appropriate eye contact. He wore the exact jacket that apparently he wears every single day regardless of weather. Even in extremely hot weather, he insists on wearing the quilted down jacket [because he reportedly needs the pockets in the jacket to store his electronic devices that he carries with him all the time.]

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> He consistently responded to his name being called and was able to engage in conversations. When he did not know the answer to a question, he would state so. With building a rapport he became more cooperative. [Claimant] . . . worked with motivation and the obtained results are viewed as a valid reflection of his current level of cognitive abilities. He did not show any stereotyped or repetitive motor mannerisms such as rocking or hand flapping. No rigidity with test materials/procedures was observed. He responded well to the requests and besides showing impatience by frequently asking how much more he had to do, he completed all test materials. (WRC Ex. 5.)

23b. Dr. du Verglas reported that as measured by the WAIS-IV, Claimant has a Full Scale IQ of 86, which is places him in the 18th percentile. According to Dr. du Verglas' report Claimant's "cognitive abilities are in the average to low average range of abilities with some scores in the borderline range. His cognitive abilities however do not fully explain his significant difficulties with executive functioning such as ability to plan, organize his time, have a sense of time, both time of the day, month or usage of calendar. Significant difficulties in the executive functioning domain are present. Additionally, there is a very significant discrepancy between Verbal skills (IQ 78) and Nonverbal skills (IQ 111) greater than two standard deviations, supporting significant weakness in the verbal domain despite extensive history and language therapy."

23c. Dr. du Verglas reported that on the WRAT-4, Claimant's reading skills were assessed at the 11.4 grade level, with sentence comprehension at the 7.9 grade level, spelling at the 4.4 grade level, and math computation at the third grade level.

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23d. Dr. du Verglas reported that Claimant's "adaptive function was in the extremely low range based on a Global Adaptive Composite score of 58 (0.3 percentile)."

> [Claimant's] . . . adaptive abilities continue to be impaired and below what would be expected for an individual with his cognitive levels of skills. [Claimant] . . . has never lived independently and apparently his capacity for doing so is not present. He does not have the organizational ability to rent an apartment of his own, nor does he have the financial means to pay for his upkeep. With the exception of working in the restaurant [while at a residential school,] . . . [Claimant] . . . has no competitive employment experience. He lacks in money management skills and household management abilities. Currently [Claimant's] . . . adaptive abilities are impaired in social functioning, skills of daily living and higher level communication (i.e., submitting an application or writing a letter of intent or interest for employment). With appropriate structure and planning [Claimant] . . . could be successful in a vocational endeavor however would need the services of a job coach to write information down for him, assist with communication abilities and organizational skills. [Claimant] . . . has a keen interest in working with animals and could possibly be successful in occupations related to animal care. (WRC Ex. 5.)

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23e. Dr. du Verglas reported that an assessment of Claimant employing the ADOS indicated that Claimant "did not meet the criteria for diagnosis of Autistic Disorder full spectrum."

> He presents with milder symptoms, which could well be explained with diagnosis of Pervasive Developmental Disorder-Not Otherwise Specified, as he does have ongoing history of difficulties in social relationships, rigid and repetitive patterns of behavior. Specifically he is very rigid and perseverative about his clothing, will only wear one jacket regardless of weather conditions. He is very perseverative about his video games and since age 10 lives in „a fantasy world preoccupied with video games and video game characters." Up to age 13, he showed repetitive perseverative head banging when frustrated. There are some symptoms of Obsessive-Compulsive Disorder (OCD). He showers very frequently.
>
> His friendships are based on chatting with people online, parents do not know how many of those people he actually sees in person or if they could be classified as viable friends. (WRC Ex. 5.)

23f. Employing the DSM-IV-TR, Dr. du Verglas diagnosed Claimant with PDD-NOS and FAS (by history). Dr. du Verglas lists Claimant's difficulties with his parents and lack of employment or viable activities during the day as moderate stressors. Dr. du Verglas assigned to Claimant a general assessment function (GAF) score of 40, which indicates serious impairment in social, occupational, or school functioning.

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24. Dr. du Verglas did not testify.

