

BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

HAYDEN W.

Claimant,

vs.

CENTRAL VALLEY REGIONAL
CENTER,

Service Agency.

OAH No. 2012110431

DECISION

This matter was heard before Administrative Law Judge Danette C. Brown, State of California, Office of Administrative Hearings, on July 29, 2013, in Fresno, California.

Shelly Celaya, Client Appeals Specialist, represented the service agency.

Lynn Hunt, Social Worker, Child Protective Services, County of Madera, represented claimant as his authorized representative.

Evidence was received, and the matter was submitted for decision on July 29, 2013.

ISSUES

1. Is claimant eligible to receive regional center services under (Welf. & Inst. Code, § 4512, subd. (a)) because he has a condition closely related to mental retardation or that requires treatment similar to that required for individuals with mental retardation?

FACTUAL FINDINGS

Background and History

1. Claimant is a four and a half-year old boy. He was placed in a foster home in May 2012 after he was found alone in an abandoned home where he resided with his mother, who was abusing drugs. Claimant's foster parents are Freda and Carl Hobart. Claimant also has a biological brother that resides in the foster home. Claimant was referred to the Central Valley Regional Center (CVRC) by Susan Bullard, a Registered Nurse at the Department of Social Services. Claimant was referred to CRVC due to developmental and speech delays and not being toilet trained. On July 27, 2012, the CRVC performed an intake assessment of claimant. The intake assessment was performed by Intake Counselor Raysa Lemons.

2. The intake assessment documented claimant's: 1) Socio-Economic Situation; 2) Developmental and Medical History; and, 3) Current Level of Functioning. The assessment also provided Ms. Lemon's summary and impressions and provided a case plan.

3. The assessment noted that claimant's speech was slow, and that he was able to say two real words. He seemed to have his own jargon. Claimant's medical information such as his vital signs, sleep patterns and appetite were noted as normal. Behaviors of concern were claimant's inability to state his needs and not being "potty trained." Claimant's previous foster family reported various behaviors such as limited eye contact and flapping hands. Ms. Lemon noted that claimant is able to use both hands and walk with good balance. He is able to run, hop, jump and balance on one foot. He can play on playground equipment. When hungry, he is able to say "eat." After playing, he is able to pick up toys. He can put his dirty clothes in the hamper when asked. When eating, he will eat with a spoon, but he will grab the food with his fingers and place it on the spoon. He tends to shove food in his mouth. He is scared of the toilet. Claimant can clothe himself and put his shoes on the correct foot.

4. With regard to claimant's social/emotional functioning, the assessment noted that claimant can sit quietly while his foster family is watching a movie. Claimant was observed playing with a [toy] dog and would say "cookie" instead of "doggie." He can play with toys appropriately. He could not say "please" when he saw a ball and wanted it.

5. With regard to claimant's cognitive abilities and communication, the assessment noted that claimant stays next to his foster father when out in the community. On preferred activities, claimant is able to stay focused for approximately three or four hours. Claimant does not know how to count or know his colors. He is able to point to what he wants. The assessment set forth a case plan to request claimant's medical records, schedule a "Tier II" psychological evaluation and perform a multidisciplinary team review to determine eligibility.

Neuropsychological Evaluation by Dr. Glidden

6. On October 9, 2012, Howard J. Glidden, Ph.D., a Developmental Neuropsychologist, performed a neuropsychological evaluation of claimant. Claimant was referred to Dr. Glidden by CRVC for assessment of cognitive and neurodevelopmental functioning.

7. Language Functioning. Dr. Glidden noted that claimant's ability to use language as a conceptual/communicative tool, to reason in the auditory modality and to express the content of his thoughts was limited. On the Wechsler Preschool and Primary Scale of Intelligence-III (WPPSI-III), claimant obtained a Global Language Composite score of 59, corresponding to the extremely low range. Claimant had difficulty pointing to pictures illustrating words presented verbally. Claimant's auditory-verbal receptive skills were variable. His ability to process information was functional, but had difficulty following complex multi-staged commands. With regard to his expressive skills, claimant's single word expressive vocabulary was limited. In the picture-naming subtest of the Wechsler-III, a task which required claimant to name pictures presented visually, claimant was in the borderline range. He would misidentify a picture as a similar object which suggested that he has a very limited vocabulary for his age.

