

BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT,

and

FAR NORTHERN REGIONAL CENTER,

Service Agency.

OAH Case No. 2015070046

DECISION

Administrative Law Judge Marilyn A. Woollard, Office of Administrative Hearings (OAH), State of California, heard this matter in Redding, California, on March 24, 2016.

Claimant was represented by his Mother and authorized representative (Mother).¹

Far Northern Regional Center (FNRC) was represented by Phyllis J. Raudman, Attorney at Law.

Oral and documentary evidence was presented and the parties offered oral closing arguments. The record was then closed and the matter was submitted for decision on March 24, 2016.

ISSUE

Did claimant establish that he has a “developmental disability” within the meaning of the Lanterman Act, Welfare and Institutions Code section 4500 et seq.,² based on autism, intellectual disability, and/or what is known as the “fifth category,” i.e., “a disabling

¹ The names of claimant, his mother and family members are subject to the March 28, 2016 Protective Order and Order Regarding Confidential Names and Confidential Names List.

² Unless otherwise indicated, all statutory references are to the Welfare and Institutions Code.

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

FACTUAL FINDINGS

1. On January 28, 2015, FNRC Intake Specialist Wendy Bell conducted a Social Assessment of claimant after Mother requested an evaluation for services due to suspicions that he had an Autism Spectrum Disorder (ASD). Mother provided most of the background and history for this assessment. She reported that claimant’s current diagnoses include asthma, Bipolar Disorder, Attention Deficit Hyperactive Disorder (ADHD) and Tourette’s syndrome, and that his medications include Loratadine, Vyvanse, Benztropine, Kapvay, Lamictal, Seroquel, Seroquel XR, Omeprazole and Albuterol. Mother indicated that claimant has few friends and that his friends are either “special needs” or on the autism spectrum. She was concerned that claimant will have a difficult time with independent living skills after he turns 18.

Claimant was referred by FNRC to J. Reid McKellar, Ph.D., for assessment. Dr. McKellar concluded that claimant did not meet the criteria for an ASD diagnosis.

2. On June 10, 2015, FNRC issued a Notice of Proposed Action (NOPA) for “case closure,” indicating that after reviewing claimant’s psychological and school records, it determined that he was not eligible for regional center services because he “does not have intellectual disability and shows no evidence of epilepsy, cerebral palsy, autism, or disabling condition found to be closely related to intellectual disability or to require treatment similar to that required for individuals with intellectual disability” (fifth category). The NOPA indicated that claimant’s “psychological records show evidence of Bi-Polar Disorder, Generalized Anxiety Disorder, Tourette’s syndrome and a history of [ADHD] but they are not qualifying conditions for regional center services.”

3. On June 28, 2015, Mother signed a Fair Hearing Request, explaining that claimant had been denied services “even though [he] has been diagnosed as having autism spectrum disorder by his psychiatrist Dr. Lynne Pappas who has been treating [claimant] for many years. [Claimant] struggles to function in many areas, especially socially, and is in desperate need of services.” To resolve the issue, Mother wrote that claimant needs regional center services “(i.e. a day program or work services) . . . to help him be able to work in today’s society with his disabilities.”

4. The case was set for hearing on August 18, 2015. On August 14, 2015, the parties met for an informal meeting at FNRC. Dr. Pappas participated and argued that claimant should also be considered for eligibility under the fifth category due to a “fixed neurological handicap.” Claimant said he wanted to become a regional center client because he wanted to be in his aunt’s day program. Mother signed a time waiver and the case was then continued periodically for further evaluations.

During this time, FNRC's staff psychologist Dr. Bob Boyle completed another cognitive evaluation and claimant was referred for another ASD evaluation by Dr. Monica Silva. In his October 13, 2015 psychological assessment, Dr. Boyle concluded that claimant did not meet the *Diagnostic and Statistical Manual, Fifth Edition (DSM-V)* criteria for ASD, intellectual disability, or the fifth category. In her January 8, 2016 psychological evaluation, Dr. Silva concluded that claimant did not meet the *DSM-V* criteria for ASD.

5. At the March 24, 2016 hearing, claimant asserted eligibility under three categories: autism (ASD), intellectual disability, and/or the fifth category. FNRC called Dr. Boyle and Lisa Benaron, M.D., as witnesses. The following witnesses testified for claimant: Mother, claimant's Aunt, and Dr. Pappas.³ The testimony of these witnesses is paraphrased as relevant below.

Lanterman Act Eligibility

6. The Lanterman Act, in section 4512, subdivision (a), provides the following definition of the "developmental disability" required for eligibility:

(a) "Developmental disability" means 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.

7. Section 4512, subdivision (1), defines substantial disability as follows:

(1) "Substantial disability" means the existence of significant functional limitations in three or more of the following areas of major life activity, as determined by a regional center, and as appropriate to the age of the person:

- (A) Self-care.
- (B) Receptive and expressive language.
- (C) Learning.
- (D) Mobility.

³ On March 16, 2016, an order was issued granting claimant's unopposed request for testimony from Dr. Pappas by telephone.

- (E) Self-direction.
- (F) Capacity for independent living.
- (G) Economic self-sufficiency.

8. California Code of Regulations, Title 17, section 54000, clarifies the Lanterman Act's definition of developmental disability and identifies three excluded conditions. It provides:

(a) "Developmental Disability" means a disability that is attributable to mental retardation, cerebral palsy, epilepsy, autism, or disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation.

(b) The Developmental Disability shall:

- (1) Originate before age eighteen;
- (2) Be likely to continue indefinitely;
- (3) Constitute a substantial disability for the individual. . .

(c) Developmental Disability shall not include handicapping conditions that are:

(1) Solely psychiatric disorders where there is impaired intellectual or social functioning which originated as a result of the psychiatric disorder or treatment given for such a disorder. Such psychiatric disorders include psycho-social deprivation and/or psychosis, severe neurosis or personality disorders even where social and intellectual functioning have become seriously impaired as an integral manifestation of the disorder.

(2) Solely learning disabilities. A learning disability is a condition which manifests as a significant discrepancy between estimated cognitive potential and actual level of educational performance and which is not a result of generalized mental retardation, educational or psycho-social deprivation, psychiatric disorder, or sensory loss.

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

Claimant's Background

9. *Testimony of Claimant's Mother:* Claimant is 18 years old and lives with his family. Claimant was Mother's fourth child. He was born very ill, following a traumatic pregnancy. He had pneumonia, a sepsis blood infection, was put on a ventilator and hospitalized for 16 days after birth. He developed Supraventricular tachycardia (SVT). Mother describes claimant as a wonderful and loving child who struggles. Claimant has an older brother who is an individual with an intellectual disability. Mother started noticing that no one could categorize claimant and that he seemed to require similar treatment and repetitive instructions like his older brother. Claimant's aunt operates a day treatment program for adults with developmental disabilities. Mother hopes that claimant can attend the same program with his brother.

Claimant was in special education most of his school life, under the eligibility category of "specific learning disability." According to Mother, the school used this label for claimant because it did not know where else to put him. Claimant was treated by Dr. Pappas between the ages of five and seven. He saw Dr. Pappas for medication management, initially for ADHD and later, after Dr. Pappas diagnosed claimant with Bi-Polar Disorder. In 2014, Dr. Pappas diagnosed claimant with Tourette's syndrome based on his verbal tics and repetitive coughing. In addition to medication management, Dr. Pappas has periodically seen claimant for counseling.

