BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: CLAIMANT, vs. EASTERN LOS ANGELES REGIONAL CENTER, Service Agency.	OAH No. 2017010399

DECISION

Eileen Cohn, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on February 21, 2017, in Alhambra, California.

Jacob Romero, Fair Hearing Coordinator, represented the Eastern Los Angeles Regional Center (RC or Service Agency). Claimant's parents represented claimant.[1]

Oral and documentary evidence was received. The record was closed and the matter submitted on February 21, 2017.

ISSUE

The parties stipulated to the following issue:

Is claimant eligible for RC services and supports under the qualifying categories of intellectual disability, autism, or the fifth category, a disabling condition closely

[1] The names of claimant and his family members are excluded throughout to protect their privacy.

related to intellectual disability or requiring treatment similar to that for individuals with an intellectual disability?

EVIDENCE RELIED UPON

Documents: RC's exhibits 1-15; Diagnostic and Statistical Manual, Fifth Edition (DSM-5).[2]

Testimony: Randi Bienstock, Doctor of Psychology (Psy.D.), claimant's mother and father.

SUMMARY

Claimant, a 12-year old boy, contends he is eligible for RC services under the category of intellectual disability (ID), fifth category, or autism.

The RC acknowledges claimant has deficits that would benefit from RC services, but maintains claimant is not eligible for services under the categories of intellectual disability, autism, or the fifth category, or as an individual with adaptive needs similar to that of an intellectually disabled individual. The RC maintains that claimant's learning and social communication deficits and recent mental health challenges account for his current adaptive functioning deficits.

Based upon the findings and conclusions of law, claimant failed to meet his burden of proof that he is eligible for services from the RC under the categories of intellectual disability, autism and the fifth category.

FACTUAL FINDINGS

1. Claimant applied for RC services in 2016. The RC assessed claimant in the

[2] The parties stipulated to Official Notice of the DSM-5 in its entirety. (Gov't. Code § 11515.)

following manner: Susan Gonzalez, the assessment coordinator, conducted a psychosocial assessment on August 4, 2016 (Exhibit 3); licensed psychologist, Larry Gaines, Ph.D. (doctor of philosophy in psychology) conducted a psychological assessment on August 4, 2015 which included a review of school and medical records (Exhibit 4); and Randi Bienstock, Psy.D., the RC consulting psychologist and expert, conducted a record review which encompassed claimant's school-based and Dr. Gaines' assessments, his individualized education program, and claimant's medical doctor's recommendations. (Exhibits 5 and 11.)

2. On December 1, 2016, after the RC's professionals completed their review and the RC's interdisciplinary assessment team determined claimant was not eligible for RC services and support, Gloria Wong, Executive Director, sent claimant a letter declining his request for eligibility for RC services under the categories of autism, "or any other disability." Ms. Wong notified claimant of the interdisciplinary team's recommendations, which included: relying on claimant's school district's obligation to provide him with appropriate special education services and behavior supports, if needed; obtaining routine medical and dental care; continuing mental health services; and obtaining a psychiatric evaluation regarding family dynamics, emotional issues, school stress, or attention deficit hyperactivity disorder (ADHD).

3. Claimant timely filed a Fair Hearing Request with the RC challenging the RC's determination that he was not eligible for RC services.

CLAIMANT'S DEVELOPMENTAL HISTORY AND ADAPTIVE BEHAVIORS

4. Claimant was born full-term without any medical complications, and has no history of illness or injuries. Claimant's motor and language and speech milestones were typical. (Exhibit 9, pp. 1, 13-14.) Claimant lives with his parents and older teenage brother in a Spanish-speaking household and is a proficient English-language speaker. His language skills were reported to be in the mild range of deficiency at the time he

was assessed in August 2016 by RC-funded psychologist, Larry Gaines, Ph.D., with the Vineland Adaptive Behavior Scales, Second Edition (Vineland). Claimant could speak in simple sentences, describe his experiences and maintain a conversation, although he could not initiate a conversation.

5. Absent from claimant's history is any reported early delays in claimant's abilities to toilet and perform general self-care tasks such as feeding himself using all utensils, brushing his teeth, or hygiene or dressing, although mother reports claimant is unable to fasten buttons, zippers, or tie shoelaces, and requires assistance bathing.

6. Claimant's adaptive behavior functioning is within the mild range of deficiency according to Dr. Gaines' RC-funded psychological evaluation of August 2016. Claimant's scores on the Vineland fell within the mild range of deficiency. Claimant's mother reported claimant does not fully clean himself after toileting, or bathe without parental prompts and assistance. Mother reported claimant cannot make a sandwich or use the microwave, and cannot cook on the stove. Claimant does not go into the community by himself, so his ability to navigate the community without assistance has not been tested. His mother does not trust him to cross the street unaccompanied. Claimant can identify the date and time, and recognize money. There is no evidence he can make purchases unassisted.