8. Intellectual Functioning. Subtest scores from the WPPSI-III ranged from the extremely low to average levels of ability. Claimant had the greatest degree of difficulty on subtests requiring language processing abilities. He had the greatest degree of success on subtests requiring nonverbal information processing. With regard to claimant's Verbal Scale IQ, Dr. Glidden noted:

Claimant's performance was in the extremely low range on subtests reflecting fund of knowledge and the ability to acquire ambient information from the environment, (Information), and word knowledge and acquired lexicon (Vocabulary). Again [claimant] was able to point to some pictures correctly, and also was able to point to his nose. He was unable to point to other body parts or answer single-work questions.

With regard to claimant's Performance Scale IQ, Dr. Glidden noted, in part:

[Claimant's] ability to reason and solve problems in the visual modality was variable, but overall, was superior to his language processing skills and abilities. Performance was in the Borderline range on a subtest requiring analysis and synthesis of visually presented materials (Block Design). Performance was in the Average range on subtests requiring nonverbal (spatial) abstract

inductive reasoning which requires the individual to infer a rule from a series of visually presented objects and to use that inference to generate solutions regarding the next element in a series (Matrix Reasoning), and constructional ability in the absence of an external model in which the individual is required to construct puzzles without being informed as to what the complete puzzle would become (Object Assembly).

Graphomotor skills (eye-hand coordination/drawing abilities) were limited. Performance on the Beery Visual-Motor Integration (5th Edition), a highly structured figural-copying test, was in the Low range.

9. Adaptive Functioning. Claimant's developing ability to provide for some of his self-care skills and to interact with objects and people was limited. Dr. Glidden noted that claimant scored a 45 under the Adaptive Behavior Assessment System-II, corresponding to the extremely low range.

10. Dr. Glidden noted that "[a]cute neuropsychological sequelae do not appear to be present in this profile. There is no evidence of a focal, lateralized or progressive organic impairment. [Claimant] does present as an individual with a complex neurodevelopmental/neurocognitive symptom presentation. These symptoms include language delays, limited verbal and nonverbal concept formation, and behavioral dysregulation. The etiology of these challenges is unclear at this time." Dr. Glidden's impressions were that claimant presented as an individual with difficulty in emotional regulation/control, coupled with poor self-soothing skills. In general, "those who cannot talk it out, act it out," and individuals who have suffered neglect often exhibit high levels of anxiety. Dr. Glidden further found that claimant presented as an individual with a high level of anxiety, and that "individuals with chronic high levels of anxiety lead to a disruption of "top down" cognitive control of prefrontal (executive) cortex and limbic emotional circuitry." As a result, the circuits run unconstrained and the emotions play a much larger role in decision-making and problem-solving than does cognitive processing. Subsequently, the individual has deficiencies in planning, monitoring, and flexibility of behavior. In addition, the individual has a disturbance in the ability to solve problems requiring foresight, goal direction, resistance to interference, use of feedback and sustained effort. Dr. Glidden noted, "[a]t this time, [claimant] is most comfortable processing information that is rehearsed and associative over that when processing more complex information. This is evident not only in his speech pattern, but also from results of the present evaluation. [Claimant] will very likely require a comprehensive multimodal/multiagency collaborative approach to maximize his developmental potential in all areas." Based on Dr. Glidden's review of the foster parent report, available records and Dr. Glidden's evaluation, his findings were consistent with a

DSM-IV TR¹ diagnosis of Lack of Expected Physiologic Development Due to Unknown Causes (799.9).

11. Dr. Glidden recommended that claimant receive a comprehensive speech and language evaluation and that his cognitive and adaptive functioning be closely monitored, particularly in relation to language limitations. He noted, “It has been demonstrated that children with delayed speech and language skills typically exhibit academic underachievement, particularly in the areas of reading, and later, in written language.” Dr. Glidden recommended that claimant should be reevaluated prior to enrolling in kindergarten to assist in placement decision-making and to provide recommendations as appropriate. Dr. Glidden also stated that claimant will require a functional behavioral analysis evaluation in order to determine those antecedents for behavior and appropriate reinforcers. Afterwards, the behaviorist must provide education to the teacher and family in order to maximize compliance in all areas. Behavioral goals should be appropriate to claimant’s age and cognitive abilities, as well as his social and communication skills.

