BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: CLAIMANT, vs. FAR NORTHERN REGIONAL CENTER, Service Agency.	OAH No. 2014120407

DECISION

This matter was heard before Administrative Law Judge Susan H. Hollingshead, State of California, Office of Administrative Hearings (OAH), in Redding, California, on April 11, 2016.

Phyllis J. Raudman, Attorney at Law, represented the Service Agency, Far Northern Regional Center (FNRC).

Erin O'Toole-McNally, Attorney at Law, represented claimant who was not in attendance.

Oral and documentary evidence was received. Submission of this matter was deferred pending receipt of closing briefs. Claimant's Closing Brief was submitted on May 16, 2016. FNRC's Closing Brief was submitted on July 5, 2016. Claimant's Reply Brief was submitted on July 13, 2016, and FNRC's Reply Brief was submitted on July 15, 2016. The record was closed and the matter submitted for decision on July 15, 2016.

ISSUES

Is claimant eligible to receive regional center services and supports because he is an individual with an intellectual disability, or based on the "fifth category" because he has a condition closely related to intellectual disability, or that requires treatment similar to that required for individuals with an intellectual disability pursuant to Welfare and Institutions Code section 4512? [1]

FACTUAL FINDINGS

1. Claimant is an 18-year-old young man who resides with his grandparents. His grandmother is his guardian. Records indicate that claimant's early years were tumultuous, evidenced by multiple placements between his biological parents and grandparents. His biological parents reportedly lived an unstable lifestyle, which included substance abuse and domestic violence and was not conducive to raising their son.

In March 2013, claimant was placed in the Cerro Vista crisis home, run by Remi Vista. It was reported that he ran away from home and his grandparents were having difficulty managing his behavior. At that time they were also caring for their son, who had returned home from active military duty with a head injury, and his two children both of whom were diagnosed with Autism Spectrum Disorder (ASD).

In May 2014, claimant was transferred from the Cerro Vista home to Remi Vista's Rocafort facility after it was disclosed that he engaged in inappropriate sexual conduct with children.

By letter dated December 12, 2014, Remi Vista gave a 30-day notice that claimant's placement with the Rocafort home was being terminated based on an inability, after

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[1] Unless otherwise indicated, all statutory references are to the California Welfare and Institutions Code.

several meetings with the family, to come to an agreement regarding claimant's care and treatment.

2. Claimant was initially referred to FNRC in 2005 by his grandmother and it was determined that he was not eligible for regional center services.

3. In 2008, his grandmother again sought FNRC services based on concerns that claimant was an individual with autism, based on "new information" she had gathered.

FNRC Medical Director, Christine Austin, M.D., completed a comprehensive records review, interviewed school personnel and observed claimant. Dr. Austin concluded that the information did not support a "best practice"[2] autism diagnosis and she recommended against re-opening intake. The FNRC Eligibility Review Team agreed with that recommendation.

4. Claimant's most current referral, also from his grandmother, occurred in 2011. Based on a questionable diagnosis of PDD-NOS (Pervasive Developmental Disorder-Not Otherwise Specified) given by Licensed Marriage and Family Therapist Gerry Blasingame, M.A., it was agreed in an informal hearing that FNRC would carry claimant as a provisional consumer for three years and then reassess for autism in 2014. He was not found eligible under intellectual disability or fifth category.

5. On October 30, 2014, FNRC Medical Director Lisa Benaron, M.D., completed a best practice autism spectrum disorder evaluation. After a thorough records review and testing, she concluded that in "my professional opinion, [claimant] is not eligible for FNRC services under the category of ASDs." She acknowledged that claimant had three previous comprehensive evaluations that all conclude that he did not meet the criteria for an autism

[2] The Best Practice Guidelines for Screening, Diagnosing and Assessment of Autism Spectrum Disorders was published by the California Department of Developmental Services (DDS) in 2002.

spectrum disorder. She also distinguished the validity of Mr. Blasingame's PDD-NOS diagnosis explaining that even Mr. Blasingame "equivocated on whether or not a PDD-NOS diagnosis was appropriate in his report."

Dr. Benaron's report included the following pertinent information:

> [Claimant] has shown behavioral issues since an early age that are most consistent with emotional dyscontrol and can be explained by many of the diagnoses he has received in the past (ODD, ADHD[3], anxiety/mood disorder). His immaturity and behavioral issues likely negatively influenced his peer relationships. . .
>
> Review of cognitive testing to date shows scattered scores from the borderline to low average range. The possibility that [claimant] might qualify for FNRC services under the Fifth Category has been evaluated twice with the same result—determined that [claimant] does not meet criteria for eligibility under the so-called fifth category (condition similar to or requiring services similar to ID). The most recent evidence that he functions higher than the cut-off for the Fifth category is the March 2014 school testing that shows a WASI IQ of 91 and Achievement tests that fell in the range between 90-111. It is clear that he does not have ID or a similar condition.
>
> [Claimant's] grandparents have been tireless advocates for [him] based on their concerns about his explosive

[3] Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder.

anger/aggression, inability to appreciate consequences, poor safety awareness and difficulties with peer relations. In their pursuit of answers and assistance, [claimant] has been evaluated by a wide range of professionals including a neurologist, multiple school psychologists, therapists, clinical psychologists/autism spectrum disorder experts, and psychiatrists. It is understandable that the grandparents are frustrated by the differences in opinions that have been rendered and continue to hope that FNRC will provide much needed support. Unfortunately, the Regional Center system has very limited eligibility categories and [claimant] does not clearly fit into any of the five categories.

. . . [Claimant's] cognitive abilities are too high for the fifth category and his complex social-emotional issues do not fit into the ASD category.

6. The FNRC eligibility team then determined that claimant was not eligible for regional center services. A Notice of Proposed Action (NOPA) was issued on November 20, 2014, informing claimant as follows:

Reason for action: [Claimant] does not have mental retardation and shows no evidence of epilepsy, cerebral palsy, autism, or other condition similar to intellectual deficit and requiring treatment similar to that required by individuals with mental retardation. During an informal hearing on 11/11/11, FNRC agreed to carry [claimant] for three years and re-evaluate if he

> has autism. Dr. Benaron, FNRC Medical Director, evaluated [claimant] on 10/30/14 and found him to not be autistic.

7. Claimant appealed FNRC's decision on or about December 1, 2014, and this fair hearing ensued.

8. After several continuances during 2015, claimant's counsel of record, Ms. O'Toole-McNally, was retained. During communications with FNRC counsel, Ms. Raudman, claimant's counsel informed FNRC that claimant intended to waive appeal based on autism and proceed to hearing asserting intellectual disability and/or fifth category as a qualifying condition for claimant to receive regional center services.

9. FNRC contends that claimant does not meet the requirements for an intellectual disability. Nor is he eligible under the "fifth category" because his deficits in adaptive functioning are not attributable to global cognitive deficits, thus he does not have a condition closely related to intellectual disability. FNRC opined that claimant does not require treatment similar to that required by persons with intellectual disability.

10. Pursuant to the Lanterman Act, Welfare and Institutions Code section 4500 et seq., regional centers accept responsibility for persons with developmental disabilities. Welfare and Institutions Code section 4512 defines developmental disability as follows:

> "Developmental disability" means a disability that originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual…. [T]his term shall include intellectual disability, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to intellectual disability[4] or to require treatment similar

[4] Effective January 1, 2014, the Lanterman Act replaced the term "mental

to that required for individuals with an intellectual disability [commonly known as the "fifth category"], but shall not include other handicapping conditions that are solely physical in nature.

11. California Code of Regulations, title 17, section 54000, further defines the term "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 Development Disability shall:

(1) Originate before age eighteen;

(2) Be likely to continue indefinitely;

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

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

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retardation" with "intellectual disability." California Code of Regulations, title 17, continues to use the term "mental retardation." The terms are used interchangeably throughout.

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

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

(3) Solely physical in nature. These conditions include congenital anomalies or conditions acquired through disease, accident, or faulty development which are not associated with a neurological impairment that results in a need for treatment similar to that required for mental retardation.