25. Thompson James Kelly, Ph.D, WRC‟s chief psychologist and autism consultant, has an extensive professional background working with emotionally disturbed and autistic children in their educational settings. Dr. Kelly provided a detailed exposition of the WRC multidisciplinary team deliberative process for generally making eligibility determinations and particularly in this matter including an examination of Claimant's developmental milestones over a period of time with a focus on any trajectory or continuity of symptomatic expressions. Dr. Kelly noted that in Claimant's case, which he considered a "difficult determination," the team examined IEPs, mental evaluations, medical history, assessments, and other data in an attempt to sort out and distinguish the developmental from the psychiatric and the attitudinal. Dr. Kelly noted that Claimant was assessed several times with varying results over time. According to Dr. Kelly, Claimant is "not classically characteristically autistic." Dr. Kelly noted that Claimant has adaptive deficits, but noted also that the dispositive question is "how much of that is due to developmental issues, to mental issues, to fetal alcohol syndrome." According to Dr. Kelly, "fetal alcohol syndrome does not necessarily mean mental retardation; you could have mild cognitive impairment. Fetal alcohol syndrome gives an explanation of the why you have impairment, but not the extent of impairment." Dr. Kelly explained that the WRC multidisciplinary team determined Claimant is learning impaired as a consequence of fetal alcohol syndrome, but that Claimant has "enough strong cognitive scores to suggest that he has the cognition to perform certain tasks." The team concluded that Claimant was not performing to his capacity "due to unwillingness" rooted in possible contributing factors such as adolescence angst and parenting techniques. Dr. Kelly explained, for example, that in school everything is language-based. Claimant's strength, however, is visual-based, so Claimant enjoyed only limited academic success. From this resulting mismatch Claimant struggled to meet

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expectations. He was frustrated and a learned helplessness emerged causing Claimant to temper his expectations until he eventually gave up.

CLAIMANT'S EXPERT'S EVALUATION

26a. Ann Eugenia Simun, Psy.D., is a private practitioner who, among other things, conducts neuropsychological and psychoeducational assessments of adolescents and young adults. Dr. Simun has a background working on cases involving mental illness, autism, and FAS. Dr. Simun specializes in brain-based disorders. Dr. Simun met with Claimant for two hours, but she "did not do any testing with [Claimant] at all." Dr. Simun's evaluation was circumscribed to review of Claimant's academic records and psychological evaluations. Dr. Simun was critical of the assessment methodologies and conclusions included in Dr. du Verglas'' Psychological Evaluation report discussed above. Using DSM-5 proposed criteria for Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure, Dr. Simun opined that Claimant has impaired neurocognitive functioning in the "mild range" in the following categories: impairment in executive functioning, impairment in learning, and memory impairment.[5]

26b. Dr. Simun further opined that an April 17, 2003 Occupational Therapy Evaluation prepared when Claimant was a 10-year-old child "supports the presence of a developmental disability." That occupational evaluation reports "below average integration of visual and motor abilities and a clear difficulty in the motor coordination section, in which [Claimant] . . . scored in the 4 percentile [on the Developmental Test of Visual Motor Integration]." Claimant reportedly had "difficulty with the motor components that are necessary to complete a task on time." He "worked slowly and cautiously; he needed to take additional time to look at visual stimuli and was able to

[5] See Footnote 5.

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reproduce them without major distortions." The report additionally indicated that Claimant was "having difficulty integrating sensory input from the proprioceptive and vestibular systems, [which] . . . explain his difficulties in fine motor coordination and graphomotor skills." Claimant reportedly exhibited poor proximal stability in shoulder girdle with a tendency to abduct his scapulae, hyperextensibility of proximal joints, and decreased antigravity patterns of movements." (Claimant Ex. 2.) Dr. Simun opined these reported observations of Claimant's sensor processing and motor skills are consistent with an autism diagnosis—Claimant "cannot properly respond to sensory input" and with fetal alcohol syndrome—Claimant has "problems with motor control (hypotonia or a lack of muscle control) and problems with sensory input when sensory input is complex." Dr. Simun summarized Claimant's deficits as a "problem with the highways in the brain that move information back and forth."

