

BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT,

Claimant,

vs.

ALTA CALIFORNIA REGIONAL
CENTER,

Service Agency.

OAH No. 2013070141

DECISION

This matter was heard before Administrative Law Judge Susan H. Hollingshead, State of California, Office of Administrative Hearings (OAH), in Sacramento, California, on August 19, 20, November 12, 13, 14, 19, 20, 21, and December 18, 2013.

The Service Agency, Alta California Regional Center (ACRC), was represented by Robin Black, Legal Services Specialist, and Judith A. Enright, Attorney at Law.

F. Richard Ruderman, Attorney at Law, represented claimant.

Oral and documentary evidence was received. Submission of this matter was deferred pending receipt of closing briefs. Alta California Regional Center's Closing Argument and Claimant's Closing Brief were submitted on February 4, 2014, and marked respectively as Exhibits 24 and 32. The record was closed and the matter submitted for decision on February 4, 2014.

ISSUE

Is claimant eligible to receive regional center services and supports based on the "fifth category" because she has a condition closely related to intellectual disability, or that requires

treatment similar to that required for individuals with an intellectual disability pursuant to Welfare and Institutions Code section 4512? ¹

FACTUAL FINDINGS

1. Claimant is a twenty-one-year old unconserved young woman, born on April 6, 1992. In 2001, claimant and her younger sister were removed from their parents care and placed in protective custody due to abuse and neglect. It was reported that claimant's father suffered a traumatic brain injury and physically abused the family, included slamming claimant's head into walls, floors and tables when he was angry, and chasing claimant and her sister with an axe. Claimant's mother, a mentally impaired regional center consumer, was not able to adequately protect and care for her children. Parental rights were terminated and claimant has an extensive subsequent history of foster care placements, estimated at approximately nineteen separate placements, since that time. Changes in placement were primarily related to behaviors including noncompliance, hyperactivity, conflict with others and inappropriate behaviors. She was continually moved from house to house and group home to group home. It was reported that her sister was adopted into a loving family home. Claimant will "age-out" of the foster care system at age twenty-two.

2. It was agreed, without exception, by all participants in this hearing that claimant is clearly impaired in her adaptive functioning. ACRC specifically stipulated to the fact that claimant has been tremendously impacted by her adaptive skills deficits. There is concern by all regarding her ability to care for herself when she is no longer assisted through the foster care system. She definitely requires assistance; however the issue to be determined here is whether she qualifies for regional center services and supports.

3. Claimant's position is that she qualifies under the "fifth category" because she has a condition closely related to intellectual disability, or that requires treatment similar to that required for individuals with an intellectual disability. She contends that she lacks the capacity to live independently, due to major impairment in cognitive and social functioning, with limitations in the areas of self-care, mobility, self-direction, capacity for independent living and economic self-sufficiency, and has a "child like innocence," which is not attributable to her mental health needs. She asserts that she presents with Borderline Intellectual Functioning and significant adaptive skills deficits.

4. ACRC contends that claimant does not meet the requirements for "fifth category" eligibility because her deficits in adaptive functioning are not attributable to global cognitive deficits, thus she does not have a condition closely related to intellectual disability. The agency opined that claimant does not require treatment similar to that required by persons with intellectual disability because she is not functioning at that level cognitively. They

¹ Unless otherwise indicated, all statutory references are to the California Welfare and Institutions Code.

conclude that claimant's adaptive functioning limitations are solely related to psychiatric disorders and/or learning disabilities and she requires treatment appropriate for an individual with psychiatric and/or learning concerns.

5. Records indicate claimant's diagnoses, at various times, have included Mood Disorder, Attention Deficit Hyperactivity Disorder (ADHD), Reactive Attachment Disorder, Post Traumatic Stress Disorder (PTSD), Pervasive Developmental Disorder, Not Otherwise Specified (PDD-NOS) and Anxiety. She has a history of being administered psychotropic medications, currently Seroquel and Zoloft.

6. Claimant initially sought regional center services in 2011. At that time, she resided at Lake Francis Resort/Environmental Alternatives (Lake Francis), a residential program established for older foster children to assist them with transition to adulthood. Carla Fisher was a Youth Mentor for the program and assisted claimant.² Ms. Fisher became concerned for claimant's future when claimant was not acquiring the skills needed to live independently. She referred claimant to ACRC to determine eligibility for services.

7. ACRC Intake Counselor Sue Wheelwright, MSW, interviewed claimant, who was accompanied by Ms. Fisher, on July 15, 2011, and subsequently completed an ACRC Social Assessment. Her Summary stated the following:

[Claimant] was referred to ACRC with suspected diagnoses or [*sic*] borderline intellectual functioning, and a diagnosis on the autism spectrum.

This intake counselor recommends scheduling [claimant] for a psychological evaluation and for [claimant] to continue on in the intake process. A determination of eligibility for Regional Center services will be decided after a comprehensive case review by the ACRC multidisciplinary team.

8. ACRC referred claimant to Licensed Clinical Psychologist Monica Silva, Ph.D., a regional center vendor, who completed her evaluation of claimant on July 27, 2011.

9. On August 29, 2011, the ACRC multidisciplinary team determined that claimant was not eligible for regional center services. The team consisted of Staff Psychologist Cynthia Root, Ph.D., Staff Medical Doctor Terrance Wardinsky, M.D., and Ms. Wheelwright.

² Ms. Fisher has maintained a relationship with claimant since they first met at Lake Francis Resort/Environmental Alternatives. She has assisted claimant and assumed a caretaker role. Claimant currently resides with Ms. Fisher.

10. As a result of the eligibility team determination, A Notice of Proposed Action (NOPA) was issued on August 29, 2011, informing claimant that ACRC determined she was not eligible for regional center services. The NOPA stated:

Reason for action: By an agreement of an Interdisciplinary Team, [claimant] has been determined ineligible for Regional Center services. The reports considered by the team in making this decision are the:

Social Assessment by Sue Wheelwright of 7/5/11
Psychological Evaluation by Dr. Silva of 7/27/11
Letter from Dr. Linda Baran of 4/5/11
Records—Sutter Yuba Mental Health
Psychoeducational Evaluation from Mendocino Office of Education of 8/13/04
Sacramento County SELPA IEP of 1/8/09
Psychological Evaluation by Dr. Stenbridge of 1/18/07
Letter from Northern CA Preparatory School of 1/28/09
High School Exit Exam reports
Woodcock Johnson scores
Sacramento County SELPA IEP of 1/24/08
Elk Grove IEP of 9/19/07
Student Transcripts Milhous Schools, Inc.
Speech, Language and Hearing report of 9/19/07
Transcript, Twin Rivers Unified School District
Report cards and Progress Reports from Northern Preparatory School
Transcript from Milhous School, Inc.

