

BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT,

vs.

ALTA CALIFORNIA REGIONAL
CENTER,

Service Agency.

OAH No. 2015100316

DECISION

This matter was heard before Administrative Law Judge Danette C. Brown, State of California, Office of Administrative Hearings, on December 16, 2015, in Sacramento, California.

Robin M. Black, Legal Services Specialist, represented Alta California Regional Center (ACRC).

Claimant's adoptive mother represented claimant.

Evidence was received, the record was closed, and the matter was submitted for decision on December 16, 2015.

ISSUES

1. Is claimant eligible to receive ACRC services and supports by reason of a diagnosis of intellectual disability?

2. Is claimant eligible to receive ACRC services and supports by reason of a diagnosis of autism?

3. If claimant is not eligible for ACRC services under the categories of intellectual disability or autism, is he eligible under the "fifth category," because he has a

condition closely related to an intellectual disability, or that requires treatment similar to that required for individuals with an intellectual disability?

FACTUAL FINDINGS

Background and History

1. Claimant is seven years old. He currently lives in South Sacramento with his adoptive mother (claimant's representative) and his three biological brothers, ages eight, nine, and 10. One brother is a client of ACRC, and another brother is in the intake process.

2. Claimant has an early childhood history of having been removed from his biological mother's care and placed with claimant's representative, along with his three biological siblings, at age six months. His biological family has significant history of mental health issues and intellectual disabilities. Claimant is currently attending first grade, where claimant's representative states that he is completing work at approximately the kindergarten level. He has been found by his most recent Individualized Education Plan (IEP) not to continue to qualify for special education under any disabling conditions. He previously qualified under the disabling condition of speech and language. His previous test results suggested cognitive abilities reaching into the low average range in certain areas. However, previous cognitive assessments also suggested significant evidence of inattention and hyperactivity, consistent with Attention Deficit Hyperactivity Disorder (ADHD), although this diagnosis was not given.

3. In 2015, claimant's representative applied to ACRC on claimant's behalf to receive services. Claimant was referred to the ACRC to assess his level of intellectual and adaptive functioning to determine his eligibility for ACRC services. As part of ACRC's eligibility assessment process, ACRC Intake Specialist Sabrina Motherspaw, MSW,¹ completed a social assessment of claimant on July 23, 2015. Additionally, ACRC-vendored psychologist Katherine Redwine, Ph.D., completed a psychological evaluation of claimant on September 1, 2015. Thereafter, ACRC's Interdisciplinary Eligibility Team, which included Ms. Motherspaw and Dr. Redwine, reviewed all of the records and information ACRC had obtained regarding claimant to determine eligibility.

On September 21, 2015, the team found that claimant does not meet the criteria for Autism Spectrum Disorder. The team also found that there was no evidence that claimant has an intellectual disability, a condition closely related to intellectual disability or requiring treatment similar to that required by individuals with an intellectual disability, cerebral palsy or epilepsy. The team concluded that claimant is not eligible for ACRC services.

4. On October 2, 2015, ACRC received a Fair Hearing Request from claimant's representative appealing the team's decision. Claimant's representative disagreed "with the

¹ Master of Social Work.

findings and determination by the regional center.” She requested a “reevaluation of eligibility and reconsideration of reports submitted.”

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

Assessments Performed by ACRC

Social Assessment

6. Ms. Motherspaw testified about the social assessment she conducted with claimant on July 23, 2015. The suspected areas of disability were intellectual disability and “fifth category” disability. Ms. Motherspaw observed claimant as a “cute 6 year old” who was friendly, and who often attempted to get her attention. Ms. Motherspaw noted some delay in claimant’s speech, and his articulation was “somewhat impacted.”

Ms. Motherspaw interviewed claimant’s representative. Claimant’s representative informed Ms. Motherspaw of claimant’s family history, and her behavior concerns such as claimant’s “selective hearing,” his short attention span, and his difficulty in understanding social cues. Socially, claimant has difficulty in making friends and remembering classroom routines. Claimant’s representative informed Ms. Motherspaw of claimant’s early development, and told Ms. Motherspaw that claimant often talks to himself and is generally a happy boy. Claimant did not suffer from any significant illnesses or injuries.

