

BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT,

v.

CENTRAL VALLEY REGIONAL
CENTER,

Service Agency.

OAH No. 2013080868

DECISION

A fair hearing was held on January 29, 30, and 31, 2014, before Karen J. Brandt, Administrative Law Judge (ALJ), Office of Administrative Hearings (OAH), State of California, in Fresno, California.

Shelley Celaya, Client Appeals Specialist, represented Central Valley Regional Center (CVRC).

Margaret S. Oppel, Attorney at Law with the Office of Clients' Rights Advocacy, represented claimant.

Evidence was received on January 29, 30, and 31, 2014. The record was held open to allow the parties to file closing briefs. On February 28, 2014, claimant filed a closing brief, which was marked for identification as Exhibit C-28, and CVRC filed a closing brief which was marked for identification as Exhibit R-41. On March 7, 2014, claimant filed a reply brief, which was marked for identification as C-29, and CVRC filed a reply brief, which was marked for identification as R-42. The record closed and the matter was submitted for decision on March 7, 2014.

ISSUES

Does claimant qualify for services from CVRC under the Lanterman Developmental Disabilities Services Act (Lanterman Act), Welfare and Institutions Code section 4500 et seq., because she is an individual with autism or an intellectual disability, or because she has

a disabling condition that is closely related to intellectual disability or requires treatment similar to that required for individuals with an intellectual disability?¹

FACTUAL FINDINGS

1. Claimant was born in 1995. She is currently 18 years old.
2. Three times in the past, claimant requested services from CVRC, and those three requests were denied. She submitted a fourth request for services from CVRC, and her request was denied. Claimant appealed from that denial. A fair hearing was held on her appeal.
3. During the fair hearing, claimant argued that she was eligible for CVRC services under the Lanterman Act because she is an individual with: (1) autism; (2) an intellectual disability; and/or (3) a disabling condition that is closely related to intellectual disability or requires treatment similar to that required for individuals with an intellectual disability (also known as the “fifth category”).

Prior Assessments and Evaluations

4. Prior to 2011, claimant was evaluated and assessed on numerous occasions by CVRC, Fresno Unified School District (FUSD), Children’s Health Center, and Fresno County Mental Health.
5. March 11, 1999 FUSD Report of Individual Study. Claimant was referred to FUSD’s Special Education Service Center “due to concerns about possible speech and language delays.” On March 11, 1999, when claimant was three years three months old, she was evaluated by a Multidisciplinary Assessment Team consisting of a school psychologist, a speech/language specialist, and a school nurse. In their Report of Individual Study, the Multidisciplinary Assessment Team described claimant as follows:

[Claimant] appeared very social and happy. She engaged in play with the examiners, and demonstrated appropriate pretend play and turn-taking. She used eye contact effectively and smiled in response to praise. She was cooperative for direct

¹ The language used to describe the developmental disabilities relevant in this matter has changed over time. The Lanterman Act was recently amended to change the term “mental retardation” to “intellectual disability. The Lanterman Act still uses the term “autism” but that developmental disability is now called an “autism spectrum disorder” in the DSM-5. In the various evaluations and assessments submitted in this matter, this developmental disability is variously referred to as “autism,” “autistic disorder,” “autistic spectrum disorder,” “autism spectrum disorder,” and “ASD.”

testing with both manipulatives and picture stimuli. She vocalized almost continually throughout the assessment, although this was noted to be jargon with occasional intelligible words in both Spanish and English mixed in. Parents were often unable to interpret her utterances and stated that they frequently find her communicative attempts to be entirely unintelligible.

After administering the Receptive-Expressive Emergent Language Scale-2 and the Preschool Language Scale-3, (PLS-3), Spanish Edition, the Multidisciplinary Assessment Team found that claimant demonstrated “significant delays in her speech and language development.” Her “general language abilities were estimated at about the two-year level.” In addition, “[v]ocabulary and concept development appear[ed] significantly depressed for her age.” Her comprehension of language was “limited,” but she was able “to follow simple directions.”

From both a structured and unstructured play-based assessment, the Multidisciplinary Assessment Team found that claimant “presented an adequate attention span and would persist with complex or unfamiliar activities until she had completed the task or until she was told to stop by the examiner rather than simply giving up.”

Claimant was administered the Developmental Test of Visual-Motor Integration, the Merrill-Palmer Scale of Mental Tests, and the Developmental Activities Screening Inventory II. Based upon the results of these tests, the Multidisciplinary Assessment Team concluded that claimant’s “current and estimated level of intellectual function is within the Average to Low Average range,” and that her “academic achievement is within the Average to Low Average range.” The team identified her specific areas of weakness as “speech/language, general concept development, seriation, and memory.” They described her areas of strength as “sensorimotor organization, discrimination, and association.” The team determined that claimant qualified for “Speech and Language services due to her clinically significant delays in both receptive and expressive language.”

6. December 10, 2001 Psychological Evaluation by Pean Lai, Ph.D. In 2001, claimant was referred to CVRC by her elementary school teacher to assess her intellectual and adaptive functioning to determine if she was eligible for CVRC services. On December 10, 2001, Dr. Lai, a Clinical Psychologist, conducted a psychological evaluation. At the time, claimant was six years old.

Dr. Lai administered the Peabody Picture Vocabulary Test: 3rd Edition (Form 3B), the Stanford Binet Intelligence Scale: 4th Edition, and the Vineland Adaptive Behavior Scales. Dr. Lai described claimant’s conduct during the evaluation as follows:

...[Claimant] showed much interest in doing all the testing items presented to her. She responded well to encouragement. When asked to draw a picture, [claimant] proceeded to draw a simple picture of a person, in addition to what she indicated to be

“chairs.” When asked if she preferred to speak in English or Spanish, [claimant] indicated in “English.” In fact, when she was asked to tell a story about the person she drew, [claimant] made simple sentences in English. She was very cooperative and attentive through the whole evaluation. She put forth good effort at doing all the items presented to her. [Claimant] was very well behaved, without any inappropriate behaviors. At the end of the testing, she was asked if she wanted candy. She stated, “no, I want a toy.”

On the Peabody Picture Vocabulary Test, claimant received a standard score of 74 and an age equivalent score of three years 11 months. On the Stanford-Binet Intelligence Scale, she received a Verbal Reasoning score of 73, an Abstract/Visual Reasoning score of 86, a Quantitative Reasoning score of 88, a Short-term Memory score of 66, for a Test Composite score of 74. On the Vineland Adaptive Behavior Scales, she received a Communication score of 66 (Grade Equivalent – 3-7), a Daily Living Skills score of 59 (Grade Equivalent – 3-3), a Socialization score of 81 (Grade Equivalent – 4-5), for an Adaptive Behavior Composite score of 63.

Dr. Lai stated that claimant’s Composite score on the Stanford-Binet Intelligence Scale placed claimant in the “slow-learner classification.” Claimant’s nonverbal skills were “relatively better” than her verbal abilities. Dr. Lai looked at these results “with caution,” considering that claimant’s mother spoke only Spanish, and that claimant was bilingual and learning two languages at the same time. Her scores indicated that she had “some attention and concentration difficulties.” She made mistakes on easier items, and correctly answered more difficult ones. The results of the Peabody Picture Vocabulary Test indicated that claimant had “some limitations with word knowledge and verbal expression.”

Dr. Lai made no diagnosis on Axis I. She diagnosed claimant with “Borderline Intellectual Functioning” on Axis II.

Dr. Lai opined that the testing indicated that claimant’s “intellectual functioning is in the borderline classification, overall.” She found that claimant’s “presentation and performance is inconsistent to that of a child with mental retardation.” She noted that claimant’s “language development is quite delayed due to verbal learning difficulties and the need to learn two languages.” Dr. Lai recommended that claimant “continue to receive speech/language services to help her learn the English language more efficiently.” She also recommended that “behavioral intervention may be helpful in dealing with [claimant’s] noncompliance reported by her mother and teacher.”

7. September 18, 2003 Neuropsychological Evaluation by Paul C. Lebbly, Ph.D. Claimant was referred by a physician at Children’s Hospital Central California for a Neuropsychological Evaluation to “assess her developmental status, and to provide recommendations as appropriate.” Claimant was seven years 10 months old at the time of the evaluation. The Neuropsychological Evaluation was conducted by Dr. Paul Lebbly, a Clinical Neuropsychologist.

Although Dr. Leppy stated in his report that he conducted an “extensive examination [of claimant] lasting several hours,” he did not identify any standardized or other tests that he used. Dr. Leppy diagnosed claimant with “high functioning autistic disorder.” He found that claimant was in the “high functioning end” of the autistic spectrum “in that many of her cognitive skills fall within age expectancies, with other skills being clearly deficient for her age, notably language processing skills...” As Dr. Leppy explained, claimant’s “[c]ognitive processing skills are variable, as expected for a child on the autistic spectrum, with verbal reasoning and language processing skills falling clearly within the impaired range for her age, given age equivalencies of approximately 3-1/2 years. In contrast, visual and nonverbal reasoning skills fell fully within age expectancies, ranging from low average to average, and with age equivalencies falling between 6-1/2 and 8-1/2 years, respectively.” According to Dr. Leppy,

Throughout the assessment, [claimant] presented with significant autistic symptomatology, although within a highly structured, one-on-one and often two-on-one situation, with constant provision of prompting, refocusing and redirection, she was able to function adequately for the purposes of the assessment, and also presented as clearly able to tolerate an educational environment with similar accommodations.