Based on her experience with claimant's older brother, Mother believes claimant functions more like a 10-to-12 year old than an 18-year-old. She provided detailed testimony about claimant's background and abilities, including his adaptive functioning. For example, Mother believes claimant can be easily victimized and has seen him give away his money to strangers; he gets lost without help, even with explicit directions; he needs information and instruction in very small steps, with repeated reminders; he wants to please and perform but is not capable of functioning; he is much slower than others in accomplishing tasks; he cannot budget or manage money or his medications; and he lacks a sense of urgency in responding to a crisis. Mother indicated that claimant has one younger friend who is intellectually disabled. They watch movies together. He had a girlfriend for one month, but did not understand that he needed to call or text her. He has played on a Challenges baseball team for students with developmental delay for many years and he has always been in adaptive physical education (APE) because he is clumsy. In Mother's experience, claimant is very similar to, and needs the same type of treatment as, individuals with intellectual disability because he cannot apply his higher IQ scores to life. She believes claimant will never be able to live alone, but will require supervision or assistance, and that he would benefit from daily reminders and instruction from a program for independent living.

10. *Testimony of Claimant's Aunt:* Claimant's aunt (Aunt) owns a supported living facility and career center for people with FNRC benefits and has worked for 25 years with adults with developmental disabilities. She testified as a percipient witness.

Aunt has spent time working with claimant over the years and attested to his functional and social delays. She described having to consistently redirect claimant to stay on task. Claimant needs written, two-step directions to complete tasks. He becomes confused and upset if more steps are provided. Aunt has worked with claimant on his poor communication skills; his lack of social cues (under or over reacting, bringing up unrelated topics, monopolizing conversations); and his poor self-care and problem-solving skills (requiring constant reminders about hygiene and extensive time to choose between two options). In her experience, claimant does not understand “friend or foe.” He is vulnerable to strangers and has poor safety and money-management skills. Aunt believes that many of claimant’s needs are as or more intense than those of the developmentally delayed adults with whom she works. The treatment she has provided claimant is identical to what she provides to the adults she serves.

ASSESSMENTS

A. *Claimant’s Special Education Triennial Evaluation and IEP*

11. Documents were provided from claimant’s March 13, 2014 special education triennial evaluation through the Shasta County Special Education Local Plan Area (SELPA), conducted when he was 16 years old and in the 11th grade. These included a Triennial Health Update; an Individualized Education Program (IEP), and a Psycho-educational Evaluation, which reported the results of claimant’s intellectual and academic testing during the February 2011 triennial evaluation, as well as current results.

12. *Wechsler Intelligence Scale for Children-Fourth Edition (WISC-IV)*: The WISC-IV is comprised of 10 subtests in four broad areas: Verbal Comprehension (similarities, vocabulary and comprehension), Perceptual Reasoning (block design, picture concepts, matrix reasoning), Working Memory (digit span and letter-number sequencing) and Processing Speed (coding and symbol search). A Full Scale intelligence quotient (IQ) is derived from these subtests. In February 2011, claimant’s WISC-IV scores were in the Average range (91) in Verbal Comprehension, Perceptual Reasoning and Working Memory; and in the Very Low range (56) for Processing Speed. This resulted in a Borderline Full Scale IQ score of 83.

In March 2014, claimant’s WISC-IV scores were in the Average range for his non-verbal abilities as measured by the Perceptual Reasoning Index (106; above approximately 66 percent of his peers); in the Average range for ability to sustain attention, concentration and exert mental control as measured by the Working Memory Index (99; above approximately 47 percent of his peers); in the Low Average range on the Verbal Comprehension Index (85); and in the Very Low range in ability to process simple or routine visual materials without errors as measured by the Processing Speed Index (68; above approximately two percent of his peers). Claimant’s Full Scale IQ was 87, in the Low Average range of intellectual functioning (overall thinking and reasoning abilities exceeded those of approximately 19 percent of his peers). Processing speed was determined to be a significant weakness for him.

13. *Academic Achievement:* Claimant's academic achievement for the triennial evaluation was assessed with the Woodcock-Johnson III Test of Achievement (WJ-III), which measures academic achievement in reading, mathematics and written expression for ages 3 through 80, with specific subtests.

a. Math: Claimant scored in the Low Average range for Math, with standard scores of 88 (21st percentile) for Broad Math and 89 (24th percentile) for Math Calculation. He was found to have average skills in math calculation (100), but in math fluency, which measures speed and accuracy in solving simple math problems, claimant had borderline skills (73). In the applied problems subtest, which measures skills in reasoning, measurement and time, claimant obtained an average range score (91).

b. Reading: Claimant scored at the Borderline range for reading. He achieved standard scores of 81 (10th percentile) in Broad Reading and Passage Comprehension; and a standard score of 73 (4th percentile) on Reading Fluency.

c. Writing: Claimant scored at the Borderline range in writing. He achieved a standard score of 84 (14th percentile) on Broad Written Language Skills, and of 81 (10th percentile) on Written Expression. He was found to be capable of written expression as demonstrated in his Writing Samples, which scored in the Average range (109), and his Spelling Skills were in the Average range (93). His Written Fluency, a measure of speed and accuracy in writing, was very low (62).

d. Academics: Claimant's academics scored in the Very Low to Average Range. He was measured in the Average range (93; 31st percentile) in Academic Skills (letter-word identification, calculation and spelling); in the Very Low range (62; 1st percentile) in Academic Fluency (in reading, math and writing); and in the Low Average range (89; 23rd percentile) in Academic Applications (passage comprehension, applied problems and writing samples).

14. *Social, Behavioral and Adaptive Behavior:* The March 2014 triennial Psychosocial Evaluation also described claimant's behavior at school. In the area of "social/behavioral functioning," claimant was characterized as having "matured greatly over the last two years. He has had no discipline problems this year. [Claimant] has excellent attendance and earned a 4.0 last semester. This is not an area of concern..." Under Adaptive Behavior, the evaluation indicated that claimant "can care for all of his independent needs while at [high school]. This is not an area of concern; current assessments are not needed at this time."

15. *Perceptual and Perceptual Motor Skills:* The 2014 evaluation reported that, in February 2011, claimant was assessed with the following instruments:

(a) the WRAML-2 [Wide Range Assessment of Memory and Learning, Second Edition] which indicated he had "Average Memory both Verbally and Visually" and Average Range "Attention/Concentration...";

(b) the “VMI” [Beery-Buktenica Developmental Test of Visual-Motor Integration] which indicated “Borderline Visual Motor Integration, Average Visual Perception and Very Low Motor Coordination”; and

(c) the TAPS-3 [Test of Auditory Processing Skills –Third Edition], which indicated “Average Auditory Processing skills.”

16. *Triennial Health Update:* This update included a review of claimant’s current health concerns, a direct assessment of his vision, hearing and dental needs, a review of his records and a telephone interview with Mother. As relevant to the issue for this decision, Current Health Concerns noted that claimant: “has a history of ADHD and Bipolar disorder. He received his mental health care from Dr. Pappas. [He] takes a number of medications including Vivance and Kapvay for ADHD, Lamictal and Seroquel for mood, Benztropine for muscle spasms....”