11. ACRC Intake Counselor Ms. Wheelwright spoke by telephone with Carla Fisher to discuss claimant's eligibility for regional center services. By letter dated August 31, 2011, Ms. Wheelwright provided the NOPA as well as suggestions for assistance that may be available to claimant including SSI, representative payee agencies, In Home Supportive Services (IHSS), psychiatric services, mental health residential services and Department of Rehabilitation (DOR) assistance. Also included was information on appealing this decision.

12. Claimant did not appeal ACRC's decision.

13. In 2013, claimant again requested regional center services. By letter dated June 25, 2013, ACRC Intake Supervisor Cindy Kenley provided claimant with information that included the following:

As was discussed with you, you were determined ineligible for regional center services in August 2011. Any individual who is found ineligible for regional center services remains ineligible

unless there is new evidence that documents a reasonable belief of the presence of a developmental disability.

At your request, the new information made available to us was carefully reviewed by our clinical team. The information provided does not support the belief that you have a developmental disability and, as such, ACRC respectfully declines your request to be reconsidered for eligibility.

14. On July 1, 2013, claimant filed a Fair Hearing Request through her attorney, disputing her ineligibility for regional center services. The reason for requesting a fair hearing was because “[claimant] was not found eligible for regional center services. [Claimant] should be found eligible for regional center services under the fifth category. [Claimant] has borderline intellectual functioning and deficient adaptive skills requiring treatment, supports, and services similar to that of a person with mental retardation.” To resolve the complaint, the following was noted: “[Claimant] needs to be found eligible for regional center and offered services. [Claimant] requires the following services: assisted living, transition, vocational training, services to support independent living, and safety training.” The Request authorized Carla Fisher to act as claimant’s authorized representative in this matter.

15. An Informal Meeting was held on August 1, 2013, with the following persons present:

Claimant
Carla Fisher, Claimant’s caretaker
Rick Ruderman, Claimant’s attorney
Lindsey Mehler, Paralegal to Mr. Ruderman
Cindy Kenley, ACRC Intake Department Supervisor
John Domeier, ACRC Intake Counselor
Cynthia Root, Ph.D., ACRC Staff Psychologist
Sindhu Philip, Psy. D., ACRC Staff Psychologist
Robin Black, ACRC Legal Services Manager and Designee of ACRC Executive Director

ACRC Designee Ms. Black concluded “no information was provided to show that the new information provided ACRC in 2013 supports a belief that Claimant has a developmental disability. Nor was information provided to refute the clinical determination of ACRC’s eligibility team in its original 2011 decision (which was not appealed) that Claimant does not have a disability and is not eligible for regional center services.” The Designee therefore upheld “ACRC’s determination that the new information provided by Claimant in 2013 does not establish a belief that Claimant has a developmental disability and that she remains therefore ineligible for regional center services.”

Ms. Black, in reaching her decision, considered “ACRC’s original ineligibility determination, and all of the records in the possession of the regional center (including the

incomplete report of Dr. Stembridge), including information and documentation provided at the informal meeting.” She also considered the following concerns raised by claimant’s attorney:

- (a) Claimant has been diagnosed with Borderline Intellectual Functioning;
- (b) Dr. Lepage believed Claimant to be eligible for regional center services;
- (c) Concern that Claimant’s academic achievement testing, CAHSEE results, and other testing completed by Claimant’s school may not be reliable; and
- (d) Belief that Claimant requires services similar to those required by individuals with mental retardation, and thus eligible under the fifth Category.

16. Pursuant to the Lanterman Act, Welfare and Institutions Code section 4500, et seq., regional centers accept responsibility for persons with developmental disabilities. Welfare and Institutions Code section 4512 defines developmental disability as follows:

“Developmental disability” means 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 intellectual disability, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to intellectual disability³ or to require treatment similar to that required for individuals with an intellectual disability [commonly known as the “fifth category”], but shall not include other handicapping conditions that are solely physical in nature.

17. California Code of Regulations, title 17, section 54000, further defines the term “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 Development Disability shall:

(1) Originate before age eighteen;

³ Effective January 1, 2014, the Lanterman Act replaced the term “mental retardation” with “intellectual disability.” The terms are used interchangeably throughout.

(2) Be likely to continue indefinitely;

(3) Constitute a substantial disability for the individual as defined in the article.

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

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

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

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

18. Welfare and Institutions Code section 4512, subdivision (1), defines substantial disability as:

(1) The existence of significant functional limitation 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.

19. California Code of Regulations, title 17, section 54001, provides:

(a) “Substantial disability” means:

(1) A condition which results in 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 functional limitation, 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:

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

20. As a result of claimant’s initial eligibility request in 2011, she was referred by ACRC to Licensed Clinical Psychologist Monica Silva, Ph.D., a regional center vendor, who completed her evaluation of claimant on July 27, 2011. Dr. Silva’s report noted the following:

REASON FOR REFERRAL

[Claimant] was referred by intake counselor Sue Wheelwright, LCSW, for an evaluation of cognitive, adaptive, and behavioral skills in order to determine eligibility. It is suspected she presents with characteristics of an Autism Spectrum Disorder and /or cognitive and adaptive delays characteristic of borderline Intellectual Functioning or Mild Mental Retardation. The following evaluation will summarize [Claimant’s] current cognitive, adaptive, and behavioral functioning and evaluate for the possibility of an Autism Spectrum Disorder.

21. Dr. Silva administered the Wechsler Adult Intelligence Scale, Fourth Edition (WAIS-IV), which consists of a series of subtests that are used to assess an individual in four major domains of intelligence and offer a summary of general intellectual abilities. The four Composite Index Scales are Verbal Comprehension Index (VCI), Perceptual Reasoning Index (PRI), Working Memory Index (WMI), and the Processing Speed Index (PSI). Dr. Silva’s report explained that the VCI measures “verbal concept formation, verbal reasoning and knowledge acquired from one’s environment.” The PRI “measures nonverbal abilities such as

spatial processing, visual motor integration and fluid reasoning.” The WMI “measures a person’s ability to retain information in memory for short periods of time (or short-term memory)” and the PSI “is a measure of an individual’s speed of information processing and is related to mental capacity and the efficient use of working memory for higher order fluid tasks.”

In her report, Dr. Silva offered the following score summary and noted that on the “Composite Index scales, the population mean is 100 and the standard deviation is 15. On the subtests, an average score is 10, with a standard deviation of 3 points.”