Initial Evaluation by Chowchilla Elementary School District

12. Claimant was referred by Ms. Hunt to the Chowchilla Elementary School District (school district) for a multidisciplinary initial evaluation. The purpose of the evaluation was to assess claimant’s progress, and current educational needs. Educational concerns were regarding possible global delays. Claimant was examined for eligibility for special education services as well as for recommendations regarding instruction and placement. School Psychologist Adrian E. Varanini, Ed.D., M.S., BCSE, BICM, performed the evaluation.

13. Dr. Varanini reviewed Dr. Glidden’s report and noted that, according to Dr. Glidden, he could not administer the WPPSI-III in its entirety due to claimant’s challenges with language comprehension. As a result, Dr. Glidden’s report contained individual subtest results reported as scaled scores. Index scores and a Full-Scale Intelligence Quotient were not calculated.

14. The following tests were administered: Test of Early Mathematical Ability-Third Edition (TEMA-3²); Test of Early Reading Ability-Third Edition (TERA-3³); Developmental Indicators for the Assessment of Learning, 3rd Edition

¹ Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision.

² The TEMA-3 is a norm-referenced, reliable, and valid test of early mathematical ability for children ages “3-10 through 8-11.”

³ The TERA-3 is an individually administered, nationally norm-referenced test of academic achievement which assesses early reading in children age “3-6 through 8-6.”

(DIAL-3⁴); Test of Nonverbal Intelligence-Third Edition (TONI-3⁵); Behavior Assessment System for Children-Second Edition (BASC-2⁶); and the Vineland Adaptive Behavior Scales, Second Edition (Vineland-II⁷).

15. TEMA-3. Dr. Varanini did not address claimant's performance on the TEMA-3.

16. TERA-3. Claimant tested in the very poor range. Dr. Varanini noted that claimant did not understand the task questions. He touched the pages and smiled a lot throughout the examination. For the McDonald's logo in the "meaning" section, he smiled when it was presented.

17. DIAL-3. Claimant's scaled score of six fell below the cut off level of 16. He is delayed in motor skills, concepts, and language skills.

18. TONI-3. The TONI-3 was assessed because claimant did not reach the age threshold at that time. However, an age equivalent was calculated. Claimant scored at an age equivalent of a child five years, nine months. Dr. Varanini provided no further discussion regarding this test.

19. BASC-2. Claimant scored in the "at-risk" range for hyperactivity (displays an unusually high number of disruptive, impulsive, and uncontrolled behaviors), attention (displays significant difficulty maintaining necessary levels of attention at school), and social skills (displays difficulty in complimenting others and making suggestions for improvement in tactful and socially acceptable manner).

20. VINELAND-2. The results indicated low adaptive behaviors in each of the domains. Claimant's relative strengths were indicated in his receptive language, his ability to take care of his own personal needs, and his gross motor skills. His

⁴ The DIAL-3 is an individually administered assessment developmental screening test designed to identify young children in need of further diagnostic assessment. The DIAL-3 consists of five screening areas: Motor Concepts; Language; Self-help; Development; and Social Development.

⁵ The TONI-3 is a nonverbal test of intellectual ability. Subtest Standard Scores are calculated and three Intellectual Quotients are reported. The Nonverbal Intelligence Quotient is a composite examining nonverbal reasoning ability such as: sequential processing; categorical thinking; and analogical reasoning.

⁶ The BASC-2 is a comprehensive set of rating scales and forms, which, together, help to understand the behaviors and emotions of children and adolescents.

⁷ The Vineland-II is a measure of personal and social skills from birth to adulthood. The following domains are measures: Communication; Daily Living Skills; Socialization; Motor Skills; and Maladaptive Behaviors.

relative weaknesses were expressive language, fine motor skills and living in the community.

21. According to the Initial Evaluation, state and federal laws outline 14 disability categories or disabling conditions under which a student may be eligible for special education and related services: Autism/Autistic-like Behaviors; Deafness; Deaf/Blindness; Intellectual Disability; Multiple Disabilities; Orthopedic Impairment; Specific Learning Disability; Speech/Language Impairment; Traumatic Brain Injury; Established Medical Disability; Hearing Impairment; Other Health Impairment; Serious Emotional Disturbance; and Visual Impairment. Dr. Varanini concluded that claimant did not meet the eligibility criteria for special education services based on the criteria for Intellectual Disability. Based on the results of her assessment and the CVRC's assessment, claimant's nonverbal cognitive ability was estimated to fall within the average range for a child his age. Claimant's foster parents reported low adaptive skills, which, according to Dr. Varanini, may be better characterized as a result of neglect as opposed to an intellectual disability. Dr. Varanini, did, however, determine that claimant met the eligibility criteria for special education services based on the criteria for Speech/Language Impairment. Claimant's Individualized Education Program (IEP) report dated May 22, 2013 reflected that claimant would be receiving Speech or Language Impairment (SLI) services from the school district from May 22, 2013 to May 22, 2014.

