

BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT

and

WESTSIDE REGIONAL CENTER,

Service Agency.

OAH No.: 2013020410

SECOND AMENDED DECISION AFTER REMANDS

On July 9 and 10, 2013, November 12, 2015, and January 7, 2016, Jennifer M. Russell, Administrative Law Judge with the Office of Administrative Hearings, heard this matter in Culver City, California. N. Jane DuBovy, Attorney at Law, represented Claimant, who was not present at the hearing. Lisa Basiri, M.A., Fair Hearing Coordinator, represented Westside Regional Center (WRC) on the first two hearing days, and Julie A. Ocheltree, Attorney at Law, represented WRC on the last two hearing days.

On January 28, 2016, the re-opened record closed and the matter was re-submitted for determination after receipt of the parties' closing briefs. Claimant's Closing Brief for Supplemental Fair Hearing Pursuant to Interlocutory Writ is marked for identification as Claimant Supplemental Exhibit 20. WRC's Service Agency's Closing Argument is marked for identification as WRC Supplemental Exhibit 10.

ISSUES FOR DETERMINATION

1. Whether Claimant is eligible for regional center services and supports under the qualifying category of autism as provided for in section 4512, subdivision (a) of the Welfare and Institutions Code.

2. Whether Claimant is eligible for regional center services and supports under the qualifying "fifth category," defined as a "disabling condition found to be closely related to intellectual disability or to require treatment similar to that required for individuals with

intellectual disability” as provided for in section 4512, subdivision (a) of the Welfare and Institutions Code.¹

STATEMENT OF THE CASE AND ITS PROCEDURAL HISTORY

WRC determined that Claimant did not present with autism or a disabling condition closely related to intellectual disability or a disabling condition requiring treatment similar to that treatment required for individuals with intellectual disability, and consequently did not fall within the qualifying developmental disability categories of autism or fifth category set forth in section 4512, subdivision (a) of the Welfare and Institutions Code, which is part of the Lanterman Developmental Disabilities Services Act (Lanterman Act).² WRC therefore determined that Claimant was ineligible for regional center services and supports. Claimant appealed WRC’s ineligibility determination and denial of services and supports under the fair hearing provisions of the Lanterman Act.³

Following an initial two-day hearing in July 2013, the Administrative Law Judge issued a September 4, 2013 Decision affirming WRC’s ineligibility determination and denial of services and supports. Claimant challenged the September 4, 2013 Decision in a petition for a writ of administrative mandate pursuant to Code of Civil Procedure section 10904.5. On February 4, 2015, the Superior Court of California, Los Angeles County, in case number BS146164, issued an interlocutory writ requiring, among other things, the Administrative Law Judge to clarify and supplement factual findings regarding Claimant’s intellectual functioning and to specify how and to what extent Claimant’s developmental deficits derive from learning disabilities or psychological disabilities. (See OAH Ex. 1.)

On May 8, 2015, the Administrative Law Judge issued an Amended Decision After Remand with an extensive analysis of the essential characteristics of intellectual disability and legal conclusions that Claimant failed to produce a preponderance of evidence establishing that his intellectual functioning is closely related or similar to that of an individual with intellectual disability, that Claimant failed to produce a preponderance of

¹ In this Second Amended Decision After Remands, the Issues For Determination section has been revised to reflect the California Legislature’s 2014 amendments replacing the term “mental retardation” with the term “intellectual disability” in Welfare and Institutions Code section 4512, subdivision (a). The amendments, which are consistent with nomenclature of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (2013) (DSM-5), became effective January 1, 2015, which is after the Administrative Law Judge issued the initial September 4, 2013 Decision in this matter. The Factual Findings and Legal Conclusions sections have not been revised to remove the term “mental retardation,” if it appeared in those sections in the September 4, 2013 Decision.

² Welf. & Inst. Code, § 4500, et seq.

³ Welf. & Inst. Code, § 4700, et seq.

evidence establishing that his demonstrated deficits in academic learning are manifestations of intellectual limitations closely related or similar to that of an individual with intellectual disability, and that Claimant failed to produce a preponderance of evidence establishing that he has substantial deficits in adaptive functioning that are closely related or similar to adaptive functioning deficits of an individual with intellectual disability, and which require treatment similar to the treatment required by an individual with intellectual disability.

Claimant thereafter maintained in the Superior Court that the May 8, 2015 Amended Decision After Remand relies on and cites to extra-record evidence—the American Psychiatric Association’s Diagnostic and Statistical Manual for Mental Disorders in its current reiteration, the DSM-5, and *Association of Regional Center Agencies Guidelines for Determining “5th Category” Eligibility for the California Regional Centers* (Approved by the ARCA Board of Directors on March 16, 2002) (*5th Category Guidelines*)—to reach its legal conclusions. Claimant asserted a lack of opportunity to address the *5th Category Guidelines* in connection with his arguments that he has a disabling condition requiring treatment similar to that of a person with intellectual disability.

On October 23, 2015, the Superior Court remanded the case to re-open the proceedings to include the DSM-5 and the *5th Category Guidelines* in the administrative record and to permit the parties to present “evidence and make arguments regarding whether [Claimant] qualifies for eligibility under the *5th Category Guidelines* with respect to whether [Claimant] requires ‘treatment similar to that required for individuals with an intellectual disability.’” (OAH Ex. 2.) The Superior Court additionally indicated that the parties “may present evidence and make arguments regarding how the criteria within the DSM-5 for specific learning disorder apply to [Claimant].” (*Id.*)

Commencing November 12, 2015, the Administrative Law Judge re-opened the proceedings in this matter. The parties acknowledged that Claimant was tested, assessed, and evaluated at a time when health professionals employed an earlier iteration of the Diagnostic and Statistical Manual for Mental Disorders, the DSM-IV-TR,⁴ which used the term “mental retardation.” By the time of the re-opened proceedings in this matter, the DSM-5, which employs the term “Intellectual Disability,” was published and in effect.⁵ Thus, as set forth in Legal Conclusions 5 and 13, analysis of Claimant’s eligibility for regional center services and supports under the qualifying category of autism and “fifth category” relies on the classifications and definitions in the DSM-5. The parties stipulated to the admissibility of the DSM-5. Provisions of the DSM-5 relied on and cited to throughout

⁴ Diagnostic and Statistical Manual of Mental Disorders, 4th ed., Text Revised.

⁵ Pursuant to Government Code Section 11515, the Administrative Law Judge takes official notice that, regardless of its iteration, the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders is a generally accepted diagnostic tool for mental disorders.

the proceedings in this matter appear in WRC Supplemental Exhibits 1 through 6, which are marked for identification and admitted in evidence.⁶

Claimant objected to the admissibility of the *5th Category Guidelines* on several grounds, all of which were overruled. Claimant argued that the *5th Category Guidelines* is not relevant because no witness testifying on behalf of WRC indicated that it informed or served a purpose in WRC's eligibility deliberative processes in Claimant's case. As set forth in Factual Findings 25, a witness involved in WRC's eligibility deliberative processes explained and clarified WRC's use of the *5th Category Guidelines* in WRC's eligibility determinations generally, and particularly in Claimant's case. Claimant additionally argued that the *5th Category Guidelines* is not controlling authority because it has never been codified, the advocacy group Disability Rights of California is critical of it, and subsequent development in the case law after its creation, namely the *Samantha C.* case,⁷ has rendered it "no longer appropriate." The argument is rejected because it evinces a fundamental misunderstanding of how regional centers use the *5th Category Guidelines* during eligibility determinations. (See Factual Finding 25.)

Claimant further argued that the Administrative Law Judge's reliance on the *5th Category Guidelines* constitutes an offer of evidence, which in turn creates an appearance of judicial bias requiring disqualification of the Administrative Law Judge. The Administrative Law Judge has accumulated specialized knowledge and technical competence from her years of experience as the presiding officer in other similar fair hearing proceedings to determine eligibility for Lanterman Act services and supports. Consequently, the Administrative Law Judge is knowledgeable about the routine use of *5th Category Guidelines* in eligibility determinations as set forth in Factual Findings 25. Government Code section 11425.40, subdivision (b), provides "[i]t is not alone or in itself ground for disqualification, without further evidence of bias, prejudice, or interest, that the presiding officer . . . [¶] . . . [h]as experience, technical competence, or specialized knowledge of . . . a legal, factual, or policy issue presented in the proceeding." The Administrative Law Judge stands corrected by the Superior Court that judicial notice pursuant to Government Code 11515 should have been taken of the *5th Category Guidelines*. Not doing so, however, does not amount to grounds for disqualification. Claimant has failed to establish grounds for judicial disqualification. Based on the foregoing, pursuant to Government Code section 11515, the Administrative Law Judge takes official notice of the *5th Category Guidelines*, which is marked for identification and admitted as WRC Supplemental Exhibit 7.

⁶ After the re-opened proceedings closed and during deliberation, the Administrative Law Judge determined that the administrative record should also include the excerpts of the DSM-IV-TR cited to or referenced in the Second Amended Decision After Remands. Those provisions of the DSM-IV-TR are marked for identification and admitted in evidence as OAH Exhibit 3.

⁷ *Samantha C. v. State Dept. of Developmental Services* (2010) 185 Cal.App.4th 1462. See Legal Conclusion 18c for analysis of the *Samantha C.* case.

Having considered the parties' presentation of additional evidence and arguments, the Administrative Law Judge determines in this Second Amended Decision After Remands that Claimant has failed to produce a preponderance of reliable, competent evidence establishing that he presents with a substantially disabling condition requiring treatment similar to that treatment required for individuals with intellectual disability.

FACTUAL FINDINGS

1. Claimant is a 21-year old man residing with his adoptive parents. In December 2010 and, most recently, in September and October 2012, WRC evaluated Claimant to determine his eligibility for services and supports provided for in the Lanterman Act. WRC has determined that Claimant is ineligible for Lanterman Act services, and Claimant has appealed.

Claimant's Academic Background and Related Evaluations

2a. Claimant commenced nursery school when he was two years old and pre-school when he was three years old. Claimant enrolled in a private, religious school when he was five years old for pre-kindergarten, which grade he repeated. In November 1997, when Claimant was five years and three months old, Lorie A. Humphrey, Ph.D., Program Supervisor at the H.E.L.P Group/UCLA Neuropsychology Program, conducted a neuropsychological assessment of Claimant, which included her observations of Claimant in the classroom and playground and her administration of several assessments, including the Wechsler Preschool and Primary Scale of Intelligence-Revised (WPPSI-R), to Claimant. On the WPPSI-R, Claimant's Full Scale IQ was reported as 95, which is within the average range. Claimant performed relatively better in the verbal domain of the WPPSI-R, but there was no significant discrepancy between Claimant's verbal and performance scores. Dr. Humphrey reported that Claimant showed "strengths on measures of psychomotor planning and understanding of everyday events" and "relative weakness on a measure asking [him] . . . to repeat sentences and on a subtest measuring his knowledge of the kinds of information learned in school." (WRC Ex. 19.) On language functioning, Claimant reportedly was "able to use language conceptually, exhibiting strengths in his ability to express relationships and explain rationales using speech. He did not require that instructions be repeated to him, and he was able to participate in a two way conversation[.]" Dr. Humphrey noted "some relative difficulties with rapid naming," and indicated that "rapid naming has been found to be sensitive to later reading skills; low scores in this area indicate that a child would benefit from early reading training." More specifically, Dr. Humphrey observed that Claimant scores "at the 35thile for naming colors, but only the 14th percentile (low average) for naming objects. He was unable to name letters or numbers, as he said he didn't know them yet." Claimant additionally "exhibited poor phonological awareness (understanding of sound/symbol relationship)," which Dr. Humphrey attributed to Claimant "not having been exposed to the relationships between sounds and letters, as he seemed to 'catch on' to this concept during the course of [the] exam." (WRC Ex. 19.)

2b. Dr. Humphrey reported a “below average” for Claimant’s executive functioning skills as expressed in his ability to plan and execute a motor task, his ability to use feedback to problem solve, and his ability to express relationships between objects. During the course of her evaluation of Claimant, Dr. Humphrey noted that Claimant was able to stay on task for extended periods when the task was stimulating; otherwise, Claimant had difficulty staying on task. Claimant’s score on the Animal Pegs performance subtest was high average, which indicates “intact sustained attention and motor control in a short-term condition.” Administration of the Test of Variables of Attention to Claimant indicated, however, that he “exhibited clinically significant difficulties with impulsivity.” Claimant had “difficulty staying on task” compared to other boys his age. Dr. Humphrey found this indication of Claimant’s impulsivity to be consistent with reporting elicited from Claimant’s mother and teachers using the Conners’ Rating Scale-Long Form, which identifies children at risk for Attention Deficit Hyperactivity Disorder (ADHD). The ADHD index indicated “significant elevations” for Claimant. (WRC Ex. 19.)

2c. Dr. Humphrey concluded that the results of Claimant’s assessment indicate that he “is a boy of average intelligence,” who functions evenly across verbal and non-verbal domains. Dr. Humphrey noted that Claimant was struggling with symptoms of inattention, hyperactivity and impulsivity, and that Claimant met the diagnostic criteria for ADHD, combined type. Dr. Humphrey indicated that Claimant’s “attention deficit disorder is making it difficult for him to participate effectively in his current nursery school classroom.” Dr. Humphrey explained as follows: “It is likely that [Claimant’s] difficulties with inattention and restlessness are impacting his ability to learn in traditional settings. Other aspects of cognitive functioning that are often impacted in an ADHD syndrome have been spared in [Claimant’s] case, however, he exhibited strengths in psychomotor planning and fine motor skills, and was able to maintain his attention on short, directed tasks. Difficulties with some aspects of executive functioning, including rapid naming and problem solving, yielded low average scores, however, and have likely been impacted by [Claimant’s] ADHD.” (WRC Ex. 19.)

2d. According to Dr. Humphrey, Claimant’s “stressful home situation and emotional distress are likely exacerbating his ADHD symptomatology.” Dr. Humphrey noted that Claimant’s family has been under considerable stress during the past few years: “Severe financial difficulties have caused the family to move to San Diego where they encountered trauma and harassment, followed by a return to Los Angeles where they have had to live in a motel room for the past two years. In addition to the lack of structure and predictability that this environment has caused, [Claimant’s] parents have experienced substantial stress leading to increased conflict in the home. [Claimant] is preoccupied with themes of ‘bad men with guns’ and exhibited both anger and nervousness during the course of this brief exam. His uncertainty about getting his needs met was clear in the anxiety and indecision he exhibited to the examiner, and his anger about his home environment and parent’s struggles was also evident in his refusal to participate in some more open-ended aspects of the testing[.]” (WRC Ex. 19.)

3a. Claimant exhibited significant difficulties with reading and writing in the first grade at a private school. Consequently, in November 1999, Dr. Humphrey conducted another evaluation of Claimant when he was seven years and three months old. Dr. Humphrey administered the Full Wechsler Intelligence Scale for Children-III (WISC-III), on which Claimant's Full Scale IQ score was assessed as 95, the 37th percentile, which is in the average range. Claimant's scores on the arithmetic subtest of the WISC-III were in the average range. He showed "specific strength" on the vocabulary subtest measuring his ability to define words. Claimant's vocabulary subtest scores placed him in the 84th percentile. He showed "relative weakness" of a measure of general fund of information (16th percentile) and on a measure requiring that he code numbers and symbols (16th percentile). An administration of the Woodcock-Johnson Revised Test of Achievement to Claimant indicated his significant difficulty with reading (scoring in the second percentile) and writing (scoring in the seventh percentile). Claimant demonstrated good ability applying mathematical concepts to actual situations. He is able to reason mathematically with the use of manipulatives.

3b. Several measurements of Claimant's executive functioning—his ability to plan, monitor and strategize in order to effectively problem-solve—yielded variable results: on the WISC-III Digit Span sub-test, Claimant achieved a score at the 50th percentile; on the WISC-III Coding sub-test, he scored at the 16th percentile; on the WISC-III Mazes sub-test, he scored in the 63d percentile; and on the Children's Category Test (CCT), which is an ambiguous problem-solving measure, Claimant achieved a score at the 42d percentile, which is in the average range, and, according to Dr. Humphrey, was consistent with his IQ score at the time. Dr. Humphrey reported that Claimant's CCT score was "an improvement from his score at the 16[sic] percentile in 1997." Claimant "performed better relative to his peers on the current administration of the [CCT] than he had in 1997." (WRC Ex. 18.)

3c. Dr. Humphrey indicated that medication has been handling Claimant's impulsive behavior since her 1997 evaluation of him. She noted that Claimant is capable of paying attention when he has taken his medication. However, when Claimant is non-compliant with his medication, his problem behaviors returned rapidly. Dr. Humphrey additionally reported that consistent with ADHD syndrome, when a task demands Claimant's combined attention and psychomotor speed, Claimant's "scores are lower." (WRC Ex. 18.)

3d. The results of language testing, which yielded "predominantly average scores," indicate that Claimant is "able to express himself well." He was able to converse about his life and to communicate ideas. On color naming and object naming tasks, Claimant's scores were above average. On letter naming and number naming tasks, Claimant's scores were impaired. Dr. Humphrey noted that "it is likely these impaired scores are due to [Claimant's] learning issues, rather than to actual rapid naming deficits." (WRC Ex. 18.) Dr. Humphrey reported that Claimant performed well on most measures of visual perceptual abilities in a manner consistent with his stronger math skills. (WRC Ex. 18.) Claimant was in the "expected range" in his ability to identify which important part of a picture was missing, to copy patterns with blocks, and to put puzzles together when the

outline was provided. He had “selected difficulties” with visual perceptual tasks when they did not have a motor component. (WRC Ex. 18.)

