BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of the Appeal of:

CLAIMANT

vs.

CENTRAL VALLEY REGIONAL CENTER, Service Agency

Agency Case No. CS0012671

OAH No. 2024020586

DECISION

Hearing Officer Coren D. Wong, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter by videoconference on April 17 and May 8, 2024, from Sacramento, California.

This matter was consolidated for hearing with the appeal in OAH Case No. 2024020585. A separate Decision addressing that appeal will be prepared pursuant to California Code of Regulations, title 1, section 1016, subdivision (d).

Sandra Saavedra, Assistant Director of Legal Services, and Jacqui Molinet, Fair Hearing & Appeals Specialist, represented Central Valley Regional Center (CVRC), the service agency.

Claimant's parents represented her.

Evidence was received, the record closed, and the matter submitted for decision on May 8, 2024.

ISSUE

Is CVRC required to fund claimant's request for three sessions per week of DIR/Floortime?

FACTUAL FINDINGS

Background

1. Claimant began receiving regional center services under the California Early Intervention Services Act (Gov. Code, § 95000) at 18 months of age due to global delays. She received specialized instruction, language/speech services, and occupational therapy.

2. Mother received prenatal care during pregnancy. Her pregnancy was considered high-risk due to her age. Additionally, pregnancy began around the start of the COVID-19 Pandemic. She tested positive for gestational diabetes during her third trimester, but subsequent testing revealed a normal blood sugar level.

3. Claimant was born at 38 weeks gestation. Upon delivery, claimant had low blood sugar and was treated with dextrose. Her birthweight was 6 pounds, 15 ounces. She and Mother stayed in the hospital for two days.

4. Claimant was referred for evaluation to determine eligibility for continued regional center services under the Lanterman Developmental Disabilities Services Act (Gov. Code, § 4500 et seq, Lanterman Act.) at 34 months of age. Parents were concerned with intellectual and adaptive functioning and the possibility of ASD.

5. Melissa Wagner, Psy.D., a licensed clinical psychologist, performed claimant's psychological evaluation on September 19, 2023. She obtained and reviewed records, interviewed parents, and observed and interacted with claimant. During her observations and interactions with claimant, she administered Wechsler Preschool and Primary Scale of Intelligence, Fourth Edition, (WPPSI-IV) (attempted), Adaptive Behavior Assessment System, Third Edition (ABAS-3), and Childhood Autism Rating Scale, Second Edition (Standard Version) (CARS-2-ST).

6. Dr. Wagner summarized claimant's psychological evaluation as follows:

> [Claimant] is a two year, ten-month-old female presenting with impairments in her communication, socialization and adaptive functioning. CVRC has requested this evaluation of [claimant's] intellectual and adaptive functioning as well as to consider a diagnosis on the Autism Spectrum to help determine her eligibility for services.
>
> [Claimant] presented for this evaluation as an aloof two-year-old who displayed inconsistent eye contact and did not respond to her name when called. She displayed a flat affect throughout half of the evaluation, however, began smiling after mother tickled and kissed her on the face and neck during testing. She tended to trip but did not respond

when she bumped into something/hurt herself. She sat in a "w" seated position and engaged in repetitive facial grimacing. She was able to label toys and objects, but did not use functional language and was unable to engage in reciprocal conversation. She engaged in verbal rituals, gibberish, jargon, echolalia, and at times spoke in a loud volume. During play, [claimant] was very self-directed. She did not respond to initiations for play, and briefly initiated play before walking away. At times [claimant] stared at toys/space blankly, or engaged in gibberish alone. She lost interest in toys quickly, but typically played with them appropriately. She did not engage in social reciprocity during this evaluation.

[Claimant] was able to participate in all of the subtests within the Visual Spatial domain, with scores falling within the Average range. Qualitatively, [claimant's] overall Visual Spatial functioning falls within age-based expectations, and constitutes Average intellectual development. [Claimant's] intellectual functioning could not be fully measured as she was unable to comply with testing at this time. It is recommended that her cognitive skills be reevaluated at a later date to rule out any cognitive deficits.

On adaptive measures, [claimant] received a General Adaptive Composite of 73, placing her adaptive development within the Low range. There appears to be

> significant discrepancies among the domains of adaptive functioning, with the scores varying from the Extremely Low to the Low range. Qualitatively, this level of functioning falls below age-based expectations and constitutes delayed adaptive development.
>
> On the CARS-2-ST, [claimant] received a total score of 35.5, indicating Mild to Moderate symptoms of Autism Spectrum Disorder.
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> Behavioral observations, reports by [Mother], information from the CVRC file, and information available in the CARS-2-ST were used to determine whether [claimant] meets the diagnostic criteria for Autism Spectrum Disorder, according to the Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition (DSM-5).

7. Dr. Wagner formally diagnosed claimant with "Autism Spectrum Disorder, Level 2: requiring substantial support, with accompanying language impairment." She recommended:

> 1. Consider a referral for an evaluation of eligibility for special education services in preschool and include a thorough speech/language and occupational evaluation to assess for any sensory sensitivities.
>
> 2. [Mother] may benefit from intervention and support managing [claimant's] emotional and/or behavioral difficulties.

3. Consider a referral for treatment for adaptive functioning specifically in the areas of Communication and Socialization.

4. Consider a referral for a play therapy group to provide the child with more opportunities to improve her social skills with other children.

5. Consider a reevaluation of [claimant's] overall functioning to assess her progress and make any necessary changes to history, diagnosis or treatment.

8. CVRC's multidisciplinary eligibility team met after Dr. Wagner's psychological evaluation. It determined claimant was eligible for continued regional center services under the Lanterman Act based on her diagnosis of Autism Spectrum Disorder (ASD). She has been receiving services ever since.

9. Claimant's current Individual Program Plan (IPP) was developed December 7, 2023, just after her third birthday. The planning team included Parents, Tiara Battle, her CVRC service coordinator, and herself.

10. Claimant lives at home with Parents and her seven- and one-year-old brothers in Fresno, California. She has an adult half-sister who no longer lives in the family home. Claimant's older brother receives regional center services based on his diagnosis of ASD.

