BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: CLAIMANT, v. ALTA CALIFORNIA REGIONAL CENTER, Service Agency.	OAH No. 2014030369

DECISION

A fair hearing was held on May 7 and 8, 2014, before Karen J. Brandt, Administrative Law Judge (ALJ), Office of Administrative Hearings (OAH), State of California, in Sacramento, California.

Robin Black, Legal Services Manager, represented Alta California Regional Center (ACRC).

Claimant's parents represented claimant.

Evidence was received on May 7 and 8, 2014. The record was held open to allow ACRC to file a closing brief and claimant's parents to file a reply. On May 16, 2014, ACRC filed a closing brief, which was marked for identification as Exhibit 26. On May 23, 2014, claimant's parents filed a reply brief, which was marked for identification as Exhibit C. The record closed, and this matter was submitted for decision on May 23, 2014.

ISSUES

Does claimant qualify for services from ACRC under the Lanterman Developmental Disabilities Services Act (Lanterman Act), Welfare and Institutions Code

section 4500 et seq., because he: (1) has an Autism Spectrum Disorder; (2) is an individual with an intellectual disability; and/or (3) has a disabling condition that is closely related to intellectual disability or requires treatment similar to that required for individuals with an intellectual disability (also known as the "fifth category")?[1]

FACTUAL FINDINGS

1. Claimant was born in 2003. He is currently 10 years old. On December 10, 2013, complainant was referred to ACRC by Jaclyn Garton, a Social Worker with Yolo County Child Protective Services (CPS). At the time, claimant was a dependent of CPS, but was placed with his parents.

2. Claimant currently lives with his mother, stepfather, two half-siblings, and, on a part-time basis, two stepsiblings. Claimant has had no contact with his biological father. Prior to the age of four, claimant was raised by his mother and an ex-boyfriend, who was abusive to claimant's mother, and claimant witnessed the domestic violence. Claimant was placed in foster care for about three months when he was four years old.

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[1] The language used to describe the developmental disabilities relevant in this matter has changed over time. In May 2013, the American Psychiatric Association issued the DSM-5. Prior to then, the DSM-IV-TR was in effect. The "DSM" is the Diagnostic and Statistical Manual of Mental Disorders. In the DSM-5, the term "mental retardation" was replaced by the term "intellectual disability." In addition, the term "Autistic Disorder" was replaced by the term "Autism Spectrum Disorder." The DSM-5 sets forth different criteria for these diagnoses. The Lanterman Act was recently amended to change the term "mental retardation" to "intellectual disability." But the Lanterman Act still includes the term "autism."

3. Claimant's mother has been married to claimant's stepfather for about six years. In May 2012, claimant was placed in a group home for about 14 months. He returned to live with his family in July 2013. Since October 2013, he has attended Capitol Academy, a non-public school.

PSYCHOLOGICAL EVALUATION CONDUCTED BY MONICA SILVA, PH.D.

4. ACRC retained Monica Silva, Ph.D., a licensed Clinical Psychologist, to conduct a psychological evaluation of claimant and issue a report. Dr. Silva conducted the evaluation on January 29, 2014. During the evaluation, she administered the Adaptive Behavior Assessment System, Second Edition (ABAS-II) Parent Form; the Autism Diagnostic Observation Scale – Second Edition (ADOS-2) Module 3; and the Wechsler Intelligence Scale for Children, Fourth Edition (WISC-IV). She also observed claimant, interviewed his parents, and reviewed his academic and mental health records.

5. Intellectual Disability Testing. On the WISC-IV administered by Dr. Silva, claimant attained a Full Scale IQ score of 74, in the Borderline range. His scores on the Verbal Comprehension Index and Perceptual Reasoning Index were in the Low Average range. His scores on the Working Memory Index and Processing Speed Index were in the Borderline range.

6. In her evaluation report, Dr. Silva stated that claimant's scores on the WISC-IV "need to be interpreted with caution due to the variability between the subtest scores and [claimant's] limited attention to some of the tasks presented." His scores on the subtests ranged from Extremely Low to Average. As Dr. Silva explained, the WISC-IV was "administered on the latter part of the afternoon after [claimant] had a full day." Based upon earlier intellectual testing, Dr. Silva opined that claimant's "cognitive potential is likely within the Low Average to Average range." According to Dr. Silva:

> Previous testing revealed a range of scores as well, though he has scored within the Average range on some measures. His pattern of scores is likely impacted by issues with distractibility and impulsivity and one questions the impact of fine motor issues on his ability to complete the Coding subtest. Given the idiosyncrasies mentioned, [claimant] may experience difficulties learning, primarily as it relates to completing written work and would likely continue to benefit from intensive intervention services in order to address these issues.

7. Autism Spectrum Disorder Testing. Dr. Silva evaluated claimant under the diagnostic criteria for Autism Spectrum Disorder set forth in the DSM-5, which, in relevant part, describe the disorder as:

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.
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 making friends; to absence of interest in peers.

[¶] ... [¶]

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two to 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 sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

[¶] ... [¶]

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

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

E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay….

8. Dr. Silva found that claimant did "not present with the marked atypicalities and idiosyncrasies in communication, socialization and behaviors characteristic of Autistic Spectrum Disorder (ASD)." She found that claimant did not have, on a persistent basis, any of the deficits in social communication and social interaction set forth in subdivision A above. She found that claimant's:

> … social-emotional reciprocity is variable. He shares a close relationship with his parents and tends to take on a "parenting" role with his siblings. [Claimant] is not always spontaneously affectionate, nor does he seek comfort, however, he seeks out adult attention and can be caring and empathetic. He developed a strong relationship with his previous counselor and relates well to unfamiliar adults. Despite his social nature, he exhibits aggressive tendencies towards his mother as well as instances of emotional dysregulation, with physical and verbal aggression towards others. During the current assessment, [claimant] presented as a friendly child who seemed to enjoy individualized adult attention. [Claimant] made spontaneous social overtures consistently throughout the assessment by sharing verbal information, asking questions and consistently making attempts at humor. Despite his social nature, [claimant] tended to quickly lose interest in the verbal interaction unless one agreed with him. This was noted to be a mild issue and in general, a strong rapport was built.