3e. Testing of Claimant’s memory yielded scores in the low average range. He had difficulty organizing information to be learned and difficulty filtering out unnecessary information from what he was trying to memorize. Dr. Humphrey reported that testing suggested Claimant would benefit from repetition of information to be learned and that information should be broken down into manageable pieces.

3f. Dr. Humphrey concluded, “Consistent with previous testing, [Claimant] continues to demonstrate age-level intellectual abilities. He is able to reason and conceptualize at the expected level across both verbal and non-verbal domains. In contrast to this adequate intellectual functioning, [Claimant] is having tremendous difficulty acquiring basic skills of reading and written language. His broad reading score is 25 points lower than his expected functioning as measured by his IQ, indicating that he meets criteria for a learning disability in reading. Additionally, although the discrepancy between his IQ and broad written language score was not quite as significant, [Claimant] is having considerable difficulty in this domain as well; he should receive intervention in both areas.” (WRC Ex. 18.)

3g. Dr. Humphrey reported that although Claimant’s IQ is at the expected level given his age, Claimant is unlikely to reason and conceptualize at the level of many of his classmates in his academically rigorous school setting. “The finding of average intelligence combined with his ADHD and learning disabilities supports the report that [Claimant] is having far more trouble experiencing success in the classroom than are his peers. The academic rigor and dual language curriculum of his current school appear to be a poor match for [Claimant’s] skills, suggesting that he may experience more success in a less academically competitive environment.” Dr. Humphrey recommended that Claimant’s parents explore other schools where Claimant’s “average-level abilities will be more the norm” and where Claimant would receive individual resource support. (WRC Ex. 18.)

3h. During the course of her 1999 evaluation of Claimant, Dr. Humphrey also administered the Children’s Depression Inventory (CDI) to Claimant, and his performance on the CDI caused her to refer him to a psychotherapist. Dr. Humphrey reported that Claimant is functioning better at school than at home, in part due to his medication, but also perhaps because his school life is more predictable and structured than what his home life offers. Claimant expressed thoughts of hurting himself because of sadness and anger associated with his parents’ fighting and marital discord. (WRC Ex. 18.)

3i. Dr. Humphrey did not testify at the hearing. Dr. Humphrey’s persistent observations and interactions with Claimant during Claimant’s earliest developmental years coupled with her cogent presentation and analysis of the assessments she administered to Claimant render her findings that Claimant presents with average intellectual functioning, learning disabilities, and ADHD credible and worthy of significant weight.

4. On May 16, 2000, an initial Individualized Education Plan (IEP) established Claimant's eligibility for special education services in the Beverly Hills Unified School District (BHUSD) under the criteria for Specific Learning Disability and Emotional Disturbance. A November 2002 BHUSD Psychoeducational Assessment, when Claimant was 10 years and three months old, reportedly indicates that Claimant displayed significant difficulty in the area of retention, which adversely affected his educational performance. There was significant discrepancy between Claimant's cognitive ability, which was measured in the low average range, and his achievement in written expression, an area in which he demonstrated significant weakness. According to this November 2002 assessment, Claimant "met special education eligibility under Multiple Disabilities due to his educationally defined attention deficit, specific learning disability, significant deficit in the area of language and emotional disturbance." (WRC Ex. 11.)

5a. In March 2003, Claimant enrolled in a non-public school for students with special needs. In May 2003, Claimant was enrolled in the fourth grade. A school psychologist in the Special Service Department at BHUSD conducted an adaptive behavior assessment of Claimant using the Vineland Adaptive Behavior Scales (Vineland). Claimant was 10 years and nine months old. The Vineland revealed "significant area of concern in communication and language skills as well as his behavior/social skills/emotionality." (WRC Ex. 11.) According to the scale reported by his mother, Claimant's communication skills fell in the moderately low range (SS⁸=78); his daily living skills fell in the moderately low range (SS=77); and his socialization skills fell in the low range (SS=66). (WRC Ex. 11.) According to the scale reported by his teacher, Claimant's communication skills fell in the moderately low range (SS=75); his daily living skills in the moderately low range (SS=74); and his socialization skills fell in the moderately low range (SS=76). (WRC Ex. 11.) In the area of social/emotional development, the school psychologist noted that Claimant "was experiencing significant difficulties with depression as well as other social-emotional problems." (WRC Ex. 11.) The school psychologist specifically noted that Claimant "exhibited a pervasive mood of unhappiness and depression which had existed for a long period of time and to a marked degree and was significantly impacting his school performance." (WRC Ex. 11.) The school psychologist opined that Claimant would benefit from academic instruction within a very structured, small group setting and that Claimant should be given more responsibilities at home to achieve independence and to experience success. (WRC Ex. 11.)

5b. In February 2004, Claimant threatened to hurt one of his classmates, and he refused to apologize to the classmate stating that rather than apologizing he preferred to kill himself. As indicated in Factual Finding 16c, Claimant was admitted to the UCLA Neuropsychiatric Hospital ABC Treatment Program, and during that admission, among other things, it was determined that the non-public school for students with special needs was "not adequate for the severity of [Claimant's] . . . current deficits," and a residential treatment

⁸ The denotation "SS" refers to standard scores, which are mathematically adjusted raw scores for the purpose of achieving comparability.

program was recommended for Claimant. (WRC Ex. 16.) A letter recommending Claimant's placement in a residential treatment environment states the following:

[Claimant] continues to exhibit enduring impairment in school functioning and a significant decline in his general functioning. This includes inappropriate types of feelings under normal circumstances, a pervasive mood of unhappiness, an inability to maintain satisfactory relationships with others, and deficits in executive functioning. These deficits include, but are not limited to the following: difficulties planning and organizing, anticipating consequences, retention and memory (e.g. holding a goal and plan in mind), shifting mental sets (mental flexibility), emotional control, inhibiting impulses, and monitoring (task-oriented monitoring and interpersonal awareness). These difficulties have now existed over an extended period of time and to a marked degree and appear to severely hinder his overall functioning.

[Claimant] has a history of and continues to exhibit the difficulties described as well as poor impulse control (especially as manifested by disruptive and rash behaviors and difficulty anticipating the effects or consequence of his behaviors), limited attention regulation, a tendency to become easily overwhelmed, a tendency to perseverate on ideas or issues, and a limited ability to identify or apply effective coping strategies. . . . [Claimant] continues to have trouble in identifying and implementing adaptive coping skills when difficulties arise at school.

Given the severity and pervasive nature of [Claimant's] emotional, cognitive, academic, and functional difficulties in conjunction with his poor response to his current special education program, it appears that he currently requires an increase in special education and related therapeutic services in all aspects of his daily program in order to ensure his continued safety, facilitate his academic progress, and direct and monitor him in appropriate . . . goal-directed activities.

(WRC Ex. 16.)

6a. Between September 2004 and March 2005, Claimant enrolled in a non-public, residential school located in Washington, Connecticut where he reportedly made progress. Unspecified medical concerns, however, caused Claimant to discontinue his attendance there. Claimant thereafter enrolled in another residential school located in Provo, Utah, which, after a one-month stay during June 2005, proved to be an inappropriate fit for Claimant. At the Utah school, Claimant exhibited mood lability, e.g., depressed mood and suicidality. In addition, without providing any specificity, the Utah school reported that Claimant's social skills lagged behind those of his peers. The Utah school referred Claimant for a psychological evaluation to determine his intellectual level. Claimant was 13 years old

at the time. A “Dr. Carlisle” reportedly⁹ conducted an August 2005 psychological evaluation and determined that Claimant had a verbal IQ score of 72, a performance IQ score of 58, a Full Scale IQ score of 62, and that he was “functioning within the range of mild mental retardation and he has ADHD and shows the characteristics of Fetal Alcohol Syndrome. He is a very emotional person and he has what appear to be auditory and visual hallucinations.” (WRC Ex. 10.)

6b. Testimonial and documentary evidence offered at the hearing did not disclose the full identity of “Dr. Carlisle” or his or her professional background or affiliation. No psychological evaluation report containing analysis and discussion of testing information attributed to Dr. Carlisle was offered at the hearing. It is unknown which assessments Dr. Carlisle administered.

7a. On September 6, 2005, Claimant was admitted to the UCLA Neuropsychiatric Hospital ABC Treatment Program where Mary J. O’Conner, Ph. D., ABPP, his attending psychologist, administered, among other assessments, the Wechsler Intelligence Scale for Children—Fourth Edition (WISC-IV) and the Wechsler Individual Achievement Test II (WIAT-II) to him. Dr. O’Conner reported Claimant’s WISC-IV subtest scores as follows: a Verbal Comprehension Index Score of 96 (39th percentile), suggesting that Claimant’s verbal skills were in the average range for tasks requiring Claimant to compare pairs of related concepts and to demonstrate an understanding of social rules and behaviors; a Perceptual Reasoning Index Score of 92 (30th percentile), placing Claimant in the average range for reasoning and problem-solving; a Working Memory Index Score of 74 (4th percentile), indicating a deficit in Claimant’s ability to hold and manipulate information in his head; and a Processing Speed Index Score of 59 (.03 percentile), indicating significant impairment of Claimant’s ability to quickly and correctly scan, sequence, and discriminate simple non-verbal information. Based on scores obtained on these four indices, Dr. O’Conner reported a Full Scale IQ score of 70 for Claimant on the WISC-IV and noted that “this overall score does not best represent [Claimant’s] general cognitive functioning.” According to Dr. O’Conner, “In [Claimant’s] case, it is more useful and appropriate to describe his abilities as lying in the Average range for Verbal Comprehension and Perceptual Reasoning, in the Borderline range for Working Memory, and in the Extremely Low range for Processing Speed.” (WRC Ex. 14.)

Dr. O’Conner reported that Claimant, who at the time was 13 years and one month old, had significant deficits across a number of academic domains including reading, math, spelling, and written expression, as measured on the WIAT-II, notwithstanding his overall cognitive functioning in the average range. In the area of Word Reading Claimant’s academic level of achievement was that of an 11-year old, and in the area of Pseudoword Decoding, a 12-year old’s academic level of achievement, but a nine-year old’s level of achievement in Reading Comprehension. In the area of Numerical Operations Claimant’s academic level was that of a seven-year old and in the Math Reasoning Claimant academic

⁹ A mention of Dr. Carlisle is contained in Claimant’s February 8, 2012 IEP, which IEP is discussed in Factual Finding 14.

level of achievement was that of a nine-year old. His Listening Comprehension was that of a 10-year old's level of achievement. According to Dr. O'Conner, "Although his ability to decode words appears to be intact (Pseudoword Decoding=47th %ile), he does not appear to understand the text that he reads (Reading Comprehension=3rd %ile). Similarly, he is unable to solve math problems or spell most words correctly and has great difficulty expressing himself in written format (Math Composite=0.2nd %ile, Written Language Composite=1st %ile). Considering his performance on these tasks, [Claimant's] current academic skills lie well below what would be expected based on his cognitive testing results. It is likely that his impairments are related to central nervous system dysfunction related [to] the effects of fetal alcohol exposure."¹⁰ (WRC Ex. 14.)

7b. In a "To Whom it May Concern" October 3, 2005 letter, Dr. O'Conner provides the following additional analysis of Claimant's cognitive functioning: Claimant's "performance on the Kaufman Brief Intelligence Test (K-BIT) indicated cognitive functioning in the 37th %ile (FSIQ=95). Of note, this score exactly matches [Claimant's] K-BIT score when he was given the measure in August 2003.¹¹ Despite evidence from August 2005 testing of cognitive deterioration, these results, in addition to behavioral observations and casual interactions with [Claimant], do not indicate a significant drop in cognitive abilities for [Claimant]. Considering this outcome, it is advised that testing conducted in August 2005^[12] be considered invalid due to the negative impact that [Claimant's] social and mood difficulties had on the process." (WRC Ex. 13.) In the October 3, 2005 letter, Dr. O'Conner noted "evidence of [Claimant's] intact cognitive functioning," Claimant's "current self-regulation gains, and Claimant's "significant deficits in adaptive functioning abilities, particularly in the areas of social skills and daily living skills, as compared to [his] same-age peers." Dr. O'Conner considered improvements Claimant made when he participated in a highly structured, behaviorally reinforcing program and she recommended "a contained, intensive special education program throughout the day" for Claimant. "He requires a highly structured classroom with a low student-to-teacher ratio in order to benefit from instruction, increase his independent academic skills, and continue to progress in adaptive classroom behaviors. For example, he requires explicit guidance and modeling to assist him in

¹⁰ Discussed in more detail in Factual Finding 16b below.

¹¹ The K-BIT measures fluid intelligence (innate ability to problem solve) as well as crystallized intelligence (information and knowledge acquired through education and experience). Dr. O'Conner's mention of Claimant's cognitive functioning as assessed using the K-BIT did not contain any analytical discussion of the K-BIT's 20 component subtests or of Claimant's performance on those subtests. No testimonial or documentary evidence, including analysis and discussion of results and scoring, was offered at the hearing regarding the August 2003 administration of the K-BIT Dr. O'Conner mentioned. It appears that a Lynn C. Siegel, Psy.D. administered the mentioned K-BIT. (WRC Ex. 8.)

¹² This reference to testing in August 2005 appears to be a reference to the psychological evaluation reportedly conducted by Dr. Carlisle. (See Factual Findings 6a and 6b.)

distinguishing adaptive and maladaptive behaviors, planning and approaching problematic situations, shifting attention and focus, and regulating emotions. [Claimant] . . . may benefit from meeting each morning with a school counselor to review the challenges of the day and to help him develop strategies for dealing with frustration.” (WRC Ex. 13.)

7c. Dr. O’Conner additionally recommended for Claimant “a modified curriculum and remedial materials in all subject areas to address his weaknesses in reading comprehension, visual-motor integration skills, writing, and oral communication. He will also benefit from shortened assignments and a reduction in the amount of external stimuli in his immediate work space, due to his limited alertness and difficulties sustaining attention for a long period of time. For example, it is recommended that he be assigned several short assignments rather than a few longer assignments and that his desk be cleared of all but the necessary items that he may need to complete the task at hand.” (WRC Ex. 13.)

8. After an unspecified period of home schooling during the 2005-2006 academic year, Claimant re-enrolled at the same non-public, residential school located in Connecticut as a 14-year-old and he remained there until he was 17 years old. Claimant’s academic performance during that time is summarized in a BHUSD Special Services Department February 2012 report as follows:

During the 2006-2007 school year, [Claimant] was performing around the 3rd and 4th grade instructional level in reading, language arts and math. [Claimant] was frequently off task, demonstrated a very slow work pace and had a low tolerance for frustration. . . . In Spring 2007, [Claimant] participated in statewide testing scoring in the Below Basic range in English Language Arts and Far Below Basic range in General Mathematics, History-Social Science and Science. [Claimant’s] services included Specialized Academic Instruction for 300 minutes daily . . . , 90 minutes per week of Speech and Language Services, 60 minutes per week of Occupational Therapy . . . and 60 minutes weekly of DMH [Department of Mental Health] counseling.

During the 2007-2008 school year, [Claimant] earned A’s, B’s and C’s in all subject areas. . . . Changing classes helped identify when [Claimant] was shutting down and prevented him from shutting down all day; he was able to recoup quicker, at times, with a new staff member. [Claimant] began to self-advocate for himself when he needed help in the classroom, however he was still dependent on the teacher to recognize his signs of shutdown to help [him] refocus. [Claimant] utilized many of the strategies he had been given, such as the Alpha-Smart for writing in his classes. He continued to have difficulty accepting suggestions and help from the teacher.

During the 2008-2009 school year, [Claimant] earned A’s and B’s in the fall. In the spring and summer, he earned B’s and C’s and an A in Work Training. [Claimant] continued to benefit from the small classroom environment. He had strong verbal and decoding skills and continued to make slow but steady

academic progress. He relied on teacher support and struggled with working independently. [Claimant] continued to have difficulty understanding the effect that his behavior had on others when discussing a conflict situation in which he was involved. [Claimant's] expectation was frequently that the other person should understand what [Claimant's] intentions were. He continued to need adult assistance in order to engage in a problem solving discussion, to explore alternative choices and develop more effective decision-making skills. With regard to behavior, [Claimant] exhibited aggression towards staff, elopement off campus and severe property destruction. In December 2008, [Claimant] participated in a Developmental Cognitive Neuroimaging Study of children and adolescents through UCLA.¹³ While no formal report was provided, cognitive scores indicate his Verbal Comprehension [SS=87] and Working Memory [SS=88] ability were within the low average range. His Perceptual Reasoning score [SS=90] was within the average range. Processing Speed [SS=85] was extremely low. In February 2009, [Claimant] took the California High School Exit Exam. He did not pass in either English Language Arts or Mathematics.

During the 2009-2010 school year, [Claimant] earned A's, B's and C's in the fall and spring terms[.] In November 2009, [Claimant] again took the California High School Exit Exam, passing English Language Arts and not passing the modified Mathematics portion. In January 2010, a behavior emergency report was filed when [Claimant] refused to separate from a group of boys, caused property damage to a teacher's car by throwing a rock at it and eloped from the campus, requiring police intervention. [Claimant] received minor injuries from the police dog and was taken to a hospital for evaluation. In Spring 2010, [Claimant] participated in statewide testing scoring in the Far Below Basic range in English Language Arts and U.S. History.

(WRC Ex. 10.)