11. Claimant is friendly, nurturing, and loving. She enjoys art, painting, little figurines, playing outside, playing on swings and slides, and fixing her hair and painting her nails with Mother. She enjoys attention, being loved, snuggling, and when

Parents comfort her after bad dreams. Sensory seeking behaviors include pressing her face against others' faces or holding hers very close to theirs, placing her opened mouth on Mother, and walking on the tips of her toes. She lines up objects and categorizes them by size.

12. Claimant has limited verbal skills. She conveys her wants and needs in phrases or song, and others are required to figure out what she wants or needs. She also points to things and says, "Oh, boy." She is prone to tantrums when not understood. She communicates her feelings by eloping, making a "surprised" face, kicking, hitting, crying, whining, grinding her teeth, picking her scabs, and throwing herself to the ground. She has no sense of personal safety or "stranger danger," and Parents keep all doors locked to prevent her from leaving the house unknowingly.

13. Claimant is not toilet trained and wears diapers. Parents dress her, but she makes helpful movements. Mother bathes her, combs her hair, and finishes brushing her teeth. She is a picky eater and does not like mushy food. Mother dyes claimant's milk yellow because she does not like white food. Claimant goes to bed between 7:30 and 8:00 p.m. and gets up around 6:30 a.m. However, she frequently wakes three or four times each night for as long as two hours. Parents sit in a rocking chair and wait until she falls asleep.

14. Claimant is not old enough to start school. Parents are deciding between homeschooling her or placing her in a preschool program. In the meantime, she enjoys spending her time playing with other children, learning, and singing songs. She dislikes going to the doctor or dentist.

15. Claimant has private health insurance through Cigna and has been "institutionally deemed" eligible for Medi-Cal benefits, a method of determining

eligibility based on her income and resources, and without consideration of Parents'. CVRC funds case management services, a dental desensitization clinic, respite services, diaper reimbursement, swim lessons, and dance classes. It recently purchased an electric toothbrush. Parents self-fund DIR/Floortime three times a week.

16. Claimant's long-term goals are learning to play sports, developing friendships, participating in activities, and becoming independent. Short-term goals include improving speech, learning to self-regulate, and becoming less rigid and fixated on things.

Mother's Testimony

17. Mother testified on behalf of herself and Father. They have three children together. The oldest and youngest children are boys, and claimant is the middle child. She and her older brother have ASD and receive regional center services. Mother believes the youngest is starting to show signs of developmental delays.

18. Father earned his bachelor's degree from Fresno State University. Mother started her higher education at Fresno City College and then transferred to Fresno Pacific University, where she earned her bachelor's and master's degrees. She is licensed with the California Board of Registered Nursing as a public health nurse and a registered nurse. She was previously licensed as a nurse practitioner.

19. Father works as a director for LifeNet Health, a non-profit agency involved in organ transplants. He works full time from home. Mother works at a medical center as a registered nurse. She previously worked as a nurse practitioner, but she switched jobs when she and Father decided to homeschool claimant's older brother and she learned she could earn a pay differential by working nights and weekends. Mother allowed her nurse practitioner license to go inactive because she

was not using it and it did not make sense to continue paying the licensing fees and for continuing education.

20. Mother began seeing signs of ASD in claimant at six months of age because claimant did not look at or acknowledge others and did not care when strangers held her. At 12 months of age, Mother noticed claimant had a flat affect, made limited eye contact, and had speech delays. She did not laugh spontaneously and showed no interest in independent play. She walked on the tips of her toes because she did not like the feeling of the ground against the bottoms of her feet.

21. Claimant's older brother was diagnosed with ASD and began receiving Applied Behavioral Analysis (ABA) prior to claimant's birth. ABA is a behavioral-based treatment modality for ASD. It is designed to modify behavior by reinforcing positive behaviors and ignoring, but not punishing, negative ones. This is accomplished by breaking down basic and complex skills into small steps. Each step is learned through repetition. Upon mastery of one step, the subject moves to the next until all are completed and the skill is learned.

22. By the time Dr. Wagner diagnosed claimant with ASD, claimant's older brother had switched treatment modalities from ASD to Developmental Individual Difference Relationship Treatment/Floortime treatment model (DIR/Floortime). His provider was Touchstone Family Development Center (TFDC) in Fresno. Claimant periodically attended her older brother's DIR/Floortime sessions with him.

23. DIR is a comprehensive treatment that focuses on creating the strong foundation necessary for developing social, emotional, and intellectual abilities. Floortime is a technique for implementing DIR that is based on play. A parent, professional, or other trusted adult joins the child in whatever the child is playing with

to deepen the engagement, facilitate joint attention, maintain the interaction, expand upon the complexity of the skill, and form symbolic capacities. The interaction may be adjusted to fit the child's specific needs, preferences, or interests. As the child develops more complex skills, the adult uses techniques to further grow the child's emotions, ideas, and ability to think by replicating discussions and interactions that occur in daily interactions at home and in the community.

24. DIR/Floortime views the child holistically and as a unique individual. While ABA and other behavioral treatment models provide little or no consideration of the child's internal mental states, DIR/Floortime encourages reciprocal communication between the adult and child during purposeful activities, so the child connects his behavior to intention rather than learning by rote and reinforcement. The child's natural emotions and interests are critical to DIR/Floortime because research has shown they are essential for creating learning opportunities that allow different parts of the mind and brain to work together to create increasingly higher levels of social, emotional, and intellectual abilities.

25. DIR is based on three principles: (1) development; (2) individual differences; and (3) relationships. The development principle is that every child must develop skills in: (1) self-regulation and interest in the world; (2) engaging and relating; (3) purposeful two-way communication; (4) complex communication and shared problem-solving; (5) using symbols and creating emotional ideas; and (6) logical thinking and building bridges between ideas. Such skills are essential to learning the higher emotional, social, and intellectual skills of: (1) multiple perspectives; (2) gray area thinking; and (3) reflective thinking and an internal standard of self. These higher emotional, social, and intellectual skills are critical to forming healthy, mature relationships.

26. The individual differences principle is that every child has biological differences unique to him. Each is unique in the way he understands and reacts to environmental sensations, such as what he sees, hears, touches, tastes, smells, and experiences. Additionally, everyone responds differently to internal sensations, such as hunger, fatigue, discomfort, and pain.