Dr. Leppy also noted that:

... it is important to understand that [claimant] does not show all of the behaviors that are often seen in autistic children, and that she possesses some capacity for interpersonal interaction and learning. It is also important to note that many of the symptoms of Autism that [claimant] does manifest are not as severe as some might expect, given this diagnosis.

Other than the above-quoted language, Dr. Leppy did not describe in his report the behaviors that he observed which caused him to opine that claimant was an individual with high functioning autistic disorder. In his report, Dr. Leppy recommended that claimant and her family “avail themselves of the services provided by” CVRC.

8. December 11, 2003 Psychological Evaluation by Arnold Herrera, Ph.D.
CVRC referred claimant to Dr. Herrera to “rule out Autistic Spectrum Disorder (ASD)/Asperger’s syndrome and assist with recommendation for treatment.” The referral was based upon the recommendation of Dr. Leppy. Dr. Herrera conducted a psychological evaluation on December 11, 2003, when claimant was eight years old.

Dr. Herrera interviewed claimant and her mother, conducted a mental status evaluation, made both structured and unstructured behavioral observations, reviewed records, and administered: (1) the Wechsler Intelligence Scale for Children – Third Edition (WISC-

III); (2) the Wide Range Achievement Test – Revision Three (WRAT-3); (3) the Gilliam Autism Rating Scale; and (4) the Vineland Adaptive Behavior Scales (VABS).

On the WISC-III, claimant received a Verbal IQ score of 84, a Performance IQ score of 99, and a Full Scale IQ score of 93. On the WRAT-3, claimant received a standard score in reading of 67 (grade level – kindergarten) and a standard score in arithmetic of 90 (grade level 2). On the Gilliam Autism Rating Scale, claimant received an Autism Quotient score of 78, which was in the seventh percentile. Based upon her scores on this scale, Dr. Herrera assessed her probability of autism as “low.” On the VABS, claimant received an Adaptive Behavior Composite score of 71.

During the evaluation, Dr. Herrera found that, although claimant had “some difficulty with select processes, such as visual sequencing, basic perceptual skills were intact.” Claimant was “alert, which, in combination with reasonably strong attention, allowed her to notice nuances in a creative manner.” She had “difficulty with word retrieval and verbal processing.” But her “underlying abstract reasoning skills were at least average.” Dr. Herrera also found that:

Overall, [claimant] clearly did not evidence the “standoffish” disposition seen in ASD, including PDD.² Not once during the evaluation did she exhibit idiosyncratic speech, perseverative tendencies, or stereotypic motor movements. Further she evidenced social appropriateness and reciprocity. As mentioned, she told the examiner she was having fun and wanted to do more, clearly warmed to the situation, and was able to use ‘please,’ thank you,’ and ‘you’re welcome’ appropriately. In short, her behavioral presentation was not indicative of ASD.

Based upon the tests that were administered, Dr. Herrera found that claimant’s intellectual abilities to be at the “low-average to average level.” Consistent with prior testing, claimant’s “verbal skills were significantly lower than [her] nonverbal abilities.” This difference was “consistent with what one sees in learning disabilities and/or speech delay.” Dr. Herrera also found that the “[a]nalysis of verbal subtest scatter was also consistent with learning dysfunction, including verbal processing difficulties.” Dr. Herrera concluded that:

Overall, [claimant] is best viewed as retaining low-average to average intelligence with an admixture of selective learning dysfunction and language delay, Mental retardation is not present or functioning similar to.

Dr. Herrera discussed in detail all the ASD criteria set forth in the DSM-IV: (A) a total of six or more items from Categories I, II, and III, with at least two from Category I and

² “PDD” stands for Pervasive Developmental Disorder.

one from each of Category II and III: (1) Category I - qualitative impairment in social interaction; (2) Category II – qualitative impairment in communication; and (3) Category III – restricted, repetitive and stereotypic patterns of behavior, interests and activities; (B) delays or abnormal functioning in at least one of the following areas, with onset prior to three years: (1) social interaction, (2) language, or (3) symbolic or imaginative play; and (C) the disturbance is not better accounted for by Rett’s Disorder or Childhood Disintegrative Disorder. Dr. Herrera found that claimant met none of the sub-items listed in Category I – qualitative impairment in social interaction. He concluded that claimant “failed to meet the DSM-IV criteria for ASD.” He stated that claimant presented as “more social and communicative than suggested by her mother’s appraisal.”

On Axis I, Dr. Herrera diagnosed claimant with “Mixed Receptive-Expressive Language Disorder,” “Learning Disorder, NOS,” “Rule out parent-child relational problem,” and “Rule out Social Anxiety Disorder.” On Axis II, he stated, “No diagnosis; retains at least low-average to average intelligence.” He discounted Dr. Lebbby’s evaluation, finding that, “given the overall fabric of information available in cumulative records and the lack of supportive information in Dr. Lebbby’s evaluation, his impression cannot be relied upon to formally diagnose ASD.”

9. September/October 2006 Student Assessment Report by the Diagnostic Center, Central California. In 2006, FUSD referred claimant to the Diagnostic Center for assessment to “help in determining her primary disability, the impact of language development and social/emotional issues on academic functioning, and appropriate strategies and interventions.” The assessment was conducted over five days in September and October 2006, when claimant was 10 years nine months old. At the time, she was in the fifth grade in a “general education class and received resource specialist services in the area of speech/language (three times per month).” She had been designated by FUSD as having a “specific learning disability and a speech and language impairment.” Over the five-day assessment period, the Diagnostic Center conducted numerous tests, including but not limited to the Wechsler Intelligence Scale for Children-IV, the Developmental Test of Visual-Motor Integration, the Achenbach Child Behavior Checklist, and the Adaptive Behavior Assessment System for both parents and teachers,

In its assessment findings, the Diagnostic Center stated that claimant was able to “display a full range of affect with a considerable degree of warmth in her mode of relatedness.” But they found that on the third day of the evaluation, claimant’s “behavior was dramatically different. She demonstrated extreme confusion for labeling even simple common objects which she had previously correctly labeled.” She “also appeared more distractible and displayed more motor restlessness.”

The Diagnostic Center found that claimant’s “[v]erbal, perceptual reasoning, and working memory skills [were] within the Low Average range.” Her visual-motor integration skills were also within the “Low Average range.” They found that she had a “[r]elative weakness in processing speed,” which was in the “Borderline range.” She had a “[r]elative strength in abstract verbal concept formation.” Her adaptive skills were assessed by her

parents to be in the “extremely low range,” but they were assessed by her school to be in the extremely low to borderline range.

With regard to claimant’s diagnosis, the Diagnostic Center stated:

There has been a lack of consensus over the years regarding [claimant’s] primary disability/diagnosis. Previous diagnoses have included: autism, pervasive developmental disability, social anxiety disorder, mixed receptive-expressive language disorder. While she has exhibited some symptoms of autism in the past, she does not meet full criteria for the diagnosis, but rather, demonstrates significant language deficits and mental health concerns.

The Diagnostic Center found that claimant “presented with a very disordered, yet perplexing profile of language skills. All areas of content (semantics/vocabulary), form (grammar) and use (social pragmatic language use) were severely impaired.”

The Diagnostic Center concluded that:

[Claimant] presents as a complex young female with many areas of challenge that inhibit her successful performance in school. These include: language deficits, learning differences, and mental health issues. All of these factors are viewed by the team as contributing to the academic concerns described by teachers and parents. It is essential that each of these be addressed in order for improvements to be made in her overall functioning and to maximize her opportunities for a successful future.

The impact of [claimant’s] language deficits is profound. Her language skills are not adequately developed to support a 5th grade instructional curriculum. Her current language abilities do not provide her with an adequate foundation for academic understanding and social interaction. Thus, the curriculum, instructional techniques and language used by all adults in the classroom, will need to be highly modified in the manner of presentation (simplifying the language used by the teacher: varying the aspects of content, rate, rhythm, pause, repetition, rewording, visually supporting all auditory instruction, etc.), teaching methodology (highly visual, hands on learning experiences, such as those techniques used with ELL students, etc.), as well as adjusting the context to [claimant’s] present skill levels.

The Diagnostic Center also found that claimant was “at significant risk for anxiety, depression and thought disorder, without intervention and support, given her longstanding challenges, family’s mental health history, and familial stressors.” The Diagnostic Center found further that given “her language challenges in both Spanish and English, [claimant] has relied on her sister to help ‘translate’ her world and reduce her level of anxiety when she becomes confused and overwhelmed. [Claimant] is at risk for an escalation of dramatic behaviors when she is significantly stressed.” The Diagnostic Center made a number of recommendations to assist claimant in the school setting. It also recommended that claimant’s parents: (1) “[c]ontinue with mental health services for [claimant] and family members; (2) “[o]btain psychiatrist for evaluation of possible medications to address anxiety symptoms and disordered thinking”; and (3) obtain formal eye examination for claimant.

10. 2008 Psychological Evaluation by Stanley F. Littleworth, Ph.D. In 2008, based upon the Diagnostic Center’s assessment, CVRC referred claimant to Stanley F. Littleworth, Ph.D., a Clinical Psychologist. Dr. Littleworth was asked to “assess [claimant’s] present intellectual and adaptive functioning, to rule out the presence of Mild Mental Retardation; and to review her extensive psychological records to determine if there is need for further clarification as to her status as a child with a possible Autistic Disorder.” At that time, claimant was 12 years and eight months old. She had completed the sixth grade and was scheduled to begin a special education program in junior high school.