Claimant’s representative informed Ms. Motherspaw of claimant’s educational history, which included physical abuse of claimant at his day care center. Claimant attended transitional kindergarten and kindergarten at Morse Elementary School, receiving speech therapy services through the school district’s Individualized Education Program (IEP) process. Elk Grove Unified School District records, dated March 2015, indicate that claimant had a psycho-educational assessment. However, he was not assessed for an intellectual disability due to the *Larry P. v. Wilson Riles*² court decision prohibiting the intellectual assessment of African-American students. Other testing showed that claimant was in the delayed range. Claimant’s representative did not agree with the most recent IEP

² *Larry P. v. Riles* (1979) 495 F.Supp. 926 [held use of Intelligence Quotient tests had a disproportionate effect on black children in violation of various federal laws and the 14th Amendment].

addendum because she believes that claimant's delays are more significant than what was decided by the school district.

With regard to self-care, claimant's representative related to Ms. Motherspaw that claimant can dress himself, but he may put his shoes on the wrong feet and his clothing on inside out and backwards. Claimant's representative likened his ability to a three year-old dressing himself. Claimant cannot tie his shoes. His bathing routine needs to be supervised. Claimant is independent with his toileting routine.

Ms. Motherspaw observed that claimant needed additional time to process what was being stated to him, and it took him additional time to answer questions. She observed claimant to use gestures and facial expressions appropriately, and his eye contact was good.

Claimant was able to count to thirty for Ms. Motherspaw, but he did make mistakes. He learned his colors and knows most of his shapes. Claimant cannot write his own last name and is only consistently identifying 10 out of the 50 sight words that are required for him. Claimant can recognize up to the number 20.

According to claimant's representative, claimant cannot appropriately choose his own clothes for the weather, and will get lost very easily in public places. He has very little safety awareness in traffic and in parking lots. He can be overly friendly with people he does not know. He can pick up after himself and can obtain simple snacks. He does not know how to make a phone call. He does not know his teacher's name, or the name of his school.

7. Ms. Motherspaw prepared, signed and dated her social assessment report on July 23, 2015. Her report was admitted into the record. She wrote at the end of her report that claimant's eligibility for service agency services would be decided after a comprehensive case review by ACRC's Multidisciplinary Eligibility Review Team.

Psychological Evaluation

8. Dr. Redwine is a licensed clinical psychologist. She has a private practice as a psychotherapist, where she provides individual, couple and family therapy in a private practice setting. She is also an ACRC independent contractor, performing cognitive and psychodiagnostic assessments. She also conducts assessments for the regional center in central California. She conducts approximately 25 to 30 psychological assessments per month to consider or rule out diagnoses of Intellectual Disability and Autism Spectrum Disorder (ASD). To date, Dr. Redwine has performed approximately 1,000 to 1,500 psychological assessments.

9. On September 1, 2015, Dr. Redwine conducted a psychological evaluation of claimant and wrote a report of her findings and conclusions, which was admitted into the record. The purpose of the evaluation was to assess claimant's level of intellectual and adaptive functioning to determine his eligibility for ACRC services. Claimant was not referred to Dr. Redwine for an autism assessment, although she did look for signs of ASD in

claimant during her evaluation, and found none. In conducting her assessment, Dr. Redwine interviewed claimant's representative, made behavioral observations of claimant, administered assessment tests, and reviewed previous evaluations of claimant.

Interview with Claimant's Representative

10. Claimant's representative reported claimant's early development, medical history, family history, current problems, social functioning, and educational history to Dr. Redwine, as she did with Ms. Motherspaw. The information that claimant's representative provided to Ms. Motherspaw was consistent with what she reported to Dr. Redwine.

Behavioral Observations and Testing

11. Dr. Redwine administered an assessment test known as the Weschler Preschool and Primary Scales of Intelligence – 4th Edition (WPPSI-IV), which measures intellectual ability and cognitive strengths and weaknesses. During the administration of the WPPSI-IV test, claimant was highly distractible and hyper-verbose. He put forth good effort, but was generally impulsive and did not appear to spend very much time checking his answers. After the administration of cognitive measures, claimant was allowed to play with toys while Dr. Redwine conducted a clinical interview with claimant's representative. During the interview, claimant was physically overactive, and displayed a constant stream of monologue. He crashed into the window blinds several times. He asked to use the restroom and stayed longer than five minutes, singing and playing until retrieved by claimant's representative. Claimant's representative stated that such behavior was typical for claimant. Dr. Redwine testified that, in general, claimant's behavior showed no signs of ASD.