¹³ The UCLA neuro-imaging study, which bears the name of Elizabeth R. Sowell, Ph.D., reported a Full Scale IQ score of 78 on the WISC-IV, which placed Claimant's general cognitive status in the borderline range of intellectual functioning. Claimant's scores on the Verbal Comprehension Subtests were within the average range for Comprehension and Vocabulary and within the low average range for Similarities. His scores on the Working Memory Subtests were within average range for Digit Span Letter Span Rhyming and Nonrhyming, within low average range for Letter Number Sequencing, Arithmetic PA Part B and Visual Digit Span, deemed extremely low for Written Arithmetic and Spatial Span Forward, and borderline for Arithmetic PA Part A and Letter Number Sequencing, PA. Claimant's scores on the Perceptual Reasoning Subtests were within the average range for Block Design, Picture Concepts and Matrix Reasoning. On the Processing Speed Subtests Claimant's Coding scores were extremely low and his Symbol Search score was borderline. Dr. Sowell's report of these scores contained no elaboration. (WRC Ex.12.) Dr. Sowell did not testify at the hearing.

9. When Claimant was 17 years and seven months old, a March 11, 2010 IEP discussing Claimant's transition from secondary school notes that Claimant "continues to exhibit emotional disturbance, including depression and anxiety. [He] also exhibits a significant discrepancy in the areas of reading, math, and written expression due to functional deficits in attention, auditory processing, and visual motor integration/perception. He exhibits significant difficulties in semantics and pragmatic skills. He has difficulty with impulsivity, mood regulation, frustration tolerance, and behavior." (WRC Ex. 11.) The March 11, 2010 IEP additionally indicates that in the adaptive/daily living skills milieu, Claimant "continues to benefit from structure and consistency." (WRC Ex. 11.)

10. A BHUSD Special Services Department report corroborates that, overall, Claimant "benefitted from the structure and consistency of the [non-public, residential out of state] program."

He was motivated by the token economy and was generally able to meet daily expectations at a high rate. He was taking the steps needed in order to become more independent and he was also making gains in his ability to manage low-level frustrations. He made significant progress in managing stressful situations by taking, self-imposed breaks. Throughout his enrollment, [Claimant] would periodically engage in higher intensity behaviors including severe property damage, aggression towards staff and off-campus elopement, usually without identified consistent antecedents.

(WRC Ex. 10.)

11. In May 2010, Claimant left the non-public, residential school in Connecticut. He thereafter attended a summer program where he earned a C minus in Language Arts and D's in Visual Performing Arts and Pre-Vocational Education.

12. During the 2010-2011 school year, Claimant enrolled in a local, non-public day school as an 18 year old. On two occasions in 2010, Claimant again took the Mathematics portion of the California High School Exit Examination without success.

13a. As a 19 year old, during the 2011-2012 school year, Claimant transferred to a post-secondary school where he was eligible to receive 314 minutes daily of specialized academic instruction, 480 minutes per week of DMH individual counseling, 60 minutes per week of individual counseling, 60 minutes per week of speech and language services, and 60 minutes per month of career vocational education/career awareness.

13b. Claimant's behavior in the classroom at his post-secondary school was reported as follows:

[Claimant] has strengths in having friends and behaving appropriately in class. When interested in a topic, [Claimant] will pay attention and ask questions for clarification. [Claimant] can be interesting and engaging. He enjoys being social with peers throughout the day. [Claimant] sometimes asks questions

when he needs clarification and openly allows teachers to assist him. He is respectful to classroom teachers and most peers. [Claimant's] greatest areas of difficulty include attending school and classes, following rules and listening to authority figures. [Claimant's special education teacher] reports that [he] does not like or want to be redirected by staff which puts him in a defensive/bad mood. He often comes to school upset due to conditions and interactions with his parents when at home, per [Claimant]. [His special education teacher] describes him as impulsive, forgetful, apathetic, talkative, disinterested, unhappy and preoccupied with outside events taking place in his life. [Claimant] will pay attention to topics/classes that interest him and ask questions for clarification. He will often need to adjust/use music during class in order to pay attention or when not interested in topic. Academically, [Claimant] is doing very poorly, as he has attended classes only a handful of times over the last two and a half months. . . . [W]hen he does come to school he rarely attends classes. His reasons for not going to class include that things happened at home, he is upset with one of the classroom staff and cannot be in the same room or he is not feeling up to it. In the meantime, he is socializing with peers/friends. At this time, [Claimant] is failing all his classes.

(WRC Ex. 10.)

13c. In early 2012, while enrolled at his post-secondary school, Claimant's special education teacher, school psychologist, and a speech and language specialist administered to him several assessments including, the Vineland, the Woodcock-Johnson III Normative Update Tests of Achievement (Form B), the Clinical Evaluation of Language Fundamentals-Fourth Edition (CELF-4) and the Comprehensive Assessment of Spoken Language (CASL). Claimant's special education teacher reported Claimant's performance on the Woodcock-Johnson as follows:

[Claimant] presents with achievement levels in the low range to average range as compared to peers similar in age. [Claimant's] ability to apply academic skills is within the low range. When compared to others at his grade level, [Claimant's] standard scores are average in basic reading skills and low average in brief reading, broad reading, and brief achievement. His standard scores are low (compared to age peers) in brief math, brief writing, and academic skills. [He] continues to have deficits in math and writing skills.

(WRC Ex. 10.)

13d. The Vineland indicated that Claimant's "communication skills fall in the moderately low range (standard score-72)." His written communication skills were in the "low range (age equivalent score-8 years, 1, month)." His expressive communication skills in the moderately low range (age equivalent-8 years, 7 months)." His receptive communication skills were deemed "adequate . . . (age equivalent-11 years) compared to average peers his age." The Vineland additionally indicated that Claimant's daily living skills "fall in the moderately low range in all areas (standard score-71). He was reported to demonstrate personal skills in the low range (age equivalent score-10, years, 6 month). He

was also reported to have domestic skills in the moderately low range (age equivalent-13 years, 3 months) and community skills in the moderately low range (age equivalent-15 years) compared to average peers his age.” Based on his assessed scores on the Vineland, Claimant’s cognitive ability was deemed “within the low average range to average range” with the notation that his communication and daily living skills are significantly delayed. (WRC Ex. 10; see also Claimant Ex. 5.)

13e. Assessment of Claimant’s speech and language skills indicated that his “pragmatic and expressive language, articulation, voice, and fluency skills fall within the expected range in comparison to his peers and he does not demonstrate a disability in these areas.” Assessment indicated “a delay in the receptive language skills, demonstrated by weakness in memory and understanding spoken paragraphs.” In addition, Claimant demonstrated low average scores in the area of non-literal language. (WRC Ex. 10.) Speech therapy with a focus on processing spoken information was recommended for Claimant.

14a. Claimant’s most recent IEP, which is dated February 8, 2012, summarizes Claimant’s then-academic status as follows:

[Claimant] presents with significant academic deficits in the areas of math and written language. Although a discrepancy in reading was not identified on academic testing, [Claimant] continues to have weaknesses in reading and reading comprehension. [Claimant] presents with significant deficits in his adaptive behavior (self-help/daily living skills) and continues to present with a functional deficit in the area of attention. In the area of language [Claimant] exhibits a delay in the receptive language skills, demonstrated by weakness in memory and understanding spoken paragraphs. Although [Claimant] may qualify for special education services under Speech and Language Impairment as well as Specific Learning Disability it is the IEP team’s opinion that these are not his primary area of disability.

In the area of social/emotional development, [Claimant] is experiencing significant difficulties with social skills, behavior, anxiety and depression. These feelings are evidenced throughout testing, projective measures, and daily habits. These difficulties are significantly impacting his learning experience (including school attendance) and have been an area of difficulty for a long period of time and to a marked degree. Consequently, [Claimant] continues to meet eligibility requirements for Special Education under Emotional Disturbance (ED) criteria. This is believed to be his primary area of disability.

(Claimant Ex. 3.)

14b. The February 8, 2012 IEP elaborates that Claimant “attended 5 English classes since the beginning of October making it very difficult to work with him on improving areas of need and reaching his goals. When completing written work, [Claimant] struggles with the use of basic spelling, grammar, punctuation, and word choice as well as the use of

descriptive language. [Claimant] has difficulty forming his thoughts into cohesive, well-written sentences and writes using poorly formed penmanship. [Claimant] has attended approximately 7 math classes since the beginning of October. [Claimant] has basic math computation deficits and has challenges answering some computations independently and/or without the use of a calculator. Since much of consumer math are word problems, [Claimant] . . . greatly benefits from information being broken down into smaller parts and written on the board for him to review and copy.” (Claimant Ex. 3.)

14c. Meeting notes accompanying the February 8, 2012 IEP indicate that when his IEP team discussed his possible enrollment in a transition program focusing on life skills including money management and using public transportation, Claimant “voiced that he does not want to work on math or any academic skills anymore.” According to the meeting notes, Claimant “expressed that he wants a break from school. He explained that he was away from home for a long time and now wants time to stay at home, catch up on movies and hang out. He stated that he is not interested and will not attend a transition program or do anything academically related at this time.” (Claimant Ex. 3.)

15. At the time of the initial two-day hearing in this matter, the evidence indicated that Claimant was unemployed and not enrolled in any academic or vocational program. During the hearing held after the second remand in this matter, it was established that pursuant to the undisclosed terms of a settlement agreement with Claimant’s school district, his school district has been funding his participation in a residential program at The Help Group’s Advance LA Live (Advance LA), a non-profit organization serving young adults with special needs. Claimant’s Mother’s testimony establishes that Advance LA provides adaptive functioning and executive functioning skills training including transportation, interview, budgeting, and hygiene skills. (See Factual Finding 30.)

Claimant’s Psychiatric History and Psychological Evaluations

16a. Between 1999 and 2008, Claimant underwent no fewer than seven psychiatric or psychological assessments and evaluations, which collectively establish the following:

16b. Claimant’s birth mother, who was 19 years old at the time of his birth, has a history of tobacco and alcohol consumption during pregnancy. At birth, Claimant presented with “Reactive Airways” disease (WRC Ex. 18). At age five, Claimant was diagnosed with Attention Deficit Hyperactivity Disorder (WRC Ex. 19), which upon re-evaluation, was changed to a multi-axial diagnosis of Adjustment Disorder with Depressed Mood and Anxiety and possible in utero alcohol exposure when Claimant was 10 years old (WRC Ex. 17). At age 11, a diagnosis of Bipolar Disorder-Not Otherwise Specified was added to Claimant’s diagnostic history (WRC Ex. 16). At age 13, Claimant was additionally diagnosed with Reading Disorder, Mathematics Disorder and Disorder of Written Expression. Claimant’s prior tentative diagnosis of “possible in utero alcohol exposure” was changed to the more definitive Fetal Alcohol Syndrome [FAS], Migraine Headaches (WRC Ex. 15).

16c. Claimant has been admitted to the UCLA Neuropsychiatric Hospital ABC Treatment Program on four separate occasions: on August 29, 2002, due to unsafe behavior related to depression and anxiety; in March 2003, for reasons not established by the evidence; on February 6, 2004, due to aggressive ideation toward a peer at school and worsening psychotic symptoms including paranoid delusions along with visual and auditory hallucinations; and on September 6, 2005, due to deterioration in his mood and impaired self-esteem.

16d. In correspondence and an evaluative report in connection with Claimant's September 2005 hospitalization, Dr. O'Conner, his treating psychologist, noted that during his early childhood, Claimant's family struggled with considerable upheaval and financial difficulties. For several years, the family resided in a motel. Claimant's parents' marital discord has been a continuing source of anxiety and frustration for Claimant. Dr. O'Conner observed that Claimant's problems maintaining attention and controlling his anxieties and frustrations "seem related to his experience in the home environment, which seems to be stressful for him at times." Dr. O'Conner observed, "It is likely that [Claimant's parents] often experience interpersonal distress that exacerbates the emotional and behavioral setbacks seen in [Claimant's] . . . behavior." (WRC Ex. 14.)

16e. Dr. O'Conner regarded Claimant as having "significant brain damage and should be viewed as having a medical disability." (WRC Ex. 15.) According to Dr. O'Conner, "those working with [Claimant] should understand that because of his prenatal alcohol exposure, he should be viewed as a child with brain damage and his teachers should become familiar with the behavioral phenotype associated with alcohol exposure and methods of working with these children." (WRC Exs. 13 and 15.) Dr. O'Conner noted in general that "[t]he FAS diagnosis has implications for education planning, societal expectations, and health" and that in particular, Claimant has "ongoing adaptive functioning deficits" that are reflected on the Vineland with an Adaptive Behavior Composite scaled score of 70, which is in the second percentile." (WRC Ex. 15.) Dr. O'Conner further noted that delays in Claimant's adaptive behaviors "do not suggest . . . [an] autistic disorder." (WRC Ex. 14.)

17. Most recently, by correspondence dated June 11, 2013, Dr. O'Conner states that Claimant's fetal alcohol syndrome has multiple consequences:

In the context of an average IQ, [Claimant] had problems in self-regulation, executive function, working memory, and adaptive functioning meeting the criteria for [central nervous system] CNS dysfunction. Regarding alcohol exposure, there is a clear history of heavy prenatal alcohol exposure. In [Claimant's] case, he received a diagnosis of Partial Fetal Alcohol Syndrome (PFAS). An individual with PFAS and CNS dysfunction should be viewed as a person with a disability, which has implications for educational planning, societal expectations, and health. With the newest edition of the DSM-5, these individuals meet criteria for 315.8 Other Specified Neurodevelopmental

Disorder—Neurodevelopmental Disorder Associated with Prenatal Alcohol Exposure.

Extensive research has documented the teratogenic effects of alcohol in both animal and human studies, and such research has highlighted a range of cognitive, behavioral, and adaptive impairments associated with it. Intellectual and learning disabilities, adaptive and executive dysfunction, speech and language delays, behavioral and emotional difficulties, poor social skills, and motor deficits have all been reported among people with FASD. People with FASD are at greatly increased risk for a host of secondary disabilities, including school failure, delinquency, and alcohol and substance abuse problems. . . .

It is critical to understand the neurological aspects of FASD in order to implement effective treatment strategies. Because of the nature of FASD and the brain damage caused by it, many affected individuals have difficulty controlling their impulses and have poor judgment, so that most will require close supervision and frequent monitoring during and well past their teen years. The ultimate success of affected individuals will be fragile and will depend on continued guidance and close monitoring that might require a one-to-one mentor or job coach and the presence of an adult in social and community situations. In adolescence and adulthood, prenatal alcohol exposure is related to high risk situations such as getting into trouble with the law, alcohol and substance abuse, exhibiting inappropriate sexual behavior, having clinical depression, and suicide ideation and attempts. Because of their multiple developmental challenges, individuals with FASD need ongoing educational opportunities adapted to address their neurocognitive deficits, medication management, supportive psychotherapy, vocational and job training. Without these supports, the individual with an FASD will become a nonproductive member of society and possibly a liability.

(Claimant Ex. 7.)¹⁴

18. Dr. O’Conner did not testify at the hearing. As Claimant’s attending psychologist at the UCLA Neuropsychiatric Hospital where Claimant has an extensive

¹⁴ The American Psychiatric Association has articulated only “proposed criteria” for Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure. These criteria are published only to encourage future research. (DSM-5 at pp. 783 and 798. [WRC Supp. Ex. 5]) The proposed criteria are not intended for clinical use. Dr. O’Conner’s June 11, 2003 letter cites to “extensive research” and contains generalized discussion regarding reported risks associated with FAS, but Dr. O’Conner does not appear to render a clinical diagnosis on the basis of FAS that is specific to Claimant. Testimony or documentary evidence that is premised on the proposed criteria for Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure without consideration of data derived from clinical observation and assessment in the presentation of Claimant’s case is accorded diminished weight.

history of clinical observation, treatment, and hospitalization, Dr. O’Conner’s report and finding regarding Claimant’s intact cognitive functioning, that Claimant’s academic deficits are related to fetal alcohol syndrome, which is a medical disability, and that Claimant has learning disabilities are accorded significant weight.

WRC’s Evaluation of Claimant

19a. Concerned about Claimant’s ability to live independently as an adult, in December 2010, when Claimant was 18 years and four months old, his parents sought to establish his eligibility for supports and services under the Lanterman Act. A WRC multi-disciplinary team assessed Claimant using, among other methods, the K-BIT-2 for assessment of cognitive functioning and the Wide Range Achievement Test-Fourth Edition (WRAT-4) for assessment of academic achievement. The multi-disciplinary team reported that the K-BIT-2 revealed average perceptual abilities, borderline verbal abilities, and an overall low average IQ composite standard score of 89, which is in the 23d percentile, for Claimant. The multi-disciplinary team reported that Claimant’s performance on the WRAT-4 was in the 39th percentile for sentence comprehension and first percentile for math computation. (WRC Ex. 8.) The multi-disciplinary team did not elaborate on Claimant’s K-BIT-2 and WRAT-4 test results.

19b. Employing the definition of “autism” contained in the DSM-IV-TR, the multi-disciplinary team determined that Claimant did not present with autism.

Although [Claimant] did show some atypical behaviors prior to age 3 years (i.e. head-banging and hyperactivity), early records (and multiple evaluations by experts in the field) do not support full spectrum symptomatology prior to age three years. Therefore, [Claimant’s] current symptomatology can be considered with respect to possible diagnosis of PDD-NOS [Pervasive Developmental Disorder-Not Otherwise Specified], but not to the full spectrum disorder. . . . [Claimant’s] symptoms are confounded by his history of family conflict and instability as well as early-onset bipolar disorder treated with multiple medications. Thus, even though he does at present appear to meet the criteria for PDD-NOS, it cannot be stated with certainty that his symptoms may possibly be better attributed to his mental illness.

(WRC Ex.8.)