Composite Score Summary

<u>Scale</u>	<u>Composite Score</u>	<u>Percentile Rank</u>	<u>95% Confidence Interval</u>	<u>Qualitative Description</u>
Verbal Comprehension	VCI 85	16	80-91	Low Average
Perceptual Reasoning	PRI 86	18	80-93	Low Average
Working Memory	WMI 74	4	69-82	Borderline
Processing	PSI 79	8	73-89	Borderline
Full Scale	FSIQ 78	7	74-83	Borderline

Verbal Comprehension Subtests Summary

<u>Subtest</u>	<u>Scaled Score</u>	<u>Percentile Rank</u>
Similarities	8	25
Vocabulary	6	9
Information	8	25

Perceptual Reasoning Subtests Summary

<u>Subtest</u>	<u>Scaled Score</u>	<u>Percentile Rank</u>
Block Design	8	25
Matrix Reasoning	7	16
Visual Puzzles	8	25

Working Memory Subtests Summary

<u>Subtest</u>	<u>Scaled Score</u>	<u>Percentile Rank</u>
Digit Span	6	9
Arithmetic	5	5

Processing Speed Subtests Summary

<u>Subtest</u>	<u>Scaled Score</u>	<u>Percentile Rank</u>
Symbol Search	9	37
Coding	3	1

22. Dr. Silva also administered the Adaptive Behavior Assessment System, Second Edition (ABAS-II), which measures the “functions an individual actually performs without the assistance of others.” Ms. Fisher completed the rating scale and claimant’s General Adaptive Composite (GAC) score was 43, in the extremely low range.

23. The Autism Diagnostic Observation Schedule, Module IV (ADOS) and Gilliam Autism Rating Scale-2 (GARS-2) were used to determine whether claimant has an autism spectrum disorder. Dr. Silva determined from those evaluations that claimant “presents with a unique and complicated clinical picture which is difficult to summarize. She presents with impairments in communication, socialization, and behaviors commonly seen in individuals diagnosed with an Autism Spectrum Disorder. [Claimant], however does not meet the full criteria for a diagnosis of Autistic Disorder, and her presentation is not typical to individuals diagnosed with Asperger’s Disorder. Her manner of relating socially, as well as her language and behaviors, may be best characterized by a diagnosis of Pervasive Developmental Disorder-Not Otherwise Specified.”

24. In addition to administering the assessment instruments noted, Dr. Silva also reviewed available records and conducted interviews.

25. Dr. Silva noted that claimant’s “demeanor and manner of communicating was reminiscent of someone much younger; she was childlike in her presentation.” She also reported that claimant is “currently prescribed medications for psychotic episodes, as well as Mood Disorder, Attention Deficit Hyperactivity Disorder, and Anxiety. She is currently prescribed Concerta, Zoloft, and Seroquel.” Dr. Silva included the following in her clinical impressions:

At this time, it is difficult to summarize [claimant’s] cognitive functioning. Results from previous testing revealed functioning ranging from Borderline to Low Average. The results of the current evaluation are difficult to summarize, as her functioning ranged from Borderline to Low Average as well, and there were significances between the subtest scores. Though [claimant]

demonstrates some areas of strength . . . her day-to-day cognitive functioning, especially as it relates to novel situations or making age-appropriate decisions, is delayed. In that sense, her cognitive abilities are better characterized by a diagnosis of Borderline Intellectual Functioning. Adaptively, there have been significant concerns noted, and her functioning in that sense may be more akin to individuals diagnosed with Mild Mental Retardation. The ABAS scores revealed that [claimant] functions in the Extremely Low range in all areas . . .

[Claimant's] teachers report that she demonstrates difficulty with focus and she has been diagnosed with Attention Deficit Hyperactivity Disorder for which she is prescribed medication. [Claimant] benefits from reminders and prompts to complete self-care tasks, including bathing, brushing her teeth, and taking her medications, and she requires step-by-step directions to clean and organize her living quarters, which is said to be very messy. [Claimant] is able to use a microwave but is not able to cook or complete most age-appropriate tasks, and she benefits from close supervision regarding her eating leftover foods, such as moldy pizza . . . she has been taken advantage of and is at risk for exploitation. She is not able to count change and will make poor decision[s] when shopping. [Claimant] is a highly disorganized young woman who requires close supervision, prompts, reminders, and assistance in all areas of adaptive functioning.

26. Dr. Silva's report offered the following:

DSM-IV-TR ⁴ DIAGNOSES

Axis I	Pervasive Developmental Disorder-Not Otherwise Specified Attention Deficit Hyperactivity Disorder (By History)
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⁴ The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) was the standard for diagnosis and classification at the time of this assessment. It is a multiaxial system which involves five axes, each of which refers to a different domain of information as follows:

Axis I	Clinical Disorders Other Conditions That May Be a Focus of Clinical Attention
Axis II	Personality Disorders Mental Retardation
Axis III	General Medical Conditions
Axis IV	Psychosocial and Environmental Problems
Axis V	Global Assessment of Functioning

	Mood Disorder-Not Otherwise Specified (By History)
Axis II	Borderline Intellectual Functioning
Axis III	None
Axis IV	Education/Occupational Issues, Social Issues
Axis V	GAF: 55

27. Christopher Lepage, Psy.D., is a pediatric neuropsychologist who was asked to perform a neuropsychological evaluation of claimant at the request of her treating neurologist Shawn Kile, M.D., through the Sutter Transition for Autism and Neurodevelopmental Disorders (STAND) Clinic. The primary concerns were:

Clarification of cognitive function and developmental delays.
Possible presence of autism.
Need for conservatorship is in question.

28. Dr. Lepage evaluated claimant on October 31, December 18 and December 19, 2012. He administered tests to assess several broad areas of function, reviewed Sutter Health medical records, Dr. Silva's July 27, 2011, Psychological Evaluation, a Marysville Joint Union School District October 22, 2012, Psychoeducational Evaluation and a "box of records." "Due to the number of previous evaluations, and the consistency between those tests over multiple years, specific tests of intellectual functioning (IQ) were not administered." Prior testing included:

2001 Psychoeducational evaluation: WISC-III full-scale IQ of 77
2011 Alta California [R]egional Center evaluation: WAIS-IV full scale 78
2012 Psychoeducational evaluation: Stanford-Binet-5 full scale IQ of 78

Dr. Lepage stated "while these scores are consistent with Borderline Intellectual Functioning, daily activity including adaptive skills shows functioning similar to a person with intellectual disability. Given the general presentation and history of functioning at the level of intellectual disability, learning and memory will be less efficient overall. Supportive services should be designed accordingly."

29. In addressing claimant's history, Dr. Lepage discussed records indicating that claimant's father "repeatedly slammed her head against objects (wall and floor) when she was an infant. CT and MRI were negative, yet neurocognitive as well as psychological impact is probable."