7. Claimant generally gets along with family members and is affectionate with his parents. Claimant does have difficulty waiting his turn and sharing his belongings. He is a poor sport when he loses at games.

8. Claimant has a history of social challenges with his peers. His social challenges were confirmed by teacher observations and are not disputed. He does not engage with his peers, initiate interaction, participate in group projects, and has no friends. In fifth grade, he considered disagreements personal attacks and maintained he was bullied by 11 of his peers. Claimant's social functioning deficits were within the mild

range of deficiency on the Vineland. Claimant reported he was nervous when thinking about returning to school and he hit and fought with his mother when stressed about going to school.

CLAIMANT'S STATUS DURING THE 2015-2016 SCHOOL YEAR

9. Claimant attends a public charter school, KIPP SOL (KIPP), and is currently in the sixth grade. Claimant's cognitive and academic challenges were not thoroughly documented prior to the 2015-2016 school year when he entered KIPP as a fifth grader, but there was evidence that he struggled academically. Claimant's final report card as a fourth grader in his previous school contained "partial progress" grades in reading literature, math and social studies; grades in reading foundation, speaking and listening were "partial and adequate." (Exhibit 9. p. 2.) However, based on the disparity between his performance and that of his peers at KIPP, and the results of his assessment, his deficits were always present, but became more pronounced as the academic work became more challenging. Shortly after arriving at KIPP, through testing and assessments and his teacher's daily monitoring of progress, KIPP found claimant was reading at a grade level equivalent to a mid-second grade student and his math skills were weak. KIPP formed a student study team (SST) with school representatives and parents to monitor claimant due to his poor academic performance and social-emotional challenges.

10. In January 2016, claimant was hospitalized for psychiatric observation. Afterward claimant was referred by his parents and teachers for a psychoeducational assessment to determine if he qualified for special education services, due to:

> [I]ncreasing resistance to school attendance and excessive emotionality that resulted in suicide threats and a psychiatric hospitalization at Kedren Mental Health Center in January

> 2016. At Kedren he was given a diagnosis of Major Depressive Disorder. The resistance to school attendance, increasing emotionality, and depression appear to limit his ability to participate in his current setting and make appropriate academic and social progress. In addition, his mother has reported [claimant] has become physically aggressive with her.

(Exhibit 9, p.1.)

11. Claimant's hospitalization occurred upon his return to school after a three-week winter recess. He reported for the first time he was bullied by 11 students, and wanted to commit suicide by hanging or by stabbing himself with a pencil in his stomach to get to his organs. KIPP called the specially-trained emergency team, referred to as the PET team, to intervene, and claimant was hospitalized.

12. Claimant resisted returning to school after his hospitalization to such an extent that he appeared to fabricate his intent to harm himself again in order to avoid going to school. On the first day of his return, he pointed a pencil at his stomach, his mother was called, and after consulting with his doctor and therapist, she notified KIPP claimant was not yet ready to attend KIPP. When he returned a week later without his mother providing a written medical release, KIPP called the PET team. The team confirmed from interviewing claimant he was not a threat to himself or others, but opined claimant was engaging in manipulative behavior to avoid school.

13. KIPP reported claimant's behavior improved after his hospitalization. Claimant had difficulty transitioning to school. When he returned to school after his January break, he frequently cried loudly, verbally protested and punched his mother. Claimant would not enter the school campus unless accompanied by his mother. However, once claimant arrived in class, he "displayed less emotionally" than before his

hospitalization. His behavior became challenging again upon return from a spring break in March 2016. (Exhibit 9, p. 3.)

14. In March 2016, KIPP administered an initial psychoeducational assessment to determine if claimant was eligible for special education (KIPP's assessment or the KIPP assessment). At the time of KIPP's assessment, claimant had not only been hospitalized but was also failing all his academic classes. (Exhibits 8 and 9.) KIPP's assessment comprehensively addressed suspected educationally-related disabilities qualifying him for special education services in the areas of emotional disturbance, other health impairment, and specific learning disability (SLD). (Cal Code Regs., tit 5, §§ 3030, subds. (b)(4), (b)(9) and (b)(10).) No mention was made of qualifying claimant for special education under the special education eligibility category of ID or autism.

15. KIPP's teachers conducted classroom observations of claimant in late February and March 2016 during instruction in fiction, non-fiction and physical education. Each observation lasted 30 minutes. The overall conclusion was that claimant could follow oral instructions, but was selective about which ones he followed and which ones he ignored. Claimant participated in class, did not appear frustrated or non-compliant, and transitioned between activities without problems.

16. Claimant's most significant behavior observed was his lack of interaction with peers. Claimant "did not initiate interactions with them and his classmates did not initiate interactions with him." (Exhibit 9.)