Dr. Silva also found that claimant's nonverbal communication skills were "variable." He demonstrated the "capacity to provide well-modulated eye contact, direct a range of facial expressions and use nonverbal gestures," but "consistency [was] dependent on his interest." He demonstrated "difficulties reading facial cues," and there were "mild issues with his eye contact noted during the current assessment, as it tended to be brief." But claimant "presented as an animated individual who used nonverbal gestures consistently and coordinated those well with speech."

With regard to claimant's abilities in developing, maintaining, and understanding relationships, Dr. Silva found that claimant was a "likeable and social child who makes friends, but [loses] them easily because of aggressive behaviors." She also found that his "relationship with his siblings [was] variable and impacted by his tendency towards aggressive behavior." He "enthusiastically shared that he had a girlfriend though his insight into typical social relationships was difficult to judge as he presented as pseudo-mature in some respects and notably immature in others."

Dr. Silva found that claimant met one of the four criteria set forth in subdivision B above relating to restricted, repetitive patterns of behavior, interests and activities. Dr. Silva opined that claimant "demonstrates sensory integration issues." He "generally accept[ed] touch on his own terms." But he became "agitated by the noise of the other children in the home and reacts strongly to the tea kettle whistle." He also demonstrated a "propensity to smell things," and a "tendency to put objects in his mouth and sometimes eat them." His "attention seemed to be distracted by external stimuli."

Dr. Silva did not, however, find that claimant met any of the other criteria under restricted, repetitive patterns of behavior, interests and activities set forth in subdivision B. Although claimant's parents noted that claimant "exhibited rocking behavior and a

history of banging his head on the floor or walls as a younger child, as well as OCD[2] behaviors and issues with repetitiveness when he was prescribed Adderall," during the evaluation, claimant did not display any "instances of echolalia, or marked atypicalities in speech." Dr. Silva found that claimant's repetitive motor movements were a "relatively mild issue."

Claimant's parents reported that claimant was resistant to transitions and had some unusual behaviors, such as covering certain objects in his room in what appeared to be a ritualized manner. He was also noted to be "rigid in his thoughts and may make statements with a great deal of conviction and becomes adamant and will react strongly if others attempt to correct him." Dr. Silva noted that claimant had "[m]ild rigidities in thought," but they were "relatively mild issues and he [did] not exhibit markedly atypical routines." Dr. Silva also found that claimant did not have "highly restricted or fixated interests that were abnormal in intensity or focus." She noted that he demonstrated "strong interests in guns and trucks," but these topics did "not come up consistently in conversations across different contexts."

9. In sum, Dr. Silva found that claimant did not have an Autism Spectrum Disorder. She diagnosed him with "Attention Deficit/Hyperactivity Disorder" (ADHD) and "Rule Out Disruptive Mood Dysregulation Disorder." According to Dr. Silva, claimant presented with a "long-standing history of behavioral and psychiatric issues, including notable symptoms of ADHD and mood disorder." He showed the "marked behavioral idiosyncrasies characteristic of ADHD, including a high level of activity, distractibility, impulsivity, frustration tolerance, emotional dysregulation, as well as poor sustained effort." In addition, Dr. Silva found that claimant experienced "notable issues with executive dysfunction." Dr. Silva stated that it was "outside the scope of the current

[2] "OCD" stands for Obsessive-Compulsive Disorder.

evaluation to address a mood disorder." But she noted that claimant experienced "the notable issues with emotional dysregulation, difficulty sleeping and behavioral challenges seen in individuals with a mood disorder."

OTHER ASSESSMENTS AND EVALUATIONS OF CLAIMANT

10. Claimant has been evaluated by his school districts, by Yolo County Alcohol, Drug & Mental Health (Yolo County Mental Health), and for CPS. Some of the more relevant of these evaluations are summarized below.

11. May 19, 2009 Psychological Evaluation. On May 19, 2009, Sherri Venezia, M.S., M.A., a School Psychologist employed by the Woodland Joint Unified School District (Woodland) conducted a Psychological Evaluation of claimant at his mother's request. At the time, claimant was five years seven months old, and in a general education kindergarten classroom. Ms. Venezia administered that WPPSI-II[3] and the Woodcock-Johnson Achievement test. Claimant's scores on these tests were generally in the Low Average to Average range. On the WPPSI-II, he had a Full Scale IQ of 100. Ms. Venezia stated that claimant's "scores were evenly distributed," and the "even, consistent scoring with no inter-scale or intra-scale differences show[ed] the rounded and smooth nature of his inherent intelligence." She found that there was "no actual area of deficit in his processing or ability when the WPPSI-III scores are analyzed." She concluded that claimant "demonstrated relative strengths in all cognitive areas."

12. Ms. Venezia summarized claimant's behavior during the evaluation as follows:

[3] "WPPSI-III" is the Wechsler Preschool and Primary Scale of Intelligence – Third Edition.

> [Claimant] came willingly over several sessions, seemed eager to perform, was concerned about the correctness of his responses, worked steadily, remained on task and seemed motivated to try the various tasks over several different days. He did not fatigue and showed focus that was appropriate for a 5½ year old boy. He asked appropriate questions, smiled when successful, wanted to engage and seemed to enjoy the 1:1 attention throughout. Rapport was established and the results may be viewed as a valid representation of his levels of ability at this time.

