

BEFORE THE  
OFFICE OF ADMINISTRATIVE HEARINGS  
STATE OF CALIFORNIA

In the Matter of:

BRENT F.

Claimant,

vs.

ALTA CALIFORNIA REGIONAL  
CENTER,

Service Agency.

OAH No. 2011060847

DECISION

This matter was heard before Administrative Law Judge Jonathan Lew, State of California, Office of Administrative Hearings, on February 6, 7 and 8, 2012, in Sacramento, California.

Judith A. Enright, Attorney at Law, represented Alta California Regional Center (ACRC or the service agency).

George Frost, Attorney at Law, represented claimant. Claimant's mother and authorized representative, Denise F., was also present. Claimant did not appear.

Submission of the case was deferred pending receipt of written closing arguments. ACRC's Closing Argument was received on March 2, 2012, and marked as Exhibit 68 for identification. Claimant's Closing Brief was received on March 19, 2012, and marked as Exhibit 69 for identification. ACRC filed a Rebuttal and Supplemental Rebuttal on March 26, and April 2, 2012, and these were marked respectively as Exhibits 70 and 71 for identification. The matter was submitted for decision on April 2, 2012.

ISSUES

1. Was the original determination that claimant was eligible for ACRC services on the basis of mental retardation clearly erroneous?

2. If so, does claimant have a condition that is closely related to mental retardation or that requires treatment similar to that required for individuals with mental retardation?

### *Procedural History*

On August 25, 2009, ACRC issued a Notice of Proposed Action (NOPA) to claimant informing him he was no longer eligible to receive regional center services. The NOPA indicated that ACRC's Best Practice Committee had met and determined claimant was no longer eligible because he functioned consistently above the mentally retarded range of cognition, and also did not have any other developmental disability within the Lanterman Act eligibility criteria. On September 4, 2009, a Fair Hearing Request was submitted on claimant's behalf, and then signed by claimant and resubmitted on September 10, 2009.

A hearing was held on August 26 and 31, 2010, and a decision issued on September 15, 2010.<sup>1</sup> The decision affirmed the earlier determination by ACRC that claimant was not eligible for regional center services.

On June 14, 2011, claimant filed a Fair Hearing Request seeking restoration of ACRC services, and basing such request on "updated IQ testing and adaptive functioning by two qualified doctors."

Various prehearing motions were brought by the parties. It was determined that the full record from the August 2010 hearing would be incorporated, considered and made part of the record in this proceeding. The parties stipulated that ACRC has the burden of proof of establishing that the original determination that claimant has a developmental disability is "clearly erroneous." (Welf. & Inst. Code, § 4643.5, subd. (b).)<sup>2</sup> The September 15, 2010 decision did not apply this standard and is therefore not governing and is accorded no weight. Issues related to continued eligibility for ACRC services were therefore considered anew in this case.

---

<sup>1</sup> *Brent F. v. Alta California Regional Center*, OAH No. 2009091237.

<sup>2</sup> Welfare and Institutions Code section 4643.5, subdivision (b) provides as follows:

An individual who is determined by any regional center to have a developmental disability shall remain eligible for services from regional centers unless a regional center, following a comprehensive reassessment, concludes that the original determination that the individual has a developmental disability is clearly erroneous.

## FACTUAL FINDINGS

### *Claimant's Background*

1. Claimant is a 31-year-old male who qualified for ACRC services based on a diagnosis of mental retardation. At the time of the August 2010 hearing, he lived in his own apartment and received assistance in his daily living activities from his mother and through In Home Supportive Services (IHSS).

2. On January 25, 2011, claimant was seen for evaluation by the Sutter Center for Psychiatry. He had been referred there by the Sutter Roseville Medical Center after a reported history of making suicidal statements and being combative with his caretakers, including his mother and a friend who provided IHSS. He was described at that time as having a "history of mental retardation, depression, anxiety, obsessive compulsive disorder, intermittent explosive disorder, and oppositional defiant disorder, admitted to the intensive care unit on a 5150 for danger to self." The Sutter Center noted that claimant "most likely will need to be referred to a board and care facility" and that "it would be beneficial to reinstate his Alta Regional services and case management."

3. Since the time of the August 2010 hearing, claimant obtained and submitted new psychological testing and cognitive assessment reports to ACRC. One report followed an examination by psychologist Baljit Atwal, Ph.D., in October and November 2010. A second report was prepared after a psychological evaluation on January 27, 2011, by Francis Allen, M.S., psychology intern, under clinical supervision by Florina Yuger, Ph.D. Their findings will be discussed later.

Claimant's representatives indicate he now wishes to return to a residential care home, and to participate in a job training program that is suitable for him. Claimant seeks help in managing his finances, shopping, education and other available assistance. Claimant would like to be in a structured environment or a closely supervised independent living situation. He would like to receive training in coping skills, assistance with and training in activities of daily living, assistance with and training in financial management, and assistance and training in effective socialization and interpersonal relationships.