ELIGIBILITY AS ID OR FIFTH CATEGORY

17. KIPP's assessment did not consider whether claimant qualified for special education under the category of ID, but based upon the assessments and claimant's reported history, there is insufficient evidence to support eligibility for RC services under the category of ID. "ID is a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social and

practical domains." (DSM-5, p. 33.) Three criteria must be met: deficits in intellectual functions determined by clinical assessment and standardized testing; deficits in adaptive functioning that result in failure to meet developmental milestones and socio-cultural standards for personal independence and requiring ongoing support to function, communicate or participate in the home, school or community, and onset during the developmental period. (*Ibid.)* Generally, individuals with ID obtain standard scores between 65 and 70, (DSM-5, p. 37), and demonstrate severe deficits in adaptive functioning that are directly related to the cognitive deficits. The designation of ID is not strictly based upon standardized assessment, but also relies upon the clinical judgment and observations.

18. KIPP's assessment did not consider ID, but concluded claimant was qualified for special education and related services under the category of SLD. SLD generally applies to individuals who possess uneven or scattered cognitive abilities resulting in deficits in the ability to listen, think, speak, read, write, spell or perform mathematical calculations, and where there is a severe discrepancy between the individual's cognitive abilities and achievement in one or more academic areas. (Exhibit 9, p. 21; Cal. Code Regs., tit 5, § 3030, subd. (j).)

19. By school district practice, KIPP's assessment did not provide a standard score for claimant's overall cognitive ability, but it did confirm claimant's deficits in various areas of cognitive processing, including successive processing, which affects his ability to remember, executive functioning, which impacts his ability to control his thinking, behavior and attention, and working memory, which affects his ability to hold information in short term memory and perform mental operations. Overall, KIPP's assessment produced scattered scores which ranged from well below average to average, but were not typical of a fairly consistent ID score of 65-70. In addition, claimant was found to have deficits in visual-motor integration on standardized

measures, with challenges in penmanship and reproducing shapes, angles and details. (Exhibit 9, p. 14.)

20. KIPP's assessment of claimant's cognition was consistent with RC's August 2016 assessment a few months later with Dr. Gaines. Dr. Gaines administered a standardized cognitive assessment test, the Wechsler Intelligence Scale for Children, Fifth Edition (WISC-V), which measured claimant's cognitive in several domains and found his abilities measuring between the average to low average range, with overall functioning, after reference to the subtests scores, consistent with low average "if not borderline abilities." (Exhibit 4, p. 4.) Claimant's overall cognitive ability, referred to as general ability index (GAI) in the WISC-V, is 82, or low average. Claimant obtained an average standard score of 91 for visual spatial abilities and a low average standard score of 81 for verbal comprehension.

21. KIPP's assessed claimant's academic achievement by administering a standardized achievement test, the Woodcock Johnson IV, Test of Achievement (WJ-IV ACH). Claimant demonstrated average achievement average in area of: applied problems; word attack; sentence reading fluency; and broad math. Claimant demonstrated low average achievement in the areas of: letter-word identification; spelling; calculation; writing samples, oral reading, broad reading, and broad writing. Claimant demonstrated low achievement in the area of passage comprehension.

22. In addition to the WJ-IV ACH, curriculum based assessment data, teacher and parent information, work samples and classroom observations established claimant's performs in the far below average when compared to his grade-level peers in the area of reading comprehension and written language.

23. KIPP's assessment report further considered the relationship between claimant's processing difficulties and his attention issues, and concluded his deficits in visual and auditory processing and attention are related to his academic delays. (Exhibit

9, p. 20.) Assessment instruments used to measure attention "suggested" attention problems, and although his math skills "seem" stronger than skills in the area of English-language arts, he exhibits the same level of inattention in both. (*Ibid.*)

24. Claimant's father testified at hearing and provided credible and sincere testimony which confirmed claimant's cognitive processing deficits. Claimant shares with his father a love for the sport of soccer, but his father maintains, despite his repeated efforts to teach him the game, claimant cannot retain the rules of the sport or follow directions.

25. Dr. Gaines concluded claimant did not qualify for RC services under the category of ID. However, he was troubled by the number of claimant's low average and borderline cognitive scores, implying claimant may meet eligibility requirements for RC services at some point.

> Although intellectual disability was not evident he may need to be monitored with regards to borderline abilities and the impact this may be having on academic, social, adaptive and other life learning problems [claimant] is having.

(Exhibit 4, p. 3.)

26. Dr. Gaines did not address claimant's eligibility under the fifth category. Dr. Gaines did not testify so it was not possible to fully clarify his written assessment report. Nevertheless, Dr. Gaines' recommendation for further monitoring of the impact of claimant's cognitive ability on his adaptive behavior supports a reassessment of ID or fifth category to clarify whether claimant's scattered and borderline cognitive profile (not solely his psychiatric disorder) results in adaptive functioning similar to an individual with ID.

27(A). The RC relied upon its consulting expert, psychologist, Dr. Randi Bienstock.