19c. The multi-disciplinary team interviewed Claimant about his ability to engage in appropriate activities of daily living and determined that Claimant was fully independent for toileting and hygiene. Claimant kept his room clean. Claimant performed no regular chores at home. Claimant had no experience budgeting money or acquiring groceries. Claimant did not have a driver’s license and did not express a desire to acquire one because there were few places to which he wanted to drive. Claimant expressed a willingness to walk to his desired destinations. Claimant exhibited no awareness of how to use public motorized transportation. Claimant expressed an interest in working in fast-food restaurants.

19d. The multi-disciplinary team's concluding impressions of Claimant are set forth in a December 21, 2010 Westside Regional Brief Team Assessment report prepared by Valerie Benveniste, Ph.D., as follows:

Current assessment reveals a young adult who in spite of his overall average I.Q. does not appear equipped to cope with typical daily activities. His impairments manifest in extremely poor arithmetic skills with limited ability to budget, slow processing speed, very poor writing skills, impaired memory, impaired judgment, limited ability for self-direction or goal setting for his future, obsessive-compulsive thoughts and behaviors. History supports that etiology of his disabilities appears to have a neurological/developmental component (e.g. head-banging at age 18 months with ADHD and behavioral challenges) that have been exacerbated by significant psychosocial/family stressors, and subsequent mental illness (early onset bipolar disorder). [Claimant] had undergone many assessments beginning at a young age and developmental disability was not discussed until relatively recently. Due to his extremely complex history, it appears unlikely that it will be possible to tease apart the relative contribution of developmental issues versus mental health/psychosocial issues. Given his current psychosocial environment, his future prognosis is fair to guarded regarding his future ability for self-care, learning, self-direction, capacity for independent living, and capacity for economic self-sufficiency.

(WRC Ex. 8.)

19e. Dr. Benveniste reported DSM-IV-TR diagnoses of PDD-NOS, Bipolar Disorder (by history), Dyssomnia-Not Otherwise Specified, Eating Disorder-Not Otherwise Specified, and Parent Child Relational Problem. WRC thereafter notified Claimant by letter and Notice of Proposed Action dated January 13, 2011 that he was ineligible for services and supports under the Lanterman Act. (WRC Ex. 8.)

19f. Dr. Benveniste did not testify at the hearing.

20. Claimant's mother, acting on his behalf, submitted updated information to the WRC on June 27, 2012, and she requested WRC's reconsideration of Claimant's eligibility for Lanterman Act supports and services when Claimant was 20 years old.

21. On August 23, 2012, Rafael Garcia, M.A., the WRC intake counselor, conducted an interview of Claimant's parents who expressed their concern about Claimant "maintaining steady employment," "improving [his] independent living skills," and "being able to live independently." Mr. Garcia prepared a psychosocial assessment indicating that Claimant's parents reported his "current functioning" as follows:

INDEPENDENT: Parents state that [Claimant] is able to do most self[-]care tasks but with prompting. [Claimant] completes toileting tasks independently. . . . With prompts [Claimant] is able to wash his hands and face, brush his

teeth, and bathe, he frequently bathes two to three times in a day. [Claimant] is able to dress himself but not appropriately to the weather or occasion and will not care to match his clothes. He is able to manipulate buttons and zippers but has difficulty with buttons. He learned to tie his shoelaces but this is a difficult task for him and he prefers to wear sandals. He learned to tie his shoes at 14 or 15 years of age. [Claimant] is able to eat with a spoon and fork with little spillage and can drink from an open cup. [Claimant] is able to make simple purchases and can count simple change. However, he has difficulty managing and budgeting his money and going grocery shopping. He has difficulty understanding the value of things and will easily pay much more than something is worth. In this regard he can easily be taken advantage of. He is willing to order food in public. He is able to use a phone to make and receive routine calls. He has not learned, despite frequently being taught, to check voicemail on [his] mobile phone. He has not learned to use public transportation. He has not obtained a drivers' license. He will not do routine chores around the house and his room is described as "a mess." He is said to hoard many things. He is not able to do laundry. He is able to go [to] the refrigerator and take out simple cold snacks for himself. He has learned to cook simple eggs on the stove. He is able to use the microwave to warm up precooked frozen burgers.

COMMUNICATION: [Claimant] speaks in complete sentences that are easy to understand and is described as being articulate. However he has difficulty expressing himself and his feelings when upset. He is able to relay a story but may require prompting for details. He has difficulty engaging in ongoing conversation. [Claimant] is said to rarely exhibit echolalia.

SOCIAL: [Claimant's] eye contact is said to vary and is described as not being typical. He shows affection but does not like to receive it. Claimant will not attempt to initiate social contact. [Claimant] does not engage with typical peers and has difficulty establishing and maintaining reciprocal relationships. He is said to have two "friends" whom he sees regularly but only when the parents arrange visits and activities. Otherwise they will not make arrangements to meet. . . . He has difficulty sharing and taking turns.

EMOTIONAL: Parents describe [Claimant] as being frustrated, impulsive, rigid, and resistive to transitions, changes in routines or changes in plans. He also has difficulty with new environments. Parents state that he always needs to be forewarned of any possible changes. He is no longer aggressive but this was an issue in the past. He will leave an environment without notice or permission but does not necessarily wander away. He might require supervision in unfamiliar settings. Parents state that [Claimant] is generally calm and never hyperactive. He has no difficulty concentrating on a preferred activity such as video games. However, with non[-]preferred activities he will only focus from 2-10 minutes and is easily distracted.

[Claimant] is very obsessed with anime and will view the same video repeatedly. He is also obsessed with video games and will play them for hours. He enjoys working with puzzle-like bionacles. He is sensitive to loud vibrating sounds. [Claimant] is also said to be sensitive to being touched and will react impulsively if touched without notice. He is said to have sensory issues and has a liking for certain textures. He will wear a heavy thick jacket regardless of how warm it is. He is said to dislike being spoken about. He has a phobia for heights. He has talent of making things out of duct tape. Parents stated that they have not noticed [Claimant] rocking or hand flapping.

COGNITIVE: [Claimant] knows his name and age. He does not know his address and phone number. He can tell time on a digital but not an analog clock. [Claimant] can name the major parts of his body. He can recognize and identify colors and shapes. Parents were not sure up to what number he can count to and were not sure if he could count to 100. He is able to add and subtract single digit numbers with difficulty. He can read and write simple sentence. He has difficulty with comprehension. He is said to have taken a special program . . . to help with his language, reading and writing. He has difficulty with spelling. [Claimant] follows basic one-step instructions but cannot be easily remember instructions.

MOTOR: [Claimant] has functional use of his upper and lower extremities. He can walk typical distances. [Claimant] can go up and down stairs without using a hand rail. He can draw and trace objects. He can write but with difficulty. He has difficulty using scissors. He has difficulty with buttons and shoe laces. He can ride a bicycle. He can open and close containers. . . .

(WRC Ex. 6.)

22. Mr. Garcia, who did not testify at the hearing, referred Claimant for evaluation of his cognitive and adaptive levels of functioning, which Gabrielle du Verglas, Ph.D. conducted in September and October 2012.

23a. During three separate sessions, Dr. du Verglas interviewed Claimant and his parents and reviewed Claimant's records including background and diagnostic information contained in Claimant's academic records and the several psychiatric and psychological reports set forth above. Dr. du Verglas administered the Wechsler Adult Intelligence Scales-Fourth Edition (WAIS-IV), WRAT-4, the Adaptive Behavior Assessment System-II (ABAS-II), the Vineland, and the Autism Diagnostic Observation Schedule (ADOS) Module 4 to Claimant. In a September 19, 2012 Psychological Evaluation, Dr. du Verglas reports that the overall test results obtained from Claimant validly reflect his current level of cognitive abilities.

Throughout the three sessions [Claimant] displayed appropriate eye contact. He wore the exact jacket that apparently he wears every single day regardless

of weather. Even in extremely hot weather, he insists on wearing the quilted down jacket [because he reportedly needs the pockets in the jacket to store his electronic devices that he carries with him all the time.]

He consistently responded to his name being called and was able to engage in conversations. When he did not know the answer to a question, he would state so. With building a rapport he became more cooperative. [Claimant] worked with motivation and the obtained results are viewed as a valid reflection of his current level of cognitive abilities. He did not show any stereotyped or repetitive motor mannerisms such as rocking or hand flapping. No rigidity with test materials/procedures was observed. He responded well to the requests and besides showing impatience by frequently asking how much more he had to do, he completed all test materials.

(WRC Ex. 5.)

23b. In the September 19, 2012 Psychological Evaluation, Dr. du Verglas reports that, as measured by the WAIS-IV, Claimant has a Full Scale IQ score of 86, which places him in the 18th percentile—a low average range. That Full Scale IQ score of 86 is comprised of a borderline Verbal Comprehension Index score of 78, a high average Perceptual Reasoning score of 111, a low average Working Memory Index score of 80, and a low average Processing Speed Index score of 84. According to Dr. du Verglas' report Claimant's "cognitive abilities are in the average to low average range of abilities with some scores in the borderline range. His cognitive abilities however do not fully explain his significant difficulties with executive functioning such as ability to plan, organize his time, have a sense of time, both time of the day, month or usage of calendar. Significant difficulties in the executive functioning domain are present. Additionally, there is a very significant discrepancy between Verbal skills (IQ 78) and Nonverbal skills (IQ 111) greater than two standard deviations, supporting significant weakness in the verbal domain despite extensive history and language therapy." (WRC Ex. 5.)

23c. Dr. du Verglas reports that on the WRAT-4, Claimant's reading skills were assessed at the 11.4 grade level, with sentence comprehension at the 7.9 grade level, spelling at the 4.4 grade level, and math computation at the third grade level.

23d. Dr. du Verglas reports that Claimant's adaptive functioning was in the extremely low range based on Claimant and his parents' responses to items on the ABAS-II,¹⁵ which was used to generate Global Adaptive Composite scores of 61 (0.5 percentile) and 58 (0.3 percentile), respectively.

¹⁵ Dr. du Verglas' September 19, 2012 Psychological Evaluation contains the following notation regarding the ABAS-II: "The Adaptive Behavior System-II (ABAS-II) provides comprehensive, norm-referenced assessment of adaptive skills for individuals from birth to 89 years. The ABAS is designed to evaluate whether an individual displays various functional skills necessary for daily living without the assistance of others. The instrument focuses on assessing independent behaviors and measures what an individual actually does.

[Claimant's] adaptive abilities continue to be impaired and below what would be expected for an individual with his cognitive levels of skills. [Claimant] has never lived independently and apparently his capacity for doing so is not present. He does not have the organizational ability to rent an apartment of his own, nor does he have the financial means to pay for his upkeep. With the exception of working in the restaurant [while at a residential school,] [Claimant] has no competitive employment experience. He lacks in money management skills and household management abilities. Currently [Claimant's] adaptive abilities are impaired in social functioning, skills of daily living and higher level communication (i.e., submitting an application or writing a letter of intent or interest for employment). With appropriate structure and planning [Claimant] could be successful in a vocational endeavor however would need the services of a job coach to write information down for him, assist with communication abilities and organizational skills. [Claimant] has a keen interest in working with animals and could possibly be successful in occupations related to animal care.

(WRC Ex. 5.)

23e. Dr. du Verglas reports that an assessment of Claimant employing the ADOS indicated that Claimant “did not meet the criteria for diagnosis of Autistic Disorder full spectrum.”

He presents with milder symptoms, which could well be explained with diagnosis of Pervasive Developmental Disorder-Not Otherwise Specified, as he does have ongoing history of difficulties in social relationships, rigid and repetitive patterns of behavior. Specifically he is very rigid and perseverative about his clothing, will only wear one jacket regardless of weather conditions. He is very perseverative about his video games and since age 10 lives in ‘a fantasy world preoccupied with video games and video game characters.’ Up to age 13, he showed repetitive perseverative head banging when frustrated. There are some symptoms of Obsessive-Compulsive Disorder (OCD). He showers very frequently.

His friendships are based on chatting with people online, parents do not know how many of those people he actually sees in person or if they could be classified as viable friends.

(WRC Ex. 5.)

23f. Employing the DSM-IV-TR, Dr. du Verglas diagnosed Claimant with PDD-NOS and FAS (by history). Dr. du Verglas lists Claimant's difficulties with his parents and

The skills are grouped into three domains: Conceptual (communication, functional academics and self[-]direction), Social (leisure and social), and Practical (community use, home living, health and safety and self[-]care). (WRC Ex. 5.)

lack of employment or viable activities during the day as moderate stressors. Dr. du Verglas assigned to Claimant a general assessment of functioning (GAF)¹⁶ score of 40, which indicates serious impairment in social, occupational, or school functioning. Dr. du Verglas made recommendations for Claimant including constructively channeling Claimant's obsessive tendencies with video games into vocational training and future employment, providing Claimant with specific instructions to improve his "hygiene, skills of daily living, money management and household management skills," and engaging Claimant and his parents in discussions about "an alternative residential facility with appropriate supervision" for Claimant to resolve his conflictive relationship his parents. Dr. du Verglas noted that Claimant "is in need of ongoing psychiatric management." (WRC Ex. 5.)

24. Dr. du Verglas did not testify at the hearing.

25a. Thompson James Kelly, Ph.D., WRC's chief psychologist and coordinator of intake services, has an extensive professional background working with emotionally disturbed and autistic children in their educational settings. Although Dr. Kelly was not involved in the development and 2002 adoption of ARCA's *5th Category Guidelines*, he knows from his work on an ARCA task force committee¹⁷ and his professional experience that ARCA serves as a consulting and advisory body for regional centers and that ARCA advocates for legislative change and makes proposals regarding the conduct of regional centers' provision of services to the developmentally disabled community.

25b. Dr. Kelly testified at both the initial hearing and the hearing after second remand in this matter. Dr. Kelly's testimony provides a detailed exposition of the WRC multidisciplinary intake team's deliberative processes generally for making eligibility determinations and particularly in this matter. In general, WRC intake team members use the *5th Category Guidelines* when determining eligibility for Lanterman Act services and supports under the qualifying "fifth category." According to Dr. Kelly, the *5th Category Guidelines* is intended to inform regional centers' eligibility teams' conceptualization and understanding of certain abstract constructs and to promote uniformity in application among

¹⁶ Pursuant to Government Code section 11515, the Administrative Law Judge takes judicial notice that a general assessment of functioning or GAF score is a subjective score given on a scale between 10 and 100 to indicate general psychological, social, and occupational functioning on a hypothetical continuum of mental health. For example, on one end of the continuum a GAF score of 100 indicates superior functioning in a wide range of activities. There are no symptoms of mental health illness. On the polar opposite end of the continuum a GAF score of 10 indicates persistent danger or harming oneself or others. In the middle of the continuum, a GAF score of 50 indicates serious social, occupational or school functioning.

¹⁷ In 2013, Dr. Kelly served on an ARCA task force Committee to define Lanterman Act terms including "substantial disability," "self-care," and "capacity for independent living."

regional centers. WRC intake team members have read through the *5th Category Guidelines*, but team members generally “do not pull it out” for each and every case under consideration.

25c. Dr. Kelly indicated that the WRC intake team relies on the Diagnostic and Statistical Manual, regardless of its applicable version, first to determine the presence or absence of the diagnostic characteristics of mental retardation or intellectual disability. Dr. Kelly noted that neither the DSM-TR-IV nor the DSM-5 has diagnostic criteria for “fifth category.” Eligibility teams therefore employ the *5th Category Guidelines* to discern whether an individual falls within the “fifth category” because the individual presents with a disabling condition like mental retardation or intellectual disability, or because the individual presents with a disabling condition requiring treatment similar to treatment required for a person with mental retardation or intellectual disability, or both. Dr. Kelly emphasized that the *5th Category Guidelines* is for the use of regional centers’ eligibility teams, and that the *5th Category Guidelines* is not for the use of vendors such as consulting mental health professionals preparing reports for the eligibility team’s consideration during its deliberations. (See also Legal Conclusion 18b.)

25d. Dr. Kelly acknowledged that the *5th Category Guidelines* makes explicit references to the DSM-IV-TR’s criteria for the diagnosis of “mental retardation,” and he explained that changes in diagnostic nomenclature and identifying criteria in the DSM-5 do not vitiate the *5th Category Guidelines*’ utility or continuing relevance when making fifth category eligibility determinations. Rather than consulting the DSM-IV-TR, eligibility teams consult the DSM-5 criteria for the diagnostic and identifying characteristics of intellectual disability. Thereafter, eligibility teams’ professional judgments are guided by the *5th Category Guidelines* to reach a determination whether an individual presents with a substantially disabling condition closely related or similar to intellectual disability or whether an individual presents with a substantially disabling condition requiring treatment similar to that treatment required for individuals with intellectual disability.

25e. With respect to the *5th Category Guidelines*, Dr. Kelly explained that its emphasis is on the characteristics of an individual’s “cognitive profile” that causes the individual to present with substantially impaired intellectual and adaptive functioning. According to Dr. Kelly, an individual can present with a variety of disabling conditions, including fetal alcohol syndrome, specific learning disabilities, or ADHD, and still not be eligible for Lanterman Act services and supports because of their “cognitive profile.” Dr. Kelly noted that there are individuals with a range of different disabilities who are not developmentally disabled who could benefit from regional center services and supports such as independent living support or behavioral intervention. Dr. Kelly noted, by way of example, that an individual with average cognitive functioning who has been diagnosed with Schizophrenia would certainly benefit from independent living support services, but that such a person is ineligible for such services through a regional center on the basis of a Schizophrenia diagnosis.