17. *Individualized Education Program:* Claimant’s March 13, 2014 IEP documents his primary special education eligibility category as Specific Learning Disability (SLD).⁴ The determination of SLD was based upon the IEP team’s finding, after a review of claimant’s assessments, that there is “a severe discrepancy between measures of intellectual ability and one or more of the following areas of achievement ... Written Expression... [and] Reading Fluency...” This discrepancy was found to be directly related to a processing disorder in the areas of “sensory motor skills.” The team also found that “the discrepancy was not due primarily to intellectual disability, or emotional disturbance.”

The IEP indicated that claimant’s anticipated high school completion date was June 1, 2015, with a diploma and reported that claimant passed his California High School Exit Examination (CAHSEE) in both English Language Arts and in Math, at a Basic level, on February 5, 2013. The IEP referenced claimant’s history of various conditions including, “SVT, Bi-Polar disorder, ADHD, and Reactive Airway Disease.” The IEP contained no mention of autism or ASD and indicated that claimant had no behaviors that impeded his learning or that of others; consequently, there was no need for a behavioral goal or behavioral intervention plan. Claimant’s IEP services included: 50 percent of his time in the regular classroom and 50 percent in specialized academic instruction in a separate classroom; APE; college and career awareness; and “extra time on tests, small group setting, graphic organizers, visual and hands-on activities, allow for testing in alternate setting, preferential seating, and frequent breaks as needed and test retakes.”

Mother and claimant both signed their agreement with the IEP on March 13, 2014. In June 2015, claimant graduated from high school with a regular diploma, rather than the certificate of completion received by many special education students.

⁴ The IEP indicates that the next annual IEP would be due March 12, 2015, three months prior to claimant’s graduation. A more recent IEP was not provided.

B. *Claimant's Eligibility Assessments for Regional Center Services*

18. *Dr. McKellar's Psychological Evaluation:* On May 15, 2015, on FNRC's referral, Dr. McKellar tested claimant using the Autism Diagnostic Observation Schedule – 2 Module 4 (ADOS-2), which he reviewed in conjunction with the *DSM-V* criteria for ASD, and the Millon Adolescent Clinical Inventory. For this evaluation, Dr. McKellar reviewed FNRC's Social Assessment, the educational documents addressed above, claimant's academic transcripts for 2015, his Assertive Discipline Records (8/19/2011 – 9/12/2012) and medical records from Dr. Pappas. Dr. McKellar also interviewed Mother who completed the Adaptive Behavior Assessment System – Second Edition (ABAS-II). At Mother's request, Dr. McKellar also spoke to one of claimant's classroom teachers.

In describing claimant's relevant background, Dr. McKellar reported that claimant was described in the records: "as a 'moody' child who has difficulty adjusting to transitions and deficits in frustration tolerance;" as one who "can be physically and verbally aggressive when agitated," with a history of self-injurious behavior; and as having "a history of repetitive body movements (body rocking) and . . . seeming to be in his own world..." According to Mother, claimant "was diagnosed with Bi-Polar Disorder at a very young age, and he exhibited prominent features of mood instability, limited frustration tolerance and marked deficits in impulse control. There is a prominent family history of Bipolar Disorder..." that included a brother diagnosed with Bipolar Disorder with psychotic features. Mother reported that:

[claimant] has a long history of Social Anxiety, and his anxiety is most prominent in group settings. [Mother] explained that in one to one settings, [claimant] is able to engage in reciprocal conversations, he is fairly adept at reading non-verbal cues, he has a fair sense of humor and he exhibits use of expressive gestures and social smiles. However, in group settings, especially peer settings, [claimant] is extremely inhibited, insecure and he does not initiate interactions with others.

[Mother] expressed the opinion that [claimant's] presentation "is more than just Bipolar," and she indicated that one of Devin's teachers suggested a diagnosis of Asperger's Disorder. In regards to Asperger's Disorder, [Mother] emphasized that [claimant] has difficulty interacting in group settings, he is extremely insecure, and he has a history of "collecting things. . . [claimant] tends to have intense interests that change over time, and as an example she reported that in the past [claimant] collected "bullet shells, and he would line them up."

Claimant's teacher later told Dr. McKellar that claimant "was a capable student, although his academic efforts were often impeded by medication side effects." The teacher did not observe claimant to exhibit behavior suggesting the presence of Asperger's Disorder, "although he did observe that [claimant] has extremely strong math skills."

19. During his clinical interview, Dr. McKellar observed claimant to be “a shy, sweet tempered and expressive adolescent who warmed up slowly during the evaluation process.” Claimant told his Mother he loved her as he left her, responded appropriately to Dr. McKellar’s social greetings, praise and humor, and he “exhibited well-modulated eye contact, a responsive social smile, and affectively congruent facial expressions.” Claimant was initially hesitant in his communication and showed prominent features of low self-esteem. During the evaluation, claimant began to speak very openly and expressively about past and present issues, “with a fair degree of insight” and awareness of his “perceived deficits.” He had “effective verbal intonation, fair use of pragmatics, and conversational pauses.” The conversation was reciprocal. Claimant was unsure whether he had Tourette’s, but he acknowledged that he makes noises “and it annoys people.” He discussed his anxiety about completing school so he could graduate and his desire to have more friends. He disclosed that he did not have many friends, and said he had only one close friend.

20. *ADOS-2*: The ADOS-2 is a semi-structured, standardized assessment of communication, reciprocal social interaction, play/imaginative use of materials, and stereotyped behaviors and restricted interests for individuals referred due to the possible presence of ASD. Dr. McKellar found that claimant’s “performance on the ADOS-2 resulted in a score of 2, which is well short of threshold for an ADOS-2 classification of Autism or Autism Spectrum.” Claimant engaged in reciprocal conversations with a wide variety of expressive gestures; he exhibited “well modulated eye contact” with “facial expressions that were “expressive and affectively congruent”; he exhibited some creative and imaginative actions; and “did not exhibit unusual sensory interests, complex mannerisms, repetitive behaviors or unusually intense interests.”

21. *DSM-V Criteria*: Dr. McKellar also reviewed claimant in light of the *DMS-V* criteria. Claimant did not demonstrate “persistent deficits in social communication and social interaction across multiple contexts” as required under Criteria A, meeting only one of the three required items. Claimant did not demonstrate deficits in social-emotional reciprocity (A1). While claimant struggles in group settings, he is able to communicate one to one quite effectively, with a “sound awareness of social emotions, a fair sense of humor” and an ability “to participate in to and fro conversations.” Claimant did not demonstrate “deficits in non-verbal communication behaviors used for social interaction” (A2). By contrast, claimant “exhibits use of flexible eye contact and expressive gestures ... [and] responds appropriately to the demonstrated affect of others.” Claimant did demonstrate deficits in developing, maintaining and understanding relationships (A3), based on reports of low self-esteem and difficulty making friends. Regarding “restricted, repetitive patterns of behavior, interests or activities,” (Criteria B), Dr. McKellar concluded that claimant did not meet any of the criteria. Dr. McKellar concluded that claimant did not meet the *DSM-V* diagnostic criteria for ASD.