27. Finally, the relationships principle is based on the concept that a child learns social emotional skills from the adults to whom he is the closest. These adults are the foundation of social emotional skills until the child starts school. As the child develops a social emotional skill, he looks for new meaningful relationships with other people such as his teachers and peers to continue developing those skills.

28. Claimant eventually began her own DIR/Floortime sessions at TFDC. On August 1, 2022, TFDC administered a Functional Emotional Assessment Scale (FEAS) to create a "baseline" for claimant's skill levels and measure her progress in skill development. The person providing the assessment wrote the following summary and recommendations at the conclusion of the FEAS:

> [Claimant] is regulated in solitary play and can generate ideas with objects when presented with repetition and up-regulated affect from her play partner. During the FEAS video, she initiated (opened) very few circles of communication with her adult play partner. She responded fleetingly to Mom's ideas and then continued with her play. She did not smile in the video other than while in the pod swing. She seemed the most regulated in isolated play.
>
> She showed difficulty in interpreting cues of others.

Based on these findings, it is recommended that [claimant] receive DIR/Floortime Intervention to improve her and her caregiver's [functional emotional developmental capacities (FEDCs)] in the engagement, sensory and symbolic play. Intervention should include, but not be limited to:

- Child will sustain shared attention with parent in sensorimotor interactive play using child's preferred sensory motor modalities such as movement, touching, looking, listening.
- Child will show emotional interest in others and their ideas.
- Child will increase shared attention by 10+ initiating circles of communication with others.
- Child will anticipate with curiosity when parent presents interesting object or idea.
- Child will socially reference across space.
- Child will use affect to engage and open circles of communication.
- Child will draw parent in to share in an idea or with an object – will offer parent the object to see and engage.
- Child will increase range of affect and tone and pacing of affect to engage others.
- Child will increase body awareness to initiate ideas, plan, and sequence steps for execution in the environment.

- Parent training on providing consistent sensory support to maintain higher levels of engagement to establish higher FEDCs, tailoring amount of speech used, tone, pace, body position.

29. Upon reassessment on March 11, 2024, claimant showed "the most gains in initiating joint attention to communicate and initiating ideas during play." She continued "to exhibit challenges with engagement, complex gestural communication, and sustaining interactions while feeling of range of emotions." She "needs movement, upregulating/high affect, processing time, verbal and emotional support to successfully engage and persevere in play and in back/forth interactions." Prognosis was noted as "good for marked improvement in FEDCs for [claimant] and her parents." It was recommended that claimant continue DIR/Floortime "1x week for 60-minute sessions at TFDC, and a minimum of 6 hours per week of intentional, current-mediated, DIR/Floortime sessions at home and/or in the community."

30. Mother described DIR/Floortime as fundamental to claimant's success "without a shadow of a doubt." Claimant has become much more engaging since attending DIR/Floortime. Mother has always told her she gets a hug whenever she is sad. Now, she comes to Mother when sad, tells her she is sad, and asks for a hug. Or, she wraps Mother's arms around her and tells Mother to "squeeze."

31. Claimant has also become more animated. She recently had an overly exaggerated reaction to being denied makeup she requested to play with.

32. Mother described DIR/Floortime as "life-changing" for her as a parent. Parents originally wanted to have several children. But after claimant was born, Mother began to worry and became anxious about what would happen to claimant after Parents passed away. She was afraid claimant would become a ward of the state.

33. However, Mother's concerns began to resolve, and her anxiety lessen, as the family continued to participate in DIR/Floortime. The sessions gave Mother the strength to have more children and the confidence in knowing claimant is learning the skills necessary for her to continue long after Parents are gone.

34. Parents pay out-of-pocket for DIR/Floortime. This creates a significant demand on their finances and prohibits them from saving for an emergency, retirement, or college for their children. The unpredictability of claimant's ASD makes it "scary to plan vacations," besides which there is no money for vacations because they "choose [their] children's care over Disneyland."

35. Parents have not had a "date night" since claimant's older brother was born. CVRC has been "generous" with authorizing respite services, but it is difficult for Parents to find a provider willing to watch two children with ASD and a baby. Mother loves her mother and mother-in-law, and they provide a lot of support, but they are also "elderly," and the children are "exhausting." Additionally, Mother said it is her job to care for the children, and it is the grandmothers' jobs "to enjoy them."

36. Parents previously received a grant from Growing Resources for Autism and Neurodevelopmental Differences (GRAND) to pay half the cost of the DIR/Floortime sessions. GRAND is a nonprofit with a mission of "helping empower autistic and neuro-diverse individuals by improving resources and promoting inclusion throughout the central San Joaquin Valley." However, donations to GRAND have declined significantly, and GRAND did not renew the grant. Parents have been paying the entire cost of the sessions themselves, which has forced them to reduce their frequency.

37. Parents asked Cigna Healthcare, their health insurance provider, to cover the cost of DIR/Floortime. Cigna Healthcare's mental health benefits are managed by a third-party, Evernorth. Despite numerous follow-up calls to Evernorth, Mother has been unable to receive an approval or denial of coverage. Instead, Evernorth representatives repeatedly tell her they have all the information they need to evaluate the claim and they are "looking into it." Evernorth has refused to provide anything in writing.

38. Mother asked Ms. Battle for regional center funding for DIR/Floortime three times a week. Her request was denied. Mother timely requested a fair hearing challenging the denial.

Maternal Grandmother's Testimony

39. Maternal Grandmother participates in DIR/Floortime with claimant. She credits those sessions with teaching her how to engage with claimant. When Maternal Grandmother arrives at claimant's house and claimant does not immediately greet her, Maternal Grandmother will ask rhetorically, "What am I, chopped liver?" Claimant then runs to greet her. When Maternal Grandmother leaves, she says, "See later, alligator." Claimant responds, "After 'while, crocodile."