25f. Dr. Kelly’s testimony further explained that the *5th Category Guidelines* addresses the matter of “treatment.” Treatment entails an intervention strategy—meaning

how services and supports are to be delivered or provided to eligible individuals. Dr. Kelly explained how treatment is delivered to individuals with intellectual disability stating that such individuals “are going to need things broken down, they are going to need a lot of rehearsal.” Among individuals with intellectual disability, the break-down process will vary; some individuals will require more or less step-by-step instructions compared to other individuals. “There is going to be a performance cap on what they might be able to attain. There is going to be deficits in retention and performance and processing.”¹⁸ Dr. Kelly clarified that the break-down process, which requires “chunking information and breaking it down into parts” is “a little bit different” from Discrete Trial Training or DTT. DTT, according to Dr. Kelly’s testimony, is employed with individuals on the autism spectrum because such individuals have really specific neurocognitive delays in, for example, social referencing or visual attention, and as a consequence are unable, for example, to track an

¹⁸ Dr. Kelly explained that, generally speaking, the more severe a person’s intellectual disability, the lower the ceiling or learning expectations for that person. A person with mild intellectual disability, for example, would be expected to perform at an elementary level in academic subjects, but have more difficulty with higher learning expectations. A person with a more severe intellectual disability would be expected to perform at an even lower level. Dr. Kelly explained that treatment plans for persons with intellectual disability must account for a “certain ceiling effect,” meaning that, depending on the severity of the intellectual disability, a person will experience “more difficulty with abstract concepts—things requiring formal operations.”

Focusing on the example of a treatment plan for a typical person with mild intellectual disability, Dr. Kelly explained that “things would be broken down step-by-step,” there would be a “slower” learning curve, and a “larger time frame” required “to make sure the individual gets it.” Dr. Kelly testified, “In terms of chunking, instead of just presenting concepts, like you would in a lecture, you would really break them down into basic steps and sequences. There would be a lot of learning and rehearsal. You would repeat things a number of times. I would expect to try and have the individual repeat steps to make sure they were clear on the information; so, there would be a lot of repetition and a lot of rehearsal.”

Dr. Kelly reviewed several skills needed for daily living including vocational skills, recreation skills, and household management skills. Focusing on household management skills, which addresses “what needs to happen as far as paying bills, how to organize finances, how to set up a shopping schedule, and what foods are needed to keep on hand,” Dr. Kelly explained that an independent living support treatment plan for a person with mild intellectual disability would entail breaking down each component of household management skills into a step-by-step process for the individual. It is not sufficient to indicate that a bill should be paid. “You have to say this is an example of how you pay a bill—this is how you write a check, this is how you address an envelope, [et cetera].” Dr. Kelly indicated that a person with severe intellectual disability is not expected to master the same skills, such as household management, as a person with mild intellectual disability.

object. Specific social relatedness tasks must be broken down into discrete steps: “First, I want you to attend to this object, and then attend to this object. Now, attend to this object and track it with me. You build on that foundation to increase social repertoire. You would not use Discrete Trial Training with a bus schedule.”

25g. WRC intake team members employed the 5th *Category Guidelines* during its deliberations regarding Claimant’s eligibility for Lanterman Act services and supports in this case. The WRC intake team conducted an examination of Claimant’s developmental milestones over a period of time with a focus on any trajectory or continuity of symptomatic expressions. Dr. Kelly noted that in Claimant’s case, which he considered a “difficult determination,” the team examined IEPs, mental evaluations, medical history, assessments, and other data in an attempt to sort out and distinguish the developmental from the psychiatric and the attitudinal. Dr. Kelly noted that Claimant was assessed several times with varying results over time. According to Dr. Kelly, Claimant is “not classically characteristically autistic.” Dr. Kelly noted that Claimant has adaptive deficits, but noted also that the dispositive question is “how much of that is due to developmental issues, to mental issues, to fetal alcohol syndrome.” According to Dr. Kelly, “fetal alcohol syndrome does not necessarily mean mental retardation; you could have mild cognitive impairment. Fetal alcohol syndrome gives an explanation of the why you have impairment, but not the extent of impairment.” Dr. Kelly explained that the WRC multidisciplinary team determined Claimant is learning impaired as a consequence of fetal alcohol syndrome, but that Claimant has “enough strong cognitive scores to suggest that he has the cognition to perform certain tasks.” The team concluded that Claimant was not performing to his capacity “due to unwillingness” rooted in possible contributing factors such as adolescence angst and parenting techniques. Dr. Kelly explained, for example, that in school everything is language-based. Claimant’s strength, however, is visual-based, so Claimant enjoyed only limited academic success. From this resulting mismatch Claimant struggled to meet expectations. Claimant was frustrated and a learned helplessness emerged causing Claimant to temper his expectations until he eventually gave up.

25h. At the hearing after the second remand in this matter, Dr. Kelly specifically addressed 5th *Category Guidelines*’ instructions to regional centers to “consider *the nature of training and intervention*[¹⁹]that is most appropriate for the individual who has global cognitive deficits” when determining whether an individual presents with a condition requiring treatment similar to that required for individuals with mental retardation (now intellectual disability). (WRC Supp. Ex. 7.)²⁰ The WRC intake team determined that, based

¹⁹ Italicized emphasis in original.

²⁰ The *Guidelines* enumerates the following for regional center eligibility teams’ consideration when determining whether an individual requires treatment similar to that required for individuals with Intellectual Disability:

A. Individuals demonstrating *performance based deficits* often need treatment to increase motivation rather than training to develop skills.

on Claimant's history of testing and evaluations, Claimant's cognitive profile did not reveal "global cognitive deficits." Dr. Kelly explained, "Over time what we have seen is a pattern where [Claimant] has demonstrated peaks and valleys in his testing. He has shown, for example, that he is really good in perceptual reasoning, but poor in verbal comprehension. In other testing he has also shown deficits on processing, but he has also shown strengths on verbal comprehension. His testing has range in which you see this sort of pattern of peaks and valleys. When you talk about global cognitive deficits you are talking about across the board. So when you talk about individuals with intellectual disability there may be slight variation, but their cognitive performance is sub-normal across domains, or if they are borderline intellectual functioning, but not intellectually disabled, we see this global pattern where all of their intellectual testing scores is kind of sub-normal. Because of these peaks and valleys [in Claimant's case], we see some are above average, borderline, average, below average; this pattern is not global." "It doesn't speak to global cognitive deficits."

The WRC intake team explicitly considered and discussed the *Samantha C.* case and determined that Claimant's cognitive and adaptive functioning profile was not comparable with the cognitive and adaptive functioning profile of the applicant for regional center services addressed in the *Samantha C.* case. The WRC team concluded that Claimant did not have a substantially disabling condition closely related or similar to intellectual disability and that Claimant did not have a substantially disabling condition requiring treatment similar to that treatment required for an individual with intellectual disability. "Our conclusion was that [Claimant] appeared much more like an individual with a learning disability."

25i. With respect the question of whether Claimant required treatment similar to that treatment for an individual with intellectual disability, Dr. Kelly emphasized that WRC

- B. Individuals with *skill deficits* secondary to socio-cultural deprivation but not secondary to intellectual limitations need short term, remedial training, which is not similar to that required by persons with mental retardation.
- C. Persons requiring habilitation may be eligible, but persons primarily requiring *rehabilitation* are not typically eligible as the term rehabilitation implies recovery of previously acquired skills; however, persons requiring rehabilitation may be eligible if the disability is acquired before age 18 and is a result of traumatic brain injury or disease.
- D. Individuals who require *long term training* with steps broken down into small, discrete units taught through repetition may be eligible.
- E. The eligibility team may consider the intensity and type of *educational supports* needed to assist children with learning. Generally, children with [Intellectual Disability] need supports, with modifications across many skill areas. (Italics in original.) (WRC Supp. Ex. 7.)

intake team members did not regard Claimant “as an individual with global cognitive deficits who would need this type of treatment strategy.” According to Dr. Kelly, Claimant “may have some issues in one area, but not in another area. So there wasn’t this global need for those same kinds of treatment strategies. His testing suggested, for example, that he does have good abstract concept formation, and he does have good abstract logic. So in those areas, he would not require that kind of treatment, that kind of intervention strategy. And so we didn’t see him needing global teaching similar to an individual with an Intellectual Disability.”

Dr. Kelly recalled his prior testimony regarding Claimant’s visual-based learning strengths²¹ to suggest a more appropriate approach to addressing Claimant’s learning deficits. According to Dr. Kelly, begin with Claimant’s strength. Claimant appears to have some deficits in verbal reasoning, verbal logic, and verbal comprehension, but he has some strength in non-verbal logic and non-verbal concept formation. So, rather than engaging Claimant in repetitive or typical didactic instruction, “you do a lot more visual instructions—like manipulatives, a lot of things you can see, a lot of visual descriptors, and hands-on tasks. As a learner, he would be much more responsive and capable of learning from that advantage rather than from primarily verbal instructions.”

25j. At the hearing after the second remand in this matter, Dr. Kelly provided additional insight into the WRC intake team’s analysis of the significance of Claimant’s FAS diagnosis. Dr. Kelly explained that Dr. Ari Zeldin, a pediatric neurologist serving on the WRC intake team, informed team members that, unlike other syndromes such as Klinefelter syndrome or Down syndrome, there is no genetic marker for fetal alcohol syndrome. Fetal alcohol syndrome or FAS is diagnosed by observing dysmorphic facial characteristics, which is a “somewhat subjective” process. Dr. Kelly noted that neither Klinefelter syndrome nor Down syndrome is an eligible condition under the Lanterman Act, but that the impact of those conditions on an individual’s cognitive and intellectual functioning is for consideration when determining eligibility.

Team members relied on Dr. Zeldin to guide them through the medical literature addressing the impact or consequences of FAS.²² Dr. Kelly’s testimony establishes that team members learned from discussions with Dr. Zeldin that there “is a huge range depending on when the mother ingested the alcohol and the extent of the alcohol. The teratogenic effects of alcohol on the developing fetus could have a very mild impact—so that a lot of individuals with fetal alcohol syndrome have learning disabilities, attention deficits,

²¹ See Factual Finding 25g.

²² Dr. Zeldin, for example, referenced a Genetics-Birth Defect Center consultation report, by John M. Graham, Jr., M. D., Sc. D., director of Clinical Genetics and Dysmorphology at Cedars Sinai Medical Center, which is referenced in Dr. du Verglas’ September 19, 2012 Psychological Evaluation. (See WRC Ex. 5. at p. 000184.) The Genetics-Birth Defect Center consultation report was not produced at the hearing. Dr. Graham did not testify at the hearing.

behavioral disorders or could have a much more profound impact—to the extent that they could be seriously or profoundly intellectually disabled depending on when in the course of neonatal development the baby was exposed to alcohol and the extent of the exposure. All of those things play into it.” With Dr. Zeldin’s guidance, the WRC intake team concluded that the impact of FAS on Claimant’s intellectual functioning did not cause Claimant to present with global cognitive deficits, and that Claimant is therefore not an individual with a substantial disabling condition requiring treatment similar to that treatment required by an individual with an Intellectual Disability.

26. Dr. Kelly’s hearing testimony on behalf of WRC’s multidisciplinary intake team lucidly explained the factual predicates and professional judgments on which the service agency based its determination that Claimant did not present with autism, or a disabling condition closely related or similar to intellectual disability, or a disabling condition requiring treatment similar to that treatment required for individuals with intellectual disability. Dr. Kelly’s vast experience informed his testimony, which is accorded significant weight.

Claimant’s Experts’ Evaluations

27a. Ann Eugenia Simun, Psy.D., is a private practitioner who, among other things, conducts neuropsychological and psychoeducational assessments of adolescents and young adults. Dr. Simun has a background working on cases involving mental illness, autism, and FAS. Dr. Simun specializes in brain-based disorders. Dr. Simun met with Claimant for two hours, but she “did not do any testing with [Claimant] at all.” Dr. Simun’s evaluation was circumscribed to review of Claimant’s academic records and psychological evaluations. Dr. Simun was critical of the assessment methodologies and conclusions included in Dr. du Verglas’ Septembr 19, 2012 Psychological Evaluation report discussed above. Using DSM-5 proposed criteria for Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure, Dr. Simun opined that Claimant has impaired neurocognitive functioning in the “mild range” in the following categories: impairment in executive functioning, impairment in learning, and memory impairment.²³

27b. Dr. Simun further opined that an April 17, 2003 Occupational Therapy Evaluation prepared when Claimant was a 10-year-old child “supports the presence of a developmental disability.” That occupational evaluation reports “below average integration of visual and motor abilities and a clear difficulty in the motor coordination section, in which [Claimant] scored in the 4th percentile [on the Developmental Test of Visual Motor Integration].” Claimant reportedly had “difficulty with the motor components that are necessary to complete a task on time.” He “worked slowly and cautiously; he needed to take additional time to look at visual stimuli and was able to reproduce them without major distortions.” The report additionally indicated that Claimant was “having difficulty integrating sensory input from the proprioceptive and vestibular systems, [which] . . . explain his difficulties in fine motor coordination and graphomotor skills.” Claimant reportedly

²³ See Footnote 14 regarding the use of these proposed criteria from DSM-5.

“exhibited poor proximal stability in shoulder girdle with a tendency to abduct his scapulae, hyperextensibility of proximal joints, and decreased antigravity patterns of movements.” (Claimant Ex. 2.) Dr. Simun opined these reported observations of Claimant’s sensory processing and motor skills are consistent with an autism diagnosis—Claimant “cannot properly respond to sensory input” and with fetal alcohol syndrome—Claimant has “problems with motor control (hypotonia or a lack of muscle control) and problems with sensory input when sensory input is complex.” Dr. Simun summarized Claimant’s deficits as a “problem with the highways in the brain that move information back and forth.”

27c. As indicated in footnote 14 supra, Dr. Simun has premised her opinion, in part, on a proposed criteria, Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure, which is intended to encourage future research and not presently intended for clinical use. Dr. Simun’s testimony is accorded diminished weight.

28a. Jennifer J. White, MSW, who has been providing individual and family therapy to Claimant since July 2011, conducted no formal assessment of Claimant. Ms. White was uncertain whether Claimant has any significant limitations in the area of self-care. She testified that Claimant relies on his parents to meet his needs, including housing and transportation needs. She observed that Claimant was rigid, in that he would get an idea in his head and became upset when asked to do something differently; that Claimant had “sensory issues” because he wore a heavy coat regardless of the temperature; that Claimant makes relationships and connections with people, but it is hard for him; and that Claimant perseverates when he is angry. Ms. White wrote a letter stating that Claimant “is working to decrease ineffective coping strategies” and lists “frequent avoidance of school, isolating in his room at home, refusing to engage with parents” as examples. The letter reads in pertinent part:

[Claimant’s] progress toward these goals appears to be impeded by deficits in executive functioning, difficulty taking responsibility and identifying his role in conflicts, and extreme rigidity.

[Claimant’s] difficulty tolerating redirection and understanding why there is a need to meet certain expectations (ie: to attend school, to do minimal household chores, to participate in additional vocational training) would likely impede his ability to obtain or hold a job. He remains reliant on his parents for meeting basic needs. From [Claimant’s] current level of functioning, it appears unlikely that [Claimant] would be able to support himself or live independently at this time. Though he has not historically carried a diagnosis of autism, [Claimant] does present with symptoms characteristic of an individual with the ASD spectrum including rigidity, sensory issues, difficulty with social interactions, perseverating on preferred activities as well as perseverating on negative interactions with others.”

(Claimant Ex. 4.)

28b. Ms. White offered no clinical basis for her conclusions that Claimant is impeded by deficits in cognitive functioning or that Claimant has characteristics of an individual with ASD. Ms. White administered no neuropsychological or other assessments to Claimant. Diminished weight is accorded Ms. White's testimony.

29a. Melissa M. Waybright, Psy.D., is a clinical and forensic psychologist with expertise in Cognitive Behavioral Therapy. Dr. Waybright has known Claimant for one and one-half years. She is Claimant's therapist who also works with Claimant's parents and his program director at Advance LA.

29b. During her post-doctoral training, Dr. Waybright worked as a psychological assistant with Dr. du Verglas conducting intake evaluations used in Lanterman Act eligibility determinations for regional centers other than WRC. For example, with supervision from Dr. du Verglas, Dr. Waybright administered psychological assessments and prepared and drafted reports for Dr. du Verglas' signature. Dr. Waybright has knowledge of individuals who qualify for regional center services under the category of intellectual disability as well as familiarity with different types of regional center services as a result of her work with Dr. du Verglas. Dr. Waybright did not indicate whether she has knowledge of individuals qualifying for regional center services under the fifth category. Nor did Dr. Waybright indicate whether she has experience with or is knowledgeable about the WRC intake team's processes and considerations for determining fifth category eligibility.

Dr. Waybright did not assist Dr. du Verglas with Dr. du Verglas' administration of the WAIS-IV, WRAT-4, ABAS-II, Vineland, or ADOS to Claimant set forth in Factual Finding 23a. Dr. Waybright did not participate with Dr. du Verglas in the WRC multidisciplinary team's interview of Claimant and his parents set forth in Factual Finding 23a. Dr. Waybright did not assist Dr. du Verglas in the preparation of the September 19, 2012 Psychological Evaluation (WRC Ex. 5) set forth in Factual Findings 23a through 23f.

29c. Dr. Waybright provides cognitive behavioral therapy and life-skill coaching and training to Claimant one to two times weekly in individual sessions. Dr. Waybright is working "on a number of things" with Claimant. When Claimant complained to her about "attentional symptoms" in connection with an internship at United Cerebral Palsy/Wheels for Humanity, Dr. Waybright administered "an adult attention deficit hyperactivity disorder screening instrument" to Claimant. Dr. Waybright testified that she conducted "no other formal assessments" of Claimant. After obtaining Dr. du Verglas' September 19, 2012 Psychological Evaluation report from Claimant's parents, Dr. Waybright reviewed the report. Dr. Waybright prepared an October 23, 2015 Confidential Memo addressed to "All Interested Parties"²⁴ containing statements consistent with her testimony set forth below.