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30. Dr. Lepage reported the following:

DIAGNOSTIC IMPRESSIONS

Axis I	300.00 296.9	Anxiety Disorder, NOS Mood Disorder, NOS
Axis II	V62.89	Borderline Intellectual Functioning <i>Current daily function at the level of mental retardation</i>
Axis III	V71.09	None documented at this time
Axis IV		Need for housing, job, and financial management assistance
Axis V	GAF	Current = 49 (severe) <i>Remains fully dependent on others for basic needs⁵</i>

31. Dr. Lepage recommended pursuing conservatorship for claimant as she “has displayed and continues to demonstrate limited capacity to manage housing, employment, medical care, and finances.” He opined as follows:

At this time, [claimant] is a young woman incapable of independent decisions for medical care, shelter, finances, and employment. Regional Center support is recommended. She is at risk of not qualifying for Regional Center Services, as her intellectual functioning (IQ score) is above the typical cut-off for a diagnosis of mental retardation. This score alone should not be used as the sole qualifying or disqualifying factor. Due to functioning comparable to a person with intellectual disability, [claimant] has failed to independently manage daily activities for basic survival including medications, finances, housing, and employment. This history and current test results demonstrate very low likelihood of successful independent living as an adult, consistent with functioning equivalent to a person with intellectual disability.

He added:

Psychiatric history is complicated, yet psychiatric needs do not reduce the impact of low intellectual functioning and should not be used as a disqualifying factor for supportive services related to

⁵ Emphasis in original.

developmental disorder. In fact, this combination increases [claimant's] vulnerability.

32. ACRC, understandably, objected to Dr. Lepage's testimony referencing a "box of records." During hearing he subsequently provided copies of the referenced records and was recalled for additional testimony and cross-examination.

33. When asked if, in his professional opinion, claimant's adaptive skills deficits were related to a psychiatric condition, he responded, "No. To consistently function so low over time and settings points more to a neurodevelopmental disorder. There was no evidence that she ever functioned at age expectations."

34. Dr. Lepage performed a follow-up assessment of claimant on August 22, 27, 28, 30, 2013, and September 4, 10 and 23, 2013, "to review current neurocognitive and adaptive skills." He testified that the purpose was to get a more accurate picture of claimant's functioning since his previous assessment in fall, 2012. Dr. Lepage's report contained a detailed chronology of the various diagnoses given claimant over the years, as well a detailed summary of prior assessments and medications.⁶ In addition, he administered additional testing including the WAIS-IV, which was reported as follows:

VCI 83
PRI 92
WMI 69
PSI 81

FSIQ 79

The following DIAGNOSTIC IMPRESSIONS were included:

Borderline Intellectual Functioning
Current WAIS-IV FSIQ of 79, 8th percentile
Valid FSIQ measured between 77 to 79, as documented in the records reviewed
Very low adaptive skills, function at the level comparable to Intellectual Disability
Attention Deficit Hyperactivity Disorder, Combined By History
Current impressions include impulsivity, disorganization, and inattention

35. Of note, Dr. Lepage no longer included Anxiety Disorder, NOS or Mood Disorder, NOS in his Diagnostic Impressions.

⁶ Current medications were noted to be Zoloft and Seroquel.

36. Dr. Lepage's report states, in part:

[Claimant's] developmental delays reduce the potential for typical function and ability to self-sustain. She receives prompting for many daily activities (e.g. transportation, self-care, medication management, housing, financial management). Without such persistent support, [claimant] would struggle to survive . . .

Previous evaluations (Moore, Silva, Resner, West, Lepage 2012) document that overall intellectual functioning is in the Borderline range and adaptive skills are impaired. Beyond any reasonable doubt, after a thorough review of 12-years of testing data and behavioral reports, [claimant's] function is comparable to that of a person with Intellectual Disability.

Multiple psychosocial and psychiatric concerns are present as well. There is a negative impact of probable emotional abuse and confirmed physical abuse as well as neglect from birth to age 6-years. The immediate impact of such experiences in early years is often seen as developmental delays, similar to those seen in [claimant] years ago. For many children, such unfortunate early experiences result in residual psychological and emotional trauma, as is likely the case for [claimant]. For many of these children, cognitive and adaptive skills eventually emerge intact, even with significant social difficulty and behavioral disruption. Given the known evaluation history including documented developmental delays, [claimant's] limited cognitive resources reduced her ability to understand and effectively cope with the unfortunate events of her childhood. [Claimant's] developmental delays extend far beyond the impact of trauma.

37. Claimant has had many psychological evaluations and they tend to be consistent in determining that she has relative deficits in WMI and PSI. ACRC opined that it is not surprising, with a diagnosis of ADHD, that claimant exhibits relative deficits in working memory and processing speed.

38. When claimant was in fourth grade, she was evaluated for special education services by the Marysville Joint Unified School District. The November 13, 2001, "Psycho-Education Report" by assessors Linda Burns, School Psychologist, and Susan Bumgardner, Special Education Teacher, utilized the Wechsler Intelligence Scale for Children-III (WISC-III), "a test of cognitive functioning which looks at a child's thinking and reasoning ability in verbal and nonverbal areas." Claimant received a FSIQ of 77 (Borderline), with a Verbal Score of 84 (Low Average) and Performance Score of 77 (Borderline). Nine of eleven subtest results showed scores in the low average or average range.

Academic achievement as measured by the Woodcock-Johnson III (WJ-III) indicated “that [claimant] has close to grade expected skills in all areas tested, with a relative strength noted in her written expression skills.

While a comprehensive assessment of adaptive skills was not performed, the assessors did administer the Behavior Assessment System for Children (BASC), which aids in understanding a child’s behaviors/emotions. Based on individual rating scales completed, claimant and her teacher rated her behaviors as “At-Risk,” and claimant’s foster parent rated her behaviors as “Clinically Significant.” “Scores in the Clinically Significant range suggest a high level of maladjustment. Scores in the At-Risk range identify either a significant problem that may not be severe enough to require formal treatment of [sic] a potential of developing a problem that needs careful monitoring.”

The assessors noted that claimant had been assessed by Dr. Michael Askins on June 19, 2001, whose “impression was that [claimant was] experiencing Post Traumatic Stress Disorder issues associated with her history of abuse. He recommended follow-up counseling on a weekly basis. He also noted that she had previously been diagnosed with ADHD and was prescribed Ritalin.

39. Claimant was found eligible for special education as Emotionally Disturbed at an Individualized Education Program (IEP) meeting on November 13, 2001. There was no identification of Mental Retardation.