Testimony of Dr. Carol Sharp

22. Carol Sharp has a Ph.D. in clinical psychology and is a staff psychologist for CVRC. She reviewed Dr. Glidden's neuropsychological evaluation report, focusing claimant's Intellectual Functioning based on his WPPSI-III scores:

Verbal Scale	Scaled Score
Information	2
Vocabulary	2
Performance Scale	
Block Design	5
Matrix Reasoning	8
Object Assembly	9
Global Language	
Receptive Vocabulary	2
Picture Naming	4

23. Dr. Sharp testified that for mental retardation, “we look at scores less than three.” Based on the scores, Dr. Sharp stated that it could not be determined that claimant is mentally retarded. On page six of Dr. Glidden’s report, Dr. Sharp pointed out that Dr. Glidden did not provide the DSM-IV code for mental retardation. Furthermore, Dr. Sharp noted that Dr. Varanini’s evaluation indicated claimant as qualifying for speech or language impairment services. Dr. Sharp indicated that Dr. Varanini’s results are consistent with Dr. Glidden’s findings. Dr. Sharp agreed that claimant’s low adaptive skills could have resulted from neglect rather than an intellectual disability. CVRC’s intake assessment, Dr. Glidden’s report, and claimant’s IEP report all document parent neglect. Dr. Sharp also noted that in claimant’s IEP, the provided services are not similar to an individual who is mentally retarded. Dr. Sharp noted in determining whether an individual is eligible for CVRC services under the “fifth category,” she looks at cognitive functioning to determine whether the individual is close to mental retardation. Here, claimant has “almost average scores,” as indicated in Dr. Glidden’s report, and in Finding 22. Dr. Sharp referred to the Guidelines for Determining 5th Category Eligibility for the California Regional Centers (Guidelines). Item A.5. of the Guidelines states:

Borderline intellectual functioning needs to show stability over time. Young children may not yet demonstrate consistent rates and patterns of development. For this reason, eligibility for young children in the 5th category should be viewed with great caution.

As a result, Dr. Sharp stated that it would be a disservice to label claimant as someone who is mentally retarded. Moreover, Dr. Sharp pointed out Item B of the Guidelines, which states, in part:

In addition to sub-average intellectual functioning the person also must demonstrate significant deficits in *Adaptive* skills including, but not limited to, communication, learning, self-care, mobility, self-direction, capacity for independent living, and economic self-sufficiency. (Italics in original.)

Dr. Sharp noted that claimant’s social deprivation would result in low adaptive skills such as those listed above. She pointed out that claimant’s adaptive functioning scores as determined by Dr. Glidden showed significant adaptive deficit. Claimant’s general adaptive composite score was 45. Dr. Sharp stated that the average score would be 100, and that a score less than 70 would be considered a deficit.

24. Lastly, Dr. Sharp indicated that claimant’ adaptive skills improved in six months as a result of being in foster care, as indicated in Dr. Varanini’s

evaluation. His marked improvement shows that claimant's condition is not expected to last indefinitely. Under the Guidelines, an individual's disability must have originated before age 18, and is likely to continue indefinitely. Dr. Varanini noted that "[b]ased on [claimant's] recent history, it is difficult to discern if claimant's abilities are due to reported neglect as opposed to a disability. However, later in the eligibility portion of her report, Dr. Varanini stated that claimant's low adaptive skills "may be better characterized as a result of neglect as opposed to an intellectual disability."