²⁴ Claimant Supp. Ex. 19.

29d. Dr. Waybright testified at the administrative hearing held after the second remand in this matter. Dr. Waybright opined that she “gave [Claimant] a few neurodevelopmental disabilities including Autism Spectrum Disorder per DSM-5, Attention Deficit Hyperactivity Disorder, and two Specific Learning Disorders in Mathematics and Written Expression along with Fetal Alcohol Syndrome.” Dr. Waybright further opined that Claimant has “a disability in the areas of expressive and receptive language” based on “all of his historical assessments[, which] have included deficits in those areas, and . . . [on how] he presents in session. He has had difficulty expressing himself, and he has difficulty understanding information that is given to him verbally.” In Dr. Waybright’s opinion, Claimant has “a significant limitation in the area of learning” “based primarily [on] the discrepancy between his IQ scores and his academic achievement scores, which indicate that he has a profound limitation when it comes to learning especially in the areas of spelling and writing and mathematics, which make it difficult to function in daily life.” Dr. Waybright opined that Claimant “absolutely” has a developmental disability requiring treatment similar to that treatment required for an individual with intellectual disability because Claimant’s “adaptive functioning is below the first percentile.” Dr. Waybright opined that Claimant’s “disability is significant.”

29e. According to Dr. Waybright, Claimant has executive functioning deficits, which “make it difficult for him to plan and organize and execute any sort of short or long term goal.” Dr. Waybright opined that Claimant’s capacity for independent living is significantly impaired based on his inability to “budget, maintain his own finances, or pay bills, or utilize public transportation,” and that Claimant has not achieved economic self-sufficiency, “which is underscored by his learning disability in the area of mathematics; he couldn’t anticipate correct change when buying goods and services, he couldn’t maintain a budget, or write checks.”

29f. Dr. Waybright claims she is knowledgeable about Claimant’s self-help skills because she “spent hundreds of hours with him,” and he communicated his difficulties with self-help to her, which difficulties Dr. Waybright claims were confirmed by staff at Advance LA. According to Dr. Waybright, Claimant “needs assistance in all areas of daily activities” because Claimant is “very limited on his own.” “He needs as much help as he can possibly get from the regional center and the kind of services they provide.” Dr. Waybright indicated that Claimant “is extremely limited when it comes to his inability to tolerate sensory inputs so some of the decisions he’ll make with regard to clothing or food are not necessarily healthy and good for him, and so he really needs help finding ways to integrate what would be healthy with what his preferred tolerances are in those areas.” Claimant “will shower independently, but his hair will be unkempt, his shoes might be broken, and he doesn’t seek out independently what he might need to resolve some issues.” Dr. Waybright testified that Claimant cannot shop for his own clothing, cannot make an appointment to go to get a haircut, and cannot make an appointment to go to the dentist because he cannot navigate public transportation to get there. According to Dr. Waybright, Claimant cannot access a bus schedule using technology because he

has great difficulty interpreting the bus schedule using numbers. Claimant does not make exercise a part of his everyday life, and he has to be reminded to exercise. Claimant will not do his laundry or attend to the garbage, unless reminded or prompted to do so.

29g. Dr. Waybright notes the regional center provides case managers to coordinated care with specialists and providers, including vocational counselors, assistance with education, job coaches, public transportation trainers, medication management, support in residential living from on-site counselors, roommates, referral services, and help with cooking, cleaning, and money management. Dr. Waybright indicated that from her work with Dr. du Verglas she knows that WRC has offered these enumerated services to individuals with intellectual disability. Dr. Waybright opined that Claimant “would benefit from and needs those types of services.”

29h. Dr. Waybright elaborated that “job coaching is crucial for individuals with intellectual disability, and individuals like [Claimant]; somebody that would both help with resources to get a job, and then also to coordinate with supervisors and managers on site at the job in order to take care of any issues that might come up.” Dr. Waybright understands that regional centers offer “financial oversight, reading [and] writing support services” to individuals with intellectual disability, and she opined that Claimant would need those services “based on his learning disability.”

29i. Dr. Waybright believes that “Fetal Alcohol Syndrome is a medical condition that affects [Claimant] in a psychological nature.” She testified, “In my opinion his disabilities are solely neurodevelopmental and there are no psychiatric diagnoses.” “I have seen references [in the records] to Bipolar Disorder being given per history; I have seen nothing to substantiate a diagnosis of Bipolar Disorder.” Dr. Waybright “heard” that Dr. Kelly administered the Minnesota Multiphasic Personality Inventory (MMPI) to Claimant, and she indicated she believed the MMPI results were insignificant and did not diagnose any psychiatric conditions.²⁵ Dr. Waybright indicated her belief that Claimant’s disabilities are not solely learning disabilities and are not solely physical in nature. Dr. Waybright imagines that Claimant’s conditions and needs “will exist in some degree for the rest of his life.” Dr. Waybright hopes that “getting [Claimant] services now, even though he has needed them for so long, will help minimize what he needs in later years.”

29j. Dr. Waybright has visited Claimant’s residential program at Advance LA, and she has attended multiple meetings with the program’s directors and treatment providers as well as participated in discussions about Claimant. Dr. Waybright opined Advance LA “purports to” offer self-help training, special

²⁵ Pursuant to Government Code section 11515, the Administrative Law Judge takes official notice that MMPI is a widely used assessment of adult personality, psychological functioning, and psychopathology.

education services, referral or information services, residential care/supported living services, job training or coaching, transportation training, behavior training or modification, financial oversight, reading, and writing services, and publications translating complex information “into more chunking skills,” but in actuality Advance LA “has been providing a shared bedroom at their facility where he can stay.” Dr. Waybright expressed that she is “extremely disappointed with what [Advance LA] purported to provide and what they have actually been able to provide. They assisted in getting [Claimant] a volunteer position, but we were hoping for help transitioning to some paid employment and we were told there were connections with these organizations and companies that might take [Advance LA] students. [Claimant] had requested multiple times for assistance with public transportation training, and he was told they don’t have a program for that or they don’t have staff for that. And, similarly with meeting his educational goals.” According to Dr. Waybright, Claimant was expected to exit Advance LA within a week [from the date of her testimony]. Claimant’s participation in Advance LA was funded through Claimant’s school district pursuant to a settlement agreement for a limited period of time, and Claimant lacks the financial capability to fund his continuing participation in the program or to access the services the program was to provide.

29k. Dr. Waybright’s opinions are informed by her impressions of Claimant gained over the past one and one-half years administering Cognitive Behavioral Therapy to Claimant. Dr. Waybright had no clinical interactions with Claimant and personally conducted no independent assessment of Claimant during his developmental years up to age 18. Dr. Waybright disputed the clinically-derived diagnosis of Bipolar Disorder reported in Claimant’s diagnostic history (See Factual Finding 16b), but articulated no reasoned analysis to explain her dissenting views. Dr. Waybright’s opinions were in large part premised on her review of Dr. du Verglas’ September 19, 2012 Psychological Evaluation Report, a report which she had no role in preparing. The evidence did not establish Dr. Waybright’s experience with or knowledge about the WRC intake team’s processes and considerations for determining eligibility on the basis of fifth category qualification. For all these reasons, moderate weight is accorded Dr. Waybright’s opinions and conclusions.

Claimant’s Mother’s Testimony

30a. Claimant’s Mother testified at the hearing after the second remand in this matter. According to Mother, Claimant is overwhelmed by directions even when they are presented to him in the form of visual images or broken down. Mother additionally indicated that Claimant gets “anxious about new things” and that Claimant is “not secure about himself because he is very aware of the fact that he is special needs and that he has a lot of issues with his auditory memory, and auditory processing skills, and his writing skills, among other things.” Mother’s testimony establishes that at the time of the hearing after the second remand in this matter, Claimant was no longer taking medication to address his ADHD.

30b. With regard to public transportation, Mother indicated that Claimant has to be taken everywhere, including to medical appointments and to his internship program, because he fears getting lost or hurt when using the bus. Claimant's father, Dr. Waybright, and Advance LA have worked with Claimant on how to take the bus. Mother recounted an incident when Claimant got on the wrong bus "and he freaked out." Claimant was unable to find the right bus on his own; he used his pre-programmed cell phone to call his father or program director for assistance.

30c. With regard to nutrition, Mother indicated that Claimant cannot plan a menu for a healthy meal. "We tried with a nutritionist [at Advance LA] and it didn't work. He eats all the wrong foods." Mother indicated that the personnel at Advance LA were to train Claimant to plan healthy meals, but that their personnel were transient. Mother has accompanied Claimant to the grocery store, and she indicated that he knows how pay for food items using a debit card, thus obviating the need to make change. According to Mother, Claimant purchases microwavable foods, which he knows how to prepare. Claimant does not know how to prepare raw foods.

30d. With regard to hygiene, Mother indicated that Claimant is capable of caring for himself, but that he does not do it properly. Claimant has cavities. Claimant does not know how to make a dental appointment because he does not have a good sense of time and calendaring. Mother has to make all of Claimant's appointments.

30e. Mother testified that Claimant has a desire to learn a skill to work. According to Mother, Claimant likes animals. Claimant is very good with toys and children. "He could test toys for a toy company. But he could not do the math in terms of the design of toys. He is like third grade math." Claimant would like to learn cooking, "but he is afraid of it." Mother believes that Claimant is capable of doing a job as long as it has a good routine or schedule to it, has supervision, is within walking distance of Claimant's residence, and does not incorporate any math or writing "because he is a first grade writer."

30f. Mother testified that it is "too close for comfort" for her as Claimant's parent to teach him skills. Mother understands that Dr. Waybright's work with Claimant includes role-playing job interviews, accompanying Claimant on job interviews, and encouraging Claimant "to talk about his gifts and his deficits." According to Mother, Dr. Waybright has a wonderful relationship with Claimant, who is "extremely comfortable with her." "She has been all things to him."

30g. Before Claimant commenced his participation in Advance LA, Mother contacted the Department of Rehabilitation (DOR) on his behalf. Mother understands that DOR "just gets him a job" and provides no support system or job coach to work with the employer.

30h. Portions of Mother’s testimony contradicts reliable accounts of her prior reporting about Claimant’s adaptive functioning. (See Factual Finding 21.) In light of these internal contradictions, Mother’s testimony is accorded moderate weight.

LEGAL CONCLUSIONS

1a. As Claimant is seeking to establish eligibility for government benefits or services, he has the burden of proving by a preponderance of the evidence that he has met the criteria for eligibility. (*Lindsay v. San Diego Retirement Bd.* (1964) 231 Cal.App.2d 156, 161[disability benefits]; *Greatorex v. Board of Admin.* (1979) 91 Cal.App.3d 54, 57 [retirement benefits]; Evid. Code, § 500.) “Preponderance of the evidence means evidence that has more convincing force than that opposed to it.’ (Citations.) . . . [T]he sole focus of the legal definition of ‘preponderance’ in the phrase ‘preponderance of the evidence’ is the *quality* of the evidence. The *quantity* of the evidence presented by each side is irrelevant.” (*Glage v. Hawes Firearms Company* (1990) 226 Cal.App.3d 314, 324-325.) (Emphasis in text.) In meeting the burden of proof by a preponderance of the evidence, the complainant “must produce substantial evidence, contradicted or un-contradicted, which supports the finding.” (*In re Shelley J.* (1998) 68 Cal.App.4th 322, 339.)

1b. It is settled that the trier of fact may accept any part of the testimony of a witness and reject another part even though the latter contradicts the part accepted. (*Stevens v. Parke Davis & Co.* (1973) 9 Cal.3d 51, 67.) The trier of fact may also “reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected material.” (*Id.*, at 67-68, quoting *Neverov v. Caldwell* (1958) 161 Cal.App.2d 762, 767.) Furthermore, the trier of fact may reject the testimony of a witness, even an expert, although not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.) The testimony of one credible witness, including that of a single expert witness, may constitute substantial evidence. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.) An expert’s credibility may be evaluated by looking to his or her qualifications. (*Grimshaw v. Ford Motor Co.* (1981) 119 Cal.App.3d 757, 786.) It may also be evaluated by examining the reasons and factual data upon which the expert’s opinions are based. (*Griffith v. County of Los Angeles* (1968) 267 Cal.App.2d 837, 847.)

2. Claimant must establish that he has a qualifying “developmental disability.” Section 4512, subdivision (a), defines “developmental disability” to mean the following:

[A] disability that originates before an individual attains age 18 years, continues, or can be expected to continue , indefinitely, and constitutes a substantial disability for that individual. . . . [T]his term shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental

retardation, but shall not include other handicapping conditions that are solely physical in nature.

3. California Code of Regulations, title 17 (CCR), section 54000 further defines “developmental disability” as follows:

(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 need for treatment similar to that required for mental retardation.

4. Establishing the existence of a developmental disability within the meaning of section 4512, subdivision (a), requires Claimant to additionally prove that the developmental disability is a “substantial disability,” defined in section 4512, subdivision (l) to mean “the existence of significant 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: (1)

Self-care. [¶] (2) Receptive and expressive language. [¶] (3) Learning. [¶] (4) Mobility. [¶] (5) Self-direction. [¶] (6) Capacity for independent living. [¶] (7) Economic self-sufficiency.”²⁶

5. The Lanterman Act and its implementing regulations contain no definition of the neurodevelopmental condition autism. The customary practice has been to import the American Psychiatric Association’s DSM-IV-TR diagnostic criteria and descriptions for “autistic disorder” into the Lanterman Act and its implementing regulations when determining eligibility for services and supports on the basis of autism. In fact, both parties’ experts in this case relied on the DSM-IV-TR to assess and to render opinions regarding Claimant’s condition. Those diagnostic criteria and descriptions have been revised with the May 2013 publication of the DSM-5. “Autism Spectrum Disorder” is the APA’s new diagnostic nomenclature encompassing the DSM-IV-TR’s diagnoses of autistic disorder, Asperger’s disorder, childhood disintegrative disorder, Rett’s syndrome, and PDD-NOS. (DSM-5 at p. 809. [WRC Supp. Ex. 6.]) Thus, individuals with a well-established DSM-IV-TR diagnosis of autistic disorder, Asperger’s disorder, or PDD-NOS are now given the diagnosis of Autism Spectrum Disorder. (*Id.* at 51. [WRC Supp. Ex. 3.]

6. The DMS-5 diagnostic criteria for Autism Spectrum Disorder are as follows:

²⁶ CCR section 54001, subdivision (a), similarly defines “substantial disability” as follows:

- (1) A condition which results in a major impairment of cognitive and/or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential; and
- (2) The existence of significant functional limitations, as determined by the regional center, in three or more of the following areas of major life activity, as appropriate to the person’s age:
 - (A) Receptive and expressive language;
 - (B) Learning;
 - (C) Self-care;
 - (D) Mobility;
 - (E) Self-direction;
 - (F) Capacity for independent living;
 - (G) Economic self-sufficiency.

CCR section 54002 defines “cognitive” as “the ability of an individual to solve problems with insight to adapt to new situations, to think abstractly, and to profit from experience.”

- A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history:
1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
 2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
 3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.
- B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history:
1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
 2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).
 3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).
 4. Hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sound or textures, excessive smelling or touching of objects, visual fascination with lights or movement).
- C. Symptoms must be present in 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.

7. These essential diagnostic features of Autism Spectrum Disorder—deficits in social communication and social interaction (Criterion A) and restricted repetitive patterns of behavior, interests and activities (Criterion B)—must be present from early childhood and limit or impair everyday functioning (Criteria C and D).