### *ACRC's Position*

4. ACRC believes that its original determination in 1988 that claimant was mentally retarded was clearly erroneous. It believes that the initial psychological evaluation upon which eligibility was based was "flawed on its face because there was no finding of mild mental retardation." ACRC also believes that the 1988 determination of eligibility conflicted with other available information at the time of the 1988 assessment, and with claimant's subsequent school record, activities and psychological testing. With respect to subsequent psychological testing, ACRC relied largely upon a psychological evaluation performed by Catherine Prudhomme, Ph.D., on December 3, 2003.

ACRC avers that it undertook a comprehensive reassessment of claimant's eligibility for regional center services on multiple occasions. Cynthia Root, Ph.D., is the ACRC staff psychologist who participated in the August 25, 2009 reassessment that led to the NOPA issued that same date. ACRC noted that its other staff psychologist, Phyllis Magnani, Ph.D., also performed a comprehensive reassessment of claimant's eligibility, independent of Dr. Root. Both staff psychologists concluded that any finding that claimant had been eligible for ACRC services was clearly erroneous. Both psychologists further opined that claimant is not eligible for ACRC services by reason of having a condition that is closely related to mental retardation or that requires treatment similar to that required for individuals with mental retardation. This condition is sometimes referred to as the "fifth category."

Neither ACRC staff psychologist prepared a comprehensive report, notes or other written documentation in connection with their comprehensive reassessments. In the prior hearing and in this hearing, Dr. Magnani testified to the reasoning behind ACRC's determination that the earlier eligibility finding was either unsupported or clearly erroneous. In the following findings and discussion, the main points gleaned from Dr. Magnani's testimony in support of non-eligibility will be summarized, along with certain other matters raised in ACRC's closing argument. ACRC has the burden of establishing that its initial determination of eligibility was clearly erroneous. Claimant's response and a broader discussion of the issues will follow.

### *Initial Assessment*

5. Claimant was born on July 21, 1980. He was age eight at the time of the psychological evaluation performed by Sidney K. Nelson, Ph.D., on September 22, 1988. Dr. Nelson was an ACRC staff psychologist at that time. ACRC determined that claimant was eligible for regional center services based upon this evaluation. Dr. Nelson noted claimant's previous cognitive test results, including Stanford-Binet test administrations on May 14, 1985 (IQ 79), and on June 4, 1986 (IQ 82).

Dr. Nelson administered the Wechsler Intelligence Scale for Children – Revised (WISC-R). Claimant achieved a verbal scale IQ score of 74, a performance scale IQ score of 70, and a full scale IQ score of 70.<sup>3</sup> Dr. Nelson explained these scores as follows:

These results would indicate that Brent's current intellectual abilities are on the border between the extreme upper range of the mild range of mental retardation, and the extreme lower end of the borderline range. Given Brent's pattern of scaled scores, I would tend to view him as a child with very significant learning disabilities, and borderline intellectual functioning.

---

<sup>3</sup> Claimant's subtest scores on the WISC-R were as follows: Verbal Scores – Information (5), Similarities (9), Arithmetic (3), Vocabulary (5) and Comprehension (7); Performance Scores – Picture Completion (7), Picture Arrangement (7), Block Design (6), Object Assembly (4) and Coding (3).

6. Dr. Nelson noted that it appeared that claimant's "I.Q. scores have been declining over the years. If this continues, Brent may eventually test out within the mild range of mental retardation." Dr. Nelson observed that claimant's academic skills were also in the mentally retarded range. "His academic skills are also below what would be expected of a child with his cognitive skills." Dr. Nelson's diagnostic impression was: 1) Tourette's Syndrome (by report), and 2) "Significant learning disability along with borderline intellectual functioning."

7. The original ACRC interdisciplinary team found claimant eligible for ACRC services on the basis of "Mild MR" with a note that claimant should be retested in one year. ACRC contends that Dr. Nelson made no finding of mild mental retardation. It also noted that Dr. Nelson's information related to adaptive living skills was not in accord with either claimant's records or the information that claimant's mother provided to ACRC for the social assessment performed on August 4, 1988. For example, claimant's mother reported at that time that her son's developmental progression was "average" and that his self-care was "age appropriate." Other specific assessments relating to communication and self-care indicated for claimant the following:

Communication: Brent is verbal and speaks in complete sentences. He was able to provide self-descriptive information. Some articulation errors were noted but generally his speech is clear and easily understood.

Self-Care: Brent feeds, bathes and dresses himself independently. Although capable of manipulating zippers, he, according to his mother, has to be forced to zip his pants. He requires no assistance with toileting. Brent's skills in the area of self-care seem to be age appropriate.