Dr. Bienstock did not personally assess claimant, but she was qualified to review claimant's previous psychological assessments, including Dr. Gaines', and offer an expert opinion about claimant's eligibility. Her more distant review of the assessment process was taken into account when weighing her opinion against conflicting evidence from Dr. Gaines' and KIPP's assessment.

27(B). Dr. Bienstock disagreed with Dr. Gaines' suggestion that claimant's cognitive and borderline abilities should be reviewed later. Dr. Bienstock maintained there was no support for claimant's RC eligibility from school records prior to his attendance at KIPP. Dr. Bienstock opined that cognitive ability is relatively fixed at a young age and does not vary.

27(C). Dr. Bienstock's testimony, with regard to possible eligibility under the fifth category, was not supported by the record and was given less weight than Dr. Gaines, who assessed claimant, and personally interviewed him and his mother.

27(D). From the record, it is apparent claimant's academic struggles did not first appear at KIPP. Claimant was not assessed prior to fifth grade and his struggles may have not been clearly isolated, but they were there. His mother did not understand the source of his deficits as she reported to the KIPP assessor he was not challenged at his prior school, disregarding school reports of partial progress in fourth grade.[3] The KIPP assessment revealed claimant was at a 2.5 grade level in reading. Such a disparity could not have suddenly occurred at KIPP.

27(E). Dr. Gaines recommendation is consistent with fifth category analysis and a psychological theory of a fixed cognitive ability. He is not suggesting claimant's

[3] Understanding the source of a child's deficits is understandably difficult. At hearing, claimant's mother stated she was not aware claimant qualified for special education under the category of SLD.

borderline cognitive abilities will change. Instead, Dr. Gaines is suggesting claimant's deficits may be further impacted, including his adaptive functioning, which is directly relevant to both ID and fifth category.

28. Claimant did not provide sufficient evidence of eligibility as ID or fifth category. Dr. Gaines reported missing documentation from a Social Security evaluation where borderline intellectual ability was noted.

29(A). There is also insufficient evidence that claimant's deficits are due solely to a learning disorder as defined by the implementing regulations of the Lanterman Act. Dr. Gaines was not firmly convinced claimant had a specific learning disability. Dr. Gaines stated claimant's "poor school performance *may* be related to a specific learning disability." (Exhibit 4, p. 4; emphasis added.)

29(B). Based upon Dr. Gaines assessment and record review and testimony of Dr. Bienstock, there is insufficient evidence to establish a significant discrepancy between claimants cognitive ability and academic achievement. The DSM-5 refers to a specific learning disorder, not a specific learning disability as used in the school setting, but the definition is similar. (DSM-5, pp. 66-67.) Under the DSM-5, a specific learning disorder is established where there are demonstrated difficulties using academic skills in one area for at least six months despite interventions targeting the difficulties. (*Ibid.*) At hearing, Dr. Bienstock acknowledged that the definition of a specific learning disorder in the DSM-5 is not the same as its definition under the implementing regulations of the Lanterman Act. Under the DSM-5, a significant numerical discrepancy between cognitive ability and achievement is not required to diagnose a specific learning disorder. As such, a DSM-5 diagnosis of a specific learning disorder may not always determine whether a claimant has a learning disorder, as that term is defined by the implementing regulations of the Lanterman Act.

30(A). Dr. Gaines considered claimant's school-based services and supports and

school records and opined they may not be sufficient. (Exhibit 5, p. 2.) According to claimant's individualized education program, he remains in a general education classroom and is provided with resource specialist support in several academic areas, as well as some counseling (thirty minutes per week) and behavior support.

30(B). Consistent with claimant's history and assessments, Dr. Gaines recommended claimant be further assessed for ADHD.

CLAIMANT'S PSYCHIATRIC AND SOCIAL-EMOTIONAL STATUS

31. Parents' report of claimant's extreme resistance to school attendance were supported by KIPP's assessment and classroom supports KIPP had committed to claimant, including having a school administrator to escort him to class and counseling. Claimant reported these services were not always provided.

32. KIPP's assessment confirmed claimant's deep-seated social-emotional and behavior challenges by history, from well-recognized rating scales provided to claimant's teachers and parents, and from his parents' report and teachers' observations. KIPP's assessment included the results from the Behavior Assessment for Children, Third Edition (BASC-3), Scales for Assessing Emotional Disturbance, Second Edition (SAED-2), and an interview with claimant. KIPP's assessment is consistent with claimant's discharge diagnosis of Major Depressive Disorder, provided by Kedren Acute Psychiatric Hospital.

33. Claimant has a well-documented history of severe social skills deficits. He is unable to develop or maintain friendships and lacks social skills. He reports having no friends. He avoids and withdraws from interaction with his peers and demonstrates a limited ability to interact in a group setting at school. Sometimes with adult prompting he can successfully interact with peers.