22. *Adaptive Behavior Assessment System – Second Edition (ABAS-II)*: Mother completed the ABAS-II for the evaluation. Based on her reports, claimant scored in the “average” range in communication; in the “borderline” range in leisure; and at the below average range in community use, functional academics, home living, health and safety, self-care, self-direction, and social. Composite adaptive scores were: General Adaptive Composite

score of 73 (fourth percentile); Conceptual Composite score of 83 (13th percentile); Social Composite score of 75 (5th percentile); and Practical Composite score of 82 (12th percentile).⁵

23. *Millon Adolescent Clinical Inventory (MACI)*: Claimant completed this self-report measure of concerns, personality patterns and clinical syndromes. The MACI profile, which Dr. McKellar deemed valid, indicated that claimant has low self-confidence in interpersonal relationships and is “likely to assume a submissive stance in peer interactions.” He endorsed items “suggesting the prominent presence of an Anxiety disorder,” as well as “a persistent presence of mild depressive symptoms.”

24. Dr. McKellar reported the following *DSM-V* diagnoses for claimant based on history: Bipolar II Disorder; Generalized Anxiety Disorder, and Tourette’s Disorder. He concluded that claimant “does not meet diagnostic criteria for Autism Spectrum Disorder, however, he does suffer from largely untreated Anxiety. Typically, symptoms of Anxiety do not respond to medication treatment without the use of adjunctive, empirically validated therapy. [Claimant] has received traditional, process focused counseling in the past, however, he would benefit from more diagnostically specific therapies.” Dr. McKellar recommended that claimant receive “therapeutic treatment that targets his prominent symptoms of Anxiety, particularly performance anxiety and social anxiety. Treatment should emphasize the use of cognitive behavioral techniques, in particular behavioral rehearsal, addressing negative cognitions and schema work.” He also recommended that claimant receive “vocational assessment and coaching to help plan a stepwise transition from high school to vocational/educational training.”

25. *Dr. Boyle’s Psychological Evaluation*: On September 25, 2105, FNRC Staff Psychologist Dr. Boyle assessed claimant by clinical interview and with the Wechsler Adult Intelligence Scale, Fourth Edition (WAIS-IV) to gain a better sense of claimant’s intellectual and adaptive functioning for potential regional center eligibility. He also conducted a clinical interview with Mother and reviewed previous educational assessments, Dr. Pappas’ medical notes and Dr. McKellar’s psychological evaluation, with the ABAS adaptive functioning information reported by Mother.⁶ Based on this evaluation, Dr. Boyle concluded that claimant did not meet any of the eligibility conditions for regional center services.

⁵Mother believed that Dr. McKellar’s assessment was not accurate because he missed an appointment with her and then called her while she was shopping. She did not have any of her notes, forgot things and answered some questions incorrectly. Mother also noted that claimant was her fourth child and her own memory of his early development was poor. In her opinion, Dr. Silva’s test, discussed *infra*, more accurately reflects claimant’s adaptive functioning abilities.

⁶ Dr. Boyle interviewed claimant conjointly with his Mother. In discussing claimant’s educational history, Mother told Dr. Boyle that claimant receives Social Security for “Bipolar and ADHD. Since he was turned down by the Regional Center, they are trying to take his Social Security away.”

In his clinical interview with claimant, Dr. Boyle noted that rapport was easily established. Claimant was cooperative, alert and oriented, presented no speech difficulties, had average vocabulary and was able to carry on a “to-and-fro conversation without any problem.” Claimant maintained “excellent eye contact throughout the interview.” Despite his history of Bipolar Disorder, his mood was euthymic (calm, neither manic nor depressive), and he displayed a normal range of affect. Claimant demonstrated “great difficulty being able to engage in abstract thinking,” and he reported having “no idea” how to interpret three common proverbs (for example, “a stitch in time saves nine”). His level of practical intelligence seemed adequate. Claimant reported that he spends most of his days in his bedroom on the Internet, watching television or movies. He enjoys music. He had a few friends, but had likely not seen them since graduation, and he had a girlfriend for one month.

26. *WAIS-IV*: Dr. Boyle characterized the *WAIS-IV* as the “gold standard” for determining intellectual functioning in adults. Claimant gave good effort on this test, demonstrating adequate concentration, focus and persistence. His scores were:

Verbal Comprehension	83
Perceptual [non-verbal reasoning]	88
Working Memory	83
Processing Speed	84
Full Scale IQ	81

Claimant’s full scale IQ of 81 is in the borderline/low average range. Dr. Boyle’s diagnostic impressions for claimant were: Learning Disorder; and, by history, Tourette’s, Bipolar Disorder and Generalized Anxiety Disorder.

27. The *DSM-V* diagnostic criteria for Intellectual Disability is 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 result in failure to meet developmental and socio-cultural 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. (Underlining supplied.)

Dr. Boyle concluded that claimant did not meet the three *DSM-V* criteria for a diagnosis of Intellectual Disability. Dr. Boyle explained that claimant's IQ scores on the WAIS-IV "are consistent with intellectual functioning in the borderline/ low average range. In the past, he has scored even higher on IQ testing (average range). Since [claimant] does not meet this first criterion (deficits in intellectual functions), he does not meet the criteria for an intellectual disability." Dr. Boyle relied on Dr. McKellar's evaluation and conclusion that claimant did not qualify based on ASD.

28. Regarding fifth category eligibility, Dr. Boyle opined:

[claimant's] IQ scores (high borderline – average range) are not uniformly low and are dissimilar to an individual with an intellectual disability. Regarding requiring services similar to an individual with an intellectual disability, [claimant's] higher intellectual capacity causes him to function at a higher level than those individuals that have an intellectual disability. His mother had completed an ABAS questionnaire during Dr. McKellar's ASD evaluation, and she gave him scores in the borderline and low average range.

29. *Dr. Silva's Psychological Evaluation:* On January 8, 2016, clinical psychologist Monica Silva, Ph.D., conducted a focused psychological evaluation of claimant to assess him for ASD and to determine his adaptive level of functioning. For the evaluation, Dr. Silva met with claimant, his mother and stepfather and she obtained an extensive psychosocial history. She reviewed previous evaluations, administered the ADOS-2 (Module 4) and had Mother complete the ABAS-III. She noted that claimant "has a complex psychiatric history dating to a young age and previous diagnoses of Bipolar Disorder, ADHD, Generalized Anxiety Disorder and Tourette's Disorder" and had been prescribed numerous psychotropic medications.

30. *ADOS-2 and ASD under the DSM-V:* Dr. Silva determined that claimant did not meet or exceed the Autism Spectrum cutoff on the ADOS-2.

a. Claimant's Communication total was a 1. The ADOS-2 cutoff is 3 for Autism and 2 for Autism Spectrum. Dr. Silva noted that claimant was talkative and seemed interested in engaging verbally with an unfamiliar adult. Although he spoke rapidly when excited, there were no atypicalities noted in claimant's speech. He had repetitive coughing, which seemed to be a tic-like behavior. He shared thoughts, feelings and experiences spontaneously. Conversational reciprocity was a "mild area of concern," based on claimant's tendency to monopolize conversation, but claimant left appropriate pauses and seemed open to questions

and comments. Claimant was able to engage in reciprocal verbal interchanges more effectively with basic scaffolding. Dr. Silva found claimant's nonverbal communication abilities to be "well-developed" as exhibited by his use of nonverbal gestures and pantomime while sharing information.