40. In 2002, at the request of the Department of Social Services, Blake D. Carmichael, Ph.D., and Dawn Blacker Ph.D. evaluated claimant to assess her cognitive, social and emotional functioning. Drs. Carmichael and Blacker reported results consistent with those reported by Dr. Burns and noted that “psychological testing confirms that [claimant] has specific deficits that impact her cognitive functioning . . . [Claimant] struggles mostly with short-term memory functioning, which can impair her ability to consolidate and use information given to her . . . This short-term working memory problem appears to be most problematic for [claimant] with verbal stimuli. [Claimant’s] performance on the VMI also confirmed that she has difficulties processing and/or recognizing visual stimuli and that these difficulties are not attributable exclusively to inattention or impulsivity.”

In addressing claimant’s social/emotional functioning, the assessors opined:

Considering her behavioral and emotional symptoms, it is like that [claimant’s] difficulties could be attributed to, in part, the significantly abusive experiences of her past (i.e., domestic violence, physical abuse, neglect, and possible sexual abuse) and resulting trauma symptomatology. However, the presence of organic deficit secondary to head trauma can compound the difficulties and problems that [claimant] is experiencing. Although [claimant’s] symptoms may be consistent with a primary attention processing deficit, considering her family and

medical history, [claimant's] behavioral difficulties (i.e. increased activity level, distractibility, non-compliance, possible dissociation, and physical cruelty) and emotional problems (i.e. anger, sadness, and irritability) are most likely not simply attributable to attention difficulties. Rather her symptoms appear to be associated with a combination of organic factors (i.e. head trauma) and her difficulty understanding and coping with traumatic experiences.

41. A 2003 Quarterly Treatment Plan & Report during placement at Trinity-Ukiah states, "Dr. Daniel Mandelbaum, Consulting Psychiatrist, has determined the following diagnosis: Attention Deficit Hyperactivity Disorder, Combined Type; Oppositional Defiant Disorder; Posttraumatic Stress Disorder, Chronic; and Learning Disorder NOS. He prescribed Ritalin and Neurontin. This mirrored the Working Diagnosis that accompanied claimant to this placement. Her Initial 30 Day Treatment Plan & Report noted that she was "functioning below grade level" and that her "IQ was in the borderline to low-average range."

42. A Psychoeducational re-evaluation was completed on August 13, 2004, by Monica Palmer, M.A. School Psychologist, for the Mendocino County Office of Education. Ms. Palmer administered the BASC which continued to indicate "several social/emotional/behavioral concerns. On the Woodcock Johnson II (WJ-III), claimant's academic skills were reported to be in the Low Average to Average range. No IQ testing was administered. Achievement test results may correlate with IQ testing results, but are not appropriately used as diagnostic tools for assessing cognitive ability. Claimant remained eligible for special education "under the eligibility of Emotional Disturbance."

Ms. Palmer reported that "According to Mone Tate, Director of Trinity,⁷ [Claimant] has a working diagnosis of: Attention Deficit Hyperactivity Disorder, combined type; Oppositional Defiant Disorder; Post Traumatic Stress Disorder, chronic; and Learning Disorder, Not Otherwise Specified.

43. In January, 2005, claimant was placed at Crossroads Residential Treatment Center, where consulting Psychiatrist Dr. Cynthia Santos gave the following "diagnostic impressions: PTSD, chronic; ADHD, combined; Parent-child relational problems; and anxiety/depressive symptoms" and her medications were changed to Concerta, Seroquel and Nasacort spray. However claimant's "Working DSM IV Diagnosis was as follows:

AXIS I:	314.01	ADHD, combined type
	309.81	Posttraumatic Stress Disorder, chronic
	313.81	Oppositional Defiant Disorder

⁷ Claimant was residing at Trinity Residential Treatment Facility and attending North Haven school.

44. On January 18, 2007, a psychological evaluation was completed by Don Stembridge, Ph.D., at the request of Yuba County Children’s Protective Services. Dr. Stembridge administered the Kaufman Brief Intelligence Test (K-BIT) and claimant obtained a composite standard score of 98, in the Average range. These results were given little weight because that K-BIT is not a comprehensive assessment of cognitive ability and is more appropriately used as a screening tool. In addition, the instrument used was outdated by approximately seventeen years. The weight of the evidence demonstrates that claimant consistently scores in the 77-79 range of FSIQ, which further calls into question Dr. Stembridge’s results.

45. Dr. Irving Baran M.D. testified that he began seeing claimant through Sutter Yuba Mental Health in 2009. He was the prescribing doctor for her psychotropic medications and explained that she was prescribed Seroquel and Zoloft for her Mood Disorder NOS. She had a loss of appetite with Concerta and was no longer taking it.

Dr. Baran testified that he agreed with the diagnosis of Borderline Intellectual Functioning and that claimant functions at the level of an individual with mental retardation/intellectual disability. He explained “she’s living in the here and now, not planning for the future, is extremely naïve and could get herself in dangerous situations. She has difficulty with organization and problem solving, doesn’t understand social interaction and is immature. She is unable to care for herself, advocate for herself.” Dr. Baran does not believe she is capable of living independently. He testified that claimant’s “adaptive deficits are clearly related to her cognitive difficulties—she has difficulty understanding what goes on in life and how to take care of things.”

46. Craig West, Psy.D. completed a Psychological Evaluation of claimant on July 26, 2010 on a referral from the Department of Social Services Disability Division. He reported the following results on the WAIS-IV:

VCI	87
PRI	86
WMI	71
PIRI	81
FSIQ	79

DSM-IV-TR Diagnosis was as follows:

Axis I:	314.01	Attention Deficit Hyperactivity Disorder, Combined type
	300.00	Anxiety Disorder, NOS
	307.46	Sleepwalking Disorder
	315.9	Learning Disorder, NOS
	309.81	Posttraumatic Stress Disorder, Rule Out
Axis II:		Deferred

Axis III: Deferred
 Axis IV: Social Impairment
 Axis V: Current GAF = 65
 Highest GAF past year: Unknown

47. School Psychologist Joyce Moore performed an additional psychoeducational evaluation of claimant, at the request of Marysville Joint Union School District, and issued her report on August 30, 2012. Ms. Moore has been a school psychologist for approximately 26 years, and the majority of her time is spent conducting assessments and reporting at IEP meetings for the Yuba County Office of Education. Among other duties, she also co-operates the 18 to 22-year-old program on the Yuba College Campus. Claimant was 20 years old at the time of assessment and the following was noted:

REASON FOR REFERRAL: [Claimant] was referred for a psychoeducational report by her care provider, Carla Fisher, to gather updated information regarding [claimant's] present level of functioning to assist in planning for serving [claimant's] needs as she has aged out of foster care and there is concern regarding her ability to live independently.