8. The DSM-5 provides that, with respect to individuals presenting for diagnosis in adulthood, “where clinical observation suggests criteria are currently met, autism spectrum disorder may be diagnosed, provided there is no evidence of good social communication skills in childhood.” (*Id.* at 56. [WRC Supp. Ex. 3.]) In the case of the adult individual, the DSM-5 provides that “the report (by parents or another relative) that the individual had ordinary and sustained reciprocal friendships and good nonverbal communication skills throughout childhood would rule out a diagnosis of autism spectrum disorder; however, the absence of developmental information in itself should not do so.” (*Id.*)

9. In adults, deficits in social-emotional reciprocity may be most apparent in difficulties processing and responding to complex social cues. The DSM-5 lists, by way of example, “when and how to join a conversation, what not to say.” (*Id.* at 53. [WRC Supp. Ex. 3.]) Deficits in nonverbal communication are manifested through “odd, wooden, or exaggerated ‘body language’ during interactions. Impairment may be relatively subtle within individual modes (e.g., someone may have relatively good eye contact when speaking) but noticeable in poor integration of eye contact, gesture, body posture, prosody, and facial expression for social communication.” (*Id.* at 54. [WRC Supp. Ex. 3.]) Adult individuals with deficits in developing, maintaining, and understanding relationships “struggle to understand what behavior is considered appropriate in one situation but not another (e.g., casual behavior during a job interview), or the different ways that language may be used to communicate (e.g., irony, white lies).” (*Id.*) According to the DSM-5, these individuals “may desire to establish friendships without a complete or realistic idea of what friendship entails (e.g., one-sided friendships or friendships based solely on shared special interests).” (*Id.*)

10. The DSM-5 indicates that adults with Autism Spectrum Disorder suppress repetitive behaviors in public. (*Id.* at 54. [WRC Supp. Ex. 3.]) Criterion B may be met “when restricted, repetitive patterns of behavior, interests or activities were clearly present during childhood or at some time in the past, even if symptoms are no longer present. (*Id.*) Those symptoms include the following: “simple motor stereotypies (e.g., hand flapping, finger flicking), repetitive use of objects (e.g., spinning coins, lining up toys), and repetitive speech (e.g., echolalia, the delayed or immediate parroting of heard words; use of ‘you’ when referring to self; stereotyped use of words, phrases, or prosodic patterns). Excessive adherence to routines and restricted patterns of behavior may be manifest in resistance to change (e.g., distress at apparently small changes, such as in packaging of a favorite food; insistence on adherence to rules; rigidity of thinking) or ritualized patterns of verbal or nonverbal behavior (e.g., repetitive questioning, pacing a perimeter).” (*Id.*) According to

DSM-5, “[h]ighly restricted, fixated interests in autism spectrum disorder tend to be abnormal in intensity or focus (e.g., a toddler strongly attached to a pan; a child preoccupied with vacuum cleaners; an adult spending hours writing out the timetables). Some fascinations and routines may relate to apparent hyper- or hyporeactivity to sensory input, manifested through extreme responses to specific sounds or textures, excessive smelling or touching of objects, fascination with lights or spinning objects, and sometime apparent indifference to pain, heat, or cold. Extreme reaction to or rituals involving taste, smell, texture, or appearance of food or excessive food restrictions are common and may be a presenting feature of autism spectrum disorder.” (*Id.*)

11a. There are reports that, in childhood, Claimant’s social skills were of significant concern or lagged behind his peers (Factual Findings 5 and 6) and that Claimant lacked understanding of the socially disruptive effects of his high-intensity behaviors (Factual Findings 8 and 10). Some clinical observations suggest Claimant’s difficulties with spoken paragraphs and non-literal language (Factual Findings 13e and 14a). Claimant has experienced speech and language-related phonological deficits, but he has no reported history of language delay, repetitive speech, or ritualized verbal behaviors. Claimant’s parents report that Claimant will not attempt to initiate social contact and that Claimant has difficulty maintaining reciprocal relationships (Factual Finding 21). The reliability of these reports and observations is undermined, however, by contrary and equally compelling evidence that prior to adulthood, Claimant presented with communication and social skills enabling him not only to form appropriate, reciprocal peer-relationships, but also establishing him as an interesting and engaging personality (Factual Finding 13b). Claimant maintains on-line friendships (Factual Finding 23e), which, in the age of the internet, is a typical social arrangement. In clinical sessions, Claimant engaged in conversation and displayed appropriate eye contact; no abnormal facial expressions, speech intonation, or body orientation was observed. Claimant has failed to produce a preponderance of evidence establishing that he manifests persistent deficits in social communication consistent with the DSM-5 Criteria A for Autism Spectrum Disorder set forth in Legal Conclusion 6.

11b. Claimant’s current interests and activities are reported as restricted to on-line gaming. Such restrictive behavior is not a matter of a disabling condition, but rather, a matter of choice evinced through Claimant’s expression of his need for a break from all things academic and his desire to stay at home and hang out (Factual Finding 14c). Claimant’s sartorial preference for his coat regardless of the temperature is not the kind of restriction encompassed by the diagnostic features of Autism Spectrum Disorder. Claimant has explained that his coat provides him with convenient, transportable storage compartments for his gaming gadgets (Factual Finding 23a). Clinical observations of Claimant’s sensory processing and motor skills indicated decreased touch, feel, and sound sensations—bio-physiological phenomena (Factual Finding 27b), but the preponderance of evidence failed to establish that Claimant presents with fascinations and routines relating to hyper-or hypo-reactivity to sensory input. During testing sessions, Claimant showed no stereotyped or repetitive motor mannerisms (Factual Finding 23a). Claimant has failed to produce a preponderance of evidence establishing that he manifests persistent deficits of

restricted, repetitive patterns of behavior, interests, or activities consistent with the DSM-5 Criteria B for Autism Spectrum Disorder as set forth in Legal Conclusion 6.

11c. Claimant has not met his burden of establishing by a preponderance of evidence his eligibility for Lanterman Act services and supports under the qualifying category of autism as provided for in section 4512, subdivision (a) of the Welfare and Institutions Code.

12. As Claimant is additionally asserting eligibility for Lanterman Act services and supports under the fifth category he must establish by a preponderance of evidence a disabling condition “closely related to mental retardation” or a disabling condition requiring “treatment similar to that required for individuals with mental retardation.” (Welf. & Inst. Code, § 4512, subd. (a).)

13. Like autism, the term mental retardation is similarly used throughout the Lanterman Act and its implementing regulations without definition. As in the case with the term autism, the customary practice has been to turn to the APA for elucidation on the etiology of this neurodevelopmental condition. Under the APA’s DSM-IV-TR, which the parties’ experts relied on to assess and render opinions regarding Claimant’s condition, the essential features of mental retardation were identified as significantly sub-average general intellectual functioning accompanied by significant limitations in adaptive functioning in certain specified skill areas. (DSM-IV-TR at pp 39-43. [OAH Ex. 3.]) With the May 2013 publication of DSM-5, the term “mental retardation” has been replaced with the diagnostic term “Intellectual Disability,” which, according to the APA “has come into common use over the past two decades among medical, educational, and other professionals, and by the lay public and advocacy groups.” (DSM-5 at p. 809. [WRC Supp. Ex. 6.]

14. The DSM-5 defines “Intellectual Disability” as “a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains.” (*Id.* at 33. [WRC Supp. Ex. 3.]) 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.

Thus, the definitive characteristics of intellectual disability include deficits in general mental abilities (Criterion A) and impairment in everyday adaptive functioning, in comparison to an individual's age, gender, and socio-culturally matched peers (Criterion B). To meet the diagnostic criteria for intellectual disability, the deficits in adaptive functioning must be directly related to the intellectual impairments described in Criterion A. Onset is during the developmental period (Criterion C). A diagnosis of intellectual disability should not be assumed because of a particular genetic or medical condition. Any genetic or medical diagnosis is a concurrent diagnosis when intellectual disability is present. (*Id.* at 39-40. [WRC Supp. Ex. 3.]

15. The APA notes that the most significant change in diagnostic categorization accompanying the change from DSM-IV-TR to DSM-5 nomenclature of Intellectual Disability is emphasis on the need for an assessment of both cognitive capacity and adaptive functioning, and that the severity of intellectual disability is determined by adaptive functioning rather than IQ score. (*Id.* at 37. [WRC Supp. Ex. 3.] The APA notes no other significant changes.

16. The DSM-5 states that “[i]ntellectual 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 general 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).” (*Id.* at 37. [WRC Supp. Ex. 3.] At the same time, the APA recognizes that “IQ test scores are approximations of conceptual functioning but may be insufficient to assess reasoning in real-life situations and mastery of practical tasks.” Thus, “a person with an IQ score above 70 may have such severe adaptive behavior problems in social judgment, social understanding, and other areas of adaptive functioning that the person’s actual functioning is comparable to that of individuals with a lower IQ score.” (*Id.*)

17. According to the DSM-5, “[a]daptive functioning is assessed using both clinical evaluation and individualized, culturally appropriate, psychometrically sound measures. Standardized measures are used with knowledgeable informants (e.g., parent or other family member; teacher; counselor; care provider) and the individual to the extent possible. Additional sources of information include educational, developmental, medical, and mental health evaluations.” (*Id.*) Whether it is intellectual functioning or adaptive functioning, clinical training and judgment are required to interpret standardized measures, test results and assessments, and interview sources.

18a. The published decisional law addressing eligibility for Lanterman Act services and supports under the fifth category is primarily embodied in two cases: *Mason v. Office of Administrative Hearings* (2001) 89 Cal. App. 4th 1119 and *Samantha C.*, *supra*, 185 Cal. App. 4th 1462. In *Mason*, the Court of Appeal upheld an Administrative Law Judge’s determination that evidence offered at an administrative hearing failed to establish the

eligibility of an applicant, who experienced a grand mal seizure within hours of his birth and who continued to have seizures up to three years after birth, for regional center services under the fifth category. (89 Cal. App. 4th at pp. 1130-1138.) The competent, reliable evidence of testing results and expert conclusions and testimony established that the applicant did not have “generalized significantly sub-average intellectual functioning.” (*Id.* at p. 1134.) The applicant’s documented learning deficits were attributed to hyperactivity and impulsivity rather than to cognitive limitations. The credible evidence established that the applicant’s “adaptability skills were not within the close range of mental retardation, and even if they were, his scores were impacted by his ADHD learning disability (which does not qualify as a developmental disability).” (*Id.* at p. 1137.) Testing of the applicant’s adaptability skills yielded a disparate scatter of scores. (*See id.* at p. 1135.) There was “no reliable evidence establishing that [applicant] required treatment similar to that required by mentally retarded individuals.” (*Ibid.*)

18b. In affirming the Administrative Law Judge’s determination, the Court of Appeal in *Mason* underscored that, structurally, the Lanterman Act and its regulations are deferential to regional center professionals requiring flexibility when making difficult, complex eligibility determinations because developmental disabilities are widely differing and difficult to define with precision. (*Id.* at pp. 1127-1130.) In response to *Mason*, ARCA proposed and adopted the *5th Category Guidelines*²⁷ to assist regional center professionals making difficult, complex determinations—premised on their areas of expertise and specialized knowledge—whether a disabling condition is closely related to the diagnostic characteristics of mental retardation (the nomenclature then in use) or whether a disabling condition requires treatment similar to that treatment required for individuals with the diagnostic characteristics of mental retardation. The *5th Category Guidelines* was subsequently employed in connection with a fifth category eligibility determination for the applicant in the *Samantha C.* case. (*See Samantha C.*, *supra*, 185 Cal. App. 4th at p. 1477.) Nothing in the *Samantha C.* case indicates that the Court of Appeal considered or ruled on the propriety of the *5th Category Guidelines*.

18c. In contrast to the applicant in *Mason*, the Court of Appeal held that the applicant in *Samantha C.* was eligible for regional center services under the fifth category because she offered sufficient evidence at the administrative hearing establishing that she presented with a disabling condition closely related to mental retardation *and* that her disabling condition required treatment similar to that required for mental retardation. (*Id.* at pp. 1492-1495.)²⁸ Reasonable inferences drawn from the evidentiary record indicated that

²⁷ The *5th Category Guidelines* is discussed in the context of the WRC intake team coordinator’s testimony set forth in Factual Finding 25.

²⁸ The Court of Appeal rejected the applicant’s argument that adaptive functioning impairment alone is sufficient for eligibility under the fifth category. (*See Samantha C.*, *supra*, 185 Cal. App. 4th at pp. 1486-1487.) To establish eligibility under the fifth category, Welfare and Institutions Code section 4512, subdivisions (a) and (l), requires evidence

the applicant, who suffered a hypoxic birth episode that caused injury to her brain, presented with a neurocognitive disorder, which explained her condition more fully than a diagnosis of learning disabilities and attention deficit disorder. (*Id.* at p. 1493.) The Court of Appeal therefore concluded that the applicant’s condition constituted a “‘disabling condition’ within the meaning of the fifth category.” (*Id.*) In *Samantha C.*, the experts did not dispute the evidence establishing the applicant’s impaired adaptive functioning derived from her disabling condition. The experts, however, disputed whether the applicant required treatment similar to that required for individuals with mental retardation. For example, there were experts claiming that the applicant was unsuitable for a day program which included individuals with mental retardation on grounds that such a program employed training strategies and task break-down that are different from those required for the applicant, whose level of intellectual functioning was regarded as higher than the intellectual functioning of individuals with mental retardation. (See *Ibid.*) Ruling in applicant’s favor, the Court of Appeal stated the following:

As set out in section 4512(a), fifth category eligibility depends on the similarity of the treatment required for an individual with a disabling condition and individuals with mental retardation. The statute does not require similarity in educational or teaching methods. Even among the class of those individuals with mental retardation, there may be some individuals who are capable of learning to a greater extent than others, or who require different educational and teaching strategies. Because educational and teaching methods may differ even among those with mental retardation, the fifth category does not require similar educational or teaching methods, but rather similar types of treatment, such as independent living skills training.

(*Id.* at p. 1494.)

18d. The APA’s revisions embodied in the DSM-5 have not altered the Lanterman Act’s fifth category eligibility analysis set forth in the *Mason* and *Samantha C.* cases. An applicant for regional center services asserting fifth category eligibility is required to establish by a preponderance of evidence a substantially disabling condition closely related or similar to intellectual disability or a substantially disabling condition requiring treatment similar to that treatment required for an individual with intellectual disability. The diagnostic characteristics of intellectual disability are found in the DSM-5. However, fifth category eligibility does not require strict replication of all of the DSM-5 diagnostic characteristics of intellectual disability. If this were so, the fifth category would be redundant. (See *Mason*, *supra*, 89 Cal. App. 4th at p. 1129 [indicating that Lanterman Act language defining the fifth category was drafted to address unanticipated conditions].) The concept of “substantial disability” (or substantially disabling) encompasses limitations in areas of major life activities or adaptive functioning impairment. The evidence must establish that the applicant has a substantially disabling condition that does not fall within CCR section 5400, subdivision (c) exclusions set forth in Legal Conclusion 3 (i.e., solely psychiatric disorders,

establishing that an applicant’s impaired adaptive functioning results from a substantially disabling condition.

solely learning disabilities, solely physical in nature). Eligibility under the fifth category requires an analysis of the quality of an applicant's cognitive or intellectual functioning and adaptive functioning and a determination of how well that applicant meets community standards of personal independence and social responsibility in comparison to others of similar age and sociocultural background. Alternatively, the evidence must establish that the applicant has a disabling condition requiring treatment similar to the treatment required for an individual with intellectual disability.

19a. In this case, Claimant failed to produce a preponderance of evidence establishing that his intellectual functioning is closely related or similar to that of an individual with intellectual disability. At ages five- and seven-years old, Dr. Humphrey assessed Claimant's intellectual functioning employing the WPPSI-R and the WISC-III, respectively, and on both occasions Dr. Humphrey determined that Claimant had an IQ score of 95, which indicated Claimant was of average intelligence and that Claimant demonstrated age-level intellectual abilities. Dr. Humphrey noted, however, that Claimant clinically exhibited difficulties with inattentiveness and impulsivity; Claimant met the diagnostic criteria for ADHD. Claimant's ADHD impacted some aspects of his executive functioning—his ability to stay on task, to organize information, and to process information rapidly. In turn, Claimant struggled to achieve success in an academically competitive environment. In particular, Claimant's ADHD affected his basic skills in reading and written language, which were below age-level. Dr. Humphrey additionally identified Claimant's stressful home environment and parent's marital discord as factors aggravating Claimant's ADHD symptomatology. (Factual Findings 2a through 3h.)

In August 2005, when Claimant was a 13-year-old, a Dr. Carlisle reportedly assessed his intellectual functioning at a time when Claimant was exhibiting a depressed mood and suicidality, and that assessment resulted in an IQ score of 62. Claimant's treating psychologist, Dr. O'Conner, advised, however, that the negative impact of Claimant's social and mood difficulties invalidated the assessment result obtained by Dr. Carlisle. (Factual Findings 6a and 7b.) The assessment result obtained by Dr. Carlisle is further rejected because the assessments used by Dr. Carlisle are unknown and no analysis, including notes of clinical observations of Claimant, accompanies the reported assessment result. (Factual Finding 6b.)

In September 2005, Dr. O'Conner assessed Claimant's intellectual functioning employing the WISC-IV. Dr. O'Conner reported an IQ score of 70 for Claimant, but Dr. O'Conner also discredited that assessment result noting that an IQ score of 70 did not represent Claimant's general intellectual functioning. Dr. O'Conner instead characterized Claimant's intellectual abilities as within average range for verbal comprehension and perceptual reasoning, within borderline range for working memory, and within the extremely low range for processing speed. Dr. O'Conner additionally noted that Claimant presented with significant deficits across a number of academic domains as measured by the WIAT-II notwithstanding his overall cognitive functioning, and Dr. O'Conner attributed the discrepancy between Claimant's intellectual abilities and academic performance to the effects of fetal alcohol syndrome (Factual Findings 7a.), a medical condition which

according to the APA does not presumptively result in intellectual disability. (See WRC Supp. Ex. 5.)

In October 2005, Dr. O’Conner reported that she administered the K-BIT to Claimant, which resulted in an IQ score of 95, and which, according to Dr. O’Conner, was validated on the basis of behavioral observations and casual interactions with Claimant and Dr. Seigel’s prior administration of the same assessment. (Factual Finding 7b.) Dr. O’Conner considered Claimant’s intellectual functioning to be intact, noted Claimant’s deficits in areas of social and daily living skills, academic weakness in reading comprehension, visual-motor skills, writing, and oral communication, and determined that Claimant would benefit from a highly structured classroom with explicit guidance and modeling to, among other things, address Claimant’s maladaptive behaviors and to regulate Claimant’s emotions. (Factual Findings 7b and 7c.)

In December 2008, Dr. Sowell assessed Claimant’s intellectual functioning using the WISC-IV when Claimant was a 16-year old. Claimant’s performance on the indices comprising Verbal IQ and Performance IQ scales yielded test scores ranging from average to borderline. Dr. Sowell reported a full scale IQ score of 78, which is in the borderline range. No analysis or explanation accompanied Dr. Sowell’s report, thereby limiting its utility in this matter. (Factual Finding 8 and footnote 13.) Although Dr. Sowell was not a testifying expert at the hearing, the following statement taken from *Jennings v. Palomar Pomerado Health Systems, Inc.* (2003) 114 Cal.App.4th 1108, 117, is apropos: “[A]n expert’s conclusory opinion that something did occur, when unaccompanied by a reasoned explanation illuminating how the expert employed his or her superior knowledge and training to connect the facts with the ultimate conclusion, does not assist the [factfinder].” (See also Evid. Code, § 801.)