Claimant's Witnesses

25. Ms. Hunt emphasized that there was never an issue that claimant is mentally retarded. She felt that claimant's assessments were flawed because they were based on statements by claimant's foster parents. As a foster parent of claimant for one year, Ms. Hunt asserted that Mr. Hobart "always wants himself to look good, and tends to tell me things [claimant] is able to do... He always presents the good side of [claimant]. Relying on Mr. Hobart for information is not as accurate as it could be." Furthermore, Ms. Hunt asserted that "the man who did the IEP did the interview at the foster home. There was a lot of distraction. He relied on Mr. Hobart." With regard to claimant's initial evaluation by Dr. Varanini, Ms. Hunt felt that the Vineland-II scores were "really slanted" because the information was obtained completely from the foster parents. Ms. Hunt asserted that claimant's behavior improved because claimant has regular meals and "does not have to look on the floor to scrounge around for his food." She did not think claimant was as advanced as his scores indicated.

26. Ms. Hunt asserted that Julia Garcia's May 21, 2013 report is a much clearer picture of what claimant is capable of. Ms. Garcia is a licensed clinical social worker and Director of Behavioral Health Services for Madera County. She did not testify on claimant's behalf. She wrote a "Treatment Summary & Recommendations" report based on her assessment of claimant, and reports by the foster father at the assessment. Ms. Garcia noted that the areas of concern continued to be claimant's overall social/emotional, cognitive, and speech/language sense of self. She further stated that there is a malfunction in how claimant receives his sensory stimuli, how he interprets that stimuli, how he processes the stimuli into a response, and how he is able to adaptively respond to the stimuli in order to function. However, Ms. Garcia did not perform any standardized tests to determine claimant's intellectual and adaptive functioning, nor did she determine claimant's verbal, performance, or full scale IQ. In addition, Ms. Garcia relied on statements by the foster father, Mr. Hobart, who Ms. Hunt viewed as an unreliable source of information about claimant.

27. Susan Bullard, a foster care nurse, testified that she has many concerns with the initial evaluation report by Dr. Varanini. Like Ms. Hunt, she asserted that he relied too much on information on information provided by the foster parents. Ms. Bullard asserted that claimant cannot provide self-care.

28. Shaylah Padgett-Weibel, a Madera County Program Manager for the Healthy Beginnings Program, stated that when claimant was referred to her program, claimant was “literally a feral child.” There is no question that claimant’s speech is an issue, however, Ms. Padgett-Weibel asserted that claimant needs more than just speech services. She further asserted that Mr. Hobart has a “vested interest,” and he will exaggerate claimant’s progress.

29. Based upon the results of the assessments by Dr. Glidden, Dr. Varanini, and Dr. Sharp, and other information available to CVRC’s interdisciplinary team, a Notice of Proposed Action was issued on October 23, 2012, stating that there was no evidence of a qualifying mental disability. Ms. Hunt made a fair hearing request on October 29, 2012, stating that claimant “has developmental delays that cannot be resolved in a school setting,” and that “this is not an environmental delay.” Claimant’s representatives contend that claimant is eligible for regional center services based upon his having a condition closely related to mental retardation, or requiring treatment similar to that required by individuals with mental retardation.

30. Under the Lanterman Act, CVRC accepts responsibility for persons with developmental disabilities. A developmental disability is a disability that originates before age 18, that continues or is expected to continue indefinitely and that constitutes a substantial disability for the individual. Developmental disabilities include mental retardation, cerebral palsy, epilepsy, autism and what is commonly known as the “fifth category” – a disabling condition found to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals. (Welf. & Inst. Code, § 4512, subd. (a).) Given the disjunctive definition – a condition closely related to mental retardation or requiring similar treatment to that required for individuals with mental retardation – the fifth category encompasses two separate grounds for eligibility.

Fifth Category

31. In *Mason v. Office of Administrative Hearings* (2001) 89 Cal.App.4th 1119, the appellate court held that “the fifth category condition must be very similar to mental retardation, with many of the same, or close to the same, factors required in classifying a person as mentally retarded. Furthermore, the various additional factors required in designating an individual developmentally disabled and substantially handicapped must apply as well.” (*Id.* at p. 1129.) It is therefore helpful to review the factors required for a diagnosis of mental retardation. The DSM-IV provides that the “essential feature of Mental Retardation is significantly subaverage general intellectual functioning....” It must be accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety.

32. Significantly subaverage intellectual functioning is defined as an IQ of about 70 or below – approximately two standard deviations below the mean. It is undisputed that claimant’s general intellectual functioning is not significantly subaverage. He is near the average range of intellectual functioning.