Kristine Gose's Testimony

40. Ms. Gose earned her Bachelor of Arts in movement and dance therapy and Master of Arts in education and human development and early childhood from California State University, Fresno. She holds a Lifetime Instructor credential in nursery school and preschool education from the Board of Governors of the California Community Colleges, an endorsement as an Infant-Family and Early Childhood Mental Health Specialist and Reflective Practice Facilitator II from the California Center for

Infant-Family and Early Childhood Mental Health, and certification as a DIR/Floortime Training Leader and Expert DIR/Floortime Provider from the International Council on Development and Learning.

41. Ms. Gose retired from Fresno City College as a member of its tenured faculty in the Department of Child Development. She previously taught movement therapy classes to school-aged children with severe emotional disturbance in the Fresno Unified School District. She has served as an Expert Level Facilitator for DIR/Floortime sessions at the Interdisciplinary Counsel on Development and Learning in Bethesda, Maryland, since 2010. She and others opened TFDC in 2018.

42. Ms. Gose is familiar with the goals set forth in claimant's current IPP and identified each as being mostly related to developing and improving social and emotional skills. She opined that those skills cannot be taught in the school setting through special education services because the social skills taught in such a setting are usually specific to skills needed in the school setting, such as learning to raise one's hand, getting your own supplies, etc. But the skills addressed in the IPP relate to emotional regulation and personal safety. Though Ms. Gose admitted having no formal training on the ABA model, she learned about the model through other training, and she has watched ABA services being provided "many times over many years." She explained that the focus of most behavior programs, such as ABA, is to create desired behavior or stop unwanted behavior. She opined that the DIR/Floortime model is better suited for addressing claimant's IPP goals.

Rachel Moongate's Testimony

43. Rachel Moongate works as an Early Intervention Specialist and DIR/Floortime Specialist at TFDC. She holds a Bachelor of Arts in child development

and Master of Arts in early childhood education from California State University, Fresno.

44. Ms. Moongate has been claimant's therapist since May 2023. Her goals are focused on learning the social and emotional skills needed to interact with others. Her DIR/Floortime sessions are held at TFDC, at home, or in a park. One parent or another family member participates in every session with Ms. Moongate. Sessions sometimes include claimant's older brother.

45. Ms. Moongate described claimant as having showed progress since coming to TFDC. Initially, claimant showed no concern for her older brother's well-being or in what he was doing. She would not initiate playing with him, and she did not talk to him. They looked like "two strangers in the same room." When they did interact, it frequently involved screaming and taking things from each other.

46. Now, claimant wants to spend time with her older brother, and she shows interest in what he is doing. Recently, they shared blueberries while sitting under a table. On another occasion, claimant approached while her older brother was playing with toy bugs. He gave one to her, and she hugged it while laying her head on his shoulder.

47. Ms. Moongate has also seen growth in the family unit. When claimant first arrived, Parents expressed significant concerns about her becoming a productive adult. They were "hesitant," "worried," and "concerned" about how she would progress and develop through life. Now, they are much more hopeful and less fearful about her future.

Andrea Davis, Ph.D.'s, Testimony

48. Andrea Davis, Ph.D., received her Bachelor of Arts in psychology from Swarthmore College. She received her Master of Arts in theology and Doctor of Philosophy in clinical psychology from Fuller Graduate School of Psychology, Fuller Theological Seminary. She served as a pre-doctoral intern at St. John's Child Study Center, post-doctoral fellow in child psychology at Brown University's Bradley Hospital, and registered psychological assistant with the private practice of Winston Gooden, Ph.D. Dr. Davis has been licensed as a psychologist by the California Board of Psychology since 1991. She has training and experience in both behavioral and developmental psychology.

49. Dr. Davis is the executive director of Greenhouse Therapy Center, which she founded in 1991. She provides psychological assessments and psychotherapy to patients of all ages, including individuals, couples, and parents. She is a vendor of five regional centers for DIR/Floortime treatment. She also is a DIR Faculty/Expert Training Leader with the International Council on Development and Learning. She has served as an assistant clinical professor and adjunct professor at Fuller Graduate School of Psychology and Azusa Pacific University, Department of Psychology's Doctoral Training Program.

50. Dr. Davis currently serves as a special advisor for advocacy and strategic partnerships for Positive Development Services, president of the DIR/Floortime Coalition of California, chair-elect of the California Psychological Association, Division I, and representative to the Division I Board for the California Psychological Association Government Affairs Committee. She previously served as the senior vice president of clinical operations for Positive Development Services and as director-at-large for the California Psychological Association, Division I.

51. Dr. Davis has not personally evaluated claimant. However, she estimated she has had "hours" of extensive conversations about her with Parents. Additionally, she has reviewed pertinent records including Dr. Wagner's initial psychological evaluation diagnosing claimant with ASD, her current IPP, and her current Individual Education Plan (IEP).

52. Dr. Davis opined that the DIR/Floortime treatment model is the best approach to meet the goals outlined in claimant's current IPP. She described DIR/Floortime as an evidence-based intervention that is based on developmental psychology. She described the ABA model as being focused on developing discrete skills, whereas DIR/Floortime is focused on developing core skills. She explained claimant needs the more foundational training that DIR/Floortime provides.

53. Dr. Davis is unaware of DIR/Floortime being available through any generic resources, such as Medi-Cal, private health insurance, or special education. This past March, she spoke with the clinical directors of seven members of the DIR/Floortime Coalition of California who provide DIR/Floortime services. All confirmed they are vendored to provide such services to consumers of multiple regional centers, including Frank D. Lanterman Regional Center, San Gabriel/Pomona Regional Center, Eastern Los Angeles Regional Center, South Central Los Angeles Regional Center, North Los Angeles County Regional Center, Tri-Counties Regional Center, Westside Regional Center, and Inland Regional Center. Collectively, these regional centers provide DIR/Floortime services to 74 consumers.

54. Several of the people with whom Dr. Davis spoke wrote letters confirming their agency is vendored to provide DIR/Floortime services, including Professional Child Development Associates. Julie Miller, MOT, OTR/L, SWC, Clinical Director, wrote:

Professional Child Development Associates (PCDA) has been providing family-centered, developmentally informed care for nearly 30 years. Our commitment to this approach is evident in the evolution of our services. Our Social Emotional Developmental Intervention (SEDI) service, vendored by Lanterman Regional Center in 1999, marked the first explicit use of DIR Floortime as the theoretical framework utilized in the service design. This service was vendored under service code 055, as a community inclusion program.