8. Dr. Magnani testified to her concerns about Dr. Nelson's cognitive test results for claimant. She noted the two prior IQ assessments that were referenced in Dr. Nelson's report, and Dr. Nelson's observation that claimant's IQ scores appeared to be declining over time. She observed that Dr. Nelson failed to provide the confidence interval levels for the WISC-R he administered, and explained that one therefore could not determine standard error measures. Dr. Magnani further noted that Dr. Nelson did not interpret individual subtests. She suggested that because claimant scored as high as nine on Similarities under the verbal scores, and since the other six subtests were in the low average range, this may have resulted in "forcing" an average. This criticism is somewhat confusing because any forcing occasioned by a single "9" score would *raise*, and not lower claimant's IQ score. Dr. Magnani also noted that his performance subtests showed such wide variation – three scores in the low average range and two scores in borderline mentally retarded range – that interpretation of his FSIQ "is not accurate."

Dr. Magnani conceded, however, that Dr. Nelson's evaluation and diagnostic

impressions would have supported a finding of eligibility under the fifth category.

9. The Diagnostic and Statistical Manual of Mental Disorders Fourth Edition Text Revision (DSM-IV-TR), discusses mental retardation in pertinent part as follows:

The essential feature of Mental Retardation is significantly subaverage general intellectual functioning (Criterion A) that is accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety (Criterion B). The onset must occur before age 18 years (Criterion C). Mental Retardation has many different etiologies and may be seen as a final common pathway of various pathological processes that affect the functioning of the central nervous system. “*General intellectual functioning*” is defined by the intelligence quotient (IQ or IQ-equivalent) obtained by assessment with one or more of the standardized, individually administered intelligence tests (e.g., Wechsler Intelligence Scales for Children, 3<sup>rd</sup> Edition; Stanford-Binet, 4<sup>th</sup> Edition; Kaufman Assessment Battery for Children). Significantly subaverage intellectual functioning is defined as an IQ of about 70 or below (approximately 2 standard deviations below the mean). It should be noted that there is a measurement of error of approximately 5 points in assessing IQ, although this may vary from instrument to instrument (e.g., a Wechsler IQ of 70 is considered to represent a range of 65-75). Thus, it is possible to diagnose Mental Retardation in individuals with IQs between 70 and 75 who exhibit significant deficits in adaptive behavior. Conversely, Mental Retardation would not be diagnosed in an individual with an IQ lower than 70 if there are no significant deficits or impairments in adaptive functioning.

10. Claimant’s general intellectual functioning, based upon his 70 IQ score from the 1988 administration of the WISC-R, met the definition of significantly subaverage intellectual functioning under the DSM-IV-TR. There was no significant variance between claimant’s verbal and performance scores on this IQ test. The differential was four. Therefore, the full scale IQ (FSIQ) was appropriate for ACRC to use at that time when it determined that claimant was eligible for regional center services.

ACRC has suggested that greater import should have been attached to earlier cognitive testing of claimant when he was administered the Stanford-Binet test in 1985 and 1986, when he received IQ scores of 79 and 82, respectively. Claimant was age four and age five during those particular test administrations. ACRC ignored other cognitive test results around that same time which were consistent with Dr. Nelson’s 1988 cognitive test results.

For example, when claimant was tested in 1987, by Thomas Johnson, Ed.D., his FISQ was 70. When claimant was tested again by Dr. Johnson in 1990, his FSIQ was 62. Dr. Johnson administered the same test (WISC-R) as Dr. Nelson. Given these two test administrations by Dr. Johnson near in time to the test administered by Dr. Nelson, ACRC cannot fairly question the validity of the FSIQ obtained by Dr. Nelson in 1988, and upon which it determined that claimant was initially eligible for services based upon mental retardation.

### *Academic Performance*

11. ACRC has pointed to claimant's academic performance and school records from the San Juan Unified School District. ACRC believes they are replete with findings of learning disability that were not the result of mental retardation. ACRC highlighted certain observations by claimant's high school teachers which it believes capture the tenor of claimant's academic experience and performance:

- a. On May 15, 1997, a teacher note indicated that claimant was absent 37 days of the 72 days in the semester, and absent 25 out of 72 days of instruction in his math class. "These 25 days of absence from instruction are reflected in Brent's low test scores – makeup work may put points in the grade book but it doesn't replace the 'teaching' he regularly misses."
- b. On April 28, 1998, a teacher noted that: "Brent has been working with Powerpoint, and I am impressed with his designing abilities. (He needs to focus more on the class assignments and not be distracted by this program.) He seems to have an ability to work in the computer program and has been very good and interested about general business."
- c. On April 29, 1998, claimant's history teacher noted: "His third quarter grade was a B. At this time it is a low C because of absences and lack of follow through on in-class assignments. This semester Brent has been absent 8 days. He also has not been participating in class as much this semester...."