12. Welfare and Institutions Code section 4512, subdivision (l), defines substantial disability as:

(l) The existence of significant functional limitation in three or more of the following areas of major life activity, as determined by a regional center, and as appropriate to the age of the person:

(1) Self-care.

(2) Receptive and expressive language.

(3) Learning.

(4) Mobility.

(5) Self-direction.

(6) Capacity for independent living.

(7) Economic self-sufficiency.

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

(a) "Substantial disability" means:

(1) A condition which results in major impairment of cognitive and /or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential; and

(2) The existence of functional limitation, 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:

(1) Receptive and expressive language.

(2) Learning.

(3) Self-care.

(4) Mobility.

(5) Self-direction.

(6) Capacity for independent living.

(7) Economic self-sufficiency.

ASSESSMENTS AND EVALUATIONS

14. January 22, 2006 report by Beth Goodlin-Jones, Ph.D., UC Davis M.I.N.D.[5] Institute. Dr. Goodwin-Jones began her report by noting that claimant had been previously diagnosed with PTSD (Post Traumatic Stress Disorder) and ODD (Oppositional Deviant Disorder). As part of her evaluation, she administered the Wechsler Abbreviated Scales of Intelligence (WASI). The WASI is a four subtest assessment that is an abbreviated scale to estimate a child's current cognitive functioning. The verbal IQ is estimated from the vocabulary subtest and the similarity subtest. The performance IQ is estimated from the block design subtest and the matrix-reasoning subtest. The IQ scores are standard scores. The estimate of claimant's IQ scores was as follows:

Verbal IQ	86
Performance IQ	83
Full Scale IQ	85

Dr. Goodlin-Jones also administered the Vineland Adaptive Behavior Scales-II (Vineland), which utilizes a questionnaire that was completed by claimant's grandmother. His scores in the four domains were as follows:

[5] Medical Investigation of Neurodevelopmental Disorders.

Communication	90
Daily Living Skills	87
Socialization	78
Overall Composite Score	83

Dr. Goodlin-Jones explained that a composite score of 83 is in the moderate to low range of adaptive functioning.

After completing a best practice autism evaluation, which included administration of the Autism Diagnostic Observation Schedule (ADOS), she concluded, "the diagnostic impression for [claimant] at this time is no concern for autism. He does show immaturity and difficulties by history by maternal interview of getting along with others. A child with cognitive abilities in the borderline range will often have difficulties keeping up with others and the fast pace of social interaction." Dr. Goodlin-Jones concluded that 'the continuing diagnoses of oppositional defiant disorder (313.81, DSM-IV) is appropriate."

15. May 8, 2006 report by Licensed Marriage and Family Therapist, Gerry Blasingame, M.A., New Directions to Hope. Mr. Blasingame conducted an autism spectrum disorder assessment and concluded that claimant's score on the ADOS was below the cut off score for an autism spectrum condition, and he did not meet the criteria for a DSM-IV-TR[6] Diagnosis. Mr. Blasingame offered the following diagnostic impression, based on the ADOS and diagnostic interview data:

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[6] The Diagnostic and Statistical Manual of Mental Disorders, Forth Edition, Text Revision (DSM-IV-TR) was the standard for diagnosis and classification at the time of this evaluation. It is a multiaxial system which involves five axes, each of which refers to a different domain of information as follows:

Axis I	Clinical Disorders
	Other Conditions That May Be a Focus of Clinical Attention

AXIS 1:	Attention Deficit Hyperactivity Disorder Not Otherwise specified Pervasive Developmental Disorder, Not Otherwise Specified Behavior Disorder Not Otherwise Specified (a downgrade of Oppositional Defiant Disorder) Enuresis
AXIS II:	No diagnosis on AXIS II
AXIS III:	None reported

The diagnosis of PDD-NOS does not appear to be supported by data but solely the following summary:

> Based on the information provided by [claimant's] guardians during the interview and ADOS session, [claimant] is assessed to not evidence symptoms of Autism itself. He does have historical symptoms suggestive of a diagnoses [sic] of pervasive developmental disorder not otherwise specified but these were not observed during the ADOS. The diagnosis is not altogether clear given his ADHD symptoms have been untreated. What is clear is that the diagnosis is not autism.

Axis II	Personality Disorders Mental Retardation
Axis III	General Medical Conditions
Axis IV	Psychosocial and Environmental Problems
Axis V	Global Assessment of Functioning

16. In Mr. Blasingame's May 8, 2006 Autism Spectrum Disorder Evaluation Summary, he included the following information regarding the referral:

> [Claimant's grandparents] expressed interest in determining what [claimant's] needs are and want help identifying how to help [him]. We agreed to seek to clarify what his current diagnosis is rather than simply rule in or out autism.

Mr. Blasingame specifically made no Axis II diagnosis.

17. September 2006 WISC-IV scores reported by Kitt Murrison, Ph.D. Dr. Murrison evaluated claimant, who was 8 years old, due to concerns with "immaturity and lack of social skills." She administered the Wechsler Intelligence Scale for Children, Fourth Edition, with the following results:

Verbal IQ	82
Performance IQ	78
Full Scale IQ	78

On the Vineland Adaptive Behavioral Scales, [claimant] received the following age equivalencies:

Communication:		Daily Living Skills:	3-5
Receptive	1-3	Socialization:	1-7
Expressive	2-4	Motor Skills:	4-6
Written	7-3		

Dr. Murrison diagnosed Dysthymic Disorder, PDD-NOS, Borderline Intellectual Functioning and Phonological Disorder.

18. May 2008 Confidential Cognitive Evaluation report by School Psychologist Janice Forest. This evaluation was completed by the Red Bluff Elementary School District and is thoroughly discussed below under *School Records and Testing*.[7]

19. June 2, 2008 Psychological Testing Evaluation report by Melissa Ford, Psy.D., Children's First Counseling. Tehama County Mental Health referred claimant to Dr. Ford for evaluation. The purpose of the testing was "for diagnostic clarification and treatment options." Dr. Ford offered the following impressions:

DSM-IV-TR Diagnosis:

Axis I:	294.9 Cognitive Disorder, NOS; 299.80 PDD, NOS by history
Axis II:	315.39 Phonological Disorder by history
Axis III:	R/O Fragile X Syndrome; R/O Neurological/Organic Impairment; Fetal Distress; traumatic birth; wears reading glasses; hx of high fevers, and several head injuries
Axis IV:	Family, Social, Academic, Financial
Axis V:	GAF 55-Current

20. October 25, 2010 Neuropsychological Evaluation report by Genevieve Reilley, Ph.D. Claimant was appealing the regional center's denial of eligibility and sought a neuropsychological evaluation from Dr. Reilley who administered the WISC-IV with the following standard scores reported:

Verbal Comprehension	61
Perceptual Reasoning	84
Working Memory	83

[7] See Factual Finding 23.

Processing Speed	78
Full Scale IQ	70

Dr. Reilley utilized the Adaptive Behavior Assessment System, Second Edition (ABAS-II). The ABAS-II is an adaptive behavior measure used to assess adaptive skills functioning utilizing rating forms. Claimant's grandmother was the informant. Based on her responses, claimant obtained scores that were within the Extremely Low range.

Dr. Reilley determined that the "results of neuropsychological measures over-all are very low." She also opined "the current findings indicate that executive functioning is a particularly vulnerable, at-risk area for this child." Her Summary/Discussion included the following:

> Current neuropsychological evaluation results describe a 12-year-old whose functioning most closely resembles that of a person with the diagnosis of Mild Mental Retardation. Evaluations over the years indicate a downward progression of cognitive results, as his functioning falls farther and farther behind that of his same age peers. By age eighteen, his results will likely fall well within the Mild Mental Retardation range.