Claimant's Social Interaction total was a 2. The ADOS-2 cutoff is 6 for Autism and 4 for Autism Spectrum. Claimant seemed "immediately comfortable" talking socially with an unfamiliar adult. He was easily engaged, had good nonverbal communication, with appropriate eye contact and a range of facial expressions and nonverbal gestures coordinated with his speech. He had a good sense of humor, which included "a healthy self-deprecating sense of humor" when he shared "some of his quirks without seeming overly preoccupied with those." Dr. Silva observed claimant to be able to express information about his emotional state and able to spontaneously pick up on the thoughts and emotions of characters he was shown from a book. He was able to lament his own history of having been bullied and teased by peers and he acknowledged that peers have become exasperated by his tendency to "talk too much." Claimant reported having a friend and seemed to be "a social individual who craves connectedness, though relating socially has been difficult for him." Claimant presented "with a palpable social immaturity and though insightful regarding some of his challenges, one questioned his ability to apply that insight to assist him in managing social situations." He presented as an "immature adolescent" who had limited mastery over his actions or specific ideas or plans about how to accomplish his goals.

Dr. Silva found that claimant had a creative imagination. Regarding "stereotyped behaviors and restricted interests," claimant did not seem to perseverate during the evaluation. Claimant did report that he watches movies repetitively for extended periods of time and has collections, including of rocks and bullet casings. Dr. Silva observed that claimant "presented with a mildly higher-than-average level of activity and could present as somewhat impulsive in his exuberance."

Claimant's total Communication/Social Interaction score was a 3. The ADOS-2 cutoff is 6 for Autism and 4 for Autism Spectrum.

b. Based on her review of the *DSM-V* criteria for ASD, Dr. Silva concluded that claimant did not meet all three required components of Criteria A, "persistent deficits in social communication and social interaction across multiple contexts..." Claimant did meet A3 ("deficits in developing, maintaining, and understanding relationships..."), based on his social and verbal immaturity and difficulty relating socially to typical peers, rather than the younger or special needs individuals to whom he typically relates. Claimant met at least two components of Criteria B ("restricted, repetitive patterns of behavior, interest, or activities..."), by showing "mild" repetitive behaviors (B1) such as rocking and head banging (reported to, but not observed by, Dr. Silva), and mild sensory integration issues (B4) to certain sounds and visual

stimuli. Claimant also met B3, based on his reported propensity to focus strongly on certain objects and interests. Claimant's symptoms did not meet Criteria C through E.⁷

31. *Adaptive Functioning:* Mother completed the ABAS-III, a revised version of the ABAS-II, which she previously completed for Dr. McKellar. Based on mother's report, claimant's adaptive level was "Extremely Low" (the lowest rating) in General Adaptive Composite (67), Social (66), and Practical (67) domains, and "Low" in the Conceptual (75) domain, with some variability in specific skill areas. Dr. Silva reported that mother's ratings indicate that claimant:

... presents with delays in his day-to-day adaptive abilities in comparison to similarly-aged peers. Adaptive skills range from Extremely Low to Below Average. Though he is able to complete day-to-day tasks independently in some respects, he requires prompts, reminders and assistance to do so. His rate of completion of activities was described as slow. Executive functions and self-direction were noted to be poor and he requires fairly intensive adult supports in to [sic] function on a day-to-day basis.

32. Based on her assessment and record review, Dr. Silva opined that the WAIS-IV results from Dr. Boyle's evaluation (Finding 26) provide the most accurate assessment of claimant's cognitive potential, and place him in the Low Average range. By contrast, his adaptive scores as reported by mother, range from extremely low to below average. Dr. Silva concluded that:

[claimant] does not present with the global cognitive delays characteristic of an Intellectual Disability or Borderline Intellectual Functioning. [Claimant] presents as a complex adolescent whose etiology of day-to-day adaptive delays is difficult to define. In this examiner's opinion, a combination of factors including poor executive functions, processing deficits, a complex psychiatric presentation as well as the history of trauma in the form of exposure to domestic violence likely account for some of the challenges he experiences. This examiner estimates that [claimant] will require supports to succeed and function as an adult.

⁷ Additional *DSM-V* criteria for ASD are: "(C) Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life); (D) Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning; and (E) "These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. . ."

Dr. Silva deferred to Dr. Pappas' psychiatric impressions, listing her diagnostic impressions as: Bipolar Disorder, ADHD, Tourette's Disorder and Generalized Anxiety Disorder, by history. She provided various recommendations, including that: (1) the eligibility team review her report to determine if claimant qualified for services; (2) claimant be referred to the Department of Vocational Rehabilitation and/or other support agency to assist him to transition to further vocational or educational training; and (3) claimant continue enrollment in a mental health support program, noting that he "may benefit from working with a therapist on improving executive functions."

EXPERT TESTIMONY

33. *Testimony of Dr. Boyle:* Dr. Boyle has a doctorate in clinical psychology and has been licensed in California since 1991. As a member of FNRC's multi-disciplinary eligibility review team, he has extensive experience in assessing individuals for developmental disabilities. Dr. Boyle reviewed his psychological evaluation described above (Findings 25 – 28), and confirmed his opinion that claimant does not have a "developmental disability" as defined by the Lanterman Act.

Intellectual disability is generally considered to be below 70; claimant's IQ scores were uniformly in the low-to-high 80s, thus excluding him from a diagnosis of intellectual disability. Further, the IQ and achievement test scores obtained from the schools in 2011 and 2014 establish that claimant had a specific learning disability and are inconsistent with intellectual disability. A specific learning disability in special education means that there is a significant discrepancy between claimant's intellectual potential (measured by his IQ) and his high borderline/low average academic achievement in certain areas due to a processing disorder. Several of claimant's IQ and achievement subtest scores were in the 90s and 100s. This does not reflect the global delay which is the hallmark of intellectual disability and there was no indication in the educational records that claimant was ever considered to be intellectually disabled. Claimant's ability to pass the California High School Exit Examinations and to obtain a regular high school diploma persuasively demonstrates that he is not an individual with intellectual disability.

In assessing whether there is fifth category eligibility that is "similar to" intellectual disability, scores in the range of 73 to 75 might qualify. Claimant's IQ scores in the low-to-high 80s rule out a condition that is "similar to" intellectual disability. Regarding fifth category eligibility based on the need for "treatment" that is similar to that received by individuals with intellectual disability, Dr. Boyle opined that the services FNRC has available are designed for individuals with a mild or moderate intellectual disability. Claimant will likely not do well with and be bored by services designed for low IQ individuals, because his intellectual potential is much higher. These services involve significant amounts of repetition designed for individuals with IQs typically below 73 to 75. In addition, there must be adaptive deficits in three or more areas. As reflected in Dr. McKellar's assessment, most of claimant's adaptive scores were in the borderline range (6 to 8) and are higher than what the regional center considers as significantly low. Dr. Boyle acknowledged that Mother reported claimant had lower adaptive functioning deficits to Dr.

Silva, which was reflected in the ABAS-III scores; however, he also noted that the triennial IEP indicated there were “no concerns” under the category “adaptive/daily living skills” signed by Mother.

Based on his assessment and review of the records, Dr. Boyle did not find that claimant met any of the qualifying conditions for eligibility. Because of this, it was not necessary to review whether he had a “substantial disability.” In his opinion, claimant did not require and would not benefit from having treatment similar to that required by individuals with intellectual disability. Dr. Boyle agreed that claimant could benefit from assistance with job skills, but “he would be far above everyone in our program.” Dr. Boyle agreed with Dr. Silva’s recommendations that claimant be referred to the Department of Vocational Rehabilitation for job training and that he continue his supported involvement with mental health psychiatric treatment.