Dr. Littleworth conducted an initial interview of claimant and her mother on April 23, 2008. Due to the “emotional nature of the interview with [claimant’s mother] and what appeared to be an increased level of anxiety in [claimant], testing was deferred to a follow-up appointment” on July 25, 2008. On that date, Dr. Littleworth administered the Wechsler Intelligence Scale for Children – Fourth Edition (WISC-IV), and the Vineland Adaptive Behavior Scales – Second Edition (Vineland II). Dr. Littleworth also conducted a review of claimant’s “extensive social/educational/psychological records.”

On the WISC-IV, claimant obtained a Verbal Comprehension index of 50, a Perceptual Reasoning index of 45, a Working Memory index of 52, a Processing Speed index of 50, for a Full Scale IQ score of 40. These results placed claimant in the Moderate Mental Retardation range. Dr. Littleworth found that:

These results are significantly decreased from the last known administration of the WISC-IV during October, 2006 at the Diagnostic Center, Central California, which placed her intellectual functioning variably within the range of Borderline Intellectual Functioning. The current results reflect a significant cognitive regression possibly due, in part, to cognitive impairment secondary to problems in emotional functioning and her medication regimen of antipsychotic medication. In addition, at times [claimant] appeared confused and did not seem to understand test directions well.

Claimant's father served as the primary informant for the completion of the Vineland-II. Claimant obtained an Adaptive Behavior Composite score of 63. According to Dr. Littleworth, claimant's score reflected "Low adaptive functioning across areas of communication, daily living skills and socialization."

On Axis I, Dr. Littleworth diagnosed claimant with "Mood Disorder, NOS (by history)," "Anxiety Disorder, NOS (by history)," "Learning Disorder, NOS (by history)," "Mixed Receptive-Expressive Language Disorder," "R/O Bipolar Disorder (per Mental Health)," and "R/O Delusional Disorder (per Mental Health)."³ On Axis II, he diagnosed claimant with "Borderline Intellectual Functioning (borderline to low average)," and "R/O Mild Mental Retardation."

In his impressions, Dr. Littleworth noted that there had been:

...a longstanding concern that [claimant] experiences symptoms of mental illness. [Claimant] talks to herself, and has experienced delusional and auditory/visual hallucinations associated with Michael Jackson. She is presently under the care of the Fresno County Mental Health Program due to a Mood Disorder NOS, Anxiety Disorder NOS, and Pervasive Developmental Disorder NOS, with rule out diagnoses of Delusional Disorder, Asperger's Disorder, and Bipolar Disorder. She is presently on Seroquel, an antipsychotic medication.

Dr. Littleworth found that claimant's "intellectual assessment suggests a significant cognitive regression." He noted that the assessment report from the Diagnostic Center noted claimant's "dramatically different" behavior on the third day of testing. He questioned whether claimant's "current performance on the WISC-IV may be reflective of the same type of emotional/cognitive regression noted during the Diagnostic Center evaluation." He stated that he was "concerned that this regression may signify deterioration in [claimant's] emotional functioning moving towards more acute Mental Health problems." He found that claimant's adaptive functioning, as measured with the Vineland-II, was "reflective of Low Mild deficits."

Dr. Littleworth opined that, in light of claimant's "prior intellectual assessments falling within the borderline to low average range, the most reliable diagnosis regarding her intellectual level would be that of Borderline Intellectual Functioning." Dr. Littleworth also opined that "although [claimant] has exhibited some symptoms associated with Autism in the past, ... she does not presently meet the criteria for diagnosis of Autism, nor Asperger's Disorder, and there appears to be no benefit to labeling her as having PDD, NOS. She appears to have significant cognitive and language disabilities, with significant mental health overlay."

³ "R/O" stands for rule out.

11. 2008/2009 Neuropsychological Evaluation by Howard J. Glidden, Ph.D. In 2008, claimant was referred by her psychiatrist (Asha Gaur, M.D.) and therapist (Mary Negrete, MSW) at Fresno County Mental Health for a Neuropsychological Evaluation by Howard J. Glidden, Ph.D., a Developmental Neuropsychologist. The purpose of the evaluation was to “assess current level of functioning in order to assist in developing appropriate diagnoses and recommendations for treatment.” At the time of the evaluation, claimant was 13 years seven months old. She was enrolled in the seventh grade, and was attending a special day class.

Dr. Glidden administered numerous tests, including the WISC-IV, Spatial Span Test, Cancellation of Rapidly Recurring Target Figure Test, Trail Making Tests A & B, Bender Gestalt Test-II, Wide Range Achievement Test V (Word reading), Stroop Color and Word Test Children’s Version, Wisconsin Card Sorting Test-64, Controlled Word Association Test, Adaptive Behavior Assessment-II, Interview for Autistic Spectrum Disorder Symptomatology, Vanderbilt Assessment Scale, Connors’ Behavior Rating Scale, Achenbach Child Behavior Checklist, Social Communication Questionnaire, Rey 15-Item Memorization Test, Mental Status Examination, and Pre-test Interview.

On October 29, 2008, the first day of evaluation, claimant’s performance was “significantly inferior to that obtained during her assessment at the Diagnostic Center...” Dr. Glidden administered the Rey 15-Item Memorization Test. According to Dr. Glidden, “It was evident that her performance was suboptimal and this appeared to be secondary to [claimant’s] attentional avoidance of activities. The evaluation was then postponed until [claimant] chose to participate, and on the second date she assented to the evaluation, was cooperative and compliant and attempted all tasks presented.”

Dr. Glidden described claimant’s behavior on July 9, 2009, the second day of testing, as follows:

Interpersonally, she was amiable, friendly, and related to the examiner in an appropriate manner. There was no indication of anxiety or oppositionality secondary to test procedures on the second test date. Interpersonally she was reserved, and while not initiating social conversation did respond to my initiation. She exhibit[ed] age-appropriate eye contact, turn taking, topic selection and maintenance, imitation, humor and joint attention. Affectively, her mood was even with adequate range and amplitude of emotional expression. There was no unusual posturing, nervous mannerisms, signs of agitation or stereotypies. Thought processes appeared to be within functional limits, with a spontaneous stream of activity. Thought content was appropriate, cogent and directed, without evidence of associational disturbance. Error recognition and utilization appeared to be within functional limits. Cognitive flexibility was evident. There was no evidence of perseverative

interference or difficulty shifting from one task to another. [Claimant] denied suicidal/homicidal ideation. Evaluation of speech was grossly within functional limits, with intact rate, rhythm and prosody.

After conducting the listed tests, Dr. Glidden diagnosed claimant with “Anxiety Disorder, Not Otherwise Specified” on Axis I, with no diagnosis or condition on Axis II.

Dr. Glidden opined that the results of the evaluation indicated that claimant was “currently functioning variably within the range associated with Borderline levels of ability.” On the WISC-IV, claimant’s General Ability Index was 79, in the Borderline range. Dr. Glidden noted that her subtest scores “ranged from the Extremely Low to Average levels of ability.” She had the “greatest degree of difficulty on the subtests requiring complex verbal and nonverbal attention.”

In his report, Dr. Glidden identified the “triad of impairment” that individuals with ASD exhibited as follows: (1) “Abnormal development of language abilities in which receptive skills are often inferior to expressive skills, and gesture language is as impaired as expressive speech”; (2) “Limited imitative abilities and imaginative play, insistence on maintenance of routines, obsessions and stereotypies”; and (3) “Impaired reciprocal social interaction.” According to Dr. Glidden, claimant’s “behavior throughout this evaluation was contrary to these impairments.” Claimant “demonstrated intact gesture language and receptive (understanding) language appears to be superior to expressive speech.” Claimant also exhibited “excellent social interactive skills, such as taking turns, following commands, pointing to objects on command, and following directions.” When a task that she enjoyed was discontinued, she “did not tantrum or exhibit difficulty in ‘transitioning.’” Dr. Glidden concluded that, “In that [claimant] prefers to play with others rather than alone, seeks to share her accomplishments with her parents, imitates a model readily, does not exhibit stereotypies and uses gesture language to circumvent speech delays, the diagnosis of Autistic Spectrum Disorder does not, in this writer’s opinion, appear warranted.”

Dr. Glidden opined that, at that time, claimant was “more controlled by emotions, again to reduce anxiety, than she is in utilizing higher-order cognitive processing.” According to Dr. Glidden, this can result in “deficiencies in planning, monitoring and flexibility of behavior,” and “in a disturbance in the ability to solve problems regarding foresight, goal direction, motivation and initiation.” He found that claimant would “benefit from the provision of a structured behavioral program in order to reinforce pro-social behavior acquisition while she continues to develop those cortical and subcortical structures which will enable [her] to exert a higher level of self-control.” In his report, Dr. Glidden made numerous recommendations for addressing the issues that he identified. He did not recommend that claimant be referred to CVRC for services.

2011/12 Psychological Evaluation by Pegeen Cronin, Ph.D.

12. In 2011, claimant was referred to Pegeen Cronin, Ph.D., for a diagnostic evaluation in conjunction with claimant’s appeal from CVRC’s denial of eligibility for

services. The evaluation was conducted on November 17, 2011, when claimant was 15 years 11 months old. Dr. Cronin issued a report of her Psychological Evaluation dated August 3, 2012. During the evaluation, numerous tests were administered, including the Achenbach Child Behavior Checklists (parent and teacher), the Autism Diagnostic Interview-Revised (ADI-R), Autism Diagnostic Observation Scale (ADOS) – Model 3, Expressive One Word Picture Vocabulary Test (EOWPT), Peabody Picture Vocabulary Test, Fourth Edition (PPVT-4), Social Responsiveness Scales (parent and teacher), Stanford-Binet Intelligence Scale, Fifth Edition (SB5), Vineland Adaptive Behavior Scales-Second Edition (VABS-II), and the Wechsler Intelligence Scales for Children, Fourth Edition (WISC-IV) – select subtests. Dr. Cronin also interviewed claimant.