48. Ms. Moore testified that she administered the Stanford-Binet Intelligence Scales – Fifth Edition (SB5) because the WAIS-IV had been administered the prior year. She reported the following IQ Scores:

Nonverbal IQ	79
Verbal IQ	78
Full Scale IQ	78

49. To assess claimant's adaptive behavior, Ms. Moore utilized the Vineland Adaptive Behavior Scales-Second Edition (Vineland-II). The Vineland II "measures the personal and social skills of individuals from birth to adulthood. Because adaptive behavior refers to an individual's performance of the day-to-day activities required for personal and social sufficiency, these scales assess what a person actually does, rather than what he/she is able to do. The Vineland II was used to assess adaptive behavior in the domains of Communication, Daily Living Skills, and Socialization. The Adaptive Behavior Composite Score summarizes claimant's performance across all domains. The Vineland II was completed through interview with Ms. Fisher and the results indicated that claimant's "overall level of adaptive behavior skills falls below the first percentile and in the Low range when compared with individuals her age."

Domain	Standard Score
Communication	59
Daily Living Skills	59

Socialization	57
Adaptive Behavior Composite	57

50. Ms. Moore testified that claimant needs a high level of prompts, redirection and assistance to stay on task. Assessment results indicate that it would take claimant longer to acquire new skills than someone her chronological age.

51. A Transcript of Student Progress from the Marysville Unified School District indicates that claimant graduated from high school on June 4, 2010. She apparently passed the English language portion of the California High School Exit Examination (CAHSEE) and was exempt from the math portion. During claimant’s twelfth-grade year while at Lake Francis, it was reported that she, and the other residents, participated in independent study and did not attend school. Her IEP indicated that she met with a teacher one time per week for sixty minutes.⁸

52. An IEP meeting was convened on September 18, 2012, to review Ms. Moore’s assessment. The district did not offer special education services because claimant had already been issued her high school diploma.

53. Lesley Irritani, MSW, who provided case management for adolescent girls residing in Southpoint Group Home, testified that claimant had difficulties with daily living skills and “could not even make toast.” Ms. Irritani explained that she tried to teach claimant and she wasn’t catching on—“she couldn’t teach her.” She described claimant as a “special and unique client” who “had difficulty relating to people in a normal way in everyday life and was extremely challenged with completing daily living skills on a consistent basis.” Claimant could not complete simple chores, handle money or personal hygiene, and was incapable of independently accessing the community. In describing claimant’s skills she explained, “If she didn’t think of it, she wouldn’t do it.”

54. Carla Fisher testified that she joined Environmental Alternatives/ Lake Francis as a Youth Mentor. The program is designed to assist residents in acquiring skills necessary to live independently. When Ms. Fisher arrived, claimant was living in a trailer by herself, apparently unsupervised. Claimant’s trailer was filthy, she was eating expired and moldy foods, and medications were strewn about. Ms. Fisher moved claimant into the mentor house for two or three weeks while she and claimant cleaned the trailer. Claimant moved back into the trailer and it became evident that she could not appropriately maintain it.

Ms. Fisher testified that she tried to teach claimant skills including cooking and cleaning but claimant wasn’t learning. There was evidence that she was physically capable but for whatever reason did not do it. The only way she was ever successful accomplishing tasks was with step-by-step instruction and monitoring. She requires prompts for personal hygiene tasks

⁸ Claimant is currently challenging the legitimacy of her graduation from high school, as well as other concerns about her school program in the district, in a separate administrative hearing before the OAH.

such as brushing her teeth and hair or changing her underwear. Ms. Fisher opined that claimant needs constant supervision for safety; for example “she will leave the stove on and wander off to watch television.”

Claimant is naïve and “child like” and can easily be taken advantage of. Ms. Fisher stated that her play skills were at an eight or nine-year-old level. She will lean over her plate and shovel food into her mouth, if allowed. Claimant does not have a driver’s license and can only take public transportation if accompanied. She cannot pay bills independently, and if given twenty dollars to buy shampoo, will purchase twenty dollars worth of shampoo rather than buying what she needs and receiving change. Ms. Fisher stated that when claimant was frustrated or did not get her way, she would stomp her feet, slam doors, be verbally aggressive, and act in a manner more commonly seen in a young child having a tantrum.

55. Due to concerns with claimant’s ability to care for herself, Ms. Fisher and the Lake Francis staff sought social security benefits for her. After an initial denial of eligibility, it was decided on appeal that claimant had a disability as defined by the Social Security Act.

56. Ms. Fisher also applied for assistance for claimant from the California Department of Rehabilitation (DOR).

57. Twila Overton is a program case manager for PRIDE Industries who receives referrals from DOR to teach individuals to look for, obtain and retain employment. She arranged for claimant to take part in an External Situational Assessment that was conducted March 13, 2012 through March 22, 2012. A report by assessor Cori Costanza indicated:

Job Description and Specific Tasks:

Claimant was a hand packager, which includes a multitude of small manufacturing procedures including kiting, making boxes, folding instruction sheets, cleaning and sealing parts, labeling boxes and bottles, and assembly of papers and cards.

The assessor concluded, in pertinent part:

She was very excited to work and to try her best. She listens and follows directions. She was able to learn very quickly simple two-to-three step processes. [Claimant] has never worked before, and she has difficulty with focusing if there are distractions, or socializing. [Claimant] has evidently not been around so many peers in a work setting and she was really thrilled to work with others, and it was a positive experience for her. [Claimant] would benefit from high supervision such as a work program or group setting. She gets easily frustrated and does not like working alone. Overall, [claimant] is very interested in working, has a good attitude, asks appropriate questions, and asks for more work when done. With time and training on work appropriate communication

and social interaction [claimant] would fare well in community employment.

. . . At this time [claimant] requires a high degree of supervision and prompts to stay focused.”

58. Ms. Fisher testified that claimant’s experience at PRIDE was the “first time she saw her truly happy. She smiled, like she truly belonged somewhere.” Claimant told Ms. Costanza that it was “fun, and I like it.”

59. Claimant testified at hearing and, in that limited time, did appear younger than her age. She shared her interest in “Duck Dynasty,” explaining how she dressed as one of the characters to go trick-or-treating at Halloween, and hoped to get the character pajamas. She enjoys drawing with colored pencils, crocheting, reading, and watching television. Claimant acknowledged concerns with attention and, when asked about pursuing a driver’s license, stated that she “couldn’t pay attention to the road, would space out and run off the road.” She also testified that she “doesn’t know how to cook” and without prompting would “forget” to clean her room, take a shower, brush her teeth, take her medications, etc. When asked how she would take care of herself without Ms. Fisher, she responded, “I probably wouldn’t.”

60. Cynthia Root, Ph.D. is an ACRC Clinical Psychologist with extensive experience assessing and diagnosing individuals with developmental disabilities. Dr. Root testified that, in her capacity as an ACRC staff psychologist, she routinely performs assessments and reviews those performed by her colleagues, for the purpose of determining the existence of developmental disabilities. One of her responsibilities is participating in the eligibility review process. She was a member of claimant’s 2011 Eligibility Review Team, and was one of three staff psychologists who reviewed the new information presented in 2013.