33. That claimant does not have this “essential feature” of mental retardation is not in dispute. Claimant contends, rather, that he is eligible because deficits in his adaptive functioning suggest either that he has a condition closely related to mental retardation, or that he requires services or treatment similar to that received by individuals with mental retardation. Fifth category eligibility determinations typically begin with a threshold consideration of whether an individual had deficits in intellectual functioning. This is done prior to consideration of other fifth category elements related to similarities between the two conditions, or the treatment needed. Claimant seeks to bypass such threshold consideration of intellectual functioning, and focus instead on his significant limitations in adaptive functioning, and need for services similar to that provided to individuals with mental retardation.

34. A recent appellate decision has suggested, when considering whether an individual is eligible for regional center services under the fifth category, that eligibility may be based largely on the established need for treatment similar to that provided for individuals with mental retardation, and notwithstanding an individual’s relatively high level of intellectual functioning. (*Samantha C. v. State Department of Developmental Services* (2010) 185 Cal.App.4th 1462.) In *Samantha C.*, the individual applying for regional center services did not meet the criteria for mental retardation. Her Wechsler Adult Intelligence Scale – Third Edition (WAIS-III) test results scored her above average in the areas of abstract reasoning and conceptual development and she had good scores in vocabulary and comprehension. She did perform poorly on subtests involving working memory and processing speed, but her scores were still higher than persons with mental retardation. The court understood and noted that the Association of Regional Center Agencies had guidelines which recommended consideration of fifth category for those individuals whose “general intellectual functioning is in the low borderline range of intelligence (I.Q. scores ranging from 70-74).” (*Id.* at p. 1477.) However, the court confirmed that individuals may qualify for regional center services under the fifth category on either of two independent bases, with one basis requiring only that an individual require treatment similar to that required for individuals with mental retardation. Here, claimant believes he requires treatment similar to that required for individuals with mental retardation. He also believes that his condition is closely related to mental retardation.

Fifth Category Eligibility – Condition Closely Related to Mental Retardation

35. Claimant seeks eligibility based upon his condition being closely related to mental retardation, his primary focus being upon his impairments in

adaptive functioning. Adaptive functioning refers to how effectively individuals cope with common life demands and how well they meet the standards of personal independence expected of someone in their particular age group, sociocultural background, and community setting.

The well-documented record demonstrated that claimant's adaptive functioning is substantially impaired. He was administered the Vineland-II. The Vineland-II is a standardized interview for quantifying a caregiver's observations and information about the person in care. It provides a comprehensive assessment of adaptive behavior and a systematic basis for preparing individual educational, rehabilitative, or treatment programs. Dr. Varanini noted that claimant's scores indicated low adaptive behavior in each of the domains. Relative strengths were his ability to take care of his own personal needs and his gross motor skills. Relative weaknesses were claimant's expressive language, fine motor skills and living in the community.

36. CVRC does not dispute that claimant has deficits in adaptive functioning. Rather, CVRC notes that such deficits may have resulted from parental neglect and social deprivation. Moreover, Dr. Varanini noted that environmental factors could not be ruled out.

37. There is no evidence that the deficits in claimant's adaptive functioning are related to cognitive deficits. In this respect, it does not parallel traditional fifth category analysis that looks for subaverage intellectual functioning "accompanied by" significant limitations in adaptive functioning. Dr. Sharps's reasoning on this matter is persuasive. Her reference to the Guidelines that borderline intellectual functioning in young children needs to show stability over time, and that claimant's intellectual functioning shows almost average scores, are inconsistent with a finding that his condition is closely related to mental retardation.

In this case, given claimant's almost average range of intellectual functioning, it was not demonstrated that any deficits suffered by him manifests as a condition similar to mental retardation.

Fifth Category Eligibility – Condition Requiring Treatment Similar to that Required by Individuals with Mental Retardation

38. Fifth category eligibility may also be based upon a condition requiring treatment similar to that required for individuals with mental retardation. Preliminarily, "treatment" and "services" do not mean the same thing. They have separate meaning. Individuals without developmental disabilities, including those without any diagnosed disabilities, may benefit from many of the services and supports provided to regional center consumers. Welfare and Institutions Code section 4512, subdivision (b) defines "services and supports" as follows:

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

Regional center services and supports targeted at improving or alleviating a developmental disability may be considered “treatment” of developmental disabilities. Thus, section 4512 elaborates further upon the services and supports listed in a consumer’s individual program plan as including “diagnoses, evaluation, *treatment*, personal care, day care, domiciliary care, special living arrangements, physical, occupational and speech therapy, training, education, supported and sheltered employment, mental health services,…” (Welf. & Inst. Code, § 4512, subd. (b). Italics supplied.) The designation of “treatment” as a separate item is clear indication that it is not merely a synonym for services and supports, and this stands to reason given the broader mission of the Lanterman Act:

It is the intent of the Legislature that regional centers assist persons with developmental disabilities and their families in securing those services and supports which maximize opportunities and choices for living, working, learning, and recreating in the community.