Since then, PCDA has continuously expanded its offerings, all grounded in the theory of DIR Floortime. Our services now include peer to peer socialization skills programs for children aged 3 to 18 years, under service code 028 and our developmental behavioral consultation service, under service code 605. Beyond these core programs, PCDA is also authorized to provide feeding services, as well as occupational, speech language, and music therapies. We also have a young adults program for consumers aged 18 to 21 through service code 102.

Presently, PCDA serves over 500 families throughout Los Angeles County, receiving funding from Lanterman Regional Center, Eastern Los Angeles Regional Center, North Los Angeles Regional Center, South Central Regional

> Center, San Gabriel Pomona Regional Center, and Westside Regional Center[,] in addition to other funding sources.
>
> PCDA's mission is to create a community that builds on strengths and relationships to prepare young people with Autism and developmental disabilities for a future in which they are empowered, fulfilled, and feel the security of belonging. DIR Floortime lies at the core of our mission and service delivery. This model highlights the vital role of relationships as the catalyst for development and emphasizes how strong family and peer relationships support community inclusion and self-advocacy.

Diane Cullinane, M.D.'s, Testimony

55. Diane Cullinane, M.D., earned her Bachelor of Science degree from Stanford University and her Doctor of Medicine degree from Baylor College of Medicine. She completed her internship and residency in pediatrics at Kaiser Foundation Hospital. She was Chief Resident during her final year. Dr. Cullinane completed a child development fellowship at the University of California, Los Angeles, Department of Pediatrics, Division of Child Development. She is triple board-certified with the American Board of Pediatrics in General Pediatrics, Developmental-Behavioral Pediatrics, and Neural Developmental Disabilities. She holds a DIR Certificate and a DIR Institute Faculty from the Interdisciplinary Council on Development and Learning.

56. The California Medical Board issued Dr. Cullinane her physicians and surgeons license in 1981. Her license is currently in "retired" status. In December 2019, she retired from PCDA after co-founding it and serving as its executive director for

almost 23 years. She started her professional career in a general pediatrics practice. She later served as the Coordinator Child Development and Behavior Rotation for pediatric residents at Cedars-Sinai Medical Center, a school physician with the Los Angeles Unified School District, a medical consultant for San Gabriel Pomona Regional Center, the Director of the Interdisciplinary Training and the Director of Training in Pediatrics at Children's Hospital of Los Angeles, and a medical consultant for Eastern Los Angeles Regional Center.

57. In 2021, Dr. Cullinane wrote an article in which she explained, "In the past couple of decades, the field of autism intervention has evolved into three main evidence-based approaches." (Cullinane, *Approaches to Autism Intervention* (2021), 12 The Carlat Report Child Psychology 1 (hereafter Cullinane).) Those three approaches are: (1) ABA; (2) Developmental Relationship-Based Intervention (DRBI); and (3) Naturalistic Developmental Behavioral Intervention (NDBI). (*Id.*, at p. 4.)

58. ABA "is based on operant learning theory, meaning that behavior is learned based on what happens before the behavior (antecedent) and what happens after it (reward)." (Cullinane, at p. 4.) Criticisms of ABA include "poor maintenance of skills, for generalization of learning to new situations, and prompt dependency: reliance on adults to tell the child what to do (Mace FC and Critchfield TS, *J Exp. Anal Behav* 2010; 93(3):293–312)." (Cullinane, at p. 4.)

59. "DRBI is a parent-mediated intervention where the primary focus is on training parents and other caregivers to build and use warm, meaningful interactions to help the child function better in communicating, learning, and problem-solving. The best-known model is DIRFloortime or simply Floortime, which came from the work of Dr. Stanley Greenspan and Dr. Serena Wieder (Greenspan SI, Wieder S. *Engaging Autism: Using the Floortime Approach to Help Children Relate, Communicate, and*

Think. Boston, MA: Da Capo Lifelong Books; 2006)." (Cullinane, at p. 4.) Developmental interventions are less structured than behavioral interventions and follow the child's lead.

> An adult takes a child's interest and builds on it, while making the activity an emotionally meaningful experience. These fun reciprocal interactions help the child extend their capacities for creating and working with ideas, communicating, and social connection. See www.profectum.org/about/dir and www.icdl.com/dir for more information.

(Cullinane, at p. 4.)

60. NDBI was developed to counter some of the problems with ABA. (Cullinane, at p. 4.) Learning occurs in natural settings, includes parents, and the rewards given are based on the child's interest. (*Ibid.*) Some goals are based on the child's developmental abilities, as opposed to a specific skill. (*Ibid.*)

61. Dr. Cullinane noted, "The most recent edition of The National Clearinghouse on Autism Evidence and Practice supports specific practices that fall within all three of these main branches of autism intervention (Steinbrenner JR, Hume K, Odom, SI, et al. *Evidence-Based Practices for Children, Youth, and Young Adults With Autism*. Chapel Hill, NC: National Clearinghouse on Autism Evidence and Practice; 2020)." (Cullinane, at p. 4.) Additionally, the American Academy of Pediatrics endorses all three interventions. (*Ibid.*) "[R]ecent reviews recognize the growing body of research legitimizing DRBI and NDBI and showing that both of these have demonstrable effect

sizes for social communication, while these effect sizes have not been shown for ABA (Sandbank, M, et al. *Psychol Bull* 2020; 146(1): 1–29)." (Cullinane, at p. 4.)

62. Dr. Cullinane added at hearing that DIR/Floortime is not considered an experimental treatment for ASD because there is plenty of evidence demonstrating its effectiveness, and it is widely used. She referenced several studies showing the efficacy of the DIR/Floortime treatment model. For example, Canadian researchers conducted a study to determine the effectiveness of DIR/Floortime as an ASD treatment model. (Dionne, M & Martini, R (2011), Floor Time Play with a child with autism: A single-subject study. *Canadian Journal of Occupational Therapy*, 78, 196–203. dol: 10.2182/cjot.2011.78.3.8 (hereafter Dionne).) They concluded:

> The statistical analysis of the data demonstrated a significant increase in the numbers of CoC in the intervention phase as compared with the number of CoC in the observation phase. The mother's Journal provided a parent's perspective of the implementation of [DIR/Floortime] at home. In view of these encouraging results, continued research studies of the [DIR/Floortime] approach are warranted.