13. On the SB5, claimant received a Nonverbal score of 42, a Verbal score of 43, a Full Scale score of 40, and an Abbreviated Battery IQ of 47, all of which were in the Moderately Impaired range. On the WISC-IV, claimant received a Verbal Comprehension Index score of 47, which was in the Extremely Low range.

14. After reviewing records evaluating claimant and discussing the results of the tests that were administered, Dr. Cronin, in her summary, stated that the results from her psychological evaluation “indicate the diagnoses of **Autistic Disorder** and **Mild-Moderate Mental Retardation.**” (Bolding in original.)

With regard to the diagnosis of Autistic Disorder, Dr. Cronin stated:

[Claimant’s] developmental history is remarkable for delays and abnormalities in communication (i.e., lack of spontaneous make-believe play, poor reciprocal conversations, and stereotyped language) including delayed onset of phrase and fluent speech that cannot be attributed to her parents’ first language of Spanish. Further, [claimant’s] development was notable for qualitative abnormalities in reciprocal social interaction (e.g., impairments in peer relationships, lack of socioemotional reciprocity) and stereotyped interests and patterns of behaviors (e.g., circumscribed interests, sensory interests, body rocking). In addition, [claimant’s] social communication skills were directly evaluated through a diagnostic schedule that provided her with ample opportunities to engage in typical social and behavioral interactions with the examiner. Similar to parent report, [claimant] demonstrated pervasive delays in the areas of communication, reciprocal social interaction, and imagination/creativity consistent with her diagnosis of autism.

With regard to her diagnosis of Mild-Moderate Mental Retardation, Dr. Cronin stated:

[Claimant's] cognitive skills consistently fell in the Very Low, or Extremely Low range across verbal and nonverbal tasks, with age equivalencies approximately between the ages of 2 to 4 years. Overall, [claimant] did not demonstrate a solid understanding of the majority of these measured skills, reflecting the extent of her cognitive delays as well as her difficulties generalizing her acquired skills across settings and individuals. Prior estimates of [claimant's] adaptive and cognitive [skills] have consistently documented her functional delays throughout the course of her development. Further results had consistently demonstrated [claimant's] slow rate of learning and progress made across various domains of activities of daily living, including academics. Results obtained from the current evaluation also concurred with prior evaluations estimating that [claimant] continues to function significantly below expectations for her chronological age across all domains (i.e., Communication, Daily Living Skills, Socialization) but presently commensurate with her cognitive abilities. Without ongoing interventions, [claimant] is especially at risk for falling further behind in her development given her current pervasive delays.

In her summary, Dr. Cronin addressed the diagnostic criteria for Autistic Disorder set forth in the DSM-IV, and found that claimant met those criteria. Dr. Cronin also concluded that, as a result of claimant's "autistic features, she evidences **substantial disability**, which is gross and sustained, is evident across multiple areas of adaptation and functioning, and cannot be attributed to other family/cultural issues." (Bolding in original.) In addition to difficulties in learning, Dr. Cronin found that claimant "demonstrated significant delays and deficits in *self-care* and *self-direction*." (Italics in original.) Dr. Cronin also found that claimant's was disabled in the areas of economic self-sufficiency and capacity for independent living.

15. On various occasions in her report, Dr. Cronin noted the significant inconsistencies and scatter in claimant's test data relating to her cognitive abilities. When discussing the results of the cognitive tests (SB5 and WISC-IV), Dr. Cronin stated that:

It is important to note: [Claimant's] performance was remarkably inconsistent within and across measures, resulting in the lack of achieving true basal scores (i.e., a sequence of correct scores on lower level items) before reaching a ceiling (i.e., a series of incorrect scores, on higher level items, thus indicating the discontinuation of a task) on multiple subtests.... Therefore these scores should be interpreted with caution.

For example, when discussing the SB5 domain for Knowledge, Dr. Cronin stated:

This unpredictable pattern of response is consistent with her overall performance on the evaluation, in that she often failed simpler items but obtained scores for more difficult questions before the task became too hard and was discontinued.

Dr. Cronin also noted that:

[Claimant] displayed several intense interests and fixations (e.g., collecting ball caps, gay rights, and old shows, toys, or cars) on which she relayed many specific details about, which is inconsistent with her general cognitive and academic functioning.

16. In her report, Dr. Cronin stated that claimant's parents and her two special education teachers completed questionnaires measuring various aspects of claimant's behavioral functions. On various occasions in her report, Dr. Cronin noted the significant differences in the responses given by these individuals. As Dr. Cronin stated:

The total scores reported from informants was variable across different settings (i.e., home and school classrooms), with scores ranging from normal to severe. [Claimant's] special education LD teacher ... indicated that she perceives [claimant's] social interactions to be within the normative range overall. [Claimant's] special education English and Biology teacher ... endorsed a total score within the moderate range. Similarly, [claimant's] parents endorsed a total score in the severe range.

Dr. Cronin also stated that:

[Claimant's] teachers tended to rate her behaviors less severely, indicating that they perceive her as having less difficulties in her social interactions in their respective classrooms.

Dr. Cronin opined that the "difference in endorsement between raters is likely due to varying environment structures and expectations of [claimant]."

2013 Psychological Evaluation by Lindsey Gerner, Ph.D.

17. In 2013, CVRC referred claimant to Lindsey Gerner, Ph.D., a Clinical Psychologist, for a Psychological Evaluation. Dr. Gerner conducted the evaluation on May 28 and June 6, 2013, when claimant was 17 years old.

Dr. Gerner administered the following tests: In Depth Records Review, Clinical Interview of Autistic Symptoms and Development, Wechsler Adult Intelligence Scale-IV, Adaptive Behavior Assessment System-Second Edition (ABAS-II), Beery Developmental Test of Visual Motor Integration (VMI), Gilliam Autism Rating Scale-Second Edition, Social Communication Questionnaire, D-Arkansas Scale, Dot Counting Test, Miller Forensic Assessment of Symptoms Test (M-FAST), b Test, and Rotter Incomplete Sentence Blank-High School Response Sheet.

18. Dr. Gerner did not include in her report the scores that claimant obtained during the cognitive testing, finding that:

Results of cognitive testing do not appear to be valid. [Claimant] did not appear to put forth adequate effort on testing and her ability to discuss events in her life appeared far superior to her test scores. Her vocabulary and ability to articulate her thoughts was above what would be expected from someone with mild to moderate mental retardation.

As an example to describe the discrepancy between claimant's test performance and her clinical interview, Dr. Gerner stated:

Her ability to define words appeared to be poor compared to her ability to use more advanced vocabulary during the clinical interview. For example, she was asked to define the word "curious" to which she said, "I don't know." Later, when she discussed wanting to learn to cook she stated that she was "scared to learn because she did not want to get burned." When I asked if she was ever burned she replied, "Yes when I was younger I was curious about the BBQ and I reached my hand over the flame and got hurt." She appeared to quickly realize that she used a word she could not define earlier and attempted to recant by saying, "I think that's the right word, maybe, I don't know."

19. With regard to the testing for autism, Dr. Gerner stated that the results of the ABAS II "as reported by [claimant's] parents indicate that [claimant's] overall adaptive skills fall within the extremely low range. This suggests that relative to individuals of comparable age, [claimant's] adaptive functioning is well below her peers." But Dr. Gerner noted that these results "may underestimate her potential as previous school reports of adaptive functioning have been higher suggesting more difficulty in the home environment."

20. After completing her record review and testing, Dr. Gerner diagnosed claimant on Axis I with:

Depression (By History)

Bipolar Disorder (By History)
Mood Disorder (By History)
Delusional Disorder (By History)
Gender Identity Disorder (By History)
Anxiety Disorder (By History)
Rule out Psychotic Disorder (By History)
Rule out Post Traumatic Stress Disorder (By History)
Parent Child Relationship Problems (By History)

Dr. Gerner did not give claimant a diagnosis on Axis II, stating that the “[r]esults of cognitive testing were invalid.”

21. In her impressions, Dr. Gerner stated that:

[Claimant] has been evaluated on multiple occasions and been given a variety of diagnoses. There have been concerns about her mental health and the impact of that on her cognitive and adaptive functioning. Her cognitive skills have significantly declined over the years, with her highest scores occurring prior to age 12. Some reports of cognitive functioning have skills in the average to low average range while others fall in the borderline range. Her most recent testing with [Dr. Cronin] suggests that she is falling within the moderate mental retardation range. This type of decline is not typical and raises the suspicion that the decline may be due to mental health factors as late adolescents [*sic*] and early adulthood are commonly times when more severe mental health symptoms emerge.

Dr. Gerner recognized that claimant has always had “language delays and behavior problems.” But Dr. Gerner opined that:

Her behaviors are suggestive of a young girl attempting to cope with difficult life circumstances and profound stress in the home. In addition, [claimant] has identified that she has never felt comfortable in her body. She feels unaccepted and picked on by her peers. This coupled with her early language difficulties which can lead to behavior problems, aggression and acting out behaviors related to frustration caused by lack of communication, impact her social skills and her. Add to that [claimant’s] parents modeling inappropriate and aggressive ways of coping with negative emotions and you have a young child who exhibits social deficits and behavior problems related to mental health factors.

Dr. Gerner opined that [claimant's] deficits in adaptive functioning are more impacted by her mental health diagnoses [than] her cognitive ability.”