(Welf. & Inst. Code, § 4640.7, subd. (a).)

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

40. In *Samantha C.*, no attempt was made to distinguish treatment under the Lanterman Act as a discrete part or subset of the broader array of services

provided to those seeking fifth category eligibility. Thus, the appellate court made reference to individuals with mental retardation and with fifth category eligibility both needing “many of the same kinds of treatment, such as services providing help with cooking, public transportation, money management, rehabilitative and vocational training, independent living skills training, specialized teaching and skill development approaches, and supported employment services.” (*Samantha C. v. State Department of Developmental Services, supra*, 185 Cal.App.4th 1462, 1493. Italics supplied.) This broader characterization of “treatment” cannot properly be interpreted as allowing individuals with difficulties in adaptive functioning, and who require assistance with public transportation, vocational training or money management, to qualify under the fifth category without more. For example, services such as vocational training are offered to individuals without mental retardation through the California Department of Rehabilitation. This demonstrates that it is not necessary for an individual to have mental retardation to demonstrate a need for services which can be helpful for individuals with mental retardation.

Individuals with mental retardation might require many of the services and supports listed in Welfare and Institutions Code section 4512, which could benefit any member of the public: assistance in locating a home, child care, emergency and crisis intervention, homemaker services, paid roommates, transportation services, information and referral services, advocacy assistance, technical and financial assistance. To extend the reasoning of *Samantha C.*, an individual found to require assistance in any one of these areas could be found eligible for regional center services under the fifth category. This was clearly not the intent of the Legislature.

Thus, while fifth category eligibility has separate condition and needs-based prongs, the latter must still consider whether the individual’s condition has many of the same, or close to the same, factors required in classifying a person as mentally retarded. (*Mason v. Office of Administrative Hearings, supra*, 89 Cal.App.4th 1119.) Furthermore, the various additional factors required in designating an individual as developmentally disabled and substantially handicapped must apply as well. (*Id.* at p. 1129.) *Samantha C.* must therefore be viewed in context of the broader legislative mandate to serve individuals with developmental disabilities only. A degree of subjectivity is involved in determining whether the condition is substantially similar to mental retardation and requires similar treatment. (*Id.* at p. 1130; *Samantha C. v. State Department of Developmental Services, supra*, 185 Cal.App.4th 1462, 1485.) This recognizes the difficulty in defining with precision certain developmental disabilities. Thus, the *Mason* court determined: “it appears that it was the intent of those enacting the Lanterman Act and its implementing regulations not to provide a detailed definition of ‘developmental disability’ so as to allow greater deference to the [regional center] professionals in determining who should qualify as developmentally disabled and allow some flexibility in determining eligibility so as not to rule out eligibility of individuals with unanticipated conditions, who might need services.” (*Id.* at p. 1129.)

For all the above reasons, the treatment needs of claimant will be viewed within the narrower context of those services and supports similar to and targeted at improving or alleviating a developmental disability similar to mental retardation.

41. Claimant's Treatment Needs. Dr. Glidden made treatment recommendations based upon claimant's diagnosis of Lack of Expected Physiologic Development Due to Unknown Causes. The focus of his recommendations was claimant's adaptive functioning, rather than his intellectual functioning. Some of Dr. Glidden's more specific recommendations are set out below:

- Conduct a more comprehensive Speech and Language Evaluation in order to fully articulate relative strengths and weaknesses;
- Demonstrate to others the limits of claimant's understanding of speech;
- Slow down the rate of speech and talk in simple, positively phrased statements. Do not use slang or unusual forms of speech, and make eye contact so that claimant can utilize available gestural clues;
- When conveying important information, have claimant repeat back, in his own words, to assure his understanding;
- Whenever possible, reduce or eliminate outside sounds or noises, as these will be distracting to his communication;
- Use a lot of gestural content in conversation (e.g., hand gestures, facial expressions, appropriate tone of voice, etc.);
- Talk to claimant while doing things around the house and while outside to increase the exposure claimant has to verbal information;
- Encourage claimant to describe, explain, and ask for things;
- Closely monitor claimant's cognitive and adaptive functioning;
- Work on eye-hand coordination skills;
- Conduct a functional behavioral analysis evaluation.