34. Claimant is easily frustrated by his peers and can be confrontational when they disagree with him. He characterizes his peers' reaction to him as bullying.

35. Claimant's mother is on the receiving end of his frustration. She describes

claimant as having "rapid" mood swings. (Exhibit 9, p. 18.) He hits and punches his mother when she insists he go to school. His cries and protests at home prior to going to school are not typical for his age.

36. Claimant responds to his academic difficulties with behaviors designed to avoid school. His complaints of physical pain and discomfort are not supported by his doctors.

37. Claimant does enjoy nonacademic activities such as performing in school concerts and talent shows and going on field trips. Claimant generally follows school and classroom rules; he does not "break" classroom or school rules more than his peers (Exhibit 9, p. 18.)

38. Claimant is receiving mental health therapy as a result of his suicidal statement and counseling at school. Dr. Gaines deferred to mental health practitioners and did not confirm a psychiatric diagnosis of Major Depressive Disorder.

AUTISM

39. At the time of KIPP's assessment, there is no evidence the KIPP's educators, who either observed claimant in the classroom or reviewed claimant's documented educational history, suspected claimant qualified for special education services under the category of characteristics often associated with autism. KIPP's educators noted claimant's social deficits, but did not connect them with autism. There is no evidence of any information from claimant's parents about claimant's history at home which would put KIPP on notice claimant may qualify for special education as a pupil with autism. (Cal. Code Regs., tit. 5, § 3030, subd. (b)(1).)

40. At the time of his assessment in August 2016 Dr. Gaines' had not seen any reference to autism from claimant's treating physicians or mental health care practitioners. On October 21, 2016, claimant began treatment at Hathaway-Sycamores Child and Family Services (Hathaway). An undated letter, entitled Progress and

Participation Report, on Hathaway's letterhead and apparently signed by claimant's child psychiatrist, Dr. Neevon Esmalil, M.D., describes claimant as having "ASD (autism spectrum disorder) symptoms or mild ASD." (Exhibit 13.) In his letter, Dr. Esmalil lists behaviors reported by claimant's mother, including, exacting hair combing, always wearing a tight belt and carrying excessive items to school in his backpack "just in case." (*Ibid.)* At hearing, claimant's mother confirmed claimant was taking anti-anxiety medication. Dr. Esmalil did not testify, and no documentary evidence was provided to support a diagnosis of ASD based upon Dr. Esmalil's letter.

41. The DSM-5 criteria for ASD are as follows:

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive, see text):

1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

Specify current severity:

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

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat the 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 interest).
4. Hyper- or hyporeactivity to sensory input or unusual interests in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

Specify current severity:

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

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

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

E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

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

42. Claimant did not provide sufficient evidence he meets the criteria for ASD. Dr. Gaines administered the well-recognized assessment for autism, the Autism Diagnostic Observation Schedule, Second Edition, Module 3 (ADOS-2), which provides a numerical system for rating different behavioral characteristics associated with autism. Claimant obtained a score of six on social affect and a score of zero on restricted or repetitive behaviors. The cut-off for ASD on the ADOS-2 is nine. Claimant's reported scores were not clinically significant for ASD. Dr. Gaines listed his assessment results, but did not fully explain how he obtained the results he did. Nevertheless, Dr. Gaines' conclusion that claimant did not have ASD was consistent with previous observations and interviews with claimant and his mother. Claimant did not meet the threshold criterion for ASD under the DSM-5. Claimant clearly had deficits in social interactions, (criterion A1 and A3). Despite his problem with transitions, and his obsessive behaviors, including his hair combing and back pack preparation, which appear to track criterion B2, these behaviors appeared to be related to his school stress, and were not sufficient

to satisfy two areas of criterion B, as required. Claimant's score of zero for restricted or repetitive behaviors on the ADOS-2 is reflective of the absence of a significant pattern of behaviors unrelated to school.

43. Dr. Gaines found school to be a significant area of stress for claimant. He determined claimant "demonstrates social difficulties" but did not find "other elements for a clear diagnosis" of ASD at the time of his testing. (Exhibit 4, p. 4.) Instead, Dr. Gaines diagnosed claimant with Social (Pragmatic) Communication Disorder. (DSM-5, pp. 47-48.) Dr. Gaines did not explain how he reached his diagnosis, but it appears from a review of the criterion for Social Communication Disorder and the evidence, this diagnosis provides a more accurate explanation of claimant's social deficits at the time of his assessment.

RECOMMENDATIONS

44. Dr. Gaines did not consider his diagnoses fixed. He acknowledged the stress claimant was experiencing at school may have affected claimant's assessment results and observed behavior. Dr. Gaines recommended school interventions to reduce claimant's stress, and offered claimant "may need to be monitored and reevaluated" not only for borderline intellectual functioning, but also "autistic concerns" if these are observed and noted in other settings or to persist with reduced stress." (Exhibit 4, p. 5.) From his statement, it is apparent that Dr. Gaines concluded claimant's deficits, other than his social skills deficits, were related to his challenges at school.