(Dionne, at p. 202.)

63. Researchers in Thailand conducted a study to determine the efficacy of adding DIR/Floortime sessions to the routine care of preschool children with ASD. (Pajareya, K & Nopmaneejumruslers, K, *A pilot randomized controlled trial of DIR/Floortime parent training intervention for pre-school children with autism spectrum disorders* (2011) 15 Autism 563 (hereafter Pajareya I).) They determined that

"after the parents added home-based DIR/Floortime intervention at an average of 15.2 hours/week for three months, the intervention group made significantly greater gains in all three measures employed in the study: Functional Emotional Assessment Scale (FEAS) (F = 5.1, p = .031), Childhood Autism Rating Scale (F = 2.1, p = .002), and the Functional Emotional Questionnaires (F = 6.8, p = .006). (*Ibid.*)

64. Drs. Pajareya and Nopmaneejumruslers conducted a one-year follow-up study. (Pajareya, K & Nopmaneejumruslers, K *A One-Year Prospective Follow-Up Study of a DIR/Floortime Parent Training Intervention for Pre-School Children with Autism Spectrum Disorders* (2012) 95 J. Med. Assoc. Thai 1184 (hereafter Pajareya II).) They concluded:

> The results of the present study showed that the improvements in FEAS score, FEAS scaled score, FEDQ, and CARS were statistical[ly] significant pre to post. For typically developed children, one level of FDL level naturally occurred within six to 12 months. When a child moved from FDL 2 to FDL 3, this showed a change from being in isolation towards being able to express his/her emotion and have two-way communication with his/her parent.
>
> On the scale FEAS scaled score, 70% of the children in the present study gained one or more level of FDL within a 12-month period. These progressions were both considered by way of a statistical and clinical significance.
>
> Our data demonstrated better results for lesser severely affected children in the same way as the previous reports of

the interventions for children with ASD [footnotes] and suggested that parents who were able to spend more time with their children could help their children to make a better progression.

The results of Solomon's study shows that 45.5% of the children participating in his project gained one or more level of FDL. Our children seem to show better result[s] within the same duration. The main reason was because, at baseline, our children lacked adequate and appropriate treatment or they went to school to[o] early and spent more time in school than those in Solomon's study. Many children in this study participated in special education or regular preschool program even while they were not yet fully engaged with their parents. In such a situation, the teacher or teacher's aides could not conduct one on one interaction with each child, and the partially engaged autistic child was being left self-absorbed most of the time.

In addition, it was found that the majority of the parents in the present study did not know how to play with their children at the beginning. They spent most of their time controlling and teaching their children. This may be the results of Thai culture and education background that do not prefer the young to express themselves but rather do only what adults told them to do. This was different from the parents in Solomon's study. As a result, the parents in

> the present study had more chance to improve their abilities after being coached.

(Pajareya II, at p. 1190.)

65. Additionally, Dr. Cullinane explained there is a shift within the American Medical Association (AMA) away from supporting only ABA as treatment for ASD and toward supporting all evidence-based treatment. On April 3, 2023, the Medical Student Section of the AMA introduced a resolution to the AMA's House of Delegates to amend Policy H-185.921 Standardizing Coverage of Applied Behavioral Analysis Therapy for Persons with Autism Spectrum Disorder by adding and deleting the following language:

> **Standardizing Coverage ~~of Applied Behavioural Analysis Therapy~~ for Persons with Autism Spectrum Disorder, H-185.921**
>
> Our AMA supports coverage and reimbursement for evidence-based ~~treatment of~~ <u>services for</u> Autism Spectrum Disorder ~~including, but not limited to, Applied Behavior Analysis Therapy~~.

66. The House of Delegates passed the resolution with minor amendments. Policy H-185.921 now reads: "Our AMA supports coverage and reimbursement for evidenced-based treatments and services for neurodivergent individuals, including Autism Spectrum Disorder."

CVRC's Employees' Testimony

67. Shelley Celaya is CVRC's Assistant Director of Case Management. She supervises seven program managers. Each program manager supervises between 11 and 13 service coordinators.

68. Melissa Beal is a program manager of a transition team at CVRC. She supervises 12 service coordinators, including Ms. Battle. Ms. Celaya is her supervisor.

69. Parents asked Ms. Battle for regional funding for DIR/Floortime for claimant. Ms. Battle brought the request to Ms. Beal. Ms. Beal did not have authority to approve or deny the request, so she brought it to Ms. Celaya. One of Ms. Celaya's duties is to decide requests for services and supports that cannot be decided by a program manager.

70. Ms. Celaya and Ms. Beal discussed Parents' request for services with Aaron Olson and Rocio Dietz. Mr. Olson is CVRC's Director of Community Services. Ms. Dietz is a board-certified behavioral analyst and is a senior behavioral analyst at CVRC. She oversees all behavioral services CVRC provides its consumers.

71. Ms. Dietz referred to a study by the National Autism Center (NAC) to determine if DIR/Floortime is an evidence-based treatment modality for ASD. The NAC is May Institute's Center for the Promotion of Evidence-Based Practice. "It is dedicated to serving individuals with [ASD] by providing reliable information, promoting best practices, and offering comprehensive resources for families, practitioners, and communities." The May Institute is a non-profit entity that supports people with ASD and other developmental disabilities, brain injuries, mental illness, and behavioral health needs.

72. The National Standards Project is NAC's attempt to develop national standards for evidence-based treatment for ASD. "Its primary goal is to provide critical information about which interventions have been shown to be effective for individuals with ASD."

73. Phase 1 of The National Standards Project was launched in 2005. It conducted a comprehensive analysis of research studies and literature published between 1957 and 2007 about different interventions for children and adolescents with ASD. It published a written report of its analysis in 2009. (National Autism Center (2009) *The National Autism Center's National Standards Project Findings and Conclusions*, Randolph, MA. (hereafter NSP, Phase 1).)