12. Dr. Magnani reviewed claimant's Wide Range Achievement Test (WRAT) scores from an April 1997 administration, when claimant was age 16. The WRAT is an achievement test that measures reading recognition, spelling and arithmetic computation. It is used to determine learning ability or disability. It is not an IQ test. His reading (90), spelling (89) and arithmetic (82) were in the low average and average range, and corresponded to grade levels 6 (arithmetic), 7 (spelling) and 8 (reading). Dr. Magnani characterized these as "nice scores."

Claimant was administered the Woodcock-Johnson test of cognitive ability in May 1997. This test is used for assessing individuals' cognitive abilities and academic achievement. Claimant's scores on the Woodcock-Johnson test are summarized as follows:

<u>Assessed Area</u>	<u>Grade Equivalent</u>	<u>Standard Score</u>
Letter-Word Identification	8.2	92
Passage Comprehension	5.6	84
Broad Reading	7.1	87
Calculation	6.2	81
Applied Problems	6.3	86
Broad Math	6.2	83
Dictation	3.7	67
Writing Sample	3.9	78
Broad Written Language	3.9	72

Dr. Magnani noted that for the most part, on the areas most affected by academic ability (the first six assessed areas) claimant's scores were all in the low average, with one area, letter-word identification, in the average range. Dr. Magnani opined that these scores were not consistent with either mental retardation or the fifth category of eligibility. Rather, Dr. Magnani believes that the scores are consistent with claimant having a learning disability.

13. At age 17, claimant was administered the Wechsler Individual Achievement Test (WIAT). The WIAT assesses individual achievement along a range of academic skills on four basic scales: reading, math, writing and oral language. Claimant tested as follows on May 11, 1998:

<u>Subtest</u>	<u>Score</u>	<u>Age Equivalent</u>	<u>Grade Equivalent</u>
Basic Reading	86	12:9	7:4
Math Reasoning	77	11:9	5:8
Spelling	84	12:0	6:9
Composite	78	12:3	6:8

Dr. Magnani opined that these scores are not consistent with a diagnosis of mild mental retardation because claimant was achieving above a sixth grade level, and the scores are also out of the range of someone under the fifth category.

14. The DSM-IV-TR discusses the elements of mild mental retardation in pertinent part as follows:

As a group, people with this level of Mental Retardation typically develop social and communication skills during the preschool years (ages 0 – 5 years), have minimal impairment in sensorimotor areas, and often are not distinguishable from children without Mental Retardation until a later age. By their

late teens, they can acquire academic skills up to approximately the sixth-grade level. During their adult years, they usually achieve social and vocational skills adequate for minimum self-support, but may need supervision, guidance, and assistance, especially when under unusual social or economic stress. With appropriate supports, individuals with Mild Mental Retardation can usually live successfully in the community, either independently or in supervised settings.

15. Claimant did poorly in school and by his senior year he was failing classes. His May 14, 1998 IEP listed his strengths as “good reading ability.” His learning/behavioral needs or weaknesses were listed as: 1) easily off task, 2) problem solving/critical thinking skills, 3) distractibility, 4) homework completion, 5) failing classes, 6) organization skills, and 7) motivation. As a high school senior in special education classes, he tested out in spelling and math at a grade level of 6:9 and 5:8, respectively, and his composite score was grade 6:8. (See Finding 13.) This is not inconsistent with the DSM-IV-TR mild mental retardation criteria of testing as a late teen up to “approximately” the sixth-grade level.

ACRC appears to have given undue weight to the above-described academic performance test measures for claimant. Dr. Atwal noted that one weakness of academic achievement testing is that they contain a significant subjective element, and that results often depend on how much “help” the examiner provides to the student. Importantly, achievement testing is not cognitive testing. Achievement testing may correlate with various IQ tests, but they are not appropriate for use as diagnostic tools for assessing cognitive ability.

16. ACRC’s criticism of Dr. Nelson’s 1988 WISC-R test administration, and its related assertion that such testing was not consistent with claimant’s academic performance through his senior year; and ACRC’s belief that claimant’s poor academic performance was better explained by poor attendance and/or learning disability, have all been considered. They reflect a somewhat strained argument that claimant technically fell without the DSM-IV-TR criteria for mild mental retardation. Claimant’s FSIQ met the definition of mental retardation. He obtained academic skills and tested in his late teens at approximately the sixth grade level. This particular evidence does not demonstrate that ACRC’s initial determination of eligibility was clearly erroneous.

*December 3, 2003 Psychological Evaluation*

17. In determining that claimant should no longer be eligible for regional center services ACRC relied largely upon a psychological evaluation performed on December 3, 2003, by Catherine Prudhomme, Ph.D. Claimant was then age 23. Dr. Prudhomme administered the Wechsler Adult Intelligence Scale (WAIS-III). Claimant scored 89 (low average) on verbal IQ, and 73 (borderline) on performance IQ. His FSIQ was 79

(borderline).<sup>4</sup> Dr. Prudhomme explained these results as follows:

The Full Scale IQ score provides an overview of Brent's thinking and reasoning skills and encompasses two broad domains: Verbal and Performance. The Verbal IQ score indicates how well he did on tasks that required him to listen to questions and give oral responses to them. Alternatively, the Performance IQ score indicates how well he did on tasks that required him to examine and think about things such as designs, pictures, and puzzles and to solve problems without using words. If the Verbal and Performance IQ scores are markedly different from each other, the Full Scale IQ score is not the best summary of an individual's performance; the Verbal and Performance scores are better individual measures of ability in this case. This was true for Brent's scores, since his Verbal and Performance scores were significantly different from each other.