27. Jennifer J. White, MSW, who has been providing individual and family therapy to Claimant since July 2011, conducted no formal assessment of Claimant. Ms. White was uncertain whether Claimant has any significant limitations in the area of self-care. She testified that Claimant relies on his parents to meet his needs, including housing and transportation. She observed that Claimant was rigid, in that he would get an idea in his head and became upset when asked to do something differently; that Claimant had "sensory issues" because he wore a heavy coat regardless of the temperature; that Claimant makes relationships and connections with people, but it is hard for him; and that Claimant perseverates when he is angry. Ms. White wrote a letter stating that Claimant "is working to decrease ineffective coping strategies" and lists "frequent avoidance of school, isolating in his room at home, refusing to engage with parents" as examples. The letter reads in pertinent part:

> [Claimant's] . . . progress toward these goals appears to be impeded by deficits in executive functioning, difficulty taking

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responsibility and identifying his role in conflicts, and extreme rigidity.

[Claimant's] . . . difficulty tolerating redirection and understanding why there is a need to meet certain expectations (ie: to attend school, to do minimal household chores, to participate in additional vocational training) would likely impede his ability to obtain or hold a job. He remains reliant on his parents for meeting basic needs. From [Claimant's] . . . current level of functioning, it appears unlikely that [Claimant] . . . would be able to support himself or live independently at this time. Though he has not historically carried a diagnosis of autism, [Claimant] . . . does present with symptoms characteristic of an individual with the ASD spectrum including rigidity, sensory issues, difficulty with social interactions, perseverating on preferred activities as well as perseverating on negative interactions with others." (Claimant Ex. 4.)

LEGAL CONCLUSIONS

1. As Claimant is seeking to establish eligibility for government benefits or services, he has the burden of proving by a preponderance of the evidence that he has met the criteria for eligibility. (*Lindsay v. San Diego Retirement Bd*. (1964) 231 Cal.App.2d 156, 161[disability benefits]; *Greatoroex v. Board of Admin*. (1979) 91 Cal.App.3d 54, 57 [retirement benefits]; Evid. Code, § 500.)

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2. Claimant must establish that he has a qualifying "developmental disability." Section 4512, subdivision (a), defines "developmental disability" to mean the following:

> . . . a disability that originates before an individual attains age 18 years, continues, or can be expected to continue , indefinitely, and constitutes a substantial disability for that individual. . . . [T]his term shall include 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.

3. California Code of Regulations, title 17 (CCR), section 54000 further defines "developmental disability" as follows:

(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 . . . ;

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

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(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 need for treatment similar to that required for mental retardation.

4. Establishing the existence of a developmental disability within the meaning of section 4512, subdivision (a), requires claimant to additionally prove that he has a "substantial disability," defined in CCR section 54001, subdivision (a), as follows:

(1) A condition which results in a major impairment of cognitive[6] 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

[6] CCR section 54002 defines "cognitive" as "the ability of an individual to solve problems with insight to adapt to new situations, to think abstractly, and to profit from experience."

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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.

5. The Lanterman Act and its implementing regulations contain no definition of the neurodevelopmental condition autism. The customary practice has been to import the American Psychiatric Association‟s DSM-IV-TR definition of "autistic disorder" into the Lanterman Act and its implementing regulations when determining eligibility for services and supports on the basis of autism. That definition has been 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 diagnoses of autistic disorder, Asperger‟s disorder, childhood disintegrative disorder, Rett‟s syndrome, and PDD-NOS. (DSM-5 at p. 809.) Thus, individuals with a well-established DSM-IV-TR diagnosis of autistic disorder, Asperger‟s disorder, or PDD-NOS are now given the diagnosis of Autism Spectrum Disorder. (*Id.* at 51.)

6. 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

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reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.

2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history:

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,

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adverse response to specific sound or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

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.

7. 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).

8. 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.*)

9. In adults, deficits in social-emotional reciprocity may be most apparent in difficulties processing and responding to complex social cures. 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

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facial expression for social communication." (*Id.* at 54.) Adult individuals with deficits in developing, maintaining, and understanding relationships "struggle to understand what 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.*)

10. 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

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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.*)