12. In order to assess claimant's adaptive behaviors, the Adaptive Behavior Assessment System, Third Edition (ABAS-3) was completed. The ABAS-3 is a survey completed by parents, caregivers, and/or teachers regarding the adaptive behavior of the person being evaluated. The answers provide a comprehensive picture of a person's ability to function in ten different domains, which are grouped into composite scores representing different aspects of adaptive functioning. The results of the ABAS-3, as completed by claimant's representative, show that claimant's conceptual, social, practical, and general adaptive composite scores fell primarily in the low to extremely low ranges.

Impressions

13. Dr. Redwine noted that claimant's current cognitive abilities "should be interpreted with extreme caution as his significant distractibility was manifested in inter-test scatter and a hit and miss response style within subtests and observed distracted behaviors. As a result, these scores are likely significant underestimates of his true abilities." In other words, Dr. Redwine had concerns that claimant's inattention may have significantly affected his IQ test scores. Dr. Redwine wrote:

He received scores falling in the Borderline range for Visual-Spatial and Processing Speed in the cusp between Borderline and Extremely Low range for Fluid Reasoning and Working Memory, and in the Mildly Impaired range with regards to his Verbal Comprehension Index. His Full Scale IQ was not calculated due to the statistically significant discrepancy between index scores. Given [claimant's] past testing in the Low Average range for certain cognitive areas and his ability to obtain scores in the Low Average range on subtests of the WPPSI-IV, including Matrix Reasoning, Object Assembly, and Bug Search, **it is this evaluator's opinion that he does not qualify for a diagnosis of intellectual disability.** (Bold added.)

With regard to claimant's adaptive abilities, Dr. Redwine noted that his scores fell into the Borderline range overall. His adaptive domain scores ranged from extremely low conceptual abilities to borderline practical abilities, and below average social abilities. "Overall, this clinical presentation is consistent with a child with Borderline to Low Average Cognitive abilities; however his untreated inattention and hyperactivity have significantly and negatively impacted his adaptive functioning and performance on cognitive measures to the extent that he functions in the Borderline range untreated at this present time."

14. Dr. Redwine's Diagnostic Impressions were:

F80.0 Phonological Disorder

Rule out Attention Deficit/Hyperactivity Disorder, Combined Presentation

Cognitive and Adaptive abilities reaching into the Borderline range as measured, and likely reaching into the Low Average range given subtest splinter strengths and previous test results.

History of surgery for umbilical hernia.
Enlarged adenoids, tonsils and turbanoids, by report.

15. One of Dr. Redwine's recommendations was to refer claimant to a mental health agency to assess for the presence of ADHD, and to obtain treatment in the form of therapy and/or medications as appropriate.

Review of Previous Evaluations³ of Claimant

16. A review of claimant's assessments for speech and language by the Elk Grove Unified School District (EGUSD) showed that claimant had delayed expressive vocabulary skills and language. His ability to articulate was significantly below age level expectations. In 2014, he qualified for language, speech and hearing services in the area of articulation and expressive language.

17. Claimant was evaluated through the EGUSD as part of psychoeducational assessments conducted in 2002, 2003 and 2015. His 2015 assessment showed that rating scale data completed by claimant's teacher and parent revealed clinically significant symptoms of ADHD Predominantly Inattentive Type, as well as difficulties forming relationships with peers. Psychoeducational assessments were conducted to identify claimant's learning strengths and weaknesses. The test scores showed claimant's strengths as: friendly and eager to learn; phonological processing; and letter identification. His weaknesses were identified as: distractible at times; below average cognitive ability; and writing skills. The EGUSD determined that claimant did not qualify for special education under the handicapping conditions of intellectual disability or other health impairment, and in general did not appear to meet special education eligibility criteria.