34. *Testimony of Lisa Benaron, M.D.:* Dr. Benaron is FNRC’s Medical Director. She received her medical degree from Yale, completed residencies in pediatrics and internal medicine at the University of North Carolina, and later specialized in neurodevelopmental disabilities. Dr. Benaron is certified by the American Academies of Psychiatry, Neuropsychology and Pediatrics. In 17 years at FNRC, Dr. Benaron’s main focus has been on ASD. She participated in the Department of Developmental Services’ California Work Group which developed a “Best Practices Guidelines for Screening, Diagnosis and Assessment” of Autism Spectrum Disorders that is publicly available and still in use. Dr. Benaron is on FNRC’s eligibility review committee and is well-versed in the definitions of “developmental disability” under the Lanterman Act. In her experience, physicians outside the regional center system often use the term “developmental disability” broadly to describe a variety of conditions which may or may not fall within the strict eligibility definitions by which regional centers are bound.

Determining whether an individual has ASD is a complex process which entails medical and educational record reviews, clinical interviews and assessments. The ADOS-2 is the “gold-standard” for diagnosing ASD. Its results are typically considered together with cognitive and adaptive behavior testing and the *DSM-V* diagnostic criteria. The typical diagnostic process will take from three and one half-to-four hours to complete. In her experience, psychiatrists generally do not perform best practice assessments and refer them out to psychologists. Nevertheless, a psychiatrist who undertakes to diagnose ASD should follow the Best Practice Guidelines. Dr. Benaron reviewed all of the assessments provided, as well as Dr. Pappas’ progress notes. She did not meet or test claimant. Based on this review, Dr. Benaron concluded that claimant does not have a “developmental disability” as defined by the Lanterman Act.

Regarding ASD, Dr. Benaron noted that there were two comprehensive evaluations from experienced psychologists who conducted best practice assessments. Both Dr. McKellar and Dr. Silva reached the same conclusion that claimant did not have ASD. On the ADOS-2, higher scores are most consistent with a diagnosis of either ASD or Autism. Claimant’s scores were consistently low, which was more consistent with individuals who do

not have ASD. Based on the ADOS-2 scores, Dr. Benaron concluded that it was “highly improbable” that claimant had ASD. In her opinion, claimant’s scores were “not even close” to ASD. She acknowledged that claimant had some unusual or concerning behaviors, but emphasized that people can have problems such as social difficulties for many different reasons. In her experience, there is a qualitative difference to the social and communications problems experienced by people with ASD that is persistent. By contrast, claimant’s problems seemed to wane and wax. Claimant has been on numerous psychotropic medications over the years and the records, including Dr. Pappas’ progress notes, indicate that he would do well for a while and fit in at school when his medication was working better, and then have difficulties at other times on other medications. Although claimant has some trouble in groups, this could be attributable to his ADHD or to social anxiety. Claimant had social strengths, for example, in having flexible eye contact and use of emphatic gestures.

Claimant did not meet all three of the *DSM-V*’s A Criteria for ASD, which requires “persistent deficits in social communication and social interaction across multiple contexts.” To qualify on this basis, all three subcategories must be met and claimant only met the third criteria. Because the A Criteria is not met, it is not necessary to review the B Criteria for “restricted, repetitive patterns of behavior, interests, or activities...” Nonetheless, Dr. Benaron discussed at length the B Criteria claimant did not meet and contrasted his behavior and history to those of individuals with ASD. Of significance, she clarified that: (1) many children and even adults will “rock” when they are upset or anxious, but this does not mean the person has ASD; (2) verbal tics are not symptoms seen in ASD and there is no increased risk for ASD in individuals who have Tourette’s Disorder; (3) many people like routines, but this is not the same as an inflexible adherence to routines and non-functional rituals seen in ASD; (4) behavioral rigidity can be a symptom of other conditions like Obsessive Compulsive Disorder (OCD); and (5) all these symptoms must be present during the developmental period, typically considered as before the ages of three to five, which was not the case with claimant. In the absence of all three A Criteria, the presence of B Criteria may be indicative of mental health issues, but not of ASD. Regarding adaptive functioning, Dr. Benaron explained that adaptive scores do not matter if the individual does not meet one of the eligibility categories. It is only after an eligible condition exists that the regional center must consider adaptive functioning to determine if there is a substantial handicap as required for a “developmental disability.”

35. *Testimony of Lynne Pappas, M.D.:* Dr. Pappas received her medical degree from the University of California, San Francisco Medical School in 1987 and completed a fellowship in child and adolescent psychiatry in 1992. She is certified by the American Board of Psychiatry and Neurology in psychiatry and in child and adolescent psychiatry. Dr. Pappas has practiced in a variety of settings: in-patient psychiatric facilities, county mental health systems, as a contract physician for regional centers and in private practice. She is currently an independent contractor with the Feather River Health Center Primary Care Clinic, providing psychiatric services to enrolled patients.

Dr. Pappas has treated claimant for many years. She testified that she initially saw claimant as a young child, roughly between the ages of five and seven years old. She diagnosed claimant with ASD at this time, but she did not administer a series of tests to reach this diagnosis. She also diagnosed claimant with Bipolar Disorder. Dr. Pappas has also seen claimant for medication management and occasional counseling every several months from 2011 to the present, has attended some of his IEP team meetings and has visited him in his home. Claimant submitted progress notes from Dr. Pappas, for 19 treatment visits during the periods from August 25, 2011 to September 24, 2014 and March 19, 2015 to January 27, 2016.

As a clinician treating a child with mental illness, Dr. Pappas tries to find the best fitting diagnosis, often in cases where there is not an appropriate diagnosis. In her opinion, claimant qualifies for regional center services under the “fifth category,” as having either a condition that is closely related to intellectual disability or that requires treatment similar to that required for individuals with an intellectual disability.

Dr. Pappas acknowledged that she is not a person who administers quantitative testing; however, as a clinician, she is able to form opinions based on information garnered during interactions with the patient. From her clinical interactions, Dr. Pappas has been able to see how claimant truly functions over time and to extrapolate an opinion. While in the school setting, claimant’s life was structured. He was directed all the time so he flourished. Consequently, his adaptive function in the school setting was not really an issue and the IEP may not accurately evidence his problems. Now that claimant is no longer in school and no longer has those inherent, built-in structures, he presents as a young man who is developmentally and cognitively “nowhere near where he needs to be to function.” Dr. Pappas noted Dr. McKellar’s references to claimant’s immaturity and extremely concrete thinking, but she took issue with his assessment that claimant had insight into his social situation. She believed Dr. Silva more accurately understood claimant’s childlike quality.