11a. There are reports that, in childhood, Claimant's social skills were of significant concern or lagged behind his peers (Factual Findings 5 and 6) and that Claimant lacked understanding of the socially disruptive effects of his high-intensity behaviors (Factual Findings 8 and 10). Some clinical observations suggest Claimant's difficulties with spoken paragraphs and non-literal language (Factual Findings 13e and 14a). Claimant has experienced speech and language-related phonological deficits, but he has no reported history of language delay, repetitive speech, or ritualized verbal behaviors. Claimant's parents report that Claimant will not attempt to initiate social contact and that Claimant has difficulty maintaining reciprocal relationships (Factual Finding 21). The reliability of these reports and observations is undermined, however, by contrary and equally compelling evidence that prior to adulthood, Claimant presented with communication and social skills enabling him not only to form appropriate, reciprocal peer-relationships, but also establishing him as an interesting and engaging personality (Factual Finding 13b). Claimant maintains on-line friendships (Factual Finding 23e), which, in the age of the internet, is a typical social arrangement. In clinical sessions, Claimant engaged in conversation and displayed appropriate eye contact; no abnormal facial expressions, speech intonation, or body orientation was observed. Claimant has failed to produce a preponderance evidence establishing that he manifests persistent deficits in social communication consistent with the DSM-5 Criteria A for Autism Spectrum Disorder set forth in Legal Conclusion 6.

11b. Claimant's current interests and activities are reported as restricted to on-line gaming. Such restrictive behavior is not a matter of a disabling condition, but rather,

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a matter of choice evinced through Claimant's expression of his need for a break from all things academic and his desire to stay at home and hang out (Factual Finding 14c). Claimant's sartorial preference for his coat regardless of the temperature is not the kind of restriction encompassed by the diagnostic features of Autism Spectrum Disorder. Claimant has explained that his coat provides him with convenient, transportable storage compartments for his gaming gadgets (Factual Finding 23a). Clinical observations of Claimant's sensory processing and motor skills indicated decreased touch, feel, and sound sensations—bio-physiological phenomena (Factual Finding 26b), but the preponderance of evidence failed to establish that Claimant presents with fascinations and routines relating to hyper-or hypo-reactivity to sensory input. During testing sessions, Claimant showed no stereotyped or repetitive motor mannerisms (Factual Finding 23a). Claimant has failed to produce a preponderance of evidence establishing that he manifests persistent deficits of restricted, repetitive patterns of behavior, interests, or activities consistent with the DSM-5 Criteria B for Autism Spectrum Disorder as set forth in Legal Conclusion 6.

11c. Claimant has not met his burden of establishing by a preponderance evidence his eligibility for Lanterman Act services and supports under the qualifying category of autism as provided for in section 4512, subdivision (a) of the Welfare and Institutions Code.

12. As Claimant is additionally asserting eligibility for Lanterman Act services and supports under the "fifth category" he must establish by a preponderance of evidence a disabling condition "closely related to mental retardation" or a disabling condition requiring "treatment similar to that required for individuals with mental retardation." (§ 4512, subd. (a).)

13. Like autism, the term mental retardation is similarly used throughout the Lanterman Act and its implementing regulations without definition. As in the case with

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the term autism, the customary practice has been to turn to the APA for elucidation on the etiology of this neurodevelopmental condition. Under the APA"s DSM-IV-TR, the essential features of mental retardation were identified as significantly sub-average general intellectual functioning accompanied by significant limitations in adaptive functioning in certain specified skill areas. (DSM-IV-TR at pp 39-43.) With the May 2013 publication of DSM-5, the term mental retardation has been replaced with the diagnostic term "Intellectual Disability," which, according to the APA "has come into common use over the past two decades among medical, educational, and other professionals, and by the lay public and advocacy groups." (DSM-5 at p. 809.)

14. 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." (*Id*. at 33.) The following three criteria must be met:

A. Deficits in intellectual functions, such as reasoning, problems 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.

(*Id*.) Thus, the definitive characteristics of intellectual disability include deficits in general mental abilities (Criterion A) and impairment in everyday adaptive functioning, in

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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. (*Id.* at 39-40.)

15. 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.

16. The DSM-5 revisions appear not 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 category would be redundant. 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 5400, subdivision (c), exclusions set forth in Legal Conclusion 3. Furthermore, the evidence must establish that the Claimant's

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disabling condition requires treatment similar to the treatment needs of an individual with intellectual disability.

17. The APA has 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 $\pm$ 5)." (*Id.* at 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.*)

18. 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.