Dr. Redwine's Conclusion on Intellectual Disability

18. Dr. Redwine did not diagnose claimant with an intellectual disability. Although her testing revealed IQ test scores that were lower than the EGUSD's IQ test scores, Dr. Redwine attributed her lower scores, including claimant's full scale IQ of 64, to claimant's inattention during testing. Dr. Redwine therefore recommended that ADHD be ruled out for claimant.

Dr. Redwine's Conclusion on Autism/Autism Spectrum Disorder

19. Dr. Redwine did not evaluate claimant for ASD because claimant was not referred to her for such an assessment. However, Dr. Redwine observed claimant for signs and symptoms of ASD, but did not find any. If she had, she testified credibly that she would have conducted additional testing on claimant.

Claimant's Evidence

20. Claimant relies on a signed letter dated November 19, 2015, written on his behalf by Keather Kehoe, M.D., Child and Adolescent Psychiatrist, River Oak Center for Children. Dr. Kehoe did not testify at hearing. Dr. Kehoe's letter was received in evidence and considered to the extent permitted by Government Code section 11513, subdivision (d).

³ The previous evaluations were received in evidence and considered to the extent permitted by Government Code section 11513, subdivision (d).

Dr. Kehoe performed a psychiatric evaluation of claimant on November 19, 2015. She diagnosed claimant with:

Pervasive Developmental Disorder NOS (PDD NOS) F84.8

Attention Deficit Hyperactivity Disorder, Inattentive Type F90.0

Communication Disorder NOS F80.9

Mild Mental Retardation F70

Her main concern was claimant's "low functional level and that this is not currently being addressed in either the school setting or by Alta California Regional Center." She listed the symptoms consistent with her diagnosis of PDD NOS as: poor socialization with peers; lack of social engagement; pattern of parallel play; documented communication delays. Dr. Kehoe conceded that claimant did not strictly meet the criteria for Autism or Asperger's Disorder, though claimant had a tendency to perseverate, getting stuck on repeating the same verbal phrase over and over again, and being unresponsive to redirection. She noted that claimant's attentional issues were most likely part of his PDD NOS.

Dr. Kehoe further wrote that clinical observation and questioning of claimant was consistent with a low IQ in the range of Mild Mental Retardation, which was reported by prior testing, "though dismissed as due to attentional issues." She described claimant as a "functional toddler in the body of a 7 year old." She opined that "a continued lack of supports will cause him to falter further."

Dr. Kehoe raised concerns with the testing performed by Dr. Redwine. The scores, according to Dr. Kehoe, were consistent with a diagnosis of Mild Mental Retardation. Dr. Kehoe was also concerned that both the school district and Dr. Redwine's testing were reported to be valid measurements of claimant's functioning, "and as such, cannot be reported as invalid for the purposes of qualifying for services because of a potential comorbid ADHD."

Dr. Kehoe noted that the presence of attentional issues does not invalidate the presence of learning and developmental issues. She did not believe that claimant's attentional issues were causing his current functional issues. She noted that claimant could be medicated for his attentional issues and then evaluated at a later date. However, she stated:

I guarantee such a course of action will NOT improve his functional status. His mother has valid concerns for why she wants to limit medication for [claimant], given a poor tolerance of ADHD treatments in his siblings and the fact that his functional issues would still not be addressed.

21. Dr. Kehoe's letter, upon which claimant primarily relies to establish claimant's eligibility for ACRC services, is given little weight. There are a number of deficiencies in her letter as noted below:

One, Dr. Kehoe provided diagnoses that are no longer used in the current Diagnostic and Statistical Manual of Mental Disorders (DSM-V). Dr. Kehoe used the prior version DSM-IV in evaluating claimant. PDD NOS is no longer a current diagnosis in the DSM-V. Communication Disorder is a diagnosis that is no longer used by mental health practitioners, and the same applies to the diagnosis of Mental Retardation. They are terms that are considered obsolete. Moreover, Dr. Kehoe did not use the current DSM-V codes in identifying her diagnoses.

Two, Dr. Kehoe did not identify the DSM-IV or DSM-V criteria, or any standardized testing in assessing claimant for ASD. Unlike Dr. Redwine, it is not known whether Dr. Kehoe is a specialist in diagnosing ASD.