74. NSP, Phase 1, developed a Strength of Evidence Classification System to evaluate its confidence about the effectiveness of the different treatment modalities analyzed. Researchers "describe the treatment as 'effective' when it has been shown to work in real-world settings such as home, school, and community. For the purposes of this report, the word 'effective' refers to studies conducted in real-world, clinical, and research settings." (NSP, Phase 1, at p. 9.) The Strength of Evidence Classification System used the following categories:

- **Established**. Sufficient evidence is available to confidently determine that a treatment produces favorable outcomes for individuals on the autism spectrum. That is, these treatments are established as effective.

- **Emerging**. Although one or more studies suggest that a treatment produces favorable outcomes for individuals with ASD, additional high[-]quality studies must consistently show this outcome before we can draw firm conclusions about treatment effectiveness.

- **Unestablished**. There is little or no evidence to allow us to draw firm conclusions about treatment effectiveness with individuals with ASD. Additional research may show the treatment to be effective, ineffective, or harmful.

- **Ineffective/Harmful**. Sufficient evidence is available to determine that a treatment is ineffective or harmful for individuals on the autism spectrum.

(Bold original.)

75. NSP, Phase 1, categorized DIR/Floortime as "Emerging" based on seven studies reviewed. (NSP, Phase 1, at p. 20.)

76. Phase 2 of The National Standards Project was launched in 2011. It was intended to provide updated information about the effectiveness of different treatment modalities for children and youth under 22 years of age. And, unlike NSP, Phase 1, it also analyzed treatment modalities for those 22 years of age and older. NSP, Phase 2, analyzed research studies and literature published between 2007 and February 2012. It published a written report of its analysis in 2015. (National Autism Center (2015) *Findings and Conclusions: National standards project, phase 2*, Randolph, MA. (hereafter NSP, Phase 2).)

77. NSP, Phase 2, used the same Strength of Evidence Classification System as NSP, Phase 1, except it omitted the "Ineffective/Harmful" category, and it referred to "intervention(s)" rather than "treatment(s)." NSP, Phase 2, categorized DIR/Floortime as "Unestablished." It did not specify whether its rating was based on "little or no evidence."

78. In addition to referencing NSP, Phase 2, Ms. Dietz considered three research studies. One concluded it provided "fragile support" for concluding DIR/Floortime was an effective treatment. (Divya, KY, et al. *DIR/Floor time in engaging autism: A systemic review*. Iran J. Nurs. Midwifery Res. (2023); 28:132–8 (hereafter Divya).) Another determined that "methodologically rigorous studies are needed to draw definitive conclusions" about DIR/Floortime's effectiveness. (Binns, A & Cardy, J (2019) *Developmental social pragmatic interventions for preschoolers with autism spectrum disorder: A systemic review*, 4 Autism & developmental Language Impairments 1 (hereafter Binns).) And the last concluded, "[D]IR/Floortime simply does not meet the basic standards of care for use as a treatment intervention." (Ross, R, et al. (2018) *Focus on Science: Is There Science Behind That?: Autism Treatment with DIR/Floortime*, 15 Science in Autism Treatment 20.)

79. In Divya, "the objective of [the] study was to systematically review the available literature and appraise the effect of floortime in engaging autism disorder among children." (Divya, at p. 132.) The authors found:

> Though the studies varied in outcome measures, all included studies showed an increase in children's social and emotional development. [Footnotes.] The more the parent engage during floortime, the better the child's improvement in various functioning. [Footnotes.] The severity of ASD, duration of treatment, parental marital status, parental earnings, familiarity with DIR, approach to ASD, and parental engagement in floortime are certain demographic factors that had a significant impact on the outcome of floortime. [Footnote.]

(Divya, at p. 136.)

80. The authors concluded:

> In general, we concluded that the existing studies have given fragile support on the efficacy of floortime and effectiveness compared to other interventions in children with ASD. Hence, more RCTs are needed to identify the actual effect of floortime activities on various developmental skills of children with autism. Every child with autism is different and every family has its unique make. Floortime is a cost-effective, completely child-led approach, which could be initiated as early as possible in improving social and emotional development among children.

(Divya, at p. 137.)

81. Binns evaluated developmental social pragmatic (DSP) interventions as a treatment option for developing social communication and language skills in preschool children with ASD. (Binns, at p. 1.) The authors explained, "DSP interventions use the developmental sequences observed in typical development to inform assessment and treatment, with the assumption that the overarching principles of development are applicable to all children regardless of diagnosis (NRC, 2001)." (Binns, at p. 2.) They concluded:

> This review suggests that developmental social pragmatic treatments positively impact children's foundational communication capacities (i.e. attention, social referencing,

> joint attention, initiation, reciprocity). Positive findings were not consistently found for supporting children's language. Further, methodologically rigorous studies are needed to draw definitive conclusions. Additional research exploring components of developmental social pragmatic treatments that might mediate response to treatment is needed.

(Binns, at p. 1.)

82. Ms. Dietz determined that the conclusions of the three studies supported a determination that DIR/Floortime in not an evidence-based treatment for ASD. The combination of that determination and NSP, Phase 2's, "Unestablished" rating led her to recommend that Parents' request for funding for DIR/Floortime Therapy be denied. Ms. Celaya and Ms. Beal concurred.

83. On January 24, 2024, Ms. Beal and Ms. Battle signed a cover letter addressed to Parents that included a Notice of Action (NOA) identifying the following proposed action: "Denying your request for DIR Floortime Therapy. Total cost of request is $450 per week (3 sessions per week @ $150 per session)." The reason for the proposed action was: "DIR/Floortime is considered an Unestablished Intervention for the treatment of ASD by the National Standards Project." The NOA cited Welfare and Institutions Code sections 4646.4 and 4648, subdivision (a)(17), as legal support for its proposed action.

Analysis

84. Claimant requested that CVRC fund three sessions per week of DIR/Floortime. CVRC denied the request. Therefore, claimant has the burden of proving by a preponderance of the evidence that she is entitled to funding under the

Lanterman Act. (*Lindsay v. San Diego Retirement Bd.* (1964) 231 Cal.App.2d 156, 161 [the party seeking government benefits has the burden of proving entitlement to such benefits]; Evid. Code, § 115 [the standard of proof is preponderance of the evidence, unless otherwise provided by law].)