22. In her report, Dr. Gerner addressed each of the criteria for Autistic Disorder set forth in the DSM-IV-TR. Dr. Gerner stated that:

On the surface, [claimant] is demonstrating many symptoms that appear to be similar to a child on the autism spectrum yet careful review of her early history indicates that many of the symptoms were not present prior to the age of three and have become worse over time, likely due to ongoing problems within the home. Based on observations and interactions with [claimant], a comprehensive review of her records, and clinical interview, [claimant] does not meet the diagnostic criteria for Autistic Disorder.

As Dr. Gerner explained, although claimant's language delays were identified when claimant was young, she was described as “interactive and social.” Her “delays began later when she began to identify that she was different from the other children and she began to isolate.” Claimant's “rocking and hand movements also began later which suggest that it may be a self-soothing activity and a way of coping rather than for self stimulation.” Dr. Gerner noted that claimant has “a long-standing history of depression, anxiety and poor self-esteem.” She has been receiving “mental health services as well as psychiatric consultation and medication management.” Claimant and her older sister “both witnessed domestic violence for many years.” In addition, “records indicate that a dramatic change in her behavior starting in the 6th grade, as reported by her teachers.” This information suggested to Dr. Gerner that claimant's “symptoms and decline in behavior are likely due to mental health factors.”

Dr. Gerner also noted that claimant “clearly identifies herself as a young boy.” She would “like to undergo medical treatment to begin her transformation to a male.” She stated that “other children at her school have difficulty with her gender identity and as a result, target her for bullying.” According to Dr. Gerner, this “complicates her ability to make friends and interact appropriately with others as others do not approve of her life choices making it difficult to reach out to be social to others.” Dr. Gerner believes that claimant “appears to shut down from others and continues to isolate in her room.”

Dr. Gerner noted that “people with severe mental illness, including depression, often have deficits in their adaptive functioning” and that her “suggested cognitive impairment is likely secondary to her emotional functioning and effort towards testing.” In sum, Dr. Gerner opined that claimant did not have an intellectual disability and is not on the autism spectrum.

Other Records Relating to Claimant

23. The parties submitted school, medical and mental health records relating to claimant. Relevant portions of some of these records are summarized below.

SCHOOL RECORDS

24. March 26, 1999 Individualized Education Plan (IEP). The school records submitted by the parties show that claimant was identified early as having significant language delays. Her March 26, 1999 IEP indicated that she was eligible for special education services in the category of “Speech/Language Impairment.” No other special education eligibility categories were checked, including “Autism” and “Mental Retardation.”

25. March 14, 2000 IEP. The March 14, 2000 IEP continued to indicate that claimant was eligible for special education services only in the category of “Speech/Language Impairment.” The IEP noted that claimant could identify colors, count to 10, and recognize her own and other children’s names, but she could not write letters. The IEP also noted that claimant “Interacts with peers. Gives appropriate eye contact. Attempts to communicate with others. Cooperative in classroom.” It stated further that claimant “likes to come to speech group. Good attendance. Likes school.”

26. April 24, 2002 Multidisciplinary Assessment Report. Claimant was referred for assessment by her mother and first grade teacher “due to limited academic progress and possible developmental delays.” Claimant was six years five months old at the time of the assessment. The Assessment noted that her strengths included that she was “polite,” “pleasant,” and “cooperative.” The Assessment stated that claimant’s “estimated learning ability appears to fall within the average range (Seq SS=102) to low-average range (Sim SS=87) of intellectual functioning.” The results of the intellectual testing found that claimant met the special education eligibility criteria in the category of a “Learning Disability.”

27. April 24, 2002 Speech and Language Evaluation. The evaluation found that claimant had “significant receptive and expressive speech and language delays,” showed a “significant lack of general knowledge as well as delayed life-skill development,” and was “below age level in all areas of academics.” It was recommended that claimant “continue to receive DIS Speech/Language services.” This evaluation described claimant’s behavior as “cooperative and compliant throughout the assessment sessions.”

28. April 12, 2005 Multidisciplinary Team Report. FUSD conducted a Triennial Evaluation on April 12, 2005, when claimant was nine years five months old. The Multidisciplinary Team found that claimant demonstrated a:

severe discrepancy between estimated ability and achievement in basic reading, reading comprehension, math calculations, and written expression. Adaptive Behavior scores from surveys completed by teacher and [sic] were in the significantly below average range. Consistent with results of previous assessment (See psychoeducational assessment dated 4/24/2002) she demonstrated an auditory processing disorder.”

The Multidisciplinary Team concluded that claimant “met the edibility criteria for special education services based on the criteria for Specific Learning Disability.” The team also concluded that claimant’s learning problems were not the result of “mental retardation,” “emotional disturbance,” or “social maladjustment.”

29. May 18, 2005 Speech Language Assessment Report. Claimant was evaluated when she was nine years old and in the third grade. The Speech/Language Specialist found that claimant’s “language abilities fall within the low-to-low average range.” The specialist noted that, in the “therapy setting, [claimant] has been observed to respond appropriately to the emotional states of others.” The specialist concluded that claimant “continues to qualify for language services in the area of pragmatics due to 2+ year delay.”

30. February 7, 2007 IEP. This IEP was conducted when claimant was 11 years two months old. It indicated that claimant was eligible for special education services in the categories of Specific Learning Disability and Speech/Language Impairment. It stated that claimant had “terrific citizenship and attitude at school.” It noted that claimant “has her friends that she counts on to be with her in homeroom and at recess time,” but that she did “not seem to initiate conversation with any other students unless grouped with them in class.”

31. March 5, 2008 IEP. This IEP provided that claimant was eligible for special education services in the primary category of Specific Learning Disability, and in the secondary category of Autism. The IEP explained that the IEP team agreed to add Autism to claimant’s eligibility criteria as a result of the assessment by Dr. Leby. The IEP described claimant as a “hard worker and a great team player.” It also stated that she was “respectful towards adults and students,” and was “well liked by teachers and her peers.” From a review of the IEP, it does not appear that any additional services or treatment were provided by the school district as a result of the inclusion of Autism as a secondary category of special education eligibility.

32. November 29, 2010 IEP. This Triennial IEP was conducted when claimant was 15 years old and in the ninth grade. The IEP noted that “[s]ignificant cognitive and adaptive deficits adversely impact [claimant’s] ability to complete activities within the general education setting.” The IEP included a note from the Speech Pathologist, which stated:

[Claimant] is doing much better socially this year. She exhibits improved pragmatics as evidenced by appropriate topic maintenance, verbal turn-taking, and interpretation of non-verbal cues. She maintains adequate eye contact for effective conversation. It is felt that pullout services are no longer needed and that pragmatics needs are being adequately addressed in the classroom.

33. October 25, 2012 IEP. This annual IEP was conducted when claimant was 16 years old and in the eleventh grade. It stated that claimant liked to “help working on math problems in the classroom even helping her peers.” It described her as a “very respectful and responsible student.” It stated that she expressed herself “very clearly and concisely” and that she was “able to hold a conversation with peers and adults.”

34. October 11, 2013 IEP. This Triennial IEP stated that claimant “has been showing tremendous maturity this school year. She behaves both inside and outside the classroom.” It also stated that she expressed herself “very well and communicate[d] effectively.”

35. California High School Exit Examination (CAHSEE). Claimant passed the math portion of the CAHSEE on her second try. She was allowed to use a calculator as an accommodation. She passed the English portion of the CAHSEE on her fourth try. She took preparation classes and was allowed to take a modified version for students who were unable to achieve grade-level proficiency.

MEDICAL RECORDS

36. The parties submitted numerous medical notes from the Children’s Health Center, where claimant received medical services. Some of the more relevant notes are summarized below.

37. Undated Progress Record/Physician’s Orders. An undated progress note when claimant was eight years old refers to Dr. Leby and notes that claimant was diagnosed with “high functioning autism.” The note also stated that claimant’s 13-year-old sister had been recently discharged from an in-patient psychiatric facility after trying to commit suicide. The note stated further that claimant “had significant regression (sleeping, sucking thumb, not talking [at] all)” while her sister was gone. In addition, the note stated that claimant’s mother was attacked and beaten four days earlier at her apartment complex, and had “huge multiple bruises over arms, legs, chest.” The note reported that claimant said she was “good,” but was “very quiet” and clung to her mother, wiping her tears and attempting to kiss her bruises. The note reported further that claimant gave “[a]ppropriate affection to parent and staff.” The note referred to “several acute life stressors in family” that were being addressed with outpatient psychiatric services.

38. February 10, 2004 Progress Record. This record summarized a phone call with claimant's third grade teacher, who had been claimant's teacher since first grade. Claimant was in an RSP/special education class. The teacher noted that claimant "follows directions, 'fits right in,' has begun looking her in the eye more, will answer questions in class, raise her hand and is now using the bathroom for the first time by herself." The teacher also noted that claimant had "made great progress" regarding social behaviors. The teacher had not "seen any of the odd behaviors reported by the family, including eating non-nutritive items off the floor, touching her private parts, licking fingers, etc." The teacher saw claimant as a "'slow learner' who is significantly affected by stress."

39. Other notes in 2004 stated that claimant had "speech/language delay," "behavioral issues," "coordination problems," a "chaotic home life," "social anxiety," "learning disability," and "extreme family stress." They indicated that claimant was found eligible for occupational therapy (OT). They also indicated that claimant's 14-year-old sister had attempted suicide again, was in a psychiatric facility for teens, and was possibly pregnant.