Three, it does not appear from Dr. Kehoe's letter that she provided any standard psychiatric assessments of claimant. Furthermore, Dr. Kehoe did not give a recommendation of treatment for claimant.

Lastly, Dr. Kehoe "guaranteed" that medications would not improve claimant's functional status. Cynthia A. Root, Ph.D. was on ACRC's Interdisciplinary Eligibility Team that reviewed and considered all of claimant's records and information for eligibility purposes. Dr. Root is a licensed staff psychologist with ACRC, and conducts approximately 800 yearly psychological evaluations for children and adults with suspected developmental disabilities, including autism. Dr. Root testified credibly, disagreeing with Dr. Kehoe's assertion that claimant would not improve with medications. Such an assertion, according to Dr. Root, is not in line with best practice standards, which recommend medications and behavioral therapies for school age children diagnosed with ADHD. (*American Academy of Pediatrics, ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents*, Pediatrics, (Oct. 16, 2011), page 2, col. 1.) She stated that medications have a 70 to 80 percent efficacy in terms of lessening symptoms. Dr. Root stated, "In my mind, it's certainly something that needs to be tried." Dr. Root was surprised to find that Dr. Kehoe did not offer "the gold standard path."

22. Claimant's representative also testified on claimant's behalf. She believes that claimant has a developmental disability based upon her knowledge and experience with ACRC involving her eldest son, and as a previous vendor for ACRC as a residential services provider. She asserted that claimant's low functioning IQ has been persistent, and that he has been in therapy for over a year. Claimant's representative disagreed with the EGUSD's March 2015 psychoeducational assessment, because the test scores showed that claimant has low intellectual functioning. Other than her reliance on Dr. Kehoe's report and her own testimony, claimant's representative did not provide any other evidence to establish that claimant has an intellectual disability, autism, or a condition closely related to an intellectual

disability, or that requires treatment similar to that required for individuals with an intellectual disability.

Intellectual Disability

23. It was not demonstrated through other evidence, oral or documentary, that claimant has an intellectual disability. (Findings 1 to 18, 20 to 22.) Accordingly, claimant is not eligible for ACRC services based upon a diagnosis of an intellectual disability.

Autism

24. It was not demonstrated through other evidence, oral or documentary, that claimant has autism. (Findings 1 to 18, 19 to 22.) Accordingly, claimant is not eligible for ACRC services based upon a diagnosis of autism.

Fifth Category

25. In *Mason v. Office of Administrative Hearings* (2001) 89 Cal.App.4th 1119, the appellate court held that “the fifth category condition must be very similar to mental retardation,⁴ with many of the same, or close to the same, factors required in classifying a person as [intellectually disabled]. Furthermore, the various additional factors required in designating an individual developmentally disabled and substantially handicapped must apply as well.” (*Id.* at p. 1129.)

26. It is therefore helpful to review the factors required for a diagnosis of intellectual disability. The DSM-V provides that the “essential features” of intellectual disability (intellectual developmental disorder) are deficits in both intellectual and adaptive functioning 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 result 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

⁴ Mental retardation is no longer a term used under the Lanterman Act or in the DSM-V. The term “intellectual disability” has replaced mental retardation, and is the term in common use by medical, educational, and other professions and by the lay public and advocacy groups. (*Intellectual Disabilities*, DSM-V, 2013, page 33.)

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.

(DSM-V, p. 33.)

Deficits in Intellectual Functioning

Claimant's IQ scores as measured by the EGUSD were in the low average to borderline range, and Dr. Redwine's scores were somewhat lower. Dr. Redwine attributed her lower test scores to claimant's inattention, distraction, chattering, and impulsivity during testing. ACRC persuasively reasoned that claimant's EGUSD test scores were higher because claimant's testing was broken up into smaller increments performed at different times on different days. The significant scatter in Dr. Redwine's subtest scores made her index and full scale IQ scores unreliable, and not a good estimate of claimant's level of intellectual functioning. ACRC further reasoned that children with ADHD often show such scatter in their IQ test scores. Both the EGUSD and ACRC noted ADHD-related concerns due to claimant's inattention. The EGUSD did not find that claimant has any specific learning disabilities or other health impairments requiring special education services. Dr. Redwine did not diagnose claimant with an intellectual disability. ADHD must be ruled out before it can be established that claimant has deficits in his intellectual functions. Claimant does not currently have this "essential feature" of intellectual disability.