18. Dr. Prudhomme opined that claimant did not meet diagnostic criteria for mental retardation. Due to the significant difference between his verbal and nonverbal abilities, she determined that his FSIQ "cannot be used as an accurate measure of his intelligence." Her Summary and Conclusions were:

The history of cognitive abilities provided by a review of Brent's chart indicates that he has performed in the borderline to average range of intelligence throughout his childhood and young adulthood. His scores show some variability. However, he consistently demonstrates poorer performance on nonverbal tests as compared to verbal tests, with few exceptions. The large differences between his verbal and nonverbal abilities make any use of composite or Full Scale IQ scores impossible. Instead, he is best described as having low average to average intelligence with the likelihood of a nonverbal learning disorder.

19. The DSM-IV-TR discusses scatter in the subtest scores and discrepancies across verbal and performance IQ scores as follows: "When there is significant scatter in the subtest scores, the profile of strengths and weaknesses, rather than the mathematically derived full-scale IQ, will more accurately reflect the person's learning abilities. When there is a marked discrepancy across verbal and performance scores, averaging to obtain a full-scale IQ score can be misleading."

The parties cited to *Essentials of WAIS-III Assessment (Essentials III)*, authored by

---

<sup>4</sup> Claimant's subtest scores on the WAIS-III were as follows: Verbal Subtests – Vocabulary (8), Similarities (9), Arithmetic (7), Digit Span (8), Information (9) and Comprehension (8); Performance Subtests – Picture Completion (5), Digit Symbol-Coding (5), Block Design (6), Matrix Reasoning (6) and Picture Arrangement (6).

Alan S. Kaufman and Elizabeth O. Lichtenberger, as a definitive guide to interpretation of WAIS-III scores. As suggested by the DSM-IV-TR, care must be taken in interpreting FSIQ when marked discrepancies are present across verbal and performance scores. Differences across verbal and performance scores are common, and the *Essentials III* guide draws a distinction between “significant” differences and “abnormal” differences. “A Verbal IQ versus Performance IQ difference of 12 points is significant at the .01 level, but the discrepancy must be at least 17 points to be considered abnormal.... Thus, even though a verbal IQ versus performance IQ of 12 or 15 points is “real” (i.e., not merely a result of chance error), such discrepancies occur too frequently among normal adolescents and adults to be considered abnormal. Absolutely high Verbal-Performance IQ discrepancies don’t begin until the magnitude reaches 17 points.” (*Essentials III*, pp. 119-120.)<sup>5</sup>

20. In this case, the discrepancy across claimant’s verbal and performance IQ scores on Dr. Prudhomme’s 2003 test administration was 16 points. This was significant, but not abnormal. It means that care must be taken in interpreting claimant’s FSIQ. It does not mean that claimant’s FSIQ cannot be interpreted at all as was suggested by both Dr. Prudhomme and Dr. Magnani.<sup>6</sup> For these several reasons, it was not established that claimant’s FSIQ on the 2003 WAIS-III test administration should be disregarded.

21. Dr. Magnani opined that the differential between claimant’s verbal and performance IQ was significant, and demonstrated that he suffered from a learning disability and not mild mental retardation. Dr. Prudhomme opined that this same differential made it “impossible” to use his FSIQ, and suggested that claimant had a “nonverbal learning disorder.” This view finds no support in the *Essentials* guide for the WAIS-III, which specifically addresses indications for finding a learning disorder. Claimant has historically scored lower on the performance compared with verbal indices. Dr. Prudhomme noted that he “consistently demonstrates poorer performance on nonverbal tests as compared to verbal tests, with few exceptions.” Persons with learning disabilities will do just the opposite. This is because verbal test scores correlate directly with “crystallized” intelligence, whereas performance scores measure raw processing power. Thus, one would expect that an individual with a learning disability would perform *lower* on the verbal index, and higher on the performance index. The *Essentials* guide explains that this is one explanation for the performance IQ greater than verbal IQ profile seen in many individuals with learning

---

<sup>5</sup> Although claimant was not administered the WAIS-IV, it is noteworthy that the authors of *Essentials IV* indicate that a non-interpretable FSIQ means that the size of the difference between the highest and lowest indexes equals or exceeds 1.5 standard deviations, or 23 points.