Ms. Venezia described claimant as "complex." She assessed his "predominant feature" as "difficulty with behavioral adjustment and subsequent concern about school progress." She found that "his behavior varies and his self-regulatory skills seem to be minimally developed." He "becomes unsettled easily, is defensive, in a 'young' form, shows a sensitivity towards taking direction as [though] he was entitled to do as he wishes, and overreacts to limit setting." Ms. Venezia opined that these "behavioral markers are not unusual in a youngster who has experienced trauma and separation from, in this case, both natural parents, with the reunification with his mother closely followed by a new marriage, step and half siblings included in his life." According to Ms. Venezia, claimant seemed to have "some separation anxiety and possible abandonment/loss issues stemming from these early life experiences, and has not yet met the milestones for self-soothing." Given his stuttering, she found that he qualified for special education services in the area of "Speech and Language."

13. July 4, 2012 Psychological Evaluation and Testing Report. Jayson Wilkenfield, Ph.D., conducted a psychological evaluation of claimant at the request of the Yolo County Juvenile Court, and issued his report on July 4, 2012. At the time,

claimant was eight years nine months old. He was living in the Atkinson Youth Services Group Home (Atkinson Group Home), a residential facility for emotionally disturbed boys. According to Dr. Wilkenfield, claimant was placed in the group home "after his parents informed CPS that they didn't believe they were capable of addressing his mental health needs and that they were concerned about the safety and welfare of their four other children with [claimant] living in the home, due to his gradually escalating pattern of aggressive behavior toward his siblings." Dr. Wilkenfield noted that over the "last three years, he has been placed in three different special schools, but he hasn't completed a full school year in any of these programs." Dr. Wilkenfield also noted that claimant had been "involuntarily psychiatrically hospitalized on three separate occasions since September of 2011 due to his rage episodes and displays of aggressive behavior at school and in the home."

14. Dr. Wilkenfield administered the Wechsler Intelligence Scale for Children – Third Edition (WISC-III), the Wide Range Achievement Test – Fourth Edition (WRAT4), the Reynolds Child Depression Scale (RCDS), the Burks' Behavior Rating Scale, and the Attention: Deficit Disorders Evaluation Scale (ADDES). Dr. Wilkenfield also conducted a clinical interview of claimant, and interviewed claimant's mother and a social worker with Atkinson Youth Services.

15. On the WISC-III, claimant attained a Full Scale IQ score of 60, in the "mildly retarded range of intellectual ability." Dr. Wilkenfield noted that there was a "considerable degree of intersubtest variability" on the portion of the test designed to examine his verbal problem-solving abilities. The results of the WRAT4 showed that claimant was "achieving two years or more below the levels expected for his age in all areas tested."

16. After reviewing the results of the tests that were conducted, Dr. Wilkenfield diagnosed claimant as follows:

Axis I: Mood Disorder Not Otherwise Specified

R/O Intermittent Explosive Disorder
Attention Deficit Hyperactivity Disorder, Combined Type
Oppositional Defiant Disorder
Stuttering

Axis II: Mild Mental Retardation (provisional)

Passive-aggressive Personality Traits noted

Axis III: None noted

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Axis IV: Psychosocial and environmental problems:

Involvement with the Child Welfare System
Residing in out-of-home placement
Separation from family

Axis V: GAF = 45 (current)

17. Dr. Wilkenfield noted that claimant cooperated with the assessment, but did not "seem motivated to put forth more than minimal effort in the testing." His mood was "irritable, and although he never seemed particularly anxious, he exhibited a rather low tolerance for frustration and was clearly eager for the assessment to be over from shortly after it began." Although he "stuttered frequently," he did not "exhibit any flagrant disturbance in the form or content of his thinking." Dr. Wilkenfield noted that the formal assessment of claimant's intellectual skills "resulted in his earning a Full Scale

IQ score that measured in the range associated with mild mental retardation." Dr. Wilkenfield recommended that ACRC be contacted to determine whether claimant was eligible for services.

18. September 2012 Psychosocial Evaluation. In September 2012, Geoff Smith, Ph.D., a School Psychologist employed by the San Juan Unified School District, conducted a Psychosocial Evaluation of claimant, when he was nine years old. Dr. Smith used the Woodcock-Johnson III: Test of Cognitive Abilities, and the Behavior Assessment System for Children, 2nd Edition (BASC-2). He also interviewed claimant's mother and teacher, reviewed records relating to claimant, and observed claimant in the classroom.

19. On the Woodcock-Johnson II, Claimant's General Intellectual Ability was measured at 90, which is in the Average range. On the subtests, his scores ranged from Low to Above Average. His lowest score was a 71 on Retrieval Fluency. His highest score was a 116, on Sound Blending.

20. With regard to claimant's social, emotional and behavioral functioning, Dr. Smith found that claimant "exhibited severe emotional and behavioral difficulties from a young age." Dr. Smith stated that claimant's "emotional and behavioral problems continue to be very severe in his residential treatment program," but that he appeared to be "adjusting and functioning within the acceptable limits in the ED-SDC[4] program at Northridge Elementary School." Dr. Smith found that the results of the assessment showed that claimant remained eligible for Special Education services under the "criteria for Emotional Disturbance and Learning Disability." The two criteria for emotional disturbance that Dr. Smith found that claimant exhibited were "Inappropriate types of behavior or feelings under normal circumstances," and "A general pervasive mood of unhappiness and/or anxiety." According to Dr. Smith, "Behaviors have been present for a

[4] "ED-SDC" stands for Emotional Disturbance – Special Day Class.

long period of time, they are to a marked degree, and they are adversely affecting his educational performance." Dr. Smith considered "Emotional Disturbance" to be claimant's "primary eligibility" for Special Education services.