40. December 10, 2004 Progress Records/Physician's Orders. In this note, written when claimant was nine years old, Dr. Carson wrote that she and Dr. Snyder, a developmental pediatrician, "evaluated" claimant, and "carried on a lengthy conversation" with her about school, therapy (OT and speech) and her friends at school. They also had a "long discussion" with claimant's parents "regarding the lack of evidence for autism (good social rel, carries on conversation, cares for others...)." They further discussed the "likelihood" that claimant had "language difficulty in that she cannot process [and] understand language, including instructions which contributes to poor performance." Dr. Carson described claimant as "alert," "interactive," and "readily involved in conversation," although the doctor noted her lack of eye contact. Dr. Carson indicated that claimant was diagnosed with "language delay, likely anxiety and family issues."

MENTAL HEALTH RECORDS

41. The parties submitted records from Fresno County Mental Health. Some of the more relevant records are summarized below.

42. 2006 Progress Notes of Behavior Analysts. The parties submitted progress notes written by behavior analysts, primarily Nancy Cantrell, who provided behavioral services to claimant during 2006. For example, in a January 5, 2006 note, Ms. Cantrell stated that she was providing "community based rehabilitation services to consumer focused on building social skills." She described the activities as follows:

Involved consumer in a semi-structured activity, discussing with her the rules to be followed prior to entering the building.
Encouraged consumer to communicate and engage with her peers also attending the activity to increase her communication

skills. Used verbal praise for consumers [*sic*] attempts to complete activities and for her attention to instructor when instructor was explaining how to do a specific activity. Explained why consumer is expected to help clean up the room after the activity when she indicated she did not want to help. BA participated in the clean up to model for consumer and verbally encouraged consumer to follow her lead when consumer quit participating. Provided unstructured time and verbal prompts to allow consumer to discuss issues important to her.

Ms. Cantrell noted that claimant “appeared to enjoy the activity but required constant verbal prompts before she would communicate with her peers.” Ms. Cantrell described claimant as “attentive to the instructions provided for each activity and did a very good job of completing each activity independently.”

43. August 22, 2006 Children’s Mental Health Clinical Assessment. Ms. Negrete, claimant’s therapist, completed this assessment when claimant was 10 years nine months old. She described the conditions affecting claimant’s physical and mental health as follows:

[Claimant] reported often feeling anxious, nervous, is clingy, is easily scared, fears insects or bugs, is afraid of the dark, is afraid to sleep by herself, often feels lonely, feels sad due to not having any friends and her sister moving out of the home. Mother also indicated that [claimant] has low self esteem, she makes comments about being lazy and not knowing how to do things correctly. She also stated that she feared her father hurting her mother. She has indicated that she wanted to call 911, but feared her father hitting her. [Claimant] has been subject to several years of domestic violence in the home. When father becomes heavily intoxicated he becomes verbally abusive towards others in the home and physically abusive towards mother. [Claimant] indicated this makes her very anxious. Mother reported being told that [claimant] has a learning disability and possibly Autism. [Claimant] has a tendency to pick things up to smell, taste, eat or stick them in her ears or nose. She also expressed concern regarding [claimant] putting her finger in genital area then smell[ing] it.

Claimant was diagnosed on Axis I with Anxiety Disorder NOS, and Depressive Disorder NOS. She was given no diagnosis on Axis II.

44. February 16, 2011 Email by Dr. Gaur. On February 16, 2011, Dr. Gaur, claimant’s psychiatrist, responded to an inquiry from Marlene Pena, who was seeking

clarification on claimant's disability. Claimant's mother had requested assistance from Ms. Pena in seeking services from CVRC. In response to Ms. Pena's inquiry, Dr. Gaur wrote:

I have been seeing [claimant] for about 3 years now. She initially presented with symptoms of Depression, Anxiety, aggressive behavior, mood swings, poor social skills, auditory and visual hallucinations and delusions. She reported seeing and talking to Michael Jackson for several months. She was started on medications for her sx and that seemed to resolve. But she continues to have some depressive, and anxiety sx at this time and is having a difficult time adjusting to her new school. She has a H/O of Developmental delay/speech delay and I believe she has received services for these problems in the past. Even though she has poor social skills and isolates herself and does not like being with people, she does have appropriate social interaction, eye contact, and is able to communicate her feelings here at her sessions with me. I do not believe she has Autism or Aspergers syndrome and I have explained that to parents. She does have a low level of intellectual and adaptive function as confirmed by Dr. Glidden's test and also has had some neurological problems in the past as per Mom, I cannot find her old chart and do not remember the details (but she was discharged by the Neurologist as per Mom.)

Testimony

45. Drs. Lai, Gerner, and Glidden all testified on behalf of CVRC. Dr. Carol Sharp, a CVRC Staff Psychologist, also testified.

46. Dr. Cronin testified on behalf of claimant. Claimant's mother and sister also testified.

47. Dr. Lai. Dr. Lai testified that, in 2001 when she evaluated claimant, she did not address in her report whether claimant had autism because she had no concerns that claimant was on the autism spectrum. Claimant was "very engaged socially" and "cooperative" throughout the testing. She did not display any repetitive or stereotypical behaviors. She responded appropriately to the questions Dr. Lai asked. She maintained eye contact and engaged in pretend play. Although claimant's speech was delayed, she used gestures to communicate and compensate for the delays. There was no indication in the school records that Dr. Lai reviewed that claimant was on the autism spectrum. In sum, Dr. Lai found that claimant did not meet the diagnostic criteria for autism set forth in the DSM-IV.

48. With regard to claimant's intellectual functioning, Dr. Lai found that claimant tested within the low average range on both abstract/visual reasoning and quantitative reasoning, well above the cutoff for intellectual disability. She tested in the borderline range for verbal reasoning. Dr. Lai attributed this lower score, in part, to the fact that claimant was living in a bilingual home and was still getting used to learning two languages.

49. With regard to the fifth category, Dr. Lai opined that claimant did not have a disabling condition that was closely related to intellectual disability given her test scores. In addition, there was also no indication that claimant needed treatment similar to that required for individuals with an intellectual disability.

50. Dr. Glidden. Dr. Glidden testified that on October 29, 2008, when he first attempted to evaluate claimant, she was uncooperative, and made it known that she did not want to be evaluated and was not putting forth her best efforts. When she "pathologically failed" the Rey 15-item Memorization Test, he decided that it was best to stop the testing for that day. On July 9, 2009, when claimant returned, Dr. Glidden evaluated her for: (1) intellectual functioning; (2) adaptive functioning; (3) autism spectrum disorder; (4) personality measures; and (5) executive functioning. The results of the testing showed that claimant had areas of strengths and weaknesses.

51. With regard to claimant's intellectual functioning, on the WISC-IV, there was a significant difference between claimant's score on the General Ability Index of 79, which measured her verbal and nonverbal skills, and her Cognitive Proficiency Index score of 54, which measured her attention and processing speed. In accordance with the guidelines set forth in a publication called "WISC-IV Advanced Clinical Interpretation," Dr. Glidden determined that, given claimant's deficits with attention and processing speed, her General Ability Index score of 79 was a better reflection of her intellectual functioning, which indicated that she was in the Borderline range. In addition, claimant performed above average on the Wisconsin Card Sorting Test. According to Dr. Glidden, the Wisconsin Card Sorting Test tests for executive functioning, including the ability to abstract, anticipate and change behavior based upon a set of rules, and that individuals with an intellectual disability have significant difficulty with this test. Dr. Glidden opined that, given claimant's above average score on this test, she did not have an intellectual disability. He opined further that she did not have a disabling condition that was closely related to intellectual disability, and did not need treatment similar to that required for individuals with an intellectual disability. Dr. Glidden stated that his opinion would be the same whether the DSM-IV or the DSM-5 diagnostic criteria were applied.

52. With regard to claimant's attention deficits, Dr. Glidden explained that attention may be impacted by a number of factors, including mental health issues, sleep, and effort. With regard to claimant's processing skills, Dr. Glidden testified that, at times, claimant was able to process more complex information better than she processed less complex information. According to Dr. Glidden, for individuals with an intellectual disability, the opposite is true. Dr. Glidden understood that, at the time of the testing, claimant was taking Seroquel, a psychotropic medication, which could have affected her

attention and processing speed. Given the significant variations in claimant's scores over time, and her ability to answer harder questions but not easier ones, Dr. Glidden raised concerns that claimant's mental health issues and her motivation impacted her attention, processing speed, and intellectual functioning scores.

53. Dr. Glidden found claimant to be amiable, to maintain eye contact, to engage in appropriate turn-taking, to have a sense of humor, and to maintain joint attention. Dr. Glidden testified that all these findings were inconsistent with a diagnosis of autism. Dr. Glidden recognized that autism can often co-exist with other disorders, and that claimant had "a lot of symptoms that looked like a lot of things." But given claimant's ability to develop social relationships, which was documented early on by her school, he could not find that she had autism.

54. Dr. Glidden diagnosed claimant with Anxiety Disorder NOS. During his testimony, he questioned why he did not also diagnose her with Psychotic Disorder NOS given her hallucinations and delusions.

55. Dr. Gerner. Dr. Gerner testified that, when she started testing claimant's intellectual functioning, it quickly became clear that claimant's answers were not "fitting together." Claimant missed questions on easier introductory items, but correctly answered more difficult later questions. When Dr. Gerner began conducting the vocabulary subtest, claimant answered with a lot of "I don't know's," and gave up easily. Dr. Gerner was concerned with claimant's level of anxiety, so she engaged claimant in "chitchat" to make her more comfortable. Claimant was very open about wanting to be a boy. She stated that she wanted to go to college in San Francisco because they were more tolerant of gay people there. As claimant spoke, it was clear that her vocabulary during the interview was more sophisticated than it appeared during the testing. She correctly used words such as "bigotry" and "discrimination." Although Dr. Gerner administered the entire Wechsler Adult Intelligence Scale-IV, she did not include the test results in her report because she believed that claimant's performance was "suspect." Based on Dr. Gerner's interview with claimant, it was Dr. Gerner's clinical judgment that claimant was functioning at a higher intellectual level than her test scores indicated.