Dr. Reilley offered the following Diagnostic Impressions:

Axis I	--
Axis II	Mild Mental Retardation (now also known as Mild Intellectual Disability)
Axis III	--
Axis IV	educational, social
Axis V	40

21. May 5, 2011 report by Monica Silva, Ph.D. FNRC referred claimant (age 13) to Licensed Clinical Psychologist Silva "for an evaluation of cognitive, adaptive, and behavioral skills in order to determine eligibility." Dr. Silva noted that claimant "may present with characteristics of an Autism Spectrum Disorder (ASD) as well as cognitive and adaptive delays." The purpose of the evaluation was to "summarize [claimant's] current cognitive, adaptive, and behavioral functioning and evaluate for the possibility of a Developmental Disorder."

Dr. Silva administered the WISC-IV and offered the following Composite Scores Summary:

Verbal Comprehension (VCI)	73
Perceptual Reasoning (PRI)	79
Working Memory (WMI)	65
Processing Speed (PSI)	83
Full Scale (FSIQ)	70

Dr. Silva also administered the ABAS-II, which utilized a parent form that was completed by claimant's grandmother. Her reporting resulted in scores within the Extremely Low range.

Dr. Silva's Summary and Clinical Opinions included the following:

> [Claimant] presents with a unique clinical picture, which is difficult to summarize. There are concerns regarding communication and socialization issues and although [claimant] presented as a highly social and verbal child, his manner of presentation was immature and atypical for a 13 year old. [Claimant], however, does not present with the

oddities and atypicalities typically seen in individuals diagnosed with Autism Spectrum Disorder (ASD).

[¶] . . . [¶]

[Claimant] does present with Borderline Intellectual Functioning and his manner of presentation is that of someone younger than his stated age. Those diagnosed with Borderline Intellectual Functioning are typically limited in terms of adaptive functioning in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, community resource use, self-direction, academic skills, work, leisure activities, health and safety. These limitations significantly interfere with an individual's ability to navigate through many everyday situations. While such individuals function at a higher level than those classified as mentally retarded, their cognitive functioning is nonetheless limited, creating problems for everyday functioning, judgment, and academic or occupational achievement. Additionally, individuals diagnosed with Borderline Intellectual Functioning are at a disadvantage when entering unfamiliar and stressful situations, but at the same time function well enough to make it difficult to determine definitively that there is a deficit present requiring assistance. Deficits often go unnoticed until affected individuals reach school settings or other demanding and unfamiliar environments. There [fore], the condition manifests itself in poor academic performance, lack of

attention to tasks, and behavioral problems, which may stem from frustration and social immaturity. Furthermore, [claimant] struggles with Sensory Integration issues, which should be further assessed and treated. Some of [claimant's] difficulties may stem from a history of trauma. She concluded as follows:

DSM-IV TR DIAGNOSIS

Axis I	No Diagnosis on Axis I
Axis II	Borderline Intellectual Functioning
Axis III	Sensory Integration Issues
Axis IV	Mild Social Issues
Axis V	GAF: 60

22. May 13, 2015 Psychological Testing Evaluation Summary by J. Reid McKellar, Ph.D. Tehama County Health Services referred claimant, at age 16, to Dr. McKellar "for evaluation for diagnostic clarification." Dr. McKellar summarized claimant's background as follows:

> [Claimant] presents with a complicated clinical picture for a variety of reasons. [Claimant] had some struggles in regards to development, likely because of early childhood depravation, and two neurodevelopmental disorders, Attention Deficit Hyperactivity Disorder and Learning Disorder. [Claimant] was diagnosed with an Autism Spectrum Disorder in 2006, although this diagnosis was refuted by two separate standard of practice evaluations. The writer has reviewed numerous past evaluations, and data indicates several behavioral issues and

> mental health complications, however a diagnosis of Autism Spectrum Disorder is not supported by available data, including numerous observations across environments.
>
> [Claimant] has bee[n] diagnosed with Attention Deficit Disorder and Anxiety Disorder in the past, and his most recent treating diagnosis is Oppositional Defiant Disorder. There is suspicion that [claimant] may be intellectually challenged due to his concrete manner of presenting and social immaturity, although past evaluation data suggests low average cognitive potential.

Dr. McKellar administered testing instruments, including the WASI, and offered the following:

> DSM-IV Diagnoses:
>
> 314.01 Attention Deficit Hyperactivity Disorder combined type
>
> 307.9 Communication Disorder NOS
>
> 315.9 Learning Disorder, NOS

Dr. McKellar explained that claimant's "intellectual functioning is in the low average range. However, [claimant] is likely to present as less intellectually endowed due to his social naiveté, deficits in processing speed and deficits in social communication." He described claimant as "an emotionally immature and naïve young man who exhibits clear lags in his communication development. These communication deficits are consistent with

one aspect of Autism, and described in the DSM-IV as Communication Disorder NOS. This disorder is more aptly described in the DSM V[8] (Social Communication Disorder.)[9]

Dr. McKellar recommended medication treatment to address symptoms of Attention Deficit Hyperactivity Disorder, behavioral services to help increase coping skills, and contact with claimant's school to determine whether or not he is eligible for speech therapy.

EDUCATIONAL RECORDS

23. May 2008 Confidential Cognitive Evaluation report by School Psychologist Janice Forest. When claimant was in the third grade, his grandmother requested Red Bluff Elementary School District perform a cognitive assessment of claimant. Janice Forest, School Psychologist, conducted her evaluation in May 2008. As part of her assessment report, Ms. Forest noted that claimant "had a series of evaluations since preschool due initially to concerns with speech and language development, and later social behavior."

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[8] The Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition (DSM-5) was released in May 2013. Most notably, it changed the diagnosis of Mental Retardation to Intellectual Disability (Intellectual Development Disorder) and no longer uses a multi-axial system. The new classification system combines the axes together and disorders are rated by severity.

[9] Dr. McKellar stated, "The current evaluation addressed diagnostic impressions based on the DSM-IV. However, the writer also was conscious of the DSM-5, and its application to [claimant's] profile during the evaluation process. [Claimant] clearly meets diagnostic criteria for DSM-5 Social (Pragmatic) Communication Disorder (315.39). Therefore, it would be advisable to work with [claimant's] school to determine whether or not he is eligible for speech therapy due to a deficit in pragmatics."

She provided educational background information, which included the following pertinent information:

> **June 11, 2003:** As a preschool student, [claimant] attended the Sacramento County SETA/Head Start Program. The Mental Health Component of SETA/Head Start referred [claimant] to Dr. Arthur Magana because of classroom behavior concerns and ongoing adjustment problems reported by [his] grandmother. Dr. Magana requested behavior rating scales by [claimant's] parents and teachers and forwarded the results to [claimant's] physician for further evaluation and treatment. At the same time, Head Start referred [claimant] to Sacramento County Mental Health with a recommendation for assessment and therapy.
>
> Dr. Magana reported that claimant's family had additional concerns about claimant's speech and language development and struggle with reciprocal relationships. They were concerned with "severe anger based episodes, problems with attention and impulse control…anxiety and perhaps depression" as well as symptoms of PTSD.
>
> Dr. Magana reported, "As with many children who are exposed to unstable attachments and a chaotic environment, [claimant] appears to be acting out in anger and anxiety, which is affecting his overall wellbeing."

October 24, 2003: [Claimant] enrolled at Jackson Heights School for kindergarten and was referred for a speech/language evaluation by the Student Study Team (SST). An Individualized Education Program (IEP) meeting was held on December 16, 2003, to discuss evaluation results. [Claimant] demonstrated significant delays in the development of receptive and expressive language skills and moderately delayed articulation development. The IEP team determined that [claimant] required special education services under the disability category of Speech or Language Impairment with goals for articulation, expressive language, and receptive language.