Deficits in Adaptive Functioning

27. Claimant's representative acknowledged claimant's borderline test scores, but still believes that claimant must be eligible because deficits in his adaptive functioning suggest that he has a condition closely related to an intellectual disability, or that he requires services or treatment similar to that received by individuals with an intellectual disability. She asserted that claimant presents like a toddler. Claimant needs her to clothe, bathe, feed and direct him. She must ensure his safety because he can easily get lost and has little safety awareness. However, Fifth category eligibility determinations typically begin with a threshold consideration of whether an individual has deficits in intellectual functioning. This is done prior to consideration of other fifth category elements related to similarities between the two conditions, or the treatment needed. Claimant seeks to move past such threshold consideration of intellectual functioning, and focus instead on his significant limitations in adaptive functioning, and need for services similar to that provided to individuals with intellectual disabilities.

28. When considering whether an individual is eligible for regional center services under the fifth category, that eligibility may be based largely on the established need for treatment similar to that provided for individuals with [an intellectual disability], and

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

Fifth Category Eligibility – Condition Closely Related to Intellectual Disability

29. Claimant seeks eligibility based upon his condition being closely related to an intellectual disability, his primary focus being upon his impairments in adaptive functioning. Adaptive functioning refers to how effectively individuals cope with common life demands and how well they meet the standards of personal independence expected of someone in their particular age group, sociocultural background, and community setting.

Claimant's representative's credible testimony demonstrated that claimant needs help in dressing, bathing, feeding and ensuring his personal safety. However, claimant does many things on his own for a seven year old, such as toileting, picking up after himself, and obtaining simple snacks. His adaptive functioning is in the borderline range overall, but does not appear to be substantially impaired. He was administered the ABAS-3 by Dr. Redwine. (Finding 12.) Dr. Redwine noted that claimant's "untreated inattention and hyperactivity have significantly and negatively impacted his adaptive functioning and performance on cognitive measures to the extent that he functions in the Borderline range untreated at the present time."

30. There is no evidence that the deficits in claimant's adaptive functioning are related to any cognitive deficits. In this respect, it does not parallel traditional fifth category analysis that looks for subaverage intellectual functioning "accompanied by" significant limitations in adaptive functioning. If claimant's adaptive deficits indeed derive from his untreated ADHD, such a finding is inconsistent with a finding that his condition is closely related to an intellectual disability. As persuasively stated by Dr. Redwine, claimant's deficits in adaptive functioning are better addressed by medications or behavior therapies that focus on his inattention and impulsivity issues.

In this case, claimant's borderline range of intellectual functioning and his adaptive deficits caused by ADHD (if diagnosed), do not manifest as a condition similar to an intellectual disability.

Fifth Category Eligibility – Condition Requiring Treatment Similar to that Required by Individuals with an Intellectual Disability

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

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

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

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

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

32. Fifth category eligibility must be based upon an individual requiring “treatment” similar to that required by individuals with an intellectual disability. The wide

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

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

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

Thus, while fifth category eligibility has separate condition and needs-based prongs, the latter must still consider whether the individual’s condition has many of the same, or close to the same, factors required in classifying a person as having an intellectual disability. (*Mason v. Office of Administrative Hearings*, *supra*, 89 Cal.App.4th 1119.) Furthermore, the various additional factors required in designating an individual as developmentally disabled and substantially handicapped must apply as well. (*Id.* at p. 1129.) *Samantha C.* must therefore be viewed in context of the broader legislative mandate to serve individuals with developmental disabilities only. A degree of subjectivity is involved in determining whether the condition is substantially similar to an intellectual disability and requires similar

treatment. (*Id.* at p. 1130; *Samantha C. v. State Department of Developmental Services*, *supra*, 185 Cal.App.4th 1462, 1485.) This recognizes the difficulty in defining with precision certain developmental disabilities. Thus, the *Mason* court determined: “it appears that it was the intent of those enacting the Lanterman Act and its implementing regulations not to provide a detailed definition of ‘developmental disability’ so as to allow greater deference to the [regional center] professionals in determining who should qualify as developmentally disabled and allow some flexibility in determining eligibility so as not to rule out eligibility of individuals with unanticipated conditions, who might need services.” (*Id.* at p. 1129.)