21. December 2012 Behavioral Health History. On December 6, 2012, while complainant was a resident at Atkinson Group Home, he was admitted to the Sutter Center for Psychiatry for evaluation. The Behavioral Health History dated December 11, 2012, the date of claimant's discharge, noted that this admission was his fourth, he "ran away from the group home twice and tried to jump off a school bus while it was moving," and he claimed to hear voices.

The doctors at Sutter Center for Psychiatry stated that claimant's diagnoses included the following:

Axis I:	Disruptive behavior disorder NOS, intermittent explosive disorder and mixed receptive-expressive language disorder.
Axis II:	None

In the "Discharge Mental Status Examination" portion of the report, the doctors described claimant, in relevant part, as follows:

> This patient is pleasant and cooperative. He participated actively in the interview. He appears somewhat hyperactive. His mood appears somewhat anxious. Affect is congruent. Speech and language are notable for some stuttering, language processing appears impaired. Thought process is logical. Thought content includes themes of coping strategies for dealing with bullies or when he gets angry. No

auditory or visual hallucinations. No SI or HI. Cognition generally intact. Insight and judgment appear limited.

22. Undated EMQ Families First Report. At the hearing, ACRC submitted an undated and unsigned report on the letterhead of EMQ Families First. ACRC's table of contents stated that the dates of this report were between January and June 2013. The report described an evaluation conducted by the writer after claimant was referred for psychotropic medication management when he was transitioning from Atkinson Group Home. The writer diagnosed claimant, in relevant part, as follows:

Axis I: Mood Disorder NOS … Anxiety NOS, Tic Disorder NOS, R/o Autism Spectrum Disorder, R/o ADHD

Axis II: Mild Mental Retardation by History

As part of the plan, the writer stated:

5. Expressed concerns re social disability to mother. After session, discussed with L. De Torre recommendation for ALTA testing to assess for Autism Spectrum Disorder (ADOS), also need to advocate with ALTA given client's reported dx of MMR.

6. Requested mother obtain copy of previous psychological testing report for review, and also seek to obtain copy of most recent triennial psychoeducational testing report. Unclear if ADOS previously performed.

23. 2009 through 2013 Progress Notes. Submitted during the fair hearing were Progress Notes written between October 22, 2009, and September 12, 2013, by Kevin Rosi, M.D., a psychiatrist employed by Yolo County Mental Health. In the first Progress Note dated October 22, 2009, Dr. Rosi stated that claimant was a six-year-old boy with a "past psychiatric history from Families First of Separation Anxiety d/o and PDD NOS (r/o GAD, r/o ADHD, r/o Bipolar d/o) who presents today at the request of his therapist and parent due to continued behavioral problems and poor emotional control."[5] Dr. Rosi diagnosed claimant as follows:

Axis I:	Mood d/o NOS, PDD NOS Separation Anxiety d/o (by history) r/o ADHD r/o PTSD r/o Intermittent Explosive d/o
Axis II:	r/o Borderline Intellectual functioning
Axis III:	None
Axis IV:	fair familial support, fair social support, poor academic performance
Axis V:	48

In his Progress Note, Dr. Rosi stated that claimant:

[5] "D/o" stands for disorder. "R/o" stands for rule out. "PDD NOS" stands for Pervasive Developmental Disorder Not Otherwise Specified. "GAD" stands for Generalized Anxiety Disorder.

> … has a mix of symptoms that are observable, though most impairing is his poor emotional control, mood regulation and frustration tolerance. There is observed PDD characteristics and some in his history as well. Anxiety has been strongly reported and was seen mildly today, though he did transition well when mom departed and chose to separate himself from her as well. Given the abuse history, PTSD is also a diagnostic likelihood, while the family history supports a mood disorder if the reporting is accurate. Mood d/o NOS is the active diagnosis at this time.

24. In his Progress Note dated October 19, 2012, Dr. Rosi changed his diagnosis on Axis II from "r/o Borderline Intellectual functioning" to "Mild Mental Retardation." He also diagnosed claimant on Axis I with "Mood d/o NOS, PDD NOS, Separation Anxiety d/o (by history), r/o ADHD, r/o Intermittent Explosive Disorder, r/o Bipolar d/o, r/o Psychosis NOS vs. Schizophrenia, r/o GAD." On Axis III, he diagnosed claimant with "r/o Temporal Lobe Epilepsy."

Dr. Rosi stated that claimant had had "two recent hospitalizations for extreme mood dysregulation, aggression, high risk impulsive acts, irritability, hyperactivity and decreased sleep." He noted that claimant continued to "display impulsivity, aggression, self-harm, behaves in an illogical manner, and was diagnosed with Mild Mental Retardation in a psychological evaluation." Dr. Rosi found that claimant was "severely impaired from his symptoms." In explaining his diagnoses, Dr. Rosi stated that "ADHD is high on the differential and IED has been moved up as well. PTSD has been removed due to lack of support. Mild MR has been added and is a major contributor to his symptoms." Dr. Rosi also stated that, "Group home staff was present to provide collateral history and a Psychological evaluation has been reviewed."

25. In his Progress Note dated September 12, 2013, Dr. Rosi noted that claimant had "transitioned well back to home but reactive aggression continued." He stated that "ADHD, PDD and Mild MR are the primary diagnoses; there is no new evidence to support Bipolar d/o."

26. December 16, 2013 Neurological Evaluation. On December 16, 2013, Shailesh M. Asaikar, M.D., a board-certified neurologist, evaluated claimant. Dr. Asaikar diagnosed claimant with "Mood disorder, rule out seizures." Dr. Asaikar described claimant as "alert and cognitively normal" on neurological examination.