December 1, 2004: As a first grader at Jackson Heights School, [claimant] had an annual IEP review. The speech and language therapist noted significant improvement in language comprehension and articulation during the previous year. [Claimant] made two years growth in his expressive language and auditory comprehension of language but continued to need speech and language services. In her progress report, the therapist also noted tremendous growth in [claimant's] behavioral skills necessary for academic progress. He was able to attend to task for long periods of time, to engage in conversation, and to stay on topic. He was far less likely to get out of his seat and wander or to be distracted by external stimuli in the speech therapy room. He was learning the importance of listening before speaking and was less likely to

interrupt others and was able to follow verbal instruction much more successfully than a year earlier. [Claimant's] grandmother presented the Jackson Heights speech and language therapist with a discharge summary of [claimant's] enrollment in the Sacramento Scottish Rite Language Center individual speech/language therapy program that occurred between June 29, 2005 and August 10, 2005. The clinician worked with [claimant] on updating performance levels and increasing receptive and expressive language skills and auditory processing abilities. The clinician at the language center focused on increasing [claimant's] language development and auditory processing abilities, devoting a significant portion of the therapy to teaching him strategies to increase organization of vocabulary in order to improve retrieval and appropriate response modes. The clinician reported that homework that she gave to [claimant's] grandmother was regularly completed. The clinician also reported that [claimant's] grandmother provided information that, since his initial evaluation in April 2004, [claimant] had been diagnosed with Oppositional Defiant Disorder (ODD), Post Traumatic Stress Disorder (PTSD), and Attachment Disorder.

December 14, 2005: Now in the second grade, [claimant] had an annual IEP review. He continued to receive services under the disability category of speech or language impairment. [Claimant's] Grandmother indicated her concerns relevant to his education progress were social skills and language

development. The speech and language therapist noted that [claimant] was not happy with current academic activities. She noted that [claimant] did not pick up on social cues, did not know how to approach other children, his choice in playmates was not always appropriate, and he was beginning to say he didn't like school. [Claimant] needed structure to start his day. He played alongside others but tended to be disruptive. [Claimant] continued with goals in expressive language and articulation. The speech and language therapist noted that [claimant] had been referred by Far Northern Regional Center (FNRC) through Dr. Lisa Benaron to the U.C. Davis Medical Investigation of Neurological Disorders Institute (M.I.N.D. Institute) because of concerns about autistic/Asperger's like behavior. She also noted that he had been receiving services from North Valley Catholic Social Services for eight months.

August 18, 2006: IEP meeting to record progress and to update new information. The IEP team used the report from New Direction to Hope[10] to change [claimant's] primary disability to Autism as a result of his diagnosis of Pervasive Developmental Disorder Not Otherwise Specified.

November 29, 2006: Third grade annual IEP Review. Goals were developed and approved in articulation and expressive language.

[10] See Factual Finding 15.

March 27, 2007: IEP amendment to discuss classroom behavior concerns. [Claimant] had been getting physical recently in peer interactions. Attendance concerns were addressed (110/134 days present to date). Academic skills were lagging behind expectations.

April 23, 2007: Rescheduled IEP meeting to review classroom behavioral concerns. IEP team developed Behavior Support Plan (BSP). Team discussed retention.

August 16, 2007: [Claimant] was retained in third grade. His grandmother chose to place him on Home Independent Study (HIS). Speech and Language services would continue at Jackson Heights while on HIS.

Ms. Forest noted that claimant's annual IEP for the 2007-2008 school year indicated that he was in the fourth grade. The team subsequently met for a planning meeting and claimant's speech and language services were reduced from 50 minutes per week to 25 minutes per week.

She administered the WISC-IV with the following scores reported:

Verbal Comprehension	87
Perceptual Reasoning	77
Working Memory	77
Processing Speed	65
Full Scale IQ	72

Ms. Forest explained that claimant's "Full Scale IQ score (FSIQ), which is the most indicative measure of his intellectual functioning, fell within the 'Borderline' range with a

standard score of 72 (69-77 90% confidence interval). This Borderline range performance indicates that [claimant] may have difficulty keeping up with his peers in a wide variety of situations that require age-appropriate thinking and reasoning abilities."

24. November 17, 2010 Tehama County SELPA[11] Individualized Education Program (IEP). Claimant's IEP indicated that he qualified for special education based on a primary disability of Autism (AUT) and a secondary disability of Speech or Language Impairment (SLI), Non Severe. Claimant "lacks age appropriate social skills. Oral communication skills are affected." Placement was in regular education for 98% of the day. Special Education and Related Services consisted of 60 minutes per month of individual counseling and 120 minutes per month of Specialized Academic Instruction to monitor behavior, homework completion and math skills. An IEP baseline noted that claimant "completes about 15% of his homework assignments."

25. Jackson Heights Elementary School Evaluation by Valerie Moran, RSP. Academic skills were in the average range, except math calculation, which was in the low average range based on results from the Woodcock Johnson Test of Achievement III.

26. March 25, 2014 Shasta Union High School District Psycho-Educational Report by School Psychologist Teresa Hankins. Ms. Hankins assessed claimant as part of his triennial review for special education services. At that time, he was in ninth grade at Foothill High School and receiving services under the primary handicapping condition of Autistic-Like. He was enrolled in four periods of general education classes and two modified classes (Modified English and Modified Academic Lab). His course of study was on track to earn a high school diploma.

Ms. Hankins added information to claimant's educational record history. Specifically, in June 2009, the IEP team assessed claimant to determine if he met criteria under

[11] Special Education Local Plan Area.

Emotional Disturbance. It was determined that he did not. In November 2011 claimant was dismissed from speech services and the secondary qualification of SLI was removed.

The WASI was administered on March 10, 2014. Ms. Hankins described the WASI as "a brief and reliable measure of general cognitive functioning [which] consists of four subtests; Vocabulary, Similarities, Matrix Reasoning, and Block Design. Age-based standard scores are generated for all subtests. The results from these subtests produce composite scores for Verbal IQ, Performance IQ and Full Scale IQ."

She reported the following scores:

Verbal IQ	87
Performance IQ	97
Full Scale IQ	91

Ms. Hankins addressed the higher score results as follows:

> According to these assessment results, [claimant's] cognitive abilities appear to be in the low average to average range when compared to same age peers. No significant strengths or weaknesses were identified through this test administration. Review of his previous testing results suggested that [claimant's] cognitive abilities fell within the borderline to low average range. All standard procedures in regards to test protocol were carried out for the recent test sessions. It is unclear on why the cognitive scores appear so different, however; [claimant's] behaviors were also noted to be frequently negative and intense at those times and it is possible that his behavior hindered the testing process and subsequently; his scores. During this test session, [claimant]

was very cooperative, positive, appropriate, and appeared to give a good amount of effort.

The WIAT-II (Wechsler Individual Achievement Test-2nd Edition) was used to assess academic achievement. The assessment provided the following scores:

Index	Standard Score	Description
Word Reading	97	Average
Reading Comprehension	91	Average
Pseudoword Decoding	95	Average
Reading	92	Average
Numerical Operations	91	Average
Spelling	111	High Average
Written Expression	94	Average
Written Language	108	Average

When compared to the scores earned by others at his grade level, [claimant's] overall achievement is average. Results indicate that claimant's skills in spelling are a relative personal strength for him. Review of his previous assessment results in 2011 indicates that there has been a significant amount of growth in his reading, math, and writing skills.

At this time, it was noted that claimant was seeing Dr. Chellappa Parkevi via telemedicine for his psychiatric care, and he was taking medication for his emotional/behavioral concerns as well as attention concerns (Abilify and Vyvanse).

The BASC-2 (Behavior Assessment Scale for Children-2nd Edition) was administered to claimant to assess his current level of socio-emotional functioning. All results were within normal limits except "typicality" and "withdrawal." Review of the scores suggests that claimant's observable behaviors at school are frequently found to fall within the normal limits. Areas considered to be At-Risk were Atypicality, Personal Adjustment, and Withdrawal; however none of the areas were reported to be in the Clinically Significant range.

27. Shasta County SELPA IEP dated March 10, 2016. Claimant was attending Anderson New Technology Charter High School and his IEP specified that he would be in regular education for 99% of his school day with 1% of the day available for RSP (Resource Specialist Program) consultation and monitoring. A transition plan was in place and claimant was on track to graduate with a diploma in June 2017. His IEP notes under "Adaptive/Daily Living Skills" that claimant "demonstrates the ability to take care of his own needs."