In December 2010, when Claimant was 18 years old, Dr. Benveniste, a participant of the WRC multi-disciplinary team administered the K-BIT-2 to Claimant and reported a low average IQ score of 89 without any elaboration. (Factual Finding 19a.) In September and October 2012, when Claimant was 20 years old, WRC multidisciplinary team again assessed Claimant’s intellectual functioning. Dr. du Verglas administered the WAIS-IV to Claimant and reported that Claimant’s intellectual abilities as in the low average to average range of abilities. Dr. du Verglas reported that Claimant had significant difficulties with executive functioning that were not explained by Claimant’s intellectual abilities. (Factual Finding 23b.) Dr. Kelly, who also participated on the WRC multidisciplinary team, elaborated at the hearing that Claimant was not performing to his intellectual capacity due to unwillingness stemming from frustration, learned helplessness, adolescence angst, and parenting techniques. Claimant gave up. (Factual Finding 25d.)

Drs. Humphrey and O’Conner’s expert determination and reporting that Claimant’s intellectual functioning is in an average range is based on their clinical observations, treatment, and testing of Claimant during Claimant’s childhood when developmental disabilities are typically manifest were more credible than other evidence, including Dr. Simun and Ms. White’s testimony, to the contrary. Dr. Simun’s opinion that Claimant has

impaired neurocognitive functioning in the mild range is discredited because Dr. Simun premised her opinion on a proposed criterion for which insufficient evidence exists to warrant its use for clinical diagnosis. Ms. White's opinion is worthy of mistrust because it is derived solely from her interaction with Claimant as a counselor without any clinical testing and analysis. In addition, Drs. Benveniste and du Verglas conducted independent assessments of Claimant and from those assessments they reached conclusions which corroborate Drs. Humphrey and O'Conner's determinations and reports. Given the diminished evidentiary value of Claimant's experts' opinions, Claimant failed to establish by a preponderance of evidence that the he presents with a level of intellectual functioning closely related or similar to that of an individual with intellectual disability. The more persuasive evidence offered at the hearing indicates that the aggregate results of intelligence testing that were not invalidated assess Claimant's level of intellectual functioning as at least within a low average range if not within an average range. Such levels of intellectual functioning are not comparable or similar to that of an individual with Intellectual Disability as defined in the DSM-5. (Legal Conclusion 16.) The substantial, credible evidence establishes Claimant's level of intellectual functioning as significantly different from the sub-average level of intellectual functioning characteristic of an individual with intellectual disability.

19b. Claimant failed to produce a preponderance of evidence establishing that his demonstrated deficits in academic learning,²⁹ a component of intellectual functioning, are manifestations of intellectual limitations closely related or similar to that of an individual with intellectual disability. As indicated above, multiple assessments of Claimant's intellectual functioning have determined that Claimant has difficulties learning and using academic skills, which difficulties are characterized as a Specific Learning Disorder. The DSM-5 provides that "specific learning disorder affects learning in individuals who otherwise demonstrate normal levels of intellectual functioning that is generally estimated by an IQ score of greater than about 70 (± 5 points allowing for measurement of error)." (DSM-5 at p.69. [WRC Supp. Ex. 3.]) Onset, recognition, and diagnosis of Specific Learning Disorder usually occurs during the elementary school years when children are required to learn to read, spell, write, and learn mathematics. Specific Learning Disorder is life-long. Changes in manifestation of symptoms occur with age. Consequently, an individual may have a persistent or shifting array of learning difficulties across the lifespan. (Id. at 70-71. [WRC Supp. Ex. 3.]

The three most common academic skill areas affected by learning disorders are reading, writing, and arithmetic. Learning disorders associated with dyslexia or reading disorder include difficulty identifying groups of letters, problems relating letters to sounds, reversals and other errors involving letter position, chaotic spelling, trouble with syllabication, failure to recognize words, hesitant oral reading, and word-by-word rather than contextual reading. Learning disorders associated with dysgraphia or disorder of written

²⁹ The analysis centers on Claimant's academic learning because it enables examination of Claimant's capacity for reasoning, planning, abstract thinking and judgment as derived from both experience and instruction.

expression include problems with letter formation and writing layout on the page, repetitions and omissions, punctuation and capitalization errors, writing from right to left, and a variety of spelling problems. Learning disorders associated with dyscalcula or mathematics disorder include problems counting, reading and writing numbers, understanding math concepts, mastering calculations, and measuring. (See *id.* at 67. [WRC Supp. Ex. 3.]) Claimant has been diagnosed with Reader Disorder, Mathematics Disorder and Disorder of Written Expression. (Factual Finding 16b.)

Academic achievement test results indicate that Claimant has a history of academic performance incommensurate with his intellectual functioning. (Factual Findings 3a, 3f, 7a, 13c, and 14a.) When Claimant was a first-grader, Dr. Humphrey reported that an administration of the Woodcock-Johnson to Claimant indicated that Claimant was having significant difficulties with reading and writing despite Claimant's demonstrated age-level intellectual abilities. (Factual Findings 3a and 3f.) Dr. Humphrey recommended placing Claimant in an academic environment where Claimant's average-level abilities are the norm. (Factual Finding 3g.) When Claimant was in middle school, Dr. O'Conner reported that an administration of the WIAT-II revealed that Claimant had significant deficits across a number of academic domains including reading, math, spelling, and written expression despite evidence of Claimant's intact intellectual functioning. Dr. O'Conner recommended a highly structured classroom with a low student-to-teacher ratio and modified curriculum with remedial materials in order for Claimant to increase his academic skills and benefit from instruction. (Factual Findings 7b and 7c.) In high school, Claimant received specialized academic instruction in a structured educational setting where Claimant earned A's, B's, and C's. Although Claimant's repeated attempts to pass the Mathematics portion of the California High School Exit Exam proved elusive, Claimant was successful on the English Arts portion of the California High School Exit Exam. (Factual Finding 8.)

The DSM-5 provides that Specific Learning Disorder commonly co-occurs with neurodevelopmental or other mental disorders such as ADHD, anxiety disorders, and depressive and bipolar disorders. (DSM-5 at p. 74. [WRC Supp. Ex. 3.]) Beginning in his early childhood, Claimant manifested inattention, hyperactivity and impulsivity. (Factual Findings 2b, 2c, 3c, and 3g.) Claimant was diagnosed with ADHD, which according to the DSM-5 is associated with reduced school performance and academic attainment. (DSM-5 at p. 63. [WRC Supp. Ex. 3.]) On more than one occasion, Dr. Humphrey attributed Claimant's poor academic performance in pre-school and first grade to his ADHD diagnosis. Assessments of Claimant throughout the rest of his academic career consistently attributed Claimant's cognitive problems on tests of executive function to his ADHD. (Factual Findings 4, 5b, 7a, and 8.) Claimant continued to exhibit significant discrepancy in areas of reading, math, and written expression that was linked to his depression and anxiety as he transitioned from high school. (Factual Finding 9.)

At age 10, Claimant was diagnosed with Adjustment Disorder with Depressed Mood and Anxiety. At age 11, Claimant was diagnosed with Bipolar Disorder-Not Otherwise Specified. (Factual Finding 16b.) Claimant was admitted to a neuropsychiatric hospital on four separate occasions before he attained age 14. (Factual Finding 16c.) Dr. O'Conner has

indicated that, among other considerations, Claimant's pervasive mood of unhappiness severely hinders his overall functioning. (Factual Finding 5b.)

Additionally, within the context of her clinical observation, testing, and treatment of Claimant, Dr. O'Conner attributed Claimant's learning disability to "central nervous system dysfunction related to the effects of fetal alcohol exposure." (Factual Findings 7a 16e, and 17.) The DSM-5 instructs that "[a]lcohol is a neurobehavioral teratogen, and prenatal alcohol exposure has teratogenic effects on central nervous system (CNS) development and subsequent function." (DSM-5 at p. 799. [WRC Supp. Ex. 5.]) The DSM-5 enumerates impaired neurocognitive functioning as manifested by impairment in learning (defined to mean lower academic achievement than expected for intellectual level), impairment in self-regulation as manifested by impairment in mood or behavior regulation (defined as mood lability) or attention deficit (defined to mean difficulty shifting attention; difficulty sustaining mental effort), impairment in adaptive functioning as manifested in communication deficit or social communication and interaction impairment and either daily living skills or motor skills impairment as indicia of gestational exposure to alcohol. (DSM-5 at p. 798. [WRC Supp. Ex. 5.]) Neither party disputes that Claimant presents with Prenatal Fetal Alcohol Syndrome. Claimant has a Prenatal Fetal Alcohol Syndrome diagnosis, which according to the credible evidence is manifested as ADHD and Specific Learning Disorders. (Factual Finding 25j.)

It is Claimant's evidentiary burden to establish that his deficits in academic learning are explained by an eligible disability. Claimant has failed to meet that burden in light of the substantial, credible evidence offered at the hearing indicating that Claimant's deficits in academic learning are best explained by a documented history of medical and psychiatric conditions including prenatal alcohol syndrome, learning disabilities, depression, bipolar disorder and anxiety. These medical and psychiatric conditions do not qualify Claimant for Lanterman Act services and supports.

19c. Claimant has failed to produce a preponderance of evidence establishing that during his developmental years up to age 18 he presented with substantial deficits in adaptive functioning that are closely related or similar to that of an individual with intellectual disability. Credible reports documenting Claimant's executive and adaptive functions during Claimant's development before he was an 18-year-old establish Claimant's capacity for attending to his hygiene and self-care needs. He knew how to prepare simple meals and how to order food in public (Factual Finding 21). He eschewed public, motorized transportation in favor of either walking or bicycling to transport himself from one location to another (Factual Findings 19c and 21). Claimant's adaptive behavior scores in the areas of daily living and domestic and community skills were reported as in the moderately low range (Factual Findings 13d and 23d). Much of Claimant's formative years were spent in residential facilities when he was not at home with his parents. Consequently, Claimant had no experience living independently before age 18. There is scant evidence that prior to age 18 Claimant had instruction or opportunity to acquire comprehensive skills necessary for home organization, banking, and money management. The full extent of Claimant's capacity, or lack thereof, for independent living and economic self-sufficiency before age 18 was not persuasively established in the historical records of Claimant's adaptive functions.

The credible evidence nonetheless suggests Claimant's unwillingness to learn skills necessary for his self-reliance and independence to meet his daily living needs. Claimant declined participating in a transition program focusing on his acquisition of day-to-day life skills (Factual Finding 14c). Prior to age 18, Claimant expressed disinterest in vocational preparation for employment (Factual Finding 14c). Claimant's recalcitrance has not been without its consequences. As a young adult, Claimant presents with limited adaptive functioning skills (Factual Findings 29f, 30b, 30c, and 30d). These limitations are either directly linked to Claimant's diagnosed ADHD and Specific Learning Disorders or were not manifested in Claimant's developmental years. (See Legal Conclusion 19d.)

Evidence of Claimant's social relations is conflicting. Claimant reportedly makes and maintains relationships with others (Factual Findings 13b and 27). Claimant has at least two friends with whom he has regular contact (Factual Finding 21). Yet Claimant's parents have concerns whether he has reciprocal relationships (Factual Finding 21). Claimant has had difficulties regulating his emotions and behaviors in age-appropriate fashion (Factual Findings 8 and 10) but, the evidence indicates that such difficulties are the manifestations of anxiety, depression, and a stressful home environment (Factual Findings 16d and 19d). Claimant is articulate, and he speaks in complete sentences (Factual Finding 21). Claimant is attentive to subjects which are of interest to him (Factual Finding 13b). Claimant has no significant difficulty with pragmatic and expressive language (Factual Finding 13e). Claimant failed to produce a preponderance of evidence establishing that during his developmental years up to age 18 he presented with substantial adaptive functioning deficits closely related or similar to that of an individual with intellectual disability.

19d. During the re-opened proceedings in this matter, Claimant asserted that he requires treatment similar to that required by an individual with intellectual disability. In support of his assertion Claimant offered evidence to establish that he currently presents with executive and adaptive functioning deficits consisting of the following: auditory processing and memory issues (Factual Finding 30b); difficulty planning, organizing, and executing goals (Factual Finding 29e); difficulty with spelling, writing, and mathematics (Factual Findings 29d and 30a); difficulty understanding and interpreting a bus schedule, and therefore difficulty navigating public transportation (Factual Findings 29e and 30b); difficulty budgeting, paying bills, writing checks, dispensing correct change, or otherwise attending to his finances (Factual Findings.); difficulty scheduling appointments (Factual Findings 29f and 30d); limited self-help skills, including meal preparation, food and clothing shopping, laundering, and garbage disposal (Factual Findings 29f, 30c, and 30d); and limited vocational skills (Factual Findings 29j, 30e, and 30g).

Guided by the 5th *Category Guidelines*, the WRC intake team determines whether an individual requires treatment similar to that required for individuals with intellectual disability by considering whether the individual presents with "global cognitive deficits." (Factual Finding 25h.) In this matter, the WRC intake team determined that Claimant's

cognitive profile revealed no evidence of global cognitive deficits.³⁰ Claimant does not present with consistent sub-par performance across domains. Claimant presents with disparate areas of strengths and weaknesses that are linked to his diagnosis of ADHD and Specific Learning Disorders.

Competent, reliable evidence offered at the hearing supports the WRC intake team's determination. (See e.g. Factual Findings 3a, 3b, 5a, 8, and 23b.) Since early childhood, Claimant was diagnosed with ADHD, a disorder impacting his executive functioning and contributing to his difficulties learning and acquiring academic as well as pragmatic skills in reading, writing, and mathematics. Claimant was additionally diagnosed with Specific Learning Disorders. (Factual Findings 2a through 3b, 3f, and 3g.) The existence of Claimant's ADHD and Specific Learning Disorders is undisputed. Since their onset, Claimant's ADHD and Specific Learning Disorders have been persistent, even as Claimant has entered young adulthood, which not surprisingly explains why Dr. Waybright has observed evidence of Claimant's ADHD and Specific Learning Disorders during Claimant's therapeutic sessions with her over the past one and one-half years. (Factual Finding 29d.)

In light of the specific nature of Claimant's average intellectual functioning, as it has been impacted by ADHD and Specific Learning Disorders, during his developmental years, Claimant was either recommended for or re-directed to structured academic or vocational programs where he was reasonably expected to succeed. (Factual Findings 2c, 5b, 7b, 7c, 10, and 23f.) Claimant's success was undermined, in part, because of Claimant's refusal during his developmental years to engage in training focusing on, for example, the math necessary for budgeting, shopping, and money management and the skills needed to take public transportation. (Factual Finding 14c.) None of the evidence offered at the hearing attributes Claimant's skills deficits to socio-cultural deprivation requiring remedial training. Nor are Claimant's skill deficits attributable to intellectual limitations. As discussed above, Claimant's level of intellectual functioning is within average range, which is dissimilar from the sub-average intellectual functioning of an individual with intellectual disability. (Factual Findings 19a and 19b.) Although Claimant was in part educated in structured academic setting, there is no evidence that Claimant was ever placed in any learning environments for individuals with intellectual disability. Although structured, Claimant's educational placements were in learning environments with peers of similar average intellectual functioning, as recommended by Drs. Humphrey and O'Conner and a BHUSD school psychologist. (See Factual Findings 3g, 7b, and 5a.) During Claimant's developmental years, suggestions that Claimant would benefit from explicit guidance and a breakdown of information into manageable pieces were made in the context of how best to accommodate Claimant's ADHD and Specific Learning Disorders. (Factual Findings 3e, 7b, 7c.) Claimant has been subjected to extensive educational and psychological habilitation and interventions during his developmental years, and he has benefited as evinced by his sporadic academic success. The reasonable inference drawn from the competent, reliable evidence is that Claimant's executive and adaptive functioning deficits, even in their current manifestation,

³⁰ Dr. Kelly clarified that the concept "global cognitive deficits" is not synonymous with a GAF score.

are associated with Claimant's ADHD and Specific Learning Disorders. Under these circumstances, Claimant has failed to produce a preponderance of evidence establishing that he presents with a substantially disabling condition requiring treatment similar to that treatment required by an individual with intellectual disability.

20. In this case, Claimant offered weakened or discredited evidence to support his claim that he presents with deficits in intellectual functioning or adaptive functioning closely related or similar to that of an individual with intellectual disability or requiring treatment similar to treatment required for an individual with intellectual disability. By contrast, the service agency offered substantial, credible evidence that Claimant presents with average intellectual functioning and adaptability skills unlike that of an individual with intellectual disability and not requiring treatment similar to treatment required for an individual with intellectual disability. Under these circumstances, Claimant has not met his burden of establishing by a preponderance of evidence his eligibility for Lanterman Act services and supports under the fifth category as defined in section 4512, subdivision (a), of the Welfare and Institutions Code. Compare with *Mason, supra*, 89 Cal.App.4th 1119 [weight of the evidence did not establish claimant's developmental disability under the fifth category] and *Samantha C. supra*, 185 Cal.App.4th 1462 [overwhelming evidence established claimant's fifth category eligibility].

21. Cause exists by reason of Factual Findings 1 through 30, inclusive, and Legal Conclusions 1 through 20, inclusive, to deny Claimant's appeal.

ORDER

1. Claimant's appeal is denied.
2. Westside Regional Center's determination that Claimant is ineligible for services and supports pursuant to the Lanterman Developmental Disability Services Act is affirmed.

Date: September 4, 2013

Date: (Amended) May 7, 2015

Date: (Amended) February 11, 2016

_____/s/_____
JENNIFER M. RUSSELL
Administrative Law Judge
Office of Administrative Hearings

NOTICE

This is a final administrative decision. This administrative decision binds both parties. Either party may appeal this administrative decision to a court of competent jurisdiction within 90 days.