85. The Lanterman Act requires CVRC to "secure services and supports that meet the needs of [claimant], as determined in [her] individual program plan, . . . and that allow [claimant] to interact with persons without disabilities and positive, meaningful ways." (Welf. & Inst. Code, § 4648, subd. (a)(1).) Claimant's current IPP outlines goals related to developing and improving social and emotional skills. Mother, Maternal Grandmother, and Ms. Moongate provided credible and persuasive testimony about the significant improvement in claimant's social and emotional skills since she started participating in DIR/Floortime. CVRC provided no evidence to the contrary.

86. Instead, CVRC denied claimant's request based on the prohibition against regional centers purchasing "experimental treatments . . . that have not been clinically determined or scientifically proven to be effective or safe . . . ." (Welf. & Inst. Code, § 4648, subd. (a)(17).) CVRC relied on NSP, Phase 2, and three research studies as support for its conclusion that DIR/Floortime has not been proven effective.

87. However, CVRC produced no evidence that NSP, Phase 2's classification of DIR/Floortime as an "Unestablished Intervention" conclusively establishes it is ineffective or unsafe as a treatment modality for ASD. Indeed, NSP, Phase 2's definition of an "Unestablished Intervention" does not support such a conclusion: an intervention is unestablished if "there is little or no evidence to allow [researchers] to draw firm conclusions about intervention effectiveness with individuals with ASD." In other words, researchers concluded they could not determine if DIR/Floortime is or is not an

effective treatment modality. They did not specify whether their conclusion was based on too little evidence of effectiveness or the absence of evidence of effectiveness; thereby leaving the possibility that there was some, but not enough, evidence of effectiveness.

88. Two of the studies Ms. Dietz relied on, Divya and Binns, provided some evidence of DIR/Floortime's effectiveness and safety. Welfare and Institutions Code section 4648, subdivision (a)(17), does not limit CVRC to purchasing only the best, most effective, or most common treatment modality. It only prohibits CVRC from purchasing ineffective or unsafe treatment. Therefore, it is wholly irrelevant that researchers concluded their study provided "fragile support" for DIR/Floortime's effectiveness or additional research is necessary. Additionally, Drs. Cullinane and Davis provided credible and persuasive evidence that DIR/Floortime has been shown to be effective and safe.

89. When all the evidence is considered, claimant established DIR/Floortime is an effective and safe treatment option for her. Therefore, the Lanterman Act requires CVRC to fund three sessions per week of DIR/Floortime for her.

LEGAL CONCLUSIONS

Standard of Proof

1. The preponderance of the evidence standard requires claimant to produce evidence of such weight that, when balanced against evidence to the contrary, is more persuasive. (*People ex rel. Brown v. Tri-Union Seafoods, LLC* (2009) 171 Cal.App.4th 1549, 1567.) In other words, she must prove it is more likely than not

CVRC is required to fund her request for DIR/Floortime. (*Lillian F. v. Super. Ct.* (1984) 160 Cal.App.3d 314, 320.)

Applicable Law

2. Under the Lanterman Act, the State of California accepts responsibility for persons with developmental disabilities and pays for the majority of the "treatment and habilitation services and supports" to enable such persons to live "in the least restrictive environment." (Welf. & Inst. Code, § 4502, subd. (b)(1).) To determine how an individual consumer is to be served, regional centers are directed to conduct a planning process that results in an IPP designed to promote as normal a lifestyle as possible. (Welf. & Inst. Code, § 4646; *Assn. for Retarded Citizens v. Dept. of Developmental Services* (1985) 38 Cal.3d 384, 389.)

3. Among other things, the IPP must set forth goals and objectives for the consumer, contain provisions for the acquisition of services (which must be based upon the consumer's developmental needs), contain a statement of time-limited objectives for improving the consumer's situation, and reflect the consumer's particular desires and preferences. (Welf. & Inst. Code, §§ 4646, subd. (a)(1), (2), & (4); 4646.5, subd, (a); 4512, subd. (b); and 4648, subd. (a)(6)(E).) The regional center must "secure services and supports that meet the needs of the consumer" within the context of the IPP. (Welf. & Inst. Code, § 4648, subd. (a)(1).)

4. Regional centers are mandated to provide a wide range of services to facilitate implementation of a consumer's IPP but must do so in a cost-effective manner. (Welf. & Inst. Code, §§ 4640.7, subd. (b), 4646, subd. (a).) They must "identify and pursue all possible sources of funding for consumers receiving regional center services." (Welf. & Inst. Code, § 4659, subd. (a).) Additionally, they are required to

adopt internal policies regarding the purchase of services for consumers. (Welf. & Inst. Code, § 4646.4, subd. (a).) The Department of Developmental Services is required to review those policies prior to implementation by the service centers, and "shall take appropriate and necessary steps to prevent regional centers from utilizing a policy or guideline that violates any provision of" the Lanterman Act or any regulation adopted pursuant to it. (Welf. & Inst. Code, § 4434, subd. (d).) Regional centers may not deny necessary services based on the application of a rigid, inflexible policy. (*Williams v. Macomber* (1990) 226 Cal.App.3d 225, 232.) Final decisions regarding the consumer's IPP shall be made pursuant to Section 4646. (Welf. & Inst. Code, § 4646.4, subd. (c).)

Conclusion

5. The credible and persuasive evidence established that DIR/Floortime is an effective and safe treatment for claimant. Such treatment has been shown to help her in meeting the goals in her IPP of developing and improving social and emotional skills. Therefore, the Lanterman Act requires CVRC to fund DIR/Floortime therapy at the rate of three sessions per week.

ORDER

Claimant's appeal from Central Valley Regional Center's denial of her request to fund three sessions per week of DIR/Floortime is GRANTED.

DATE: May 22, 2024

COREN D. WONG
Administrative Law Judge
Office of Administrative Hearings

NOTICE

This is the final administrative decision. Each party is bound by this decision. Either party may request a reconsideration pursuant to subdivision (b) of Welfare and Institutions Code section 4713 within 15 days of receiving the decision, or appeal the decision to a court of competent jurisdiction within 180 days of receiving the final decision.