IEP teacher notes mention a "big drop off in grades. No homework is being done and now there is less classwork being completed." "If these assignments were turned in (and on time), he could easily be holding a passing grade."

FNRC INDIVIDUAL PROGRAM PLANS (IPP)

28. Claimant's May 2, 2014 FNRC Individual Program Plan (IPP) states that claimant "is eligible for FNRC services based on an administrative decision as he was diagnosed with PDD-NOS, with a re-evaluation due in July 2014."

The IPP states that claimant will reside at the Remi Vista – Rocafort facility, with family contact, with the following explanation:

> [Claimant] was voluntarily placed by his grandmother/guardian in the Remi-Vista Cerro facility in March 2013. He has a history

> of exhibiting maladaptive sexual behaviors. He was showing a lack of boundaries and had been exposing himself and touching others in inappropriate ways. [Claimant] had begun to stabilize and discussion of transitioning him home had begun until he had an incident on a home visit. The incident involved him inappropriately touching a younger cousin *(incident reported to CPS by Remi Vista)*. The decision was then made to transition [claimant] to long term care and he moved to the Remi Vista-Rocafort facility in July 2013. [Claimant] displays socially disruptive behaviors and self-injurious behaviors. [Claimant] will engage in emotional outbursts when frustrated and sometimes reacts by eloping. He has greatly approved [sic] upon these behaviors since moving into the facility and the facility staff rarely sees them but is aware of the need for monitoring. [Claimant] requires assistance with personal care, including hygiene and bathing, dressing and safety awareness.

Remi Vista was responsible for IPP objectives including, training in household skills, respecting the personal boundaries of others, maintaining control of aggressive tendencies during times of conflict and frustration, and not manipulating others in an attempt to have his needs met.

An additional IPP objective provides for claimant to receive telemedicine services because he "has been diagnosed with Oppositional Defiant Disorder and ADHD. He is in need of telemedicine services for psychotropic medication management."

29. A July 1, 2014 IPP Addendum provided for claimant to receive an ABEL[12] Assessment by Gerry Blasingame. The reason for this need was:

> [Claimant] has shown a lack of boundaries having had incidents of exposing himself to others and touching others. He has recently shared information about past incidents that has caused concern amongst the ID team. It was agreed that an ABEL Assessment would be beneficial in determining the future services claimant] may require as he nears adulthood.

MEDICAL RECORDS

30. July 2008 assessment by Dr. Shailesh Asaiker. Dr. Asaiker's impressions included "Autistic [sic] spectrum disorder with intermittent discontrol behavior, mood disorder, anxiety, OCD, Attention Deficit Hyperactivity Disorder Impulsive, Inattentive subtype, oppositional/defiant behavior and intermittent discontrol behavior." The review does not include a review of DSM-IV criteria or observation. Dr. Asaikar prescribed Abilify.

31. September 28, 2015 Medical & Diagnostic Executive Summary by Pediatrician Patrick Quintal, M.D., Lassen Medical Group. Dr. Quintal noted that claimant had been his patient since August 31, 2009 and a patient of the medical group since 2006. He offered inconsistent opinions regarding claimant's condition based on record review. He opined as follows:

> I believe there is very little doubt of a proper diagnosis of intellectual disability (ICD-9 318.0) moderate with serious

[12] The ABEL assessment is designed as a tool to evaluate people who may be a sexual risk to children.

> behavioral difficulties. This is also equivalently labeled as borderline IQ, pervasive developmental delay, not otherwise specified (PDD/NOS), or mild mental retardation in other records. There have been other diagnoses that have been proposed and debated in various specialists' reports that may in fact apply as well; the overall impression of developmental delay with serious behavioral difficulties is repeatedly noted in the reports (developmental delay is included in autism spectrum disorder if not specifically stated. And is a possible underlying cause of attention deficit/hyperactivity disorder [ADHD], anxiety disorder, or oppositional-defiant disorder).[13]

Dr. Quintal concludes, "The most recent IQ scores from May 2015 indicate a 95% probability that [claimant's] IQ is between 73 and 82." He then opines that an "IQ in the 70s explains very well his past and present symptoms." Diagnostically, he states, "In the past, [claimant's] social behaviors have raised the question of autism. As he has gotten older, it appears that social communication disorder (ICD-9 307.9) is a more appropriate diagnosis for this. In addition, I am treating him for attention deficit/hyperactivity disorder (ICD-9 314.01)."

MENTAL HEALTH RECORDS

32. Tehama County Mental Health records include a September 2003 evaluation by Barbara Spear, LCSW followed by an October 2004 evaluation by Denise Smith, LCSW.

[13] Dr. Quintal comments about the apparent inconsistency in the evaluations stating, "these conditions are truly difficult to sort out unless they are quite severe. [Claimant's] problems are serious, but there are other patients more profoundly affected."

Claimant received a diagnosis of PTSD, Adjustment Disorder with Mixed Emotions and Disturbance of Conduct.

33. 2006 and 2007 records from Tehama County Mental Health state, "Symptoms do not meet the criteria for autism" and offered the diagnoses of ODD and PDD.

34. An April 2013 Tehama County Health Services Agency Mental Health Recovery Plan provides the following diagnosis:

Axis I	313.81 ODD
	299 Autistic D/O
Axis II	317 Mild Mental Retardation
Axis III	Scoliosis, leg & feet problems, gets overheated
Axis IV	EDU, SOC, OTH
Axis V	38

There was no information provided to explain this diagnosis. The objective of the Recovery Plan was for claimant "to improve his ability to keep himself & others safe by following rules & direction through increasing his ability to stop before he behaves & think about whether his behavior is safe & matches the rules or direction." Claimant was living in the Remi Vista Cerro Vista home at that time.

TESTIMONY

35. Robert Boyle, Ph.D. is a FNRC Staff Psychologist with extensive experience assessing and diagnosing individuals with developmental disabilities. Dr. Boyle testified that, in his capacity as an FNRC staff psychologist, one of his responsibilities is participating in the eligibility review process.

Dr. Boyle testified that having adaptive impairments does not establish that an individual has a qualifying disability making him eligible for regional center services and

supports. Adaptive deficits can exist without a developmental disability. They must be attributable to one of the five eligible conditions. FNRC concluded that the evidence failed to establish regional center eligibility. Although claimant has deficits in adaptive skills, Dr. Boyle agrees that he does not have an eligible condition causing those deficits.

Dr. Boyle testified that claimant does not have an intellectual disability and that testing over the years has rendered scores between the low average and borderline range. He explained that it was important to consider subtests scores; an individual with ID would show uniformly low scores over indices demonstrating global deficits in cognitive functioning. Claimant's scores showed considerable "scatter" which may be indicative of other difficulties. "For ID you are looking for scores that are uniformly low and consistent over time. A Full Scale IQ score may be deceptive if there is significant disparity in subtest scores."

36. Dr. Boyle disagreed with Dr. Reilley's assertion that claimant's functioning on his neuropsychological evaluation most closely resembles that of a person with the diagnosis of Mild Mental Retardation and that, with a downward progression of cognitive results, as his functioning falls farther and farther behind that of his age peers, by age eighteen his results will likely fall well within the Mild Mental Retardation range.

Since Dr. Reilley's report was completed in 2010, we have the benefit of time to see that claimant, who is now 18, does not have results well within the Mild Mental Retardation range. No lower scores have been reported since that time; however higher scores have been received since 2010.

37. Dr. Boyle opined that the family is seeking eligibility based upon a contention that claimant's condition is ID or fifth category, because of the impairments under which he struggles. He testified that the evidence did not demonstrate intellectual functioning at the level of or similar to ID. Through claimant's entire school career, those disabilities were never diagnosed, and he suggested that claimant's adaptive skills deficits

result from other sources. To have a condition which requires treatment similar to that required by an individual with ID is not simply determining whether the services provided to such persons would benefit claimant. It is whether claimant's condition requires such treatment.