Dr. Pappas described claimant as always having been an “odd child.” She diagnosed him with ADHD and Bipolar Disorder long ago, at a time when there were no criteria for mood regulation disorders in the DSM. While claimant might have a normal IQ in some areas of functioning, his processing deficits handicap him in ways which make it neurologically difficult to use his capacities. The analogy of a Swiss cheese-type presentation is appropriate. She disagreed that claimant might be easily bored with treatment similar to that required for individuals with an intellectual disability. The vocational supports and life skills from FNRC are exactly what claimant needs. In Dr. Pappas’ opinion, claimant is in his own category. He “does not fit” in many ways that may not be seen in a brief quantitative testing interaction. Dr. Pappas has treated many patients with developmental disabilities. She indicated that there are a variety of day treatment and vocational programs for persons with lower functioning. These are not the same as mental health services. Claimant would benefit from and requires “treatment similar” to that required for individuals with an intellectual disability. Without this, claimant will have “a hard road ahead.” Dr. Pappas clarified that these symptoms were always of concern before

claimant turned 18, but were placed “on the back burner” because he was in a protective environment and the focus was on getting him to graduate.

On cross-examination, Dr. Pappas testified that, if she was asked to list all the *DSM-V* criteria required for a particular diagnosis, she could not do that. In order to treat claimant, she had to “come up with something as he is such an outlier.” In her experience, it is difficult to treat patients who are “on the extremes” and it is hard to pinpoint her reasoning based on testing. She uses the term “developmental disability” for patients, like claimant, who have severe adaptive development issues. She did not have a diagnosis for claimant that accurately fit within the *DSM-V*, and provided a diagnosis so she “can justify his treatment.” She has “pushed” claimant’s mother to have an ASD assessment. There are several symptoms of ASD that claimant meets, as well as others that do not fit. Dr. Pappas declined to further discuss the details of her specific diagnoses for claimant. She explained that her purpose in testifying was not to debate a particular label when claimant does not fit a label. Rather, her goal is to address a child who has needs. She had no recollection why she made the specific diagnoses of ASD and Intellectual Disability in 2015 and 2016. The fifth category came up in a meeting with Mother and the regional center. Claimant did not fit the diagnoses of ASD or intellectual disability; the fifth category was pursued as there was not an accurate diagnosis.

DISCUSSION

36. Both Dr. Boyle and Dr. Benaron reviewed Dr. Pappas’ notes for claimant. In their opinions, it is significant that Dr. Pappas’ progress notes contained no mention or diagnosis of Autism, ASD or intellectual disability until the fair hearing process began. On June 1, 2015, Dr. Pappas added “Autism Spectrum Disorder, requiring support, associated with another neurodevelopmental, mental, or behavioral disorder...” to claimant’s problem list. This is continued forward on her progress notes of September 21, 2015, which also: (1) indicated an “evaluation with FNRC is scheduled for Friday,” and (2) recorded “Objective: Thoughts: Orientation, judgment, insight, and memory all remain hampered by patient’s Developmental Disability, more stable with current medication regimen.” This last comment is continued forward in Dr. Pappas’ January 27, 2016 progress note, which also indicates: “Mom is still fighting for him to receive FNRC services...” This progress note for the first time adds “Intellectual Disability” to claimant’s problem list and provides that:

while [claimant] is showing signs of stability compared to mental status upon initial admission and global assessment, they are never the less [sic] chronically disabled with respect to normal functional criteria. Mood, affect and cognition are no longer severely impaired to the point of rendering patient a danger to self or others, however they are still extremely fragile and susceptible to relapse even in the face of normal environmental and emotional stressors, because of their chronic brain illness.

Dr. Benaron described these diagnoses as coming “out of the blue” without explanation, supporting information or best practice assessment by Dr. Pappas. The use of the term “developmental disability” by Dr. Pappas is unexplained and may indicate a reference to claimant’s special education eligibility of specific learning disability, which is expressly excluded from eligibility under the Lanterman Act. The use of the term “chronic brain illness” is not typical medical verbiage and seems designed to support eligibility. Dr. Benaron noted that Dr. Pappas had previously expressed concern about claimant’s low processing score which she believed pulled his functioning scores “down to the profound level.” As a consequence, Dr. Pappas advocated that FNRC make claimant eligible under the fifth category “due to a fixed neurological handicap.” Dr. Benaron explained that “a fixed neurological handicap” does not reference a condition that is closely related to intellectual disability. This is not a medical diagnosis. It is a more general term similar to “static encephalopathy.” It suggests that claimant cannot learn; however, specific learning disabilities are remediable. While claimant’s adaptive functioning may be lower than his peers, they are much higher than those of individuals with intellectual disabilities.

Dr. Boyle testified that the best practice for assessing intellectual disability is giving IQ tests and adaptive behavior measurements. While Dr. Pappas may have clinically assessed claimant, there was no indication that she conducted any testing, any best practice type evaluation or that she had reviewed the *DSM-V* diagnostic criteria to confirm a diagnoses of intellectual disability or condition similar to intellectual disability.

37. Ordinarily, the testimony of a provider who has a lengthy history of treating an applicant for regional center services would be given significant weight. Dr. Pappas’ concern for claimant’s well-being as he enters adulthood was genuine and palpable. Nevertheless, Dr. Pappas’ opinion that claimant is eligible for regional center services based on ASD, intellectual disability or under the fifth category was not persuasive. Her testimony was characterized by sharp hostility, a refusal to allow questioning by FNRC’s attorney, and by an unwillingness to objectively analyze claimant’s eligibility under the Lanterman Act. By contrast, the opinions of Dr. Benaron and Dr. Boyle, both of whom have significant experience in determining eligibility under the Lanterman Act, were persuasive and were based on the professional and objective assessments as discussed below. Their opinions are more persuasive than those of Dr. Pappas.

38. *Autism Spectrum Disorder*: As set forth in the assessments of Dr. McKellar and Dr. Silva, and as further elucidated in the opinions of Dr. Benaron and Dr. Boyle, claimant does not have a “developmental disability” based on ASD. It was undisputed that the ADOS-2 is the gold standard assessment instrument for determining ASD and that both Dr. McKellar and Dr. Silva conducted best practice assessments of claimant using this assessment tool, the *DSM-V* criteria and clinical interviews and observations. While both Mother and Dr. Pappas testified that claimant was diagnosed as ASD by Dr. Pappas as a young child, there are no records to substantiate this history, which is contradicted by the developmental history previously provided by Mother and completely absent from the special education history. The burden is on claimant to establish eligibility, and no persuasive evidence was provided to support a finding that claimant has an ASD diagnosis.

39. *Intellectual Disability*: As set forth in claimant’s special education triennial assessments, the IEP and the WAIS-IV assessment results, claimant does not have an intellectual disability. Claimant’s WAIS-IV full scale IQ of 81 is in the borderline/low average range and is consistent with his cognitive testing in 2011 and 2014 with the WISC-IV during his years in special education. (Findings 12 and 26.) As emphasized by Dr. Boyle, claimant has scored even higher on some subtests of the IQ tests and achieved some scores that are in the 90s and 100s, in the average range. Thus, claimant does not have the global delays that are indicative of intellectual disability. The *DSM-V*, in explaining Diagnostic Features, provides:

Intellectual functioning is typically measured with individually administered and psychometrically valid, comprehensive, culturally appropriate, psychometrically sound tests of intelligence. Individuals with intellectual disability have scores of approximately two standard deviations or more below the population mean, including a margin for measurement error (generally + 5 points). On tests with a standard deviation of 15 and a mean of 100, this involves a score of 65-75 (70 ± 5). Clinical training and judgment are required to interpret test results and assess intellectual performance. (*DSM-V*, p. 37.)