Dr. Gerner opined that claimant did not have an intellectual disability. She opined further that claimant did not have a disabling condition that was closely related to intellectual disability, and that she did not need treatment similar to that required for individuals with an intellectual disability. According to Dr. Gerner, claimant's learning disabilities are not similar to an intellectual disability and would not constitute a qualifying condition for eligibility under the Lanterman Act.

56. Dr. Gerner testified that, during the interview, claimant openly talked about her emotions. She demonstrated "a lot" of insight into her gender identity issues. She expressed interest in getting involved in LGBT groups. She recognized that she was bullied and made fun of because she looked different. She struggled to maintain friendships. She expressed her difficulties regulating her frustration and anger. She admitted to being abusive

to her mother and felt badly about it. She displayed social and emotional reciprocity. Dr. Gerner testified that this conduct was inconsistent with a diagnosis of autism.

57. Because individuals suffering from mental health conditions can have symptoms similar to individuals with autism, when reaching her conclusions, Dr. Gerner considered several differential diagnoses and the environment in which claimant was raised. According to claimant's mental health records, claimant had been exposed to numerous family problems. There was domestic violence in her home, her mother struggled with anxiety and depression, and there was a history of psychotic disorder in her family. Claimant was taking psychotropic medications for depression, anxiety, hallucinations, delusions, and sleep issues. Her school records indicated that there was a significant change in her behavior in 2008, when she was about 12 or 13 years old and in the sixth grade. This significant change later in life indicated to Dr. Gerner that claimant's symptoms were more likely due to mental health issues, rather than autism, which generally manifests before the age of three.

58. Dr. Sharp. Dr. Sharp is a CVRC staff psychologist and a member of CVRC's eligibility committee. Claimant has applied four times for services from CVRC. Dr. Sharp was on the team that reviewed the most recent requests, but not the earlier ones. At hearing, Dr. Sharp reviewed the evaluations, assessments and records CVRC had received regarding claimant. After reviewing these documents, Dr. Sharp opined that claimant was not eligible for services from CVRC under any of the eligibility criteria set forth in the Lanterman Act. According to Dr. Sharp, the records did not establish that claimant has an autism spectrum disorder, an intellectual disability, or a disabling condition that is closely related to intellectual disability or requires treatment similar to that required for individuals with an intellectual disability.

59. Dr. Sharp explained that claimant's communication development and her social/emotional interactions were inconsistent with a finding of an autism spectrum disorder. She explained further that claimant's sporadic lack of eye contact and withdrawal from social interactions could be caused by anxiety or depression, instead of an autism spectrum disorder. Dr. Sharp also explained that, on testing for intellectual functioning, individuals cannot score higher than their abilities, but they can score lower, and that mental health conditions may depress their scores. Dr. Sharp also opined that claimant's specific learning disability and speech/language impairment were not conditions closely related to intellectual disability and did not require treatment similar to that required for individuals with an intellectual disability. Dr. Sharp testified that her opinions would be the same whether the DSM-IV or the DSM-5 diagnostic criteria were applied.

60. Dr. Cronin. Dr. Cronin testified that she and her team evaluated claimant for an autism spectrum disorder when she was almost 16 years old, based upon the Best Practice Guidelines for Screening, Diagnosis, and Assessment of Autistic Spectrum Disorders published by the California Department of Developmental Services (DDS) in 2002. Dr. Cronin pointed particularly to her use of ADOS and ADI-R. Dr. Cronin found that claimant had deficits in the three areas identified in the DSM-IV for diagnosing an autism spectrum disorder: (1) social interaction; (2) communication; and (3) repetitive behaviors.

61. Dr. Cronin testified that claimant also was diagnosed as having an autism spectrum disorder when she was evaluated under the diagnostic criteria set forth in the DSM-5, which was issued in May 2013.⁴ Dr. Cronin explained that, in the DSM-5, the first two deficit areas – social interaction and communication – have been collapsed. She stated that the DSM-5 recognizes that autistic symptoms may not be manifest by age three or may be masked. She also explained that about one-half of individuals with an autism spectrum disorder also have an intellectual disability. She explained further that an autism spectrum disorder may be found when there is a “qualitative impairment” in social interactions appropriate for an individual’s developmental level; there does not have to be a complete absence of social interactions, peer relationships or friendships to find an autism spectrum disorder. Dr. Cronin recognized that claimant was able to respond appropriately to questions and engage in conversations with adults. But she could not adequately initiate conversations with her peers, or sustain reciprocal conversations in which she exchanged information and shared enjoyment. Dr. Cronin also found that claimant used stereotypical and repetitive language and did not engage in real make-believe play when she was young. Dr. Cronin testified that girls with an autism spectrum disorder generally demonstrate better nonverbal social behavior, including better gestures and eye contact, than boys. She also testified that an autism spectrum disorder may be co-morbid with mental health conditions and may adversely impact an individual’s motivation.

62. Dr. Cronin testified that under the DSM-5, a determination as to whether an individual has an intellectual disability is not based solely on that individual’s IQ score. Deficits in adaptive functioning, reasoning, planning, and judgment are also taken into consideration. Dr. Cronin opined that claimant’s adaptive functioning is significantly below that expected of individuals her age. According to Dr. Cronin, claimant is currently functioning at a second or third grade level. Based upon both claimant’s testing and her extremely low level of adaptive function, Dr. Cronin opined that claimant has mild to moderate mental retardation.

63. Dr. Cronin opined that claimant qualified for services from CVRC under the fifth category because she cannot rely upon her cognitive abilities to function effectively given her extremely low level of adaptive functioning. Dr. Cronin also opined that claimant requires treatment similar to that required for individuals with an intellectual disability. Dr. Cronin pointed to the benefits claimant received from the behavioral services she obtained from Ms. Cantrell in 2006. According to Dr. Cronin, claimant requires the type of structure, frequent repetition, and systematic reinforcement that was provided during those behavioral intervention sessions.

⁴ The diagnostic criteria for an autism spectrum disorder set forth in the DSM-5 include: (A) “Persistent deficits in social communication, and social interaction across multiple contexts...”; (B) “Restricted, repetitive patterns of behavior, interests, or activities...”; (C) “Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies later in life)”; and (D) “Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.”

64. Dr. Cronin recognized the remarkable variability in claimant's test performances over time. She did not know why claimant's intellectual abilities seemed to "come and go," or why she appeared to know something one day and not the next. Dr. Cronin believed that claimant was trying to perform her best on the tests, but was unable to maintain information and skills over time. Dr. Cronin opined that the "elusiveness" of claimant's intellectual abilities was a component of her disability, and demonstrated that she qualified for services under the fifth category.

65. Claimant's mother and sister. Claimant's mother was born in Mexico. She has had only one year of formal education and speaks Spanish. Claimant's sister is a Certified Nurse Assistant and an interpreter for Madera Community Hospital. She is fluent in both Spanish and English. She has a young daughter, who lives with and is taken care of by her mother. Although she no longer lives with claimant, she sees her every day. Claimant's mother and sister both testified that claimant had speech and language difficulties from a very young age. She did not play or interact well with other children. She would play with only one toy, a boy doll, which she would spin around and stare at. She would take her clothing off and touch her private parts. She would eat toilet paper and feces. She would rock back and forth. She was a very picky eater. She was bothered by smells and loud noises. She would play with her mother's and sister's hands, calling them by made-up names. According to her mother, claimant cannot ride the bus by herself, use money, or take care of herself.

Discussion

66. When all the evidence is considered, the evaluations, assessments and opinions of Drs. Lai, Glidden, Gerner, Herrera, Littleworth, Sharp, Gaur and Snyder, MSW Negrete, and the Diagnostic Center were more persuasive than those of Drs. Cronin and Leby.⁵

AUTISM SPECTRUM DISORDER

67. Only two of the many evaluations and assessments submitted in this matter opined that claimant was an individual with an autism spectrum disorder – Dr. Leby's September 18, 2003 Neuropsychological Evaluation and Dr. Cronin's 2011/12 Psychological Evaluation.

68. All of the witnesses who testified about Dr. Leby's evaluation criticized it. As Dr. Cronin testified, Dr. Leby did not follow best practices when he diagnosed claimant with "high functioning autistic disorder." There was no information included in his evaluation to determine whether he reviewed and applied the diagnostic criteria for autism

⁵ Claimant questioned the opinions of Dr. Herrera, due to the possible discipline of his professional license, and of MSW Negrete, because she is unlicensed. Claimant did not show that the license status of these two individuals were relevant to or adversely impacted the assessments and evaluations they conducted with regard to claimant. Claimant's arguments in this regard were given no weight.

set forth in the DSM-IV. He did not list any of the tests he utilized to make his diagnosis. He did not identify any of claimant's behaviors that caused him to reach his conclusions. As Dr. Cronin explained, the term "high functioning autistic disorder" is not a clinical term. It is a nonclinical term that is sometimes used to describe individuals with an autism spectrum disorder who have high intellectual functioning and mild social deficits. Dr. Cronin could not understand how Dr. Leiby was applying that term to claimant, who does not have high intellectual functioning and who has low adaptive skills. Given all these factors, Dr. Leiby's evaluation can be given no weight.