Claimant has consistently scored in the borderline/low average range on standardized intelligence tests. He exhibits adaptive deficits which are best explained by his social communication disorder coupled with other diagnoses such that services required would most appropriately be provided from the treatment perspective of mental health rather than mental retardation.

38. Dr. Boyle noted that in Dr. Reilley's evaluation, and others, claimant's grandmother was the sole reporter for adaptive functioning on the ABAS and suggested that it is helpful to have more than one person complete the questionnaire to address adaptive functioning across contexts.

39. Finally, Dr. Boyle addressed claimant's argument that results from WASI administrations were not reliable because it is an abbreviated evaluation. While the WISC-IV is more thorough, the WASI scores are compared to standardized norms and are a psychometrically reliable indicator known to correlate with scores on the WISC.

40. Claimant's grandmother testified to the adaptive difficulties claimant has had throughout his life. She explained her concern that she feels he does not have self-help skills that are at peer level, he does not attend to personal hygiene well, has difficulty with social relationships and choses to play with younger children more than same-age peers. He exhibits unacceptable social behaviors, enjoys playing with stuffed animals, is not respectful of personal boundaries, and can be taken advantage of because he is gullible and trusting of strangers. She is extremely concerned with his ability to live independently.

During claimant's school years, he had trouble with his speech and learning, and making friends was difficult. He has made poor life choices and was reported to function

below his chronological age in some areas, but not all. She did testify that he was doing well in school, which was later attributed to the smaller size of the charter high school.

Claimant does not choose appropriate clothing for weather conditions. He still has 'temper tantrums" but will no longer run away as he is fearful of going to a group home. She stated that he will need future help in the home with behaviors, money management, safety skills and other daily living skills. She believes he requires assistance and support to live independently.

Claimant's grandmother believes that he qualifies for regional center services; he has needs similar to regional center consumers, and could benefit from the services FNRC could provide.

41. Jenna Ball, BCBA, is a behavior analyst with Best Behavior, LLC. She has worked with claimant and testified to her observations. She testified that claimant was immature, and lacks understanding of what is socially appropriate in various settings. For example, she described that he enjoyed playing with action figures and stuffed animals and did not understand that it might be inappropriate to bring these items into public view. She described him as being naïve and trusting and was concerned that he could be taken advantage of. Ms. Ball testified that claimant lacks independent living, behavioral and social skills.

She explained that she has not worked with claimant for the last couple of years because his insurance will not cover the service if he does not have an ASD diagnosis. However, in the time she did work with him, she explained that he could be noncompliant, aggressive, and was susceptible to peer pressure and coercion. Ms. Ball opined that claimant would not be able to live independently, would be a safety risk, and would require assistance in numerous areas of daily living.

ELIGIBILITY BASED ON INTELLECTUAL DISABILITY

42. The diagnostic criteria for "Mental Retardation" as set forth in section 4512 is defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) as follows:

> A. Significantly subaverage intellectual functioning: an IQ of approximately 70 or below on an individually administered IQ test…
>
> B. Concurrent deficits or impairments in present adaptive functioning (i.e., the person's effectiveness in meeting the standards expected for his or her age by his or her culture group) in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety.
>
> C. The onset is before 18 years.

43. The DSM-IV-TR includes the following explanation of diagnostic features:

> The essential feature of Mental Retardation is significantly subaverage general intellectual functioning (Criterion A) that is accompanied by significant limitations in adaptive functioning[14] in at least two of the following skill areas:

[14] DSM-IV-TR states that "[*a*]*daptive functioning* refers to how effectively individuals cope with common life demands and how well they meet the standard of personal independence expected of someone in their particular age group, sociocultural

communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety. (Criterion B). The onset must occur before age 18 years (Criterion C). Mental Retardation has many different etiologies and may be seen as a final common pathway of various pathological processes that affect the functioning of the central nervous system.

General intellectual functioning is defined by the intelligence quotient (IQ or IQ-equivalent) obtained by assessment with one or more of the standardized, individually administered intelligence tests . . . Significantly subaverage intellectual functioning is defined as an IQ of about 70 or below (approximately 2 standard deviations below the mean). It should be noted that there is a measurement of error of approximately 5 points in assessing IQ, although this may vary from instrument to instrument (e.g., a Wechsler IQ of 70 is considered to represent a range of 65-75). Thus, it is possible to diagnose Mental Retardation in individuals with IQs between 70 and 75 who exhibit significant deficits in adaptive behavior. Conversely, Mental Retardation would not be

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background, and community setting. Adaptive functioning may be influenced by various factors, including education, motivation, personality characteristics, social and vocational opportunities, and the mental disorders and general medical conditions that may coexist with Mental Retardation."

diagnosed in an individual with an IQ lower than 70 if there are no significant deficits or impairments in adaptive functioning.

The DSM-IV-TR uses codes based on the degree of severity reflecting level of intellectual impairment:

317	Mild Mental Retardation:	IQ level 50-55 to approximately 70
318.0	Moderate Mental Retardation:	IQ level 35-40 to 50-55
318.1	Severe Mental Retardation:	IQ level 20-25 to 35-40
318.2	Profound Mental Retardation:	IQ level below 20 or 25

44. The Diagnostic Criteria for Intellectual Disability in the DSM-V[15] is set forth as follows:

> Intellectual Disability (intellectual developmental disorder) is a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains. The following three criteria must be met:

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

[15] The DSM-IV-TR governed during claimant's developmental period. The DSM-5 is the current standard for diagnosis and classification. Testimony presented addressed both versions.

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 adaptive deficits during the developmental period.

45. The DSM-V offers the following pertinent diagnostic features:

> The essential features of intellectual disability (intellectual developmental disorder) are deficits in general mental abilities (Criterion A) and impairment in everyday adaptive functioning, in comparison to an individual's age-, gender-, and socioculturally matched peers (Criterion B). Onset is during the developmental period (Criterion C). The diagnosis of intellectual disability is based on both clinical assessment and standardized testing of intellectual and adaptive functions.
>
> Criterion A refers to intellectual functions that involve reasoning, problem solving, planning, abstract thinking, judgment, learning from instruction and experience, and practical understanding. Critical components include verbal comprehension, working memory, perceptual reasoning, quantitative reasoning, abstract thought, and cognitive efficacy. Intellectual 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 population mean, including a margin for measurement error (generally +5 points. On tests with a standard deviation of 15 and a mean of 100, this involves a score of 65-75 (70 ± 5). Clinical training and judgment are required to interpret test results and assess intellectual performance.

[¶] . . . [¶]

IQ test scores are approximations of conceptual functioning but may be insufficient to assess reasoning in real-life situations and mastery of practical tasks. For example, 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. Thus, clinical judgment is needed in interpreting the results of IQ tests.

Deficits in adaptive functioning (Criterion B) refer to how well a person meets community standards of personal independence and social responsibility, in comparison to others of similar age and sociocultural

background. Adaptive functioning involves adaptive reasoning in three domains: conceptual, social and practical. The *conceptual (academic) domain* involves competence in memory, language, reading, writing, math reasoning, acquisition of practical knowledge, problem solving and judgment in novel situations, among others. The *social domain* involves awareness of others' thoughts, feelings and experiences; empathy; interpersonal communication skills; friendship abilities; and social judgment, among others. The *practical domain* involves learning and self-management across life settings, including personal care, job responsibilities, money management, recreation, self-management of behavior, and school and work task organization, among others. Intellectual capacity, education, motivation, socialization, personality features, vocational opportunity, cultural experience, and coexisting general medical conditions or mental disorders influence adaptive functioning.