45. Dr. Gaines recommended continued participation in school-based special education, social support, a mental health evaluation, and school interventions to reduce claimant's school-related stress. Claimant has only been receiving special education and related counseling services for approximately one year, and it is not within the scope of this decision to assess whether the academic and behavior interventions are sufficient. Dr. Esmalil's recommended social skills training, and

pragmatic speech therapy to address what he also concluded claimant's clinically-significant social communication deficits. Dr. Esmalil's diagnosis was not supported by evidence, but his recommendation for interventions are consistent with Dr. Gaines' diagnosis of a Social Communication (Pragmatic) Disorder, and provides constructive advice for the family to present to KIPP and other available service providers.

46. Claimant's parents provided credible and sincere testimony, and participated in the fair hearing process in good faith to obtain additional services and supports for their son. However, at this time, there is insufficient evidence that claimant has a substantial disability arising from his intellectual functioning, or from behaviors consistent with a diagnosis of autism, and which are not solely related to his school-based anxiety, to support his eligibility for RC services. Based upon Dr. Gaines' opinion, claimant's eligibility might be appropriate for review at a later time in these three areas, if his challenges persist and his adaptive functioning is further impacted and not confined to school-related stress.

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LEGAL CONCLUSIONS

Based upon the foregoing Factual Findings, the Administrative Law Judges makes the following Legal Conclusions:

1. The Lanterman Developmental Disabilities Services Act (Lanterman Act) governs this case. (Welf. & Inst. Code, § 4500 et seq. (Code).)[4] An administrative "fair hearing" to determine the rights and obligations of the parties, if any, is available under the Lanterman Act. (Code §§ 4700-4716.) Proper jurisdiction was established by virtue of

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

the RC's denial of the request for funding and claimant's Fair Hearing Request.

2. Where applicants seek to establish eligibility for government benefits or services, the burden of proof is on them. (See, e.g., *Lindsay v. San Diego Retirement Bd.* (1964) 231 Cal.App.2d 156, 161 [disability benefits].) The standard of proof in this case is the preponderance of the evidence, because no law or statute (including the Lanterman Act) requires otherwise. (Evid. Code, § 115.) Further, the claimant's burden of proof for disputes regarding issue of eligibility for regional center services is supported by the deference the Lanterman Act and implementing regulations give to the expertise of the DDS (California Department of Developmental Services) and the local regional center professionals' determination as to whether an individual is developmentally disabled." (*Mason v. Office of Administrative Hearings* (2001) 89 Cal.App.4th 1119, 1127.) In *Mason*, the court focused on whether the applicant's expert witnesses' opinions on eligibility "sufficiently refuted" those expressed by the regional center's experts that the applicant was not eligible. (*Id.,* at p. 1137.) Based on the above, claimant in this case has the burden of proving by a preponderance of the evidence that he is eligible for RC services under the categories of intellectual disability, autism, or the fifth category. Claimant did not sufficiently refute RC's determination that he is not eligible for RC services under these three categories.

3. The credibility of witnesses is an important factor in determining whether claimant met his burden of proof. It is settled that the trier of fact may accept any part of the testimony of a witness and reject another part even though the latter contradicts the part accepted. (*Stevens v. Parke Davis & Co*. (1973) 9 Cal.3d 51, 67.) The trier of fact may reject the testimony of a witness, even an expert, although not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.) The testimony of one credible witness, including that of a single expert witness, may constitute substantial evidence. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040,

1052.) An expert's credibility may be evaluated by looking to his or her qualifications. (*Grimshaw v. Ford Motor Co*. (1981) 119 Cal.App.3d 757, 786.) It may also be evaluated by examining the reasons and factual data upon which the expert's opinions are based. (*Griffith v. County of Los Angeles* (1968) 267 Cal.App.2d 837, 847.) Further, the weight to be given to expert opinion may be evaluated by its reasoning.

4. As set forth in the factual findings, Dr. Bienstock did not personally conduct the claimant's assessments or interview him or his family. Accordingly, her testimony was given deference in the determination of claimant's eligibility where her opinion was consistent with Dr. Gaines' assessment and school and medical records. Dr. Gaines' assessment report, was brief, but nevertheless, comprehensive, because he faithfully relied upon all data available to him at the time. Dr. Bienstock erred with regard to possible ID or fifth category eligibility. She assumed little indication before fifth grade of claimant's intellectual and academic problems. Claimant's fourth grade records showed academic difficulties, and he was clearly struggling early on at KIPP. Shortly after claimant arrived at KIPP, an SST was formed to monitor claimant. Dr. Bienstock did not consider his transfer from another school which noted his academic problems, but did not fully record them, or the results of his assessment where his severe deficit in reading comprehension was recorded as a 2.5 year grade level. Dr. Gaines did not assess claimant for fifth category, and at this time, there is insufficient evidence claimant has a substantial disability related to ID or fifth category. Nevertheless, Dr. Gaines' suggestion that claimant should be reevaluated in the future to review his eligibility should be followed.