<sup>6</sup> *Essentials IV*, at page 155 further specifies: “Exception to the Rule: Always interpret a person’s overall score on the WAIS-IV whenever a global score is essential for diagnosis (e.g., of intellectual disability) or placement (e.g., in a gifted program). Even if both the FSIQ and GAI [a newly refined form of overall measure] are noninterpretable based on our empirical criteria, select the one that provides the most sensible overview of the child’s intelligence for use in the diagnostic or placement process.”

disabilities:

Learning disabled individuals often display Performance > Verbal profiles on Wechsler instruments. This pattern has been noted for both children and adults. Across many studies of adolescents and adults with various learning disabilities, a consistent pattern of a higher Performance IQ than Verbal IQ of about 7 to 19 points is present (e.g., Frauenheim & Heckerl, 1983; Sandoval, Sassenrath, & Penaloza, 1988). This pattern is not that surprising since the Verbal tasks on Wechsler's scales are heavily achievement dependent. Several Verbal subtests tap information taken directly from school-learned knowledge. By definition, individuals with a learning disability are not good achievers. Thus, the Performance > Verbal pattern in learning-disabled individuals may be a reflection of their poor crystallized knowledge.

(*Essentials*, at p. 133.)

22. To summarize, ACRC was incorrect in suggesting that claimant's FSIQ score should be disregarded as non-interpretable because of the differential between his verbal and performance IQ scores. ACRC also erred in interpreting such differential as an indication that claimant had a learning disorder, and was not mentally retarded or otherwise eligible under the fifth category.

23. Claimant's 2003 FSIQ of 79 is borderline, and above significantly subaverage intellectual functioning which is defined as an IQ of about 70 or below. Even with a standard measurement of error of approximately five points (e.g., a Wechsler IQ of 70 is considered to represent a range of 65-75), claimant would still score above 70.

Claimant's representative posited one explanation for the relatively high scores. To paraphrase, ACRC's use of the WAIS-III may account for the higher scores since the WAIS-III had been around for almost seven years at the time of the 2003 administration, and was in need of "renorming." According to the authors of *Essentials* for the WAIS-IV test, FSIQ scores dropped an average of 2.9 points upon adoption of the WAIS-IV test; verbal comprehension scores dropped an average of 4.3 points. Similarly, claimant's representative cited to findings in the *American Psychologist* suggesting that students who were in the borderline and mild mental retardation range lost an average of 5.6 IQ points when tested on the renormed WISC for children. ACRC contends such studies are inapplicable to individual test administrations.

### *Discussion*

24. This is a difficult case. The above Factual Findings constitute the primary reasons and information relied upon by ACRC when it made its determination to

discontinue regional center services for claimant. Other matters were also raised by the parties, some of which will be briefly summarized here.

Claimant questioned whether ACRC ever undertook to perform a comprehensive reassessment as that term is used under Welfare and Institutions Code section 4643.5, subdivision (b). ACRC issued its NOPA in 2009, yet relied upon a “stale” IQ test administered in 2003. Claimant contends that ACRC’s decision to discontinue services was not driven by any comprehensive reassessment, but was in large part a reaction to more recent problem behaviors exhibited by claimant. ACRC viewed these same problem behaviors as evidencing a degree of sophistication not expected by one who is mentally retarded. The behaviors included securing and using credit cards in other people’s names, purchasing gift cards with credit cards and then telling the credit card company that the purchase was fraudulent and should be removed, and then using the gift cards. Claimant also transferred funds from other regional center clients’ bank accounts for his own use.

ACRC noted that claimant has not been willing to participate in job training programs and he cannot be made to do so. Claimant’s past participation in such training programs has been disruptive to others in the program. ACRC believes claimant takes advantage of other program participants and regional center consumers. ACRC also believes that claimant is using the fact of his “developmental disability” as a shield to avoid criminal prosecution.

25. Claimant was evaluated for general intellectual functioning subsequent to Dr. Prudhomme’s 2003 test administration. Baljit Atwal, Ph.D., evaluated claimant on October 27, November 5 and 18, 2010. Claimant was referred to her by the Placer County Superior Court for an evaluation regarding his adaptive and intellectual functioning in regards to his competency to stand trial. Dr. Atwal is a forensic and clinical psychologist. She testified at hearing.

Dr. Atwal administered the Reynolds Intellectual Assessment Scales (RIAS) to get a measure of claimant’s general intellectual functioning. The RIAS is a comprehensive measure of verbal, nonverbal intelligence and memory. It uses a verbal, nonverbal and composite index. Its indices measure both crystallized and fluid intelligence. The crystallized intelligence index includes reading comprehension, vocabulary and facts. The fluid intelligence index measures one’s ability to think, reason abstractly and solve problems. Claimant’s scores on the RIAS were as follows: Verbal Intelligence Index (68); Nonverbal Intelligence (61); Composite Intelligence Index (58); and Composite Memory Index (48). Claimant’s performance placed him in the significantly below average category in most indices. Dr. Atwal summarized his RIAS scores as follows:

Brent has significant deficits and processing verbal and nonverbal material. He also has severe deficits in memory for both verbal and nonverbal material. These deficits in cognitive and memory functioning will significantly impair Brent’s ability to carry out day-to-day tasks and to function independently.