27. February 24, 2014 Psychiatric Evaluation. Mark D. Edelstein, M.D., is a board-certified Child and Adolescent Psychiatrist, who works for Victor Community Support Services (Victor). He conducted a psychiatric evaluation when claimant was 10 years five months old. At the time, claimant was a dependent of the Yolo County Juvenile Court, but he was residing with his family. According to Dr. Edelstein, claimant had a "history of serious problems with behavior, social functioning, mood and sleep since about age 2." He presented for "medication management with an increase in the past week or 2 of reactive agitation and aggression, as well as a marked increase in insomnia over the past week." Dr. Edelstein described claimant's behavioral difficulties a "quite severe." Claimant had "done a great deal of property destruction, verbal assaults and physical assaults, including trying to choke a dog, trying to choke his mother and becoming extremely agitated and assaultive if he does not get his way." According to Dr. Edelstein, claimant "does particularly poorly with changes in routine, which make him much more reactive." He has "intentionally harmed himself, e.g., biting himself repeatedly on the arm last weekend, and has been hospitalized for thoughts and acts of self-harm."

28. Dr. Edelstein diagnosed claimant as follows:

Axis I: Mood Disorder, NOS, 296.09

Pervasive Developmental Disorder, NOS, 299.80

Stuttering, 307.0, by report.

Rule out Oppositional Defiant Disorder, rule out Reactive Attachment Disorder

Axis II: None, V71.09 (rule out mild mental retardation).

Axis III: None. No known drug allergies.

Axis IV: History of neglect and abuse early in life. Special education needs.

Axis V: 50

29. Dr. Edelstein noted that claimant had a "long history of reactive outbursts with verbal and physical aggression," and that he had had four psychiatric hospitalizations. Dr. Edelstein stated that claimant's

> … symptoms do not fit neatly into any DSM diagnosis, but, like some other evaluators, I think his ASD symptomatology is impressive enough to warrant a diagnosis on that spectrum.… He is not socially attuned, He seems unempathic, and he is uninterested in having friends. He does not seem in touch with his emotional world. He gets preoccupied with items/topics. He functionally deteriorates with changes in routine, e.g., with activities and where his belongings are

> located. As can be seen in kids with ASD, he has very poor anger modulation that is best captured with a diagnostic label of Mood Disorder, NOS.

Dr. Edelstein stated that, "At the next appointment, I will inquire more about his early life experiences and the quality of his social interactions."

30. April 15, 2014 Psychiatric Medication Management Note. Dr. Edelstein met with claimant and his parents again on April 15, 2014. During the appointment, Dr. Edelstein asked claimant's parents for "input on the DSM-IV criteria for Autism and additional DSM-5 criteria for ASD." In his note, Dr. Edelstein described claimant as follows:

> He has impaired non-verbal interpersonal behaviors. He has poor peer relationships. He does share interests and achievements. He does not entirely lack social reciprocity but his understanding/appreciation of reciprocal social behavior is significantly impaired. Mom does not recall specifics of language development but Dr. Silva noted receptive language delay in her 1/14 assessment. He can engage in conversations but often they involve events that never actually happened. He sings repetitive tunes with odd, language-like vocalizations. If someone around him says a cuss word or he likes a line from a movie, he will repeat it again and again. He plays "army" with toy soldiers "all day long." i.e., for hours at a time. He [has been] preoccupied for about a year with guns: drawing them, talking about them, etc. He insists that his belongings, e.g., his Hot Wheels,

remain arranged a certain way. He does very poorly with change of routine. He transitions poorly. At bedtime he insists on a certain routine with his dad or he will not go to bed. When excited or nervous, he will rock and make a rapid repetitive motion touching his thumb to his index and middle fingers of the same (right) hand. No preoccupation with parts of objects. Mom cannot remember many details about his development prior to age 3, but she recalls that he always played by himself. He is overly sensitive to physical touch and loud noise. He experiences the sensation of gauze on his face as scratchy and rough. The older he gets, the fewer foods he likes; not clear whether this is about food or texture. He often puts non-food items in his mouth, e.g., chewing on Kleenex or picking up a leaf off the ground.

31. Dr. Edelstein diagnosed claimant as follows:

Axis I: Mood Disorder NOS 296.90

PDD NOS 299.80
Stuttering 307.0 by report (in speech therapy)
Developmental Coordination Disorder 315.4 (see 1/14 psychological testing)
Communication Disorder NOS 307.9 (receptive language delays according to 1/14 psychological testing)
R/O Oppositional Defiant Disorder, R/O RAD, R/O ADHD (unlikely)

Axis II: None V71.09

Axis III: None. NKDA (1/13 sleep EEG normal. 8/13 EKG & echocardiogram normal)

Axis IV: History of neglect, exposure to domestic violence. Special educational needs.

Axis V: 55

32. In his note, Dr. Edelstein discussed the medications claimant was taking, including Depakote, Melatonin and Clonidine. Dr. Edelstein opined that claimant "does not have severe ADHD, but it is possible that he has mild ADHD, and a trial of MPH would in my opinion be worthwhile." Dr. Edelstein also stated that claimant "has an extremely poor capacity to problem-solve and to deal with stress and frustration, and he bit himself during a fit of agitation." Dr. Edelstein discussed the diagnoses Dr. Silva listed in her January 2014 evaluation, and stated that he did "not see how this combination of diagnoses accounts for the ASD symptomology described above – what Dr. Sanchez [*sic*] refers to as 'Autistic-Like' symptoms and I would call 'ASD diagnoses.'" With regard to Dr. Silva's evaluation of claimant's intellectual abilities, Dr. Edelstein stated that Dr. Silva "sees his inattention as invalidating the scores he achieved on cognitive testing. I do not question her professional opinion that his 'cognitive potential is likely within the Low Average to Average range' (I am not an expert in intellectual disabilities), but I would point out that this conclusion is neither supported nor contradicted by the testing scores."