Adaptive 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. Scores from standardized measures and interview sources must be interpreted using clinical judgment . . .
>
> Criterion B is met when at least one domain of adaptive functioning—conceptual, social or practical—is sufficiently impaired that ongoing support is needed in order for the person to perform adequately in one or more life settings at school, work, at home, or in the community. To meet diagnostic criteria for intellectual disability, the deficits in adaptive functioning must be directly related to the intellectual impairments described in Criterion A. Criterion C, onset during the developmental period, refers to recognition that intellectual and adaptive deficits are present during childhood or adolescence.

46. Claimant argues that his lowest reported Full Scale IQ score of 70 justifies a finding of mild mental retardation based on the measurement of error of approximately 5 points. However this measurement supports a range, above or below, the given score and would apply equally to all of claimant's IQ test results. Claimant was reported to exert varying amounts of effort at different test administrations. It is generally considered that an individual may score lower than his ability but would be unable to score above his ability.

While the DSM-5 does not rely on IQ scores alone, it does require clinical assessment *and* standardized testing of both intellectual and adaptive functioning. While the essential feature per DSM-IV is "significantly subaverage general intellectual

functioning," the DSM-V looks to "deficits in general mental abilities." And, "intellectual functioning is typically measured with individually administered and psychometrically valid, comprehensive, culturally appropriate, psychometrically sound tests of intelligence." A determination cannot be based solely on claimant's adaptive deficits, but they must be related to deficits in general mental abilities.

Claimant does have limitations in adaptive skills. The evidence presented at hearing did not establish that claimant, presented with the necessary global deficits confirmed by both clinical assessment and standardized intelligence testing to support a diagnosis of intellectual disability. Consequently, claimant does not qualify for regional center services under the category of intellectual disability.

ELIGIBILITY BASED ON THE "FIFTH CATEGORY" (A DISABLING CONDITION FOUND TO BE CLOSELY RELATED TO INTELLECTUAL DISABILITY OR TO REQUIRE TREATMENT SIMILAR TO THAT REQUIRED FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY)

47. In addressing eligibility under the fifth category, the Court in *Mason v. Office of Administrative Hearings* (2001) 89 Cal.App.4th 1119, 1129, stated:

> …The fifth category condition must be very similar to mental retardation, with many of the same, or close to the same, factors required in classifying a person as mentally retarded. Furthermore, the various additional factors required in designating an individual developmentally disabled and substantially handicapped must apply as well.

48. Fifth category eligibility determinations typically begin with an initial consideration of whether claimant has global deficits in intellectual functioning. This is done prior to consideration of other fifth category elements related to similarities between the two conditions, or the treatment needed.

49. An appellate decision has suggested, when considering whether an individual is eligible for regional center services under the fifth category, that eligibility may be largely based on the established need for treatment similar to that provided for individuals with mental retardation, and notwithstanding an individual's relatively high level of intellectual functioning. (*Samantha C. v. State Department of Developmental Services* (2010) 185 Cal.App.4th 1462.) In *Samantha C.*, the individual applying for regional center services did not meet the criteria for mental retardation. The court understood and noted that the Association of Regional Center Agencies had guidelines which recommended consideration of fifth category for those individuals whose "general intellectual functioning is in the low borderline range of intelligence (I.Q. scores ranging from 70-74)." (*Id.* at p. 1477). However, the court confirmed that individuals may qualify for regional center services under the fifth category on either of two independent bases, with one basis requiring only that an individual require treatment similar to that required for individuals with mental retardation. Here, claimant believes that his condition is closely related to mental retardation. He also believes he requires treatment similar to that required for individuals with mental retardation.

FIFTH CATEGORY ELIGIBILITY-CONDITION CLOSELY RELATED TO MENTAL RETARDATION

50. Claimant contends that he is eligible for regional center services based upon a condition being closely related to mental retardation due to his impairments in adaptive functioning. The DSM explains that deficits in adaptive functioning can have a number of causes. The fact that claimant has deficits in adaptive functioning alone, is not sufficient to establish that he has a condition closely related to mental retardation. To meet diagnostic criteria for intellectual disability, the DSM-IV-TR requires significantly subaverage general intellectual functioning that is "accompanied by" significant limitations in adaptive

functioning. The DSM-V also requires that the deficits in adaptive functioning must be directly related to the intellectual impairments.

51. Claimant's general intellectual functioning, based on his IQ scores on standardized, intelligence tests, did not meet the definition of significantly subaverage intellectual functioning under the DSM. Thus, claimant does not have this "essential feature" of mental retardation. The fact that claimant may have deficits in adaptive functioning alone, without global intellectual impairment, does not establish that he has a condition closely related to mental retardation.

52. Over the years, claimant has been diagnosed with a variety of conditions, including; ODD, ADHD, anxiety, mood, behavior, learning and communication disorders, inappropriate sexual behaviors, and PTSD. Any of these conditions, individually or together, could cause his adaptive functioning difficulties.

For example, the DSM-5 describes the functional consequences of ADHD, in part, as follows:

> ADHD is associated with reduced school performance and academic attainment, social rejection, and, in adults, poorer occupational performance, attainment, attendance, and higher probability of unemployment as well as elevated interpersonal conflict. Children with ADHD are significantly more likely than their peers without ADHD to develop conduct disorder in adolescence and antisocial personality disorder in adulthood . .
>
> Inadequate or variable self-application to tasks that require sustained effort is often interpreted by others as laziness, irresponsibility, or failure to cooperate. Family relationships may be characterized by discord and negative interactions.

> Peer relationships are often disrupted by peer rejection, neglect, or teasing of the individual with ADHD. On average, individuals with ADHD obtain less schooling, have poorer vocational achievement, and have reduced intellectual scores than their peers, although there is great variability. In its severe form, the disorder is markedly impairing, affecting social, familial, and scholastic/occupational adjustment.
>
> Academic deficits, school-related problems, and peer neglect tend to be most associated with elevated symptoms of inattention, whereas peer rejection and, to a lesser extent, accidental injury are most salient with marked symptoms of hyperactivity or impulsivity.

There was no persuasive evidence presented that any of these conditions required significantly subaverage intellectual functioning or were shown to be closely related to intellectual disability. There was no evidence presented that claimant qualified for special education as a student with intellectual disability.

FIFTH CATEGORY ELIGIBILITY-CONDITION REQUIRING TREATMENT SIMILAR TO THAT REQUIRED FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY

53. Fifth category eligibility may also be based upon a condition requiring treatment similar to that required by individuals with mental retardation. "Treatment" and "services" do not mean the same thing. Individuals without developmental disabilities may benefit from many of the services and supports provided to regional center consumers. Section 4512, subdivision (b) defines "services and supports" as follows:

> "Services and supports for persons with developmental disabilities" means specialized services and supports or special adaptations of generic services and supports directed toward the alleviation of the developmental disability or toward the social, personal, physical, or economic habilitation or rehabilitation of an individual with a developmental disability, or toward the achievement and maintenance of independent, productive, normal lives.

Regional center services and supports targeted at improving or alleviating a developmental disability may be considered "treatment" of developmental disabilities. But regional center services and supports go beyond treatment, focusing on improving an eligible individual's social, personal, physical or economic status or assisting the individual in living an independent, productive and normal life. Thus, section 4512 elaborates further upon the services and supports listed in a consumer's individual program plan as including "diagnoses, evaluation*, treatment,* personal care, day care, domiciliary care, special living arrangements, physical, occupational and speech therapy, training, education, supported and sheltered employment, mental health services…" (Welf. & Inst. Code, § 4512, subd. (b). (Emphasis added). The designation of "treatment" as a separate item is clear indication that it is not merely a synonym for services and supports, and this stands to reason given the broader mission of the Lanterman Act:

> It is the intent of the Legislature that regional centers assist persons with developmental disabilities and their families in securing services and supports which maximize opportunities and choices for living, working, learning, and recreating in the community. (Welf. & Inst. Code, § 4640.7, subd, (a)).