61. Dr. Root testified that, with the introduction of new information and Dr. Lepage clearly ruling out autism, the eligibility team focused on claimant’s eligibility under the fifth category, while considering both the DSM-IV-TR and DSM-V criteria. She explained that qualitative descriptions, and not just IQ scores, were considered; “clinical judgment is necessary and you never want to look at test scores in isolation.” However, when subtest scores show high variability, she opined that the Full Scale IQ score may not be a true representation of an individual’s overall intellectual ability.

62. Dr. Root explained her disagreement with Dr. Silva’s finding of Borderline Intellectual Functioning explaining that claimant’s VCI and PRI were both outside the range of significant impairment, in the Low Average range (standard scores of 85 and 86, respectively). She felt Dr. Silva worked backwards diagnostically from claimant’s adaptive deficits to make a diagnosis of Borderline Intellectual Functioning and did not take into account her history of abuse, deprivation and psychiatric issues and how they might impact her adaptive functioning. She testified that the ACRC Eligibility Team unanimously agreed that Dr. Silva’s diagnostic conclusions did not fit the evidence.

63. Dr. Root explained her disagreement with Dr. Lepage's finding of Borderline Intellectual Functioning contending that the FSIQ score he reported is invalid because there is a 23-point difference between her Working Memory score of 69 and her Perceptual Reasoning score of 92. She cited to *Essentials of WAIS-IV Assessment (Essentials IV)*, authored by Alan S. Kaufman and Elizabeth O. Lichtenberger, as a definitive guide to interpretation of WAIS-IV scores. *Essentials IV* explains:

Two composites are available for the WAIS-IV—the traditional FSIQ and the General Ability Index (GAI), composed only of the subtests that constitute the VCI and PRI. The GAI, which excludes subtests associated with a person's working memory and processing speed, has also been used as an alternate measure of global intelligence for the WISC-III and WAIS-III. The three VCI and three PRI subtests that compose the WAIS-IV GAI are usually the best measure of *g*, whereas the Working Memory and Processing Speed subtests are often among the worst measures. Because the GAI is composed of strong measures of general ability, it is especially useful for estimating cognitive ability for individuals whose scores on memory and speed subtests deviate significantly from their scores on measures of verbal and nonverbal tasks.

Steps 2a and 2b, described next, help determine whether the FSIQ or GAI provides the best measure of a person's global intellectual ability (or whether neither global score should be used).

Step 2a. Consider the person's four WAIS-IV Indexes. Subtract the lowest index from the highest index. Answer this question: *Is the size of the standard score difference less than 1.5 SDs (<23 points)?*

- If YES, then the FSIQ may be interpreted as a reliable and valid estimate of a person's global intellectual ability. Proceed directly to step 3.
- If NO, then the variation in the indexes that compose the FSIQ is considered too great (i.e., >23 points) for the purpose of summarizing global intellectual ability in a single score (i.e., the FSIQ). Proceed to Step 2b.

Step 2b. When the FSIQ is not interpretable, determine whether the General Ability Index (GAI) may be used to describe overall intellectual ability. Answer this question: *Is the size of the standard score difference between the VCI and PRI less than 1.5 SDs (<23 points)?*

- If YES, then the GAI may be calculated and interpreted as a reliable and valid estimate of a person’s general intellectual ability. To calculate the GAI and obtain its 90% or 95% confidence intervals, simply sum the scaled scores on the six subtests that compose the GAI (Similarities, Vocabulary, Information, Block Design, Matrix Reasoning, and Visual Puzzles) and enter this sum into the appropriate table (see Appendix C of the *WAIS-IV Technical and Interpretive Manual*) . . .

64. *Essentials IV* explains that “the FSIQ as originally conceptualized by Wechsler, should be the global score of choice *unless it includes so much variability that it cannot be meaningfully interpreted*. In that instance, it is sensible to substitute the GAI for the FSIQ. But, again, we believe that the GAI should be interpreted as an estimate of a person’s overall cognitive ability only if it does not contain too much variability.”

65. Dr. Root calculated claimant’s GAI score as 86, which is in the Low Average range. She used this score based on the 23-point difference between claimant’s WMI and PRI, and the fact that there is only a 9-point (non-significant) difference between the VCI and PRI.

66. Dr. Lepage countered this argument by presenting evidence from the publishers of the WAIS-IV (Pearson, PsychCorp.), that the reporting of the GAI is “optional” and a “matter of clinical judgment.”

Even if Dr. Lepage’s reporting of claimants FSIQ is not interpretable, there is a history as documented of FSIQ scores that are interpretable.

67. Dr. Root also emphasized that to meet the DSM diagnostic criteria for intellectual disability, deficits in adaptive functioning must be directly related to intellectual impairments. Adaptive skills assessments “measure where claimant was functioning at the time of the assessment, not how she got there. You can see what she doesn’t do but doesn’t know what she is capable or not capable of. Adaptive functioning difficulties may result from behavior and/or personality disorders, it just depends.”

Dr. Root suggested that there was considerable evidence of psychotic disorder on the record and a psychotic disorder such as schizophrenia might explain her presentation. However, there was no evidence that schizophrenia was diagnosed and, in fact, there was no evidence of a psychodiagnostic evaluation to further explain any psychiatric conditions and the potential impact on adaptive functioning.

68. Claimant does carry a diagnosis of ADHD, and Dr. Root suggests that claimant’s functional deficits could be a consequence of that diagnosis. The DSM-5 describes the functional consequences of ADHD, in part, as follows:

ADHD is associated with reduced school performance and academic attainment, social rejection, and, in adults, poorer occupational performance, attainment, attendance, and higher probability of unemployment as well as elevated interpersonal conflict. Children with ADHD are significantly more likely than their peers without ADHD to develop conduct disorder in adolescence and antisocial personality disorder in adulthood . . .

Inadequate or variable self-application to tasks that require sustained effort is often interpreted by others as laziness, irresponsibility, or failure to cooperate. Family relationships may be characterized by discord and negative interactions. Peer relationships are often disrupted by peer rejection, neglect, or teasing of the individual with ADHD. On average, individuals with ADHD obtain less schooling, have poorer vocational achievement, and have reduced intellectual scores than their peers, although there is great variability. In its severe form, the disorder is markedly impairing, affecting social, familial, and scholastic/occupational adjustment.

Academic deficits, school-related problems, and peer neglect tend to be most associated with elevated symptoms of inattention, whereas peer rejection and, to a lesser extent, accidental injury are most salient with marked symptoms of hyperactivity or impulsivity.