TESTIMONY

33. Dr. Silva, Susan Wheelwright, and Jamie Milotz, Psy.D., testified on behalf of ACRC. Claimant's mother and Jon Page testified on behalf of claimant.

34. Dr. Silva. During her testimony, Dr. Silva reviewed her evaluation findings described above in Findings 4 through 9. With regard to her testing of claimant's intellectual ability, Dr. Silva stated that the hallmark of claimant's scores were their "variability." As she explained, his scores on the WISC IV subtests "were all over the place." They ranged from extremely low to average. She attributed the variability in his scores to his impulsivity, poor frustration tolerance, and lack of sustained effort. His energy and motivation "petered out" in the late afternoon, after a long day for him. Because of the variability in his scores, Dr. Silva believed that the results he achieved on the tests she administered were "not as valid."

Dr. Silva also attributed the low scores claimant achieved on the cognitive testing administered by Dr. Wilkenfield to claimant's lack of motivation, as suggested in Dr. Wilkenfield's report. Dr. Silva opined that the scores claimant achieved on the cognitive testing administered by his school districts better identified his actual cognitive potential. On those tests, claimant tested in the Low Average to Average range. Given these scores, Dr. Silva opined that claimant did not have an intellectual disability.

35. With regard to whether claimant has an Autism Spectrum Disorder, Dr. Silva testified that claimant displayed some "mild atypicalities," but not the "glaring" behaviors seen in children with ASD. He presented as "very socially confident" and talkative. He readily shared verbal information. He sometimes expressed his thoughts fluidly. At other times, he struggled to find words. Although he stuttered at times, he did not engage in any echolalia. He used "a lot of nonverbal gestures" and a "nice range of facial expressions," but his eye contact was brief and he was distracted. Dr. Silva observed no significant issues in claimant's social interactions. She did, however, find that claimant appeared to be socially connected about 90 percent of the time, but there were periods of noticeable "disconnect." She did not observe any stereotypic behaviors typical for children with an Autism Spectrum Disorder. She found that he had sensory

integration issues: noises bothered him, he had a keen sense of smell, and he had a tendency to put objects in his mouth. But because he did not display most of the other criteria set forth in the DSM-5, she found that he could not be diagnosed as having an Autism Spectrum Disorder.

36. Dr. Silva also found that claimant did not have a condition closely related to intellectual disability or requiring treatment similar to that required for individuals with an intellectual disability.

37. Dr. Silva found, however, that claimant's functioning was severely impaired. He appeared to be unable to regulate his emotions, manage his behaviors, or tolerate frustration. He displayed the distractibility, impulsivity, emotional dysregulation, and executive functioning deficits associated with ADHD. Dr. Silva was also concerned about his level of anxiety, fear and aggression. She questioned whether he might have a mood dysregulation disorder given his "host of mood dysregulation issues." She agreed that he required intensive mental health treatment and services. But she opined that the type of mental health treatment claimant needs is not similar to that provided to individuals with an intellectual disability.

38. Dr. Silva questioned the diagnosis of PDD NOS given by Dr. Edelstein. She could not tell how Dr. Edelstein had reached the conclusion that claimant had PDD NOS from the history and short mental health status examination that Dr. Edelstein included in his report. She stated that PDD NOS is no longer included as a disorder in the DSM-5.

39. Susan Wheelwright. Ms. Wheelwright is an Intake Counselor at ACRC. She has a bachelor's and a master's degree in Social Work. She conducted a social assessment of claimant on January 24, 2014, and prepared a report. During her social assessment, she spoke to claimant and his parents, and observed claimant's behavior. When she socially assesses a child, she generally looks for the "odd or unusual presentation" typical of children with an Autism Spectrum Disorder, including repetitive

behaviors and words, echolalia, and lack of social interaction. According to Ms. Wheelwright, during her social assessment of claimant, she did not observe most of the typical behaviors children with an Autism Spectrum Disorder generally display.

40. Jamie Milotz, Psy.D. Dr. Milotz is a Staff Psychologist employed by ACRC. She was a member of ACRC's Eligibility Team that reviewed claimant's request for services from ACRC. Also on the team were Terry Wardinsky, M.D., and Ms. Wheelwright. During the eligibility review, all three members of the team reviewed the records ACRC had received relating to claimant. They determined that claimant did not have a developmental disability that would qualify him for services from ACRC.

41. Dr. Milotz compared the diagnostic criteria for Mental Retardation as set forth in the DSM-IV-TR to those for Intellectual Disability as set forth the DSM-5. The diagnostic criteria for Mental Retardation in the DSM-IV-TR require: (1) significantly subaverage intellectual functioning as indicated by an IQ of 70 or below; and (2) concurrent deficits in adaptive functioning. The diagnostic criteria for Intellectual Disability in the DSM-5 require deficits in both intellectual and adaptive functioning. Individuals with an intellectual disability have scores approximately two standard deviations or more below the population mean. As set forth in the DSM-5, "highly discrepant individual subtest scores may make an overall IQ score invalid." In addition, the DSM-5 states that, "To meet diagnostic criteria for intellectual disability, the deficits in adaptive functioning must be directly related to the intellectual impairments…"

42. With regard to claimant's intellectual functioning, Dr. Milotz noted that in 2009 and 2012, his school districts found that claimant tested in the Low Average to Average range. She also noted that in 2012, Dr. Wilkenfield found that claimant tested in the mild mental retardation range. She questioned the validity of claimant's scores on the tests Dr. Wilkenfield administered, given claimant's lack of motivation, difficulty sustaining attention, and minimal effort, and the significant variation in his subtest

scores. She noted that Dr. Wilkenfield's diagnosis of claimant as having mild mental retardation was "provisional." She stated that a "provisional" diagnosis generally means that a doctor was "hesitant" to give the diagnosis because he was not sure that it was appropriate. Dr. Milotz also noted that in 2014, Dr. Edelstein did not diagnose claimant with an intellectual disability, but he did include in his diagnosis a parenthetical "rule out mild mental retardation." Dr. Milotz did not know what prompted Dr. Edelstein to include this parenthetical. She stated that the term "rule out" generally means that a doctor has not assessed for the condition or that he does not have enough information for a diagnosis.