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

Claimant’s Treatment Needs

34. Dr. Root provided persuasive testimony on the best practice guidelines for treating ADHD in children and adolescence. According to the Clinical Practice Guideline published by the American Academy of Pediatrics, the primary care clinician should prescribe U.S. Food and Drug Administration-approved medications for ADHD and/or evidence-based parent and/or teacher-administered behavior therapy as treatment for ADHD, preferably both, for elementary school-aged children, ages six to 11 years. Medications and behavioral therapy are also recommended by the American Academy of Child and Adolescent Psychiatry and the American Psychiatric Association. Dr. Redwine concurred with this “gold standard path,” and recommended, along with the EGUSD, that claimant be assessed for ADHD. Dr. Redwine and Dr. Root made no other treatment suggestions.

35. The above matters have been considered, along with the relative experience and expertise that Dr. Redwine and Dr. Root have in assessing individuals with developmental disabilities. This is a case where deference should properly be given to ACRC professionals in determining eligibility. (*Mason v. Office of Administrative Hearings*, *supra*, 89 Cal.App.4th 1119, 1129.) Claimant did not call witnesses who were specialists in the field and had the educational or professional experience commensurate with Dr. Redwine or Dr. Root. It does appear that claimant’s adaptive behavior deficits arise from his undiagnosed ADHD, and not a developmental disability. Under these circumstances, it cannot be found that he requires treatment similar to that received by individuals with an intellectual disability.

36. In reaching this conclusion, it was also determined that claimant did not demonstrate that treatment for individuals with ADHD is similar to treatment for individuals with an intellectual disability. Dr. Root summarized recommendations for treatment of ADHD published by the American Academy of Pediatrics and the American Academy of Child and Adolescent Psychiatry and the American Psychiatric Association. She testified that the gold standard treatment is medication and behavioral therapy. Dr. Redwine concurred. Dr. Redwine testified that claimant did not have a condition closely related to an

intellectual disability, or required treatment similar to that required for individuals with an intellectual disability.

37. It was not established that claimant is eligible to receive regional center services and supports by reason of a condition found to be closely related to an intellectual disability or to require treatment similar to that required for individuals with an intellectual disability. Claimant does not have a condition that is closely related to an intellectual disability. He has borderline general intellectual functioning. Recommended assessment of his ADHD is not suggestive of it being a condition similar to an intellectual disability. Claimant has significant deficits in adaptive functioning. However, these deficits do not result from any deficits in general cognitive ability. They likely result from difficulties with attention and impulsivity characteristic of ADHD. ADHD is a psychiatric disorder requiring mental health treatment, very different than that provided for individuals with an intellectual disability. As such, claimant does not have a developmental disability as defined under the Lanterman Act and claimant does not qualify for services through ACRC.

LEGAL CONCLUSIONS

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

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

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

3. In seeking government benefits, the burden of proof is on the person asking for the benefits. (See, *Lindsay v. San Diego Retirement Bd.* (1964) 231 Cal.App.2d 156, 161

(disability benefits.) The standard of proof in this case is a preponderance of the evidence, because no applicable law or statute (including the Lanterman Act) requires otherwise. (Evid. Code, § 115.) Because claimant is requesting services and supports not authorized by ACRC, he bears the burden of proof.

4. It was not established that claimant has a developmental disability that originated before age 18 and that continues, and that constitutes a substantial disability for him. He does not have an intellectual disability. (Finding 23.) He does not have autism. (Finding 24.) He does not have a disabling condition closely related to intellectual disability or requiring treatment similar to that required for individuals with an intellectual disability, or otherwise qualifies under the fifth category. (Findings 25 to 37.) Claimant is therefore not eligible to receive services through Alta California Regional Center.

ORDER

Claimant's appeal from the Alta California Regional Center's denial of services is denied. Claimant is not eligible for services under the Lanterman Act at this time.

DATED: December 31, 2015

DANETTE C. BROWN
Administrative Law Judge
Office of Administrative Hearings

NOTICE

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