69. Dr. Cronin opined that claimant had an autism spectrum disorder under the diagnostic criteria set forth in both the DSM-IV and DSM-5. Claimant argued that Dr. Cronin's opinion should be accepted because she followed DDS's Best Practice Guidelines, particularly in her use of ADOS and ADI-R. Claimant's arguments were not persuasive.

70. As set forth above, Dr. Cronin evaluated claimant when she was almost 16 years old. Dr. Cronin relied, to a significant degree, on the information that claimant's mother and sister provided about claimant's history. As set forth in Dr. Cronin's report, and in the records of FUSD, Children's Health Center, and Fresno County Mental Health, claimant's mother often described claimant's social deficits as being far worse than those that were observed by her teachers, her doctors, and the numerous psychologists and other professionals who evaluated her. Drs. Lai, Glidden and Gerner all found claimant's social communication and interaction to be appropriate. They did not find her to have significant deficits in these areas. They did not observe any restricted or repetitive patterns of behavior, interests or activities. Their observations were consistent with the observations of her teachers and doctors included in the school, medical and mental health records. As Dr. Glidden explained, during his evaluation, claimant displayed "excellent social interactive skills, such as taking turns, following commands, pointing to objects on command, and following directions." Dr. Glidden's evaluation and testimony were particularly persuasive. He was not retained or paid by CVRC for his evaluation and testimony. He presented as a fair, impartial, and knowledgeable evaluator with considerable expertise and insight.

71. Dr. Cronin also failed to adequately address the mental health diagnoses given by claimant's psychiatrist and doctors. As other psychologists explained, there may be some overlap of symptoms between an autism spectrum disorder and other mental health conditions. While Dr. Cronin recognized that autism may often exist in conjunction with other mental health conditions, she did not adequately evaluate claimant's conduct in light of the multiple mental health conditions identified in this matter. When Dr. Littleworth's, Dr. Glidden's, Dr. Gerner's and Dr. Gaur's opinions relating to claimant's mental health conditions are reviewed, the evidence was strong that claimant's behavioral issues are primarily the result of those mental health conditions and not due to an autism spectrum disorder. When all the evidence is considered, claimant failed to establish that she qualifies for services from CVRC under the developmental disability of autism.

INTELLECTUAL DISABILITY

72. As Dr. Cronin explained, there is a difference between how mental retardation was defined in the DSM-IV-TR and how intellectual disability is now defined in the DSM-5. The DSM-IV-TR stated that:

The essential feature of Mental Retardation is significantly subaverage **general intellectual functioning** (Criterion A) that is accompanied by significant limitations in adaptive functioning in a 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 (Criterion B). The onset must occur before age 18 years (Criterion C). (Bolding added.)

The DSM-IV-TR stated that “general intellectual functioning” is defined by the intelligent quotient (IQ or IQ-equivalent) obtained by assessment with one or more of the standardized, individually administered intelligence tests.” The DSM-IV-TR defined “mild mental retardation” to be an IQ level from “50-55 to approximately 70.” It defined “moderate mental retardation” to be an IQ level from “35-40 to 50-55.” The DSM-IV-TR distinguished learning and communication disorders from mental retardation, stating, “In **Learning Disorders** or **Communication Disorders** (unassociated with Mental Retardation), the development in a specific area (e.g., reading, expressive language) is impaired but there is no generalized impairment in intellectual development and adaptive functioning.” (Bolding in original.)

73. The DSM-5 defines “intellectual disability” as follows:

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

- A. Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing.
- B. Deficits in adaptive functioning that results in failure to meet developmental and sociocultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or

more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.

C. Onset of intellectual and adaptive deficits during the developmental period.

As set forth in the DSM-5, “The essential features of intellectual disability (intellectual developmental disorder) are deficits in **general mental abilities** (Criterion A) and impairment in everyday adaptive functioning, in comparison to an individual’s age-, gender-, and socioculturally matched peers (Criterion B).” (Bolding added.) The DSM-5 also distinguishes intellectual disability from communication and specific learning disorders: “These neurodevelopmental disorders are specific to the communication and learning domains and do not show deficits in intellectual and adaptive behavior.”

74. While the emphasis on adaptive functioning in the DSM-5 appears to be greater than in the DSM-IV-TR, in both manuals, there is a requirement that the intellectual deficits must be “general” in nature in order to meet the definition of an intellectual disability. In other words, an individual must display global intellectual deficits to be identified as having an intellectual disability under both the DSM-IV-TR and DSM-5.

75. The intellectual testing of claimant has shown a wide degree of variation in the subtests of the various standardized tests. On the subtests, claimant’s scores have ranged from Extremely Low to Average levels of ability. While claimant tried to attack the Merrill-Palmer Scale of Mental Tests utilized by FUSD in 1999, her results on that test were similar to the results obtained on other intellectual assessments. What is apparent in the intellectual testing conducted over time by or for the FUSD and by numerous psychologists is the significant degree of scatter in the scores claimant achieved on the various subtests.

76. During the time claimant has been in the FUSD, she has been identified as having a “speech/language impairment” and a “specific learning disability.” The FUSD never identified claimant as having “mental retardation.” Dr. Cronin was the only psychologist who tested claimant who opined that claimant had mild to moderate mental retardation. In reaching her conclusion, Dr. Cronin utilized an abbreviated battery of the subtests on both the SB5 and WISC-IV. As Dr. Glidden explained, while Dr. Cronin administered the entire language component of subtests on the WISC-IV, she administered only one component of the nonverbal subtests. Dr. Glidden was unable to opine as to how claimant might have performed if she had been given the full battery of nonverbal subtests.

77. In addition, many evaluators, including Dr. Cronin, emphasized how remarkably inconsistent claimant’s test results were within cognitive measures. Claimant was often able to answer more difficult questions after missing easier ones.

78. When all the intellectual testing submitted in this matter is considered, given the significant degree of variability within and across the intellectual testing, claimant did not

establish that she has the type of general or global cognitive deficits required to find that she has an intellectual disability. Consequently, her request for eligibility for CVRC services under this developmental disability category must be denied.

FIFTH CATEGORY

79. At the fair hearing, claimant argued for the first time that, even if it is determined that she does not qualify for services under the categories of autism and intellectual disability, she should be found eligible under the fifth category because she has a disabling condition that is closely related to intellectual disability or requires treatment similar to that required for individuals with an intellectual disability. Because her claim for eligibility under the fifth category was not raised prior to the hearing, none of the written reports assessed whether claimant was eligible under this category. But CVRC did not oppose claimant adding the fifth category to her request for services and the psychologists who testified at the hearing addressed fifth category eligibility in their testimony.

80. The significant scatter and remarkable inconsistencies in claimant's intellectual testing preclude a finding that claimant has a condition that is similar to an intellectual disability. Her cognitive functioning is too variable and inconsistent. From the evaluations conducted by Drs. Glidden, Gerner and Littleworth, and the Diagnostic Center, claimant's cognitive abilities appear to be significantly impacted by her mental health conditions. And as Drs. Sharp and Gerner testified, claimant's learning disability and speech/language impairment are not comparable to an intellectual disability. Given these factors, it cannot be found that claimant has a condition similar to an intellectual disability.

81. Dr. Cronin testified that given claimant's low adaptive functioning, she requires treatment similar to that required by individuals with an intellectual disability. As set forth above, Dr. Cronin opined that the benefits claimant obtained from the behavioral services provided in 2006 primarily by Behavior Analyst Cantrell show that claimant requires such treatment. Dr. Cronin's opinion was not persuasive. There was no indication in the evidence that the behavioral services provided by Ms. Cantrell were intended to provide treatment to address claimant's cognitive functioning. Ms. Cantrell's behavioral services were obtained through Fresno County Mental Health. From a review of the behavior analysts' notes, it appears that the goals of the behavioral services were to address claimant's inappropriate behaviors resulting from her mental health conditions, not her intellectual deficits. Moreover, most of the treatment and services recommended for claimant by Dr. Cronin appears to be designed to address her behavioral issues, not her cognitive functioning.

82. When all the evidence is considered, claimant failed to establish that she has a disabling condition that requires treatment similar to that required for individuals with an intellectual disability.

83. While claimant may have a low level of adaptive functioning, the evidence did not establish that her low adaptive functioning is due to an autism spectrum disorder, an intellectual disability, or a disabling condition that is closely related to intellectual disability or requires treatment similar to that required for individuals with an intellectual disability. Instead, the overwhelming weight of the evidence established that claimant's low adaptive functioning is the result of her psychiatric disorders and learning disabilities. To find otherwise and adopt Dr. Cronin's opinions would require ignoring the numerous evaluations and assessments conducted over much of claimant's life by or on behalf of the FUSD, Children's Health Center, Fresno County Mental Health, and CVRC.

84. The legislature made the determination that only individuals with the five specified types of disabling conditions identified in the Lanterman Act are eligible for services from regional centers. The legislature chose not to grant services to individuals who may have other types of disabling conditions, including mental health disorders and learning disabilities, if they cannot show that they fall within one of the five categories delineated in the act. Although the result may seem harsh, particularly for individuals with mental health conditions as troubling as claimant's, the legislature did not grant regional centers the authority to provide services to individuals whose disabilities fall outside the five specified categories. Because claimant did not show that she currently has autism, an intellectual disability, or a disabling condition that is closely related to mental retardation or requires treatment similar to that required for individuals with mental retardation, she did not establish that she is eligible for services under the Lanterman Act.

LEGAL CONCLUSIONS

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

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

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

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

ORDER

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

DATED: March 19, 2014

KAREN J. BRANDT
Administrative Law Judge
Office of Administrative Hearings

NOTICE

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