43. In sum, Dr. Milotz opined that the evaluations and assessments received by ACRC did not show that claimant has an intellectual disability.

44. During her testimony, Dr. Milotz compared the diagnostic criteria for Autistic Disorder set forth in the DSM-IV-TR to those for Autism Spectrum Disorder set forth in the DSM-5. She noted that there was no diagnosis of either an Autistic Disorder or an Autism Spectrum Disorder in any of the assessment and evaluation reports ACRC received relating to claimant, other than Dr. Edelstein's reference to "ASD symptomatology" described above in Findings 29 and 32, and a rule out by EMQ as set forth in Finding 22. She also stated that the evaluation and assessment reports prepared by his school districts did not include any analysis of whether claimant might be on the autism spectrum. She would have expected the school districts to screen claimant for autism if they suspected that he might have an Autism Spectrum Disorder. In addition, Dr. Wilkenfield did not address autism in his report.

45. She questioned the diagnosis of PDD NOS given to claimant by Dr. Edelstein and Dr. Rosi. She noted that PDD NOS is described in the DSM-IV-TR 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 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 threshold symptomatology, or all of these.

Dr. Milotz noted further that the DSM-5 no longer includes PDD NOS as a disorder. Instead, the DSM-5 states:

> Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of Autism Spectrum Disorder. Individuals who have marked deficits in social communication, but whose symptoms do not otherwise meet criteria for Autism Spectrum Disorder, should be evaluated for social (pragmatic) communication disorder.

46. Dr. Milotz testified that there was no indication in Dr. Edelstein's reports that he conducted an evaluation of claimant for an Autism Spectrum Disorder, or that he utilized any of the assessment tools that have been developed for testing for an Autism

Spectrum Disorder, such as ADOS. In addition, Dr. Edelstein did not discuss the diagnostic criteria for autism set forth in the DSM-IV-TR or the DSM-5, and how these criteria applied to claimant. Dr. Milotz raised the same concerns about Dr. Rosi's diagnosis relating to PDD NOS, particularly the fact that there was no indication that Dr. Rosi conducted any testing to determine whether claimant had an Autism Spectrum Disorder. Dr. Milotz explained that many of the symptoms seen in individuals with an Autism Spectrum Disorder are also seen in individuals with mental health disorders, and that thorough evaluations must be conducted to ensure that an individual who exhibits symptoms that are seen in a number of different disorders are properly diagnosed and treated.

47. In sum, Dr. Milotz opined that the evaluations and assessments received by ACRC did not show that claimant has an Autism Spectrum Disorder.

48. Dr. Milotz also opined that claimant did not have a condition similar to an intellectual disability. The most valid intellectual testing showed that claimant has Low Average to Average cognitive functioning. In addition, Dr. Milotz opined that claimant did not require treatment similar to that required for an individual with an intellectual disability. Dr. Milotz recognized that claimant had significant deficits in adaptive functioning, but that these deficits were not the result of an intellectual impairment. Instead, they were due to his severe mental health issues. As she explained, appropriately identifying the cause of claimant's deficits is essential in order to provide appropriate and effective treatment. Because treatment must be properly tailored to a specific disorder in order to be effective, and because claimant does not have an intellectual disability, he does not require treatment similar to that required by individuals with an intellectual disability. Instead, he requires treatment appropriate to his mental health disorders.

49. Jon Page. Mr. Page is employed by Victor as a wrap-around facilitator. He has a master's degree in psychology, with an emphasis in marriage and family therapy. He has worked as a therapist with children with emotional disturbance and ASD. He is currently working as claimant's team leader. He is the "hub" for information about claimant. He "connects with" claimant's parents, his therapist, his psychiatrist, and other members of the Victor team.

Mr. Page testified that, when he first met claimant at a Round Table Pizza, he noticed that claimant had mannerisms that were "off," and not typical. Claimant did not acknowledge Mr. Page "as a person." He did not make eye contact. Mr. Page also described claimant's "self-injurious behaviors," his lack of social skills, and his rocking. Mr. Page described these behaviors as "in line with some" on the autism spectrum. He questioned whether claimant might have an Autism Spectrum Disorder.

Mr. Page admitted that he was not an expert on autism, but he has worked with children on the autism spectrum. He has not evaluated claimant for an Autism Spectrum Disorder. He stated that Victor refers consumers to other service providers for evaluation if they suspect that a child may have an Autism Spectrum Disorder.

50. Claimant's Mother. Claimant's mother testified that claimant has received mental health services since he was four years old. He has been seen by multiple psychiatrists, including Drs. Hart, Rosi and McCarthy through EMQ. It was Dr. McCarthy who suggested that claimant be evaluated by ACRC. His current psychiatrist, Dr. Edelstein, thinks that claimant is on the autism spectrum. In addition, friends and family members believe that claimant is on the spectrum.