26. Dr. Atwal opined that claimant “does have substantial evidence of mental retardation, including onset before age 18, significantly below average intellectual and adaptive behavior functioning as indicated by a score of 58 on the RIAS [Composite Intelligence Index] and low scores on the Adaptive Behavior Assessment System II. Thus, a diagnosis of mental retardation is warranted.” Dr. Atwal further noted that his history of low intelligence test scores, participation in special needs preschool program, eligibility for special education through high school, prior eligibility for ACRC services, and documented hypoxia at birth “all suggest significant cognitive, social, and adaptive functioning deficits as well as psychiatric symptoms.”

27. ACRC urged that Dr. Atwal’s written evaluation and testimony are unreliable because: 1) cognitive test results were reflective of claimant’s functioning at age 30, not age 18; 2) claimant was upset at the time of his test administration and because he was being tested to determine his competency to stand trial these factors might affect test results; 3) Dr. Atwal did not have access to most of claimant’s significant records and testing; 4) claimant’s mother was not an accurate reporter of facts concerning claimant; 5) Dr. Atwal was not aware of directives for the WAIS *Essentials* or DSM-IV-TR concerning averaging of IQ scores; and 6) Dr. Atwal demonstrated prejudice by insisting that claimant’s school records did not really mean what they said about his disability being related to a learning disability, not to mental retardation, even though this was recorded over a period of years.

ACRC’s criticism of Dr. Atwal’s test administration being at age 30, and not age 18, is incongruous given ACRC’s reliance upon a test administration given to claimant at age 23. The same might be said of ACRC’s criticism of Dr. Atwal relying upon information provided by claimant’s mother. ACRC determined that claimant’s mother was an accurate reporter when it relied upon information provided by her to challenge the validity of Dr. Nelson’s 1988 assessment.

The RIAS does appear, however, to be a more abbreviated test instrument designed to provide an estimate of general ability when more extensive batteries are not needed. Dr. Atwal’s primary focus was on claimant’s competency to stand trial and a RIAS served as a useful test instrument in that more limited context. A WAIS-III or WAIS-IV test administration is a more useful and comprehensive measure of claimant’s cognitive abilities in determining mental retardation.

28. Claimant was most recently tested at the Sutter Center for Psychiatry. He was administered the Wechsler Abbreviated Scale of Intelligence (WASI), a screening test for obtaining estimates of overall intelligence for children and adults. It has four subtests – Vocabulary, Block Design, Similarities and Matrix Reasoning. The test was administered by Francis Allen, M.S., a psychology intern under the supervision of Florina Yuger, Ph.D. The two described the test results as follows in their report:

Results from the Wechsler Abbreviated Scale of Intelligence

(WASI), a test measuring cognitive abilities, were consistently in the Extremely Low range, including subtests measuring Verbal and Performance IQ (57 and 66 respectively), as well as his Full Scale IQ (58). For his age group, 99.7% of all people in the normed group scored higher than [claimant]. The WASI results indicate that the Patient has limited acquired knowledge, compromised verbal reasoning and difficulty with attention to verbal information, as well as poor fluid reasoning, difficulties with special reasoning, problems with attention to detail, and compromised visual-motor integration.

29. The WASI is also an abbreviated test. It is used more as a screening test, and was not intended to be used as a replacement for more comprehensive tests such as the WISC-IV or WAIS-III. In that respect, it is similar to the RIAS test administration. Both tests were consistent in their findings that claimant was significantly below average in his cognitive abilities. Both supported ACRC's earlier finding that claimant was mentally retarded. Both contradicted findings by Dr. Prudhomme based upon the 2003 WAIS-III test administration.

30. A developmental disability must arise prior to age 18. Claimant likely suffered neurological damage at birth. ACRC noted that he was released from the hospital four days after his birth "in good condition on no medication," and is now suggesting that there is no evidence that claimant has suffered any lasting effects from his anoxia at birth.

In 1988, ACRC's own assessment team noted claimant's anoxia and incubator time and neurological complaints. Lee Neidengard, M.D., is the pediatrician who examined claimant on July 22, 1986, for Tri-Counties Regional Center. Dr. Neidengard noted a history of "evident perinatal asphyxia with very low initial Apgar scores and delayed spontaneous respirations as well as documented fetal decelerations in labor." Claimant's Apgar scores were 1 at one minute and 5 at five minutes. Claimant appeared "dusky with tachypnea" and independent respirations could not be established until about 12 minutes of age. Claimant required incubator care for "perhaps 3 or 4 days in order to clear transient tachypnea as a newborn."