ELIGIBILITY CRITERIA

5. To be eligible for services under the Lanterman Act, claimant must establish that he is suffering from a developmental disability that is attributable to intellectual disability, cerebral palsy, epilepsy, autism or what is referred to as the fifth

category, closely related to intellectual disability or to require treatment similar to that required for individuals with intellectual disability. (Code § 4512, subd. (a).) The qualifying condition must originate before one's 18th birthday and continue indefinitely thereafter. (Code § 4512.)

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

(a) 'Developmental Disability' means a disability that is attributable to ID[5], cerebral palsy, epilepsy, autism, or disabling conditions found to be closely related to ID or to require treatment similar to that required for individuals with ID.

(b) The Developmental Disability shall:

(1) Originate before age eighteen;

(2) Be likely to continue indefinitely;

(3) Constitute a substantial disability for the individual . .

7. CCR section 54000, subdivision (c) excludes the following conditions from the definition of "developmental disability:"

(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

[5] The term mental retardation has been changed to intellectual disability.

level of educational performance and which is not a result of generalized ID, educational or psycho-social deprivation, psychiatric disorder, or sensory loss.

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

8. Based on the language "solely," a person with a "dual diagnosis," that is, a developmental disability coupled with a psychiatric disorder, a physical disorder, or a learning disability, could still be eligible for services. However, someone whose conditions originates from just the excluded categories (psychiatric disorder, physical disorder, or learning disability, alone or in some combination), and who does not have a developmental disability, would not be eligible.

9(A). Claimant met his burden of proof that his deficits are not due solely to a physical, psychiatric or learning disorder.

9(B). Dr. Gaines did not consider in his report whether claimant's deficits are the result solely of any psychiatric conditions, including Major Depressive Disorder. Dr. Gaines did not find a firm diagnosis of any psychiatric disorder at the time of his assessment in August 2016. Later, Dr. Esmalil diagnosed claimant with Major Depressive Disorder, but his diagnosis was consistent with Dr. Gaines opinion that claimant's intellectual deficits were the cause of his behavioral and social-emotional problems. Accordingly, claimant's psychiatric diagnosis was not the sole cause of claimant's disability.

9(C). There is no evidence that claimant's deficits are solely attributed to a physical disorder. There is also insufficient evidence claimant has a learning disorder. California Code of Regulations, Title 17, section 54000, subdivision (c), defines a learning disorder as a significant discrepancy between cognitive ability and educational

performance, i.e., educational performance that is significantly below cognitive ability. Based on KIPP's assessment, Dr. Gaines' opinion, and Dr. Bienstock's testimony, there is insufficient evidence of a significant discrepancy between claimant's cognitive ability and his academic performance.

DOES CLAIMANT HAVE A SUBSTANTIAL DISABILITY?

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

(1) A condition which results in a 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 significant functional limitations, as determined by the regional center, in three or more of the following areas of major life activity, as appropriate to the person's age:

(A) Receptive and expressive language;

(B) Learning;

(C) Self-care;

(D) Mobility;

(E) Self-direction;

(F) Capacity for independent living;

(G) Economic self-sufficiency.

11(A). Claimant satisfied by the preponderance of the evidence criterion (A). There is substantial evidence he possesses a major impairment of cognitive and social functioning and would benefit from coordinated services and interventions, including

counseling, social skills training and pragmatic communication.

11(B). Claimant satisfied by the preponderance of the evidence criterion (B). Claimant has established by a preponderance of the evidence he has significant functional limitations in at least three areas appropriate to his age, including receptive and expressive language, learning and self-care. In its Notice of Proposed Action, the RC did not dispute whether claimant had significant functional limitations, and Dr. Gaines assessment supported claimant's burden of proof on this threshold criteria for establishing RC eligibility. Dr. Gaines did not dispute claimant's functional limitations, but based upon the information presented to him, questioned whether they were related to a covered eligibility category.

11(C). In the area of receptive and expressive language, Dr. Gaines identified claimant with a social communication disorder, which is defined by a persistent difficulty in the social use of verbal and nonverbal communication (DSM-5, p. 47). Assessments and interviews established substantial learning deficits for his age as demonstrated by his poor passage comprehension. Claimant's inability to initiate conversation also is demonstrative of a significant functional language deficit.

11(D). In the area of learning, both the assessments of KIPP and Dr. Gaines established cognitive processing deficits which severely impact his ability to learn and retain information.