Claimant's mother described the difficulty claimant has in interacting with his siblings. He gets upset if there is noise that is too loud. He does not like to be touched. He has a difficult time performing regular daily activities. Routine is important to him. He needs to do the same thing every day at the same time. He follows a special routine

before going to bed. Only a "couple of people" are willing to stay with him other than his parents.

CPS put in place the wrap-around services claimant is currently receiving from Victor, but those services are about to expire. Claimant's parents had asked the County to take claimant because, although they tried all they could, they could not help him. The behavior interventions that have been tried to date do not appear to be working. They would like help from ACRC to teach claimant to "thrive."

DISCUSSION

51. When all the evidence is considered, the opinions of Drs. Silva and Milotz that claimant does not qualify for services from ACRC under the Lanterman Act were persuasive.

AUTISM SPECTRUM DISORDER

52. Dr. Silva conducted a thorough evaluation of claimant, using the "best practices" assessment tools. She thoroughly reviewed the evaluations, assessments and other records received by ACRC relating to claimant. In addition, Dr. Milotz thoroughly reviewed all the records relating to claimant. As Drs. Silva and Milotz testified, when claimant's behavior is viewed in light of the diagnostic criteria in both the DSM-IV-TR and the DSM-5, there was not sufficient evidence of persistent deficits in social communication and social interaction, or restricted, repetitive patterns of behavior, interests or activities to find that he has an Autism Spectrum Disorder.

53. The reports of Drs. Rosi and Edelstein were not persuasive. They did not conduct the type of assessments and evaluations needed to diagnose claimant with an Autism Spectrum Disorder.

54. When all the evidence offered in this matter is considered, claimant's parents did not establish that claimant qualifies for services from ACRC on the basis of autism.

INTELLECTUAL DISABILITY

55. The testimony of Drs. Silva and Milotz were persuasive that claimant does not have an intellectual disability based upon the testing conducted by his school districts. That testing showed that claimant's cognitive ability is in the Low Average to Average range. Although Dr. Wilkenfield diagnosed claimant with mild mental retardation, his diagnosis was only "provisional." As he explained in his report, there was significant variability in claimant's scores on the subtests, and claimant was "irritable," did not seem motivated, did not put forth more than minimal effort, and exhibited "a rather low tolerance for frustration." (Findings 15 and 17.) These factors cast serious doubt on the results claimant attained on the testing Dr. Wilkenfield administered.

56. When all the evidence offered in this matter is considered, claimant's parents did not establish that claimant qualifies for services from ACRC on the basis of intellectual disability.

FIFTH CATEGORY

57. The testimony of Drs. Silva and Milotz was persuasive that claimant does not have a disabling condition that is closely related to intellectual disability or requires treatment similar to that required for individuals with an intellectual disability. As set forth above, claimant's intellectual ability is in the Low Average to Average range. Although claimant has low adaptive functioning, the evidence established that his deficits in adaptive functioning are not related to intellectual impairments. Instead, they are directly related to his significant mental health issues. As Dr. Milotz made clear, to be effective, treatment must be tailored to an individual's disorder. The treatment that

claimant requires is not similar to that required for individuals with an intellectual disability. Instead, it is that required for individuals with mental health conditions.

58. When all the evidence offered in this matter is considered, claimant's parents did not establish that claimant qualifies for services from ACRC under the fifth category.

59. It was apparent at the hearing that claimant's parents were seeking services from ACRC in an effort help their child achieve his highest potential. But the legislature made the determination that only individuals with the five specified types of disabling conditions identified in the Lanterman Act are eligible for services from regional centers. The legislature chose not to grant services to individuals who may have other types of disabling conditions, including mental health disorders, if they cannot show that they fall within one of the five categories delineated in the Act. Although the result may seem harsh, especially for individuals with mental health conditions as severe as claimant's, the legislature did not grant regional centers the authority to provide services to individuals whose disabilities fall outside the five specified categories. Because claimant's parent did not show that claimant has an Autism Spectrum Disorder, an intellectual disability, or a disabling condition that is closely related to intellectual disability or requires treatment similar to that required for individuals with intellectual disability, they did not establish that claimant is eligible for services under the Lanterman Act.[6] Consequently, their request for services from ACRC must be denied.

[6] There was no indication during the hearing that claimant was eligible for services from ACRC under the developmental disability categories of cerebral palsy or epilepsy.

LEGAL CONCLUSIONS

1. Under the Lanterman Act, regional centers provide services to individuals with developmental disabilities. As defined in Welfare and Institutions Code section 4512, subdivision (a), a "developmental disability" is:

> a disability that originates before an individual attains 18 years of age; continues, or can be expected to continue, indefinitely; and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include intellectual disability, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability, but shall not include other handicapping conditions that are solely physical in nature.

2. Handicapping conditions that consist solely of psychiatric disorders, learning disabilities or physical conditions do not qualify as developmental disabilities under the Lanterman Act. (Cal. Code Regs., tit. 17, § 54000, subd. (c).)

3. As set forth in the Findings, claimant's parents did not establish that claimant qualifies for services under the Lanterman Act because he is an individual with autism or an intellectual disability, or because he has a disabling condition that is closely related to intellectual disability or requires treatment similar to that required for individuals with an intellectual disability. His handicapping conditions consist of psychiatric disorders. Consequently, claimant's appeal must be denied.

ORDER

Claimant's appeal is DENIED. Alta California Regional Center's denial of services to claimant under the Lanterman Act is SUSTAINED.

DATED: June 2, 2014

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KAREN J. BRANDT

Administrative Law Judge

Office of Administrative Hearings

NOTICE

This is the final administrative decision in this matter. Each party is bound by this decision. An appeal from the decision must be made to a court of competent jurisdiction within 90 days of receipt of the decision. (Welf. & Inst. Code, § 4712.5, subd. (a).)