42. Dr. Varanini provided similar recommendations with regard to claimant's speech and language impairment. Dr. Sharp did not dispute the recommendations by Dr. Glidden and Dr. Varanini. The Guidelines indicate that mentally retarded individuals require long term training with steps broken down into small, discrete units taught through repetition. Claimant did not demonstrate that the recommendations by Dr. Glidden are similar to treatment for individuals with mental retardation.

43. The matters testified to by Dr. Sharp, and set forth in Findings 22 to 24, have also been considered and determined to be persuasive. Dr. Sharp is an experienced licensed clinical psychologist who assesses and evaluates individuals for the presence of developmental disabilities. Dr. Sharp believes that claimant's deficits in adaptive functioning arise from neglect and social deprivation. Other than his speech and language impairment, claimant has not been diagnosed with any other disabilities.

44. The above matters have been considered, along with the relative experience and expertise that Dr. Glidden and Dr. Sharp have in assessing individuals with developmental disabilities. This is a case where deference should properly be given to CVRC professionals in determining eligibility. (*Mason v. Office of Administrative Hearings, supra*, 89 Cal.App.4th 1119, 1129.) Claimant’s witnesses were not specialists in diagnosing developmental disabilities and did not have the educational or professional experience commensurate with Dr. Glidden or Dr. Sharp. It does appear that claimant’s adaptive behavior deficits arise from parental neglect and not a developmental disability. Under these circumstances, it cannot be found that he requires treatment similar to that received by individuals with mental retardation.

45. It was not established that claimant is eligible to receive regional center services and supports by reason of a condition found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation. Claimant does not have a condition that is closely related to mental retardation. He has close to average general intellectual functioning. Claimant has significant deficits in adaptive functioning. However, these deficits do not result from any deficits in general cognitive ability. They likely result from neglect and social deprivation. As such, they are not developmental disabilities as defined under the Lanterman Act and claimant does not qualify for services through CVRC.

LEGAL CONCLUSIONS

1. Under the Lanterman Developmental Disabilities Services Act, the State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge. (Welf. & Inst. Code, § 4501.) As defined in the Act a developmental disability is a disability that originates before age 18, that continues or is expected to continue indefinitely and that constitutes a substantial disability for the individual. Developmental disabilities include mental retardation, cerebral palsy, epilepsy, autism, and what is commonly known as the “fifth category” – a disabling condition found to be closely related to mental retardation or requiring treatment similar to that required for mentally retarded individuals. (Welf. & Inst. Code, § 4512, subd. (a).)

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

2. “Substantial handicap” is defined by regulations to mean “a condition which results in major impairment of cognitive and/or social functioning.” (Cal. Code Regs., tit. 17, § 54001, subd. (a).) Because an

individual's cognitive and/or social functioning is multifaceted, regulations provide that the existence of a major impairment shall be determined through an assessment that addresses aspects of functioning including, but not limited to: 1) communication skills, 2) learning, 3) self-care, 4) mobility, 5) self-direction, 6) capacity for independent living and 7) economic self-sufficiency. (Cal. Code Regs., tit. 17, § 54001, subd. (b).)

3. It was not established that claimant has a developmental disability that originated before age 18 and that continues, and that constitutes a substantial disability for him. He does not have a disabling condition closely related to mental retardation or requiring treatment similar to that required for mentally retarded individuals. (Findings 11 through 24.)

4. It was not established that claimant suffers from cerebral palsy, autism, mental retardation or otherwise qualifies under the fifth category. Claimant is therefore not eligible to receive services through Central Valley Regional Center.

ORDER

Claimant's request for services from the Central Valley Regional Center is denied. Claimant is not eligible for services under the Lanterman Act.

DATED: August 9, 2013

DANETTE C. BROWN
Administrative Law Judge
Office of Administrative Hearings

NOTICE

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