Dr. Nelson noted claimant suffered neonatal asphyxia, along with claimant's Apgar scores of 1 and 5.

Claimant's psychiatrist, Dr. David Sisemore, wrote ACRC on August 31, 2011:

[Claimant] is diagnosed on the DSM-IV axis I with Major depressive disorder, Obsessive compulsive disorder, Intermittent explosive disorder and Tourettes syndrome. On axis II he is diagnosed with mental retardation. It is my professional opinion that [claimant's] mental retardation has been present prior to the age of 18 years of age, secondary to oxygen deprivation at birth.

Claimant's disability clearly originated prior to age 18.

31. Summary and Conclusions. ACRC has not established that its original determination that claimant has a developmental disability was clearly erroneous. One might readily conclude that an individual with mental retardation could never score as high as claimant did during the 2003 test administration by Dr. Prudhomme, and then discount the validity of earlier and subsequent testing where claimant scored within the range of mental retardation. That is essentially ACRC's case. Claimant obtained a FSIQ score of 79 on the 2003 test administration by Dr. Prudhomme. This reasonably raised doubts about whether the earlier determination of mental retardation was correct. The fact that claimant's verbal IQ score was 89 on that particular test administration amplified such concerns. But the differential between claimant's verbal and performance IQ scores was not to such degree that his FSIQ might be disregarded entirely as suggested by Doctors Prudhomme and Magnani. And the fact that claimant's performance IQ scores have consistently been below his verbal IQ scores, and not the reverse, over the years runs counter to ACRC's alternative explanation that claimant's has a learning disability. Although no findings were made on this point, claimant reasonably proffered an explanation for the spike in claimant's verbal performance – it reflected crystallized knowledge acquired by claimant over the years, and it reflected the use of a dated test instrument (WAIS-III) instead of the WAIS-IV, on which norming might have depressed IQ scores.

ACRC's criticism of the validity of Dr. Nelson's initial test was not supported by the evidence. As earlier noted, claimant consistently scored at that same level on similar IQ test administrations near the time of Dr. Nelson's test administration in 1988. Claimant's subsequent academic performance was not inconsistent with his earlier IQ testing to the extent that he tested in his late teens at approximately a sixth grade level. This is consistent with the DSM-IV-TR definition of mental retardation.

The two more recent test administrations by Dr. Atwal and Dr. Yuger did not independently establish that claimant is mentally retarded. This is because the tests employed (RIAS and WASI) were more summary screening tests, and not the type of comprehensive test instruments typically used to establish regional center eligibility. But such recent test results did temper and raise questions about the validity of Dr. Prudhomme's 2003 test results. In this case, ACRC relied upon test results that now date back nine years. ACRC is certainly not precluded from engaging in any future comprehensive reassessment that relies upon a more comprehensive test instruments such as the WAIS-IV.

32. If this were an initial eligibility determination case, claimant may not prevail on the current record. He would carry the burden of demonstrating by a preponderance of the evidence that he is mentally retarded. In the alternative, he would carry the burden of establishing fifth category eligibility, which by definition would be easier to establish in a given case. However, the appropriate inquiry in this case requires that any change in

claimant's status as a regional center client be supported by evidence that the original determination of eligibility was "clearly erroneous." ACRC bears this heavier burden.

33. The above evidence and arguments having all been considered, it is determined that ACRC did not establish, based upon the current record, that its original determination that claimant has a developmental disability is clearly erroneous. Given this determination, it is not necessary to consider whether claimant should also be made eligible under the fifth category.

## LEGAL CONCLUSIONS

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

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

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

3. Under Welfare and Institutions Code section 4643.5, subdivision (b):

An individual who is determined by any regional center to have a developmental disability shall remain eligible for services from regional centers unless a regional center, following a comprehensive reassessment, concludes that the original determination that the individual has a developmental disability is clearly erroneous.

4. ACRC determined in 1988 that claimant has a developmental disability (mental retardation) that originated before age 18 and that continues, and that constitutes a substantial disability for him. It now believes this determination was clearly erroneous.

5. The matters set forth in Findings 24 through 33 have been considered. ACRC did not establish that its original determination that claimant has a developmental disability is clearly erroneous. Given this determination, it is unnecessary to consider whether claimant has a disabling condition closely related to mental retardation or requiring treatment similar to that required for mentally retarded individuals.

6. Claimant is eligible for continued services through Alta California Regional Center. He should immediately be reinstated for ACRC services.

7. Claimant seeks costs and/or reasonable attorney fees associated with this case. Such are not authorized under the Lanterman Act or other laws governing this proceeding. Any other assertions raised by the parties which are not addressed above are found to be without merit and are rejected.

#### ORDER

Claimant's appeal from Alta California Regional Center's denial of eligibility for continued services is granted. Claimant is eligible for continued regional center services under the Lanterman Act. He shall immediately be reinstated for ACRC services.

DATED: April 10, 2012

---

JONATHAN LEW  
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).)**