Based on all available evidence, claimant does not demonstrate “deficits in intellectual functions.” As a result, although he has some delays in adaptive functioning, he does not meet the criteria for an intellectual disability because both must be present, with onset during the developmental period. (Finding 27.) Further, claimant’s longstanding special education designation as a student with a specific learning disability is premised on the existence of a statistically significant discrepancy between his cognitive potential and his demonstrated abilities due to processing deficits. The specific learning disability is expressly excluded from a finding of “developmental disability.” (Finding 8.) Claimant was able to pass the high school exit examination and graduate from high school with a diploma. Claimant provided no persuasive evidence to the contrary to establish that he is an individual with an intellectual disability.

40. *Fifth Category Eligibility Based on a Disabling Condition Found to be Closely Related to Intellectual Disability or to Require Treatment Similar to Intellectual Disability*: In addressing eligibility under the fifth category, the Court in *Mason v. Office of Administrative Hearings* (2001) 89 Cal.App.4th 1119, 1129, stated in part:

... The fifth category condition must be very similar to mental retardation [now, intellectual disability], with many of the same, or close to the same, factors required in classifying a person as mentally retarded. Furthermore, the various additional factors required in designating an individual developmentally disabled and substantially handicapped must apply as well.

More recently, in considering whether an individual is eligible for regional center services under the fifth category, an appellate decision has suggested that such eligibility may be largely based on the established need for treatment similar to that provided for individuals with intellectual disability, notwithstanding an individual's relatively high level of intellectual functioning. (*Samantha C. v. State Department of Developmental Services* (2010) 185 Cal.App.4th 1462.) In *Samantha C.*, the individual applying for regional center services did not meet the criteria for mental retardation. The court noted that the Association of Regional Center Agencies had guidelines which recommended consideration of fifth category for those individuals whose "general intellectual functioning is in the low borderline range of intelligence (I.Q. scores ranging from 70-74)." (*Id.* at p. 1477). However, the court confirmed that individuals may qualify for regional center services under the fifth category on either of two independent bases, with one basis requiring only that an individual require treatment similar to that required for individuals with mental retardation.

As poignantly expressed in the testimony of Mother, Aunt and Dr. Pappas, and as demonstrated in the ABAS-II and ABAS-III assessment results reported by Dr. McKellar and Dr. Silva, claimant has deficits in adaptive functioning. Claimant argues that these deficits demonstrate that his condition is closely related to intellectual disability and/or that he requires treatment similar to that received by individuals with intellectual disability.

41. Condition Closely Related to Intellectual Disability: As detailed in the evaluation and testimony of Dr. Boyle, claimant's general intellectual functioning is not significantly sub-average in a manner that is similar to an individual with an intellectual disability. His cognitive testing throughout his high school years and now as an adult is in the borderline/low average range with some peaks well into the average range. Claimant's intellectual functioning is not "closely related" to intellectual disability. While it is undisputed that claimant has deficits in adaptive functioning, there is no evidence that the deficits in claimant's adaptive functioning are related to any cognitive deficits. Such deficits may have a number of causes other than a significant deficit in general cognitive ability. Claimant has a long history of significant health problems and psychiatric disorders with diagnoses that include SVT, ADHD, Bipolar Disorder, General Anxiety Disorder and Tourette's Disorder. He has been prescribed multiple medications to address these conditions, which have at various times helped and hindered his ability to function positively and to learn at school. Impaired intellectual or social functioning which originated as a result of the psychiatric disorder or treatment given for such a disorder are excluded from "developmental disability." (Finding 8.) As persuasively indicated by Dr. Silva (Finding 32), claimant has experienced significant traumas and life experiences, unrelated to cognitive deficits, that resulted in his adaptive functioning deficits. These deficits do not establish that claimant has "a condition that is closely related to intellectual disability."

42. Require Treatment Similar to Intellectual Disability: Many individuals without "developmental disabilities" under the Lanterman Act may "benefit" from the "services and supports" provided to regional center consumers. These include individuals in the borderline and low average range of intellectual functioning, as well as individuals who suffer from psychiatric disorders and side effects caused by medications designed to treat those

conditions. The term “treatment” is not synonymous with the “services and supports” listed in Welfare and Institutions Code section 4512. “Treatment” cannot properly be interpreted as allowing individuals with skills deficits or difficulties in adaptive functioning who might benefit from regional center services to qualify under the fifth category without more. Properly interpreted, the “treatment required” under the fifth category means a need for services and supports targeted at improving or alleviating a developmental disability.⁸

A person with intellectual disability might require many of the services and supports listed in section 4512, which could also benefit any member of the public. Such services include constant care and supervision, assistance in locating a home, vocational programs, learning skills for self-help and safety, supported employment and supportive living. 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, in determining fifth category eligibility on this basis, consideration must be given to whether the individual’s condition has many of the same, or close to the same, factors required in classifying a person as intellectually disabled. (*Mason v. Office of Administrative Hearings, supra*, 89 Cal.App.4th 1119.) The additional factors required to designate an individual as developmentally disabled and as 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 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 certain developmental disabilities with precision. 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

⁸ Welfare and Institutions Code section 4512, subdivision (b), defines “services and supports” as “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.” This statute 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,…” (§ 4512, subd. (b); Italics supplied.) The designation of “treatment” as a separate item is clear indication that it is not merely a synonym for services and supports.

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.)

43. This is a case where deference is properly given to FNRC professionals in determining eligibility. (*Mason v. Office of Administrative Hearings, supra*, 89 Cal.App.4th 1119, 1129.) Claimant is close to his older brother and wishes to attend the same program with him at his Aunt’s day treatment facility. Mother is a responsible and highly concerned mother, who is seeking out the best possible care and treatment for her son now and for the future when she will not be there for him. Claimant has adaptive functioning deficits which have been reported variously as between the borderline and extremely low range. The cause of claimant’s adaptive functioning deficits arises largely from his specific learning disability, his mental health conditions and his difficult life experiences rather than intellectually disability. Dr. Pappas’ testimony to the contrary was not persuasive. As acknowledged by Dr. Silva, Dr. McKessler, Dr. Boyle and Dr. Benaron, claimant would benefit from services from the Department of Vocational Rehabilitation, as well as from ongoing mental health counseling to address his social anxieties. Claimant did not meet his burden of establishing that he requires treatment similar to that received by individuals with intellectual disability.

LEGAL CONCLUSIONS

1. The Lanterman Act does not assign the burden of proof to either party, and no appellate court has decided this issue. Typically, the burden of proof is on an individual seeking rights or services. Consistent with this principle and in the absence of any applicable statute under the Lanterman Act, the burden of proof is on the claimant to prove, by a preponderance of the evidence, that he has a “developmental disability” that originated prior to age 18 that constitutes a substantial disability for him. (§ 4512, subd. (a); Evid. Code, §§ 500, 115.)

2. As set forth in the Factual Findings and Legal Conclusions as a whole and, particularly, in Findings 6 through 8 and 33 through 43, claimant did not meet his burden of establishing that he has a “developmentally disability” as defined by the Lanterman Act, based on an Autism Spectrum Disorder, an Intellectual Disability, or a Disabling Condition Found to be Closely Related to Intellectual Disability or to Require Treatment Similar to Intellectual Disability.

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ORDER

Claimant's appeal is DENIED.

DATED: April 4, 2016

MARILYN WOOLLARD
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 this decision. (Welf. & Inst. Code, § 4712.5, subd.(a).)