11(E). In the areas of self-care and capacity for independent living, claimant's functional limitations are significant for a person his age. He cannot dress or bathe unassisted, and cannot attend to his hygiene after toileting. From the Vineland, Dr. Gaines concluded claimant's adaptive behavioral deficits were in the mild range of impairment. It is also possible that the impairments in self-care are related to his school stress, but there is no evidence they are temporary. In the area of capacity for independent living, claimant is not yet trusted to cross the street independently and

there is no evidence he can make purchases unassisted. In addition, Dr. Gaines recommended a reassessment to determine whether claimant's borderline intellectual deficits directly affect his social and adaptive functioning deficits. Dr. Gaines' recommendation is prudent given the increased functional demands on claimant as he ages.

11(F). With regard to the other age-appropriate functional areas, mobility is inapplicable, and economic self-sufficiency is inapplicable at this time. There is insufficient evidence from classroom and assessor observations that claimant has substantial functional deficits for his age in the area of self-direction unrelated to school work.

DOES CLAIMANT HAVE AN INTELLECTUAL DISABILITY?

12. Claimant failed to establish by a preponderance of the evidence he is eligible for RC services under the category of ID. Individuals with ID generally have scores two standard deviations below the mean or approximately 65-75, or 70 with the margin of error of plus or minus five points. (DSM-5, p. 37.) Not one assessor evaluated claimant for ID, and based on history, it was not considered a suspected disability for the KIPP assessment. The DSM-5 changed the focus of ID from IQ scores to adaptive functioning, particularly because adaptive functioning determines the level of support required, not IQ scores which are "less valid in the lower end of the IQ range." (DSM-5, p. 33.) The DSM-5's changed focus informs the fifth category, but based upon the assessments, there is insufficient evidence to support a determination of eligibility under the category of ID.

DOES CLAIMANT HAVE AUTISM?

13. Claimant failed to establish by a preponderance of the evidence he is eligible for RC services under the category of autism. The Lanterman Act has not been

revised since the publication of the DSM-5 to reflect the current terminology of ASD. Nevertheless, there is no contrary statutory or regulatory scheme for determining eligibility under the category of autism, and accordingly, determinations using the DSM-5 should treat autism as synonymous with ASD and has been treated as such in this matter.

DOES CLAIMANT HAVE A FIFTH CATEGORY CONDITION?

14. Claimant failed to establish by a preponderance of the evidence he is eligible for RC services under the fifth category. The "fifth category" is described as "disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for intellectually disabled individuals." (Code § 4512, subd. (a).) A more specific definition of a "fifth category" condition is not provided in the statutes or regulations. Whereas the first four categories of eligibility are specific (e.g., epilepsy or cerebral palsy), the disabling conditions under this residual fifth category are intentionally broad so as to encompass unspecified conditions and disorders. But the Legislature requires that the condition be "closely related" or "similar." "The fifth category condition must be very similar to [intellectual disability], with many of the same, or close to the same, factors required in classifying a person as [intellectually disabled]." (*Mason v. Office of Administrative Hearings*, (2001) 89 Cal.App.4th 1119, 1129.(*Mason*))[6] Developmental disabilities differ widely and are difficult to define with precision. (*Id.* at p. 1130.)

15. *Mason* was decided before the adoption of the DSM-5. The American Psychiatric Association (APA) notes that the most significant change in diagnostic categorization accompanying the change from DSM-IV-TR to DSM-5 nomenclature of

[6] As noted above, the DSM-5 has replaced the diagnosis of "Mental Retardation" with "Intellectual Disability."

ID is emphasis on the need for an assessment of both cognitive capacity and adaptive functioning, and that the severity of intellectual disability is determined by adaptive functioning rather than IQ score. (*Id.* at p. 37.) The DSM-5 recognizes that a person with an IQ 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." (DSM-5, p. 37.) The APA notes no other significant changes.

16. Under the DSM-5, a claimant asserting fifth category eligibility is required to establish by a preponderance of evidence significant deficits in cognitive capacity or deficits in adaptive functioning, or both. Code section 54002 defines "cognitive" as "the ability of an individual to solve problems with insight to adapt to new situations, to think abstractly, and to profit from experience." The evidence must establish that the claimant's disabling condition requires treatment similar to the treatment needs of an individual with ID.

17. At this time, there is insufficient evidence to support a finding of eligibility based on the fifth category. By history, claimant's adaptive deficits appeared to be related to his school-related stress, which at this time do not result in significant functional deficits in three areas. Dr. Gaines recommended claimant's eligibility for RC services be reassessed at some point in order to clearly ascertain whether his intellectual deficits contribute to significant adaptive behavior problems which are not apparent at this time.

ORDER

Claimant's appeal of the Eastern Los Angeles Regional Center's denial of eligibility is denied.

DATED:

EILEEN COHN

Administrative Law Judge

Office of Administrative Hearings

NOTICE

This is the final administrative decision; both parties are bound by this decision. Either party may appeal this decision to a court of competent jurisdiction within 90 days.