19a. Claimant presents with FAS, which according to Dr. O'Conner is a medical condition. Claimant additionally has a documented history of handicapping conditions including learning disabilities, depression, bipolar disorder, and anxiety (Factual Findings 16b and 16c). These medical and psychiatric conditions do not qualify Claimant for

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Lanterman Act services and supports. Claimant's IQ score has been twice assessed as 95 (Factual Findings 2 and 3) and most recently as 86 (Factual Finding 23b). An IQ score of 78 was once noted without any analytic report (Factual Finding 8). On the one occasion when Claimant's IQ score was reported as 70, his treating psychologist, Dr. O'Conner, dismissed that score as unrepresentative of Claimant's general cognitive function notwithstanding Claimant's significant academic deficits (Factual Finding 7a). Claimant failed to produce evidence of uncontroverted IQ scores to establish that he presents with a disabling condition closely related or similar to Intellectual Disability.

19b. Claimant is capable of attending to his hygiene and self-care needs. He knows how to prepare simple meals and how to order food in public (Factual Finding 21). He eschews public, motorized transportation in favor of either walking or cycling to transport himself from one location to another (Factual Findings 19c and 21). Claimant's adaptive behavior scores in the areas of daily living and domestic and community skills are reported as in the moderately low range (Factual Findings 13d and 23d). Much of Claimant's formative years were spent in residential facilities when he was not at home with his parents. Claimant has never lived independently, and there is scant evidence that Claimant has had instruction or opportunity to acquire comprehensive skills necessary for home organization, banking, and money management. Consequently, the full extent of Claimant's capacity, or lack thereof, for independent living and economic self-sufficiency was not persuasively established. The evidence nonetheless suggests that Claimant's present reliance on others, namely his parents, to meet some or all of his daily living and domestic requirements is more indicative of unwillingness rather than of a disabling condition related or similar to intellectual disability. Claimant has foregone participation in a transition program focusing of his acquisition of day-to-day life skills (Factual Finding 14c.) Claimant has expressed his disinterest in vocational preparation

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for employment (Factual Finding 14c.) Claimant's recalcitrance it not a disabling condition requiring Lanterman Act services and support.

19c. Evidence of Claimant's social relations is conflicting. Claimant reportedly makes and maintains relationships with others (Factual Findings 13b and 27). Claimant has at least two friends with whom he has regular contact (Factual Finding 21). Yet Claimant's parents have concerns whether he has reciprocal relationships (Factual Finding 21). Claimant has had difficulties regulating his emotions and behaviors in age-appropriate fashion (Factual Findings 8 and 10) but, the evidence indicates that such difficulties are the manifestations of anxiety, depression, and a stressful home environment (Factual Findings 16d and 19d). Claimant is articulate, and he speaks in complete sentences (factual Finding 21). Claimant is attentive to subjects which interest him (Factual Finding 13b). Claimant has no significant difficulty with pragmatic and expressive language (Factual Finding 13e). Claimant failed to produce a preponderance of evidence establishing that he presents with significant adaptive functioning deficits requiring treatment similar to that required for individuals with Intellectual Disability.

19d. Claimant has not met his burden of establishing by a preponderance of evidence his eligibility for Lanterman Act services and supports under the fifth category as provided for in section 4512, subdivision (a), of the Welfare and Institutions Code. Compare with *Samantha C. v. State Department of Developmental Services* (2010) 185 Cal.App.4th 1462 [overwhelming evidence established Claimant's fifth category eligibility] and *Mason v. Office of Administrative Hearings* (2001) 89 Ca.App.4th 1119 [weight of the evidence did not establish Claimant's developmental disability under the fifth category].

20. Cause exists by reason of Factual Findings 1 through 27, inclusive, and Legal Conclusions 1 through 19, inclusive, to deny Claimant's appeal.

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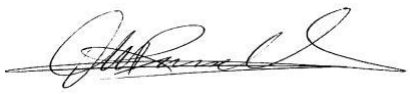
ORDER

1. Claimant's appeal is denied.

2. Westside Regional Center's determination that Claimant is ineligible for services and supports pursuant to the Lanterman Developmental Disability Services Act is affirmed.

Dated: September 4, 2013



JENNIFER M. RUSSELL
Administrative Law Judge
Office of Administrative Hearings

NOTICE

This is a final administrative decision. This administrative decision binds both parties. Either party may appeal this administrative decision to a court of competent jurisdiction within 90 days.

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