54. Fifth category eligibility must be based upon an individual requiring "treatment" similar to that required by individuals with mental retardation. The wide range of services and supports listed under section 4512, subdivision (b), are not specific to mental retardation. One would not need to suffer from mental retardation, or any developmental disability, to benefit from the broad array of services and supports provided by ACRC to individuals with mental retardation. They could be helpful for individuals with other disabilities, or for individuals with mental health disorders, or individuals with no disorders at all. The Legislature clearly intended that an individual would have a condition similar to mental retardation, or would require *treatment* that is specifically required by individuals with mental retardation, and not any other condition, in order to be found eligible.

55. In *Samantha C.*, no attempt was made to distinguish treatment under the Lanterman Act as a discrete part or subset of the broader array of services provided to those seeking fifth category eligibility. Thus, the appellate court made reference to individuals with mental retardation and with fifth category eligibility both needing "many of the same kinds of treatment, such as services providing help with cooking, public transportation, money management, rehabilitative and vocational training, independent living skills training, specialized teaching and skill development approaches, and supported employment services." (*Samantha C. v. State Department of Developmental Services, supra*, 185 Cal.App.4th 1462, 1493.) This broader characterization of "treatment" cannot properly be interpreted as allowing individuals with difficulties in adaptive functioning, and who require assistance with public transportation, child care, vocational training, or money management, to qualify under the fifth category without more. For example, such services as vocational training are offered to individuals without mental retardation through the California Department of Rehabilitation. This demonstrates that it is not necessary for an

individual to have mental retardation to demonstrate a need for services which can be helpful for individuals with mental retardation.

Individuals with mental retardation might require many of the services and supports listed in Welfare and Institutions Code section 4512, which could benefit any member of the public: assistance in locating a home, child care, emergency and crisis intervention, homemaker services, paid roommates, transportation services, information and referral services, advocacy assistance, technical and financial assistance. To extend the reasoning of *Samantha C.*, an individual found to require assistance in any one of these areas could be found eligible for regional center services under the fifth category. However, it is unreasonable to conclude that any individual that might benefit from a service or support provided by the regional center, which might also benefit an individual with intellectual disability, requires treatment similar to that required by individuals with intellectual disability. This was clearly not the intent of the Legislature.

Thus, while fifth category eligibility has separate condition and needs-based prongs, the latter must still consider whether the individual's condition has many of the same, or close to the same, factors required in classifying a person as mentally retarded. (*Mason v. Office of Administrative Hearing, supra*, 89 Cal.App.4th 1119.) Furthermore the various additional factors required as designating an individual as developmentally disabled and substantially handicapped must apply as well. (*Id.* at p. 1129.) *Samantha C.* must therefore be viewed in context of the broader legislative mandate to serve individuals with developmental disabilities only. A degree of subjectivity is involved in determining whether the condition is substantially similar to mental retardation and requires similar treatment. (*Id.* at p. 1130; *Samantha C. v. State Department of Developmental Services, supra*, 185 Ca.App.4th 1462, 1485.) This recognizes the difficulty in defining with precision certain developmental disabilities. Thus, the *Mason* court determined: "it appears that it was the intent of those enacting the Lanterman Act and its implementing regulations not to

provide a detailed definition of 'developmental disability' so as to allow greater deference to the [regional center] professionals in determining who should qualify as developmentally disabled and allow some flexibility in determining eligibility so as not to rule out eligibility of individuals with unanticipated conditions, who might need services." (*Id.* at p. 1129.)

56. The Lanterman Act and Title 17 Regulations do not discuss services and supports available from regional centers in the eligibility criteria. Rather, an individual's planning team discusses services and supports after that individual is made eligible. Section 4512, subdivision (b) explains:

> . . . The determination of which services and supports are necessary for each consumer shall be made through the individual program plan process. The determination shall be made on the basis of the needs and preferences of the consumer or, where appropriate, the consumer's family, and shall include consideration of a range of service options proposed by individual program plan participants, the effectiveness of each option in meeting the goals stated in the individual program plan, and the cost-effectiveness of each option.

There is no mandate that eligibility determinations include consideration of whether an individual might benefit from an available regional center service or support. Rather, services and supports are determined by the planning team based on "needs and preferences" of the consumer. A need or preference for a specific service or support determined by the planning team is not the same as a determination by a qualified

professional of what treatment is required for an individual with a specific developmental disability.

57. The evidence was not persuasive that claimant's treatment needs were targeted at improving or alleviating a developmental disability similar to intellectual disability. The fact that claimant might benefit from some of the services that could be provided by the regional center does not mean that he requires treatment similar to that required by individuals with intellectual disability. Rather, claimant's recommended treatments included such things as medication management, speech therapy, counseling and behavior services geared at addressing mental health, communication and social behavior disorders.

DISCUSSION

58. When all the evidence is considered, claimant did not establish that he qualifies for services from FNRC under the Lanterman Act. While claimant has challenges and exhibits a wide array of symptoms, his challenges and symptoms result from his medical and mental health issues, which do not constitute a developmental disability under the Lanterman Act.

Educational history shows that he functions cognitively at a higher level than an individual with an intellectual disability. His IEPs over the years have focused on social, communication, and behavioral concerns. He was never identified as a student with mental retardation/intellectual ability. Development delays do not mean developmental disability within the meaning of the Lanterman Act. Global deficits in cognitive functioning are distinguishable from communication and specific learning disorders. Claimant is attending high school in regular education 99% of his day and completing a course of study leading to a diploma with an anticipated graduation date of June 2017. Any current grade struggles appear to be related to his failure to complete and turn in assignments.

Adaptive deficits do not appear consistent across environments. The school does not report seeing many of the behaviors/concerns noted in the home environment.

The possibility of benefiting from regional center services also does not create eligibility. Many people might benefit from the array of services provided by the regional center, whether or not they are diagnosed as Developmentally Disabled.

59. Claimant bears the burden of establishing that he meets the eligibility requirements for services under the Lanterman Act.[16] He has not met that burden. The evidence presented did not prove that claimant is substantially disabled by a qualifying condition that is expected to continue indefinitely. He did not meet the diagnostic criteria for an intellectual disability, or a disabling condition found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability. There was no evidence to show that he has epilepsy, cerebral palsy, or autism. Accordingly, claimant does not have a developmental disability as defined by the Lanterman Act. Consequently, claimant's request for services and supports from FNRC under the Lanterman Act must be denied.

LEGAL CONCLUSIONS

1. Eligibility for regional center services is limited to those persons meeting the eligibility criteria for one of the five categories of developmental disabilities set forth in section 4512 as follows:

> "Developmental disability" means a disability that originates before an individual attains age 18 years, continues, or can be

[16] California Evidence Code section 500 states that "[e]xcept as otherwise provided by law, a party has the burden of proof as to each fact the existence or nonexistence of which is essential to the claim for relief or defense that he is asserting."

> 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 [commonly known as the "fifth category"], but shall not include other handicapping conditions that consist solely physical in nature.

2. The statutory and regulatory definitions of "developmental disability" (Welf. & Inst. Code, § 4512 and Cal. Code. Regs., tit. 17, §54000) exclude conditions that are solely physical in nature. California Code of Regulations, title 17, section 54000, also excludes conditions that are solely psychiatric disorders or solely learning disabilities.

Claimant contends that he exhibits deficits or impairments in his adaptive functioning, is impaired by these limitations, and would benefit from regional center services. However, regional center services are limited to those individuals meeting the stated eligibility criteria. The evidence presented did not prove that claimant has impairments that result from a qualifying condition which originated and constituted a substantial disability before the age of eighteen. There was no evidence to support a finding of intellectual disability or a condition closely related to intellectual disability, or requiring treatment similar to that required for individuals with intellectual disability.

3. Claimant did not prove that he has a developmental disability as defined by the Lanterman Act. Therefore, he is not eligible for regional center services.

ORDER

Claimant's appeal from the Far Northern Regional Center's denial of eligibility for services is DENIED. Claimant is not eligible for regional center services under the Lanterman Act.

DATED: July 25, 2016

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SUSAN H. HOLLINGSHEAD

Administrative Law Judge

Office of Administrative Hearing

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).)