69. Dr. Root also suggested that claimant lacks motivation to succeed at independence. She cited to an October 22, 2012, Psychoeducational Evaluation Performed by Marysville Joint Union School District Psychologist, Janice Rosner, MS, LEP, who opined:

Although it is beyond the scope of this evaluation, [claimant] may have developed learned helplessness as a coping mechanism to keep people engaged with her. [Claimant] clearly does not have a desire to live independently or to take any responsibility for herself . . . she demonstrated clearly on testing that she lacks the problem solving skills to start with this fear of independence and make a plan to approach it. What has worked for her in the past is that she has been “sent” to a placement to be cared for. She gives no indication that she has any understanding that she may have “aged out” of services and she may assume that there is another placement for her which has always been the case in the past. If she does come to an understanding that the “system” is no longer available for her, more than likely this will put an even greater strain on her limited ability to problem solve . . . Adults working with [claimant] will need to motivate her to begin to take

responsibility for herself. Since living independently is not a goal of [claimant's], this will not be a motivator for her and may, in fact, frighten her into less responsibility.

Dr. Root opined that claimant's IQ scores would suggest that she has the capacity to do some of the things she is not doing, such as making toast. She questioned claimant's motivation and whether she "won't or can't" do a specific task.

70. Looking at entirety of the record, Dr. Root concluded that claimant does not have borderline intelligence. Though her FSIQ scores may be psychometrically accurate, they are not a meaningful summary of her overall ability. Her adaptive deficits may have many causes. ACRC contends that there was no psychodiagnostic evaluation presented to demonstrate a full and careful evaluation of psychotic disorders claimant might possess. However, records indicate that claimant has been psychologically impacted since a young age and has been prescribed various psychotropic medications. Though achievement testing has shown inconsistent results, three time points of testing showed she performed at levels higher than would be expected of individual with intellectual disability. She opined that it was more consistent with an individual with an IQ in the Low Average range. She contends that claimant has already acquired academic skills in excess of the maximum level expected for individuals with even mild mental retardation. Claimant has never qualified for educational services and supports as a student with mental retardation.

Eligibility Based on the "Fifth Category" (A Disabling Condition Found to be Closely Related to Intellectual Disability or to Require Treatment Similar to that Required for Individuals with an Intellectual Disability)

71. In addressing eligibility under the fifth category, the Court in *Mason v. Office of Administrative Hearings* (2001) 89 Cal.App.4th 1119, 1129, stated in part:

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

72. The diagnostic criteria for "Mental Retardation" as set forth in section 4512 is defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) as follows:

A. Significantly subaverage intellectual functioning: an IQ of approximately 70 or below on an individually administered IQ test...

B. Concurrent deficits or impairments in present adaptive functioning (i.e., the person's effectiveness in meeting the standards expected for his or her age by his or her culture group) in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety.

C. The onset is before 18 years.

73. The DSM-IV-TR includes the following explanation of diagnostic features:

The essential feature of Mental Retardation is significantly subaverage general intellectual functioning (Criterion A) that is accompanied by significant limitations in adaptive functioning⁹ in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety. (Criterion B). The onset must occur before age 18 years (Criterion C). Mental Retardation has many different etiologies and may be seen as a final common pathway of various pathological processes that affect the functioning of the central nervous system.

General intellectual functioning is defined by the intelligence quotient (IQ or IQ-equivalent) obtained by assessment with one or more of the standardized, individually administered intelligence tests . . . Significantly subaverage intellectual functioning is defined as an IQ of about 70 or below (approximately 2 standard deviations below the mean). It should be noted that there is a measurement of error of approximately 5 points in assessing IQ, although this may vary from instrument to instrument (e.g., a Wechsler IQ of 70 is considered to represent a range of 65-75). Thus, it is possible to diagnose Mental Retardation in individuals with IQs between 70 and 75 who exhibit significant deficits in adaptive behavior. Conversely, Mental Retardation would not be diagnosed in an individual with an IQ lower than 70 if there are no significant deficits or impairments in adaptive functioning.

⁹ DSM-IV-TR states that “[a]daptive functioning refers to how effectively individuals cope with common life demands and how well they meet the standard of personal independence expected of someone in their particular age group, sociocultural background, and community setting. Adaptive functioning may be influenced by various factors, including education, motivation, personality characteristics, social and vocational opportunities, and the mental disorders and general medical conditions that may coexist with Mental Retardation.”

The DSM-IV-TR uses codes based on the degree of severity reflecting level of intellectual impairment:

317	Mild Mental Retardation:	IQ level 50-55 to approximately 70
318.0	Moderate Mental Retardation:	IQ level 35-40 to 50-55
318.1	Severe Mental Retardation:	IQ level 20-25 to 35-40
318.2	Profound Mental Retardation:	IQ level below 20 or 25

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

As a group, people with this level of Mental Retardation typically develop social and communication skill during the preschool years (ages 0-5 years), have minimal impairment in sensorimotor areas, and often are not distinguishable from children without Mental Retardation until a later age. By their late teens, they can acquire academic skills up to approximately the sixth-grade level. During their adult years, they usually achieve social and vocational skills adequate for minimum self-support, but may need supervision, guidance, and assistance, especially when under unusual social or economic stress. With appropriate supports, individuals with Mild Mental Retardation can usually live successfully in the community, either independently or in supervised setting.

75. The Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition (DSM-V) was released in May 2013. Most notably, it changed the diagnosis Mental Retardation to Intellectual Disability (Intellectual Development Disorder)¹⁰ and no longer uses a multi-axial system. The new classification system combines the axes together and disorders are rated by severity.

The Diagnostic Criteria for Intellectual Disability in the DSM-V is set forth as follows:

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

- A. Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both

¹⁰ The DSM-V further clarifies that the terms intellectual disability and mental retardation, as well as intellectual developmental disorder, are used interchangeably.

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 adaptive deficits during the developmental period.

76. The DSM-V offers the following pertinent diagnostic features:

The essential features of intellectual disability (intellectual developmental disorder) are deficits in general mental abilities (Criterion A) and impairment in everyday adaptive functioning, in comparison to an individual's age-, gender-, and socioculturally matched peers (Criterion B). Onset is during the developmental period (Criterion C). The diagnosis of intellectual disability is based on both clinical assessment and standardized testing of intellectual and adaptive functions.

Criterion A refers to intellectual functions that involve reasoning, problem solving, planning, abstract thinking, judgment, learning from instruction and experience, and practical understanding. Critical components include verbal comprehension, working memory, perceptual reasoning, quantitative reasoning, abstract thought, and cognitive efficacy. Intellectual functioning is typically measured with individually administered and psychometrically valid, comprehensive, culturally appropriate, psychometrically sound tests of intelligence. Individuals with intellectual disability have scores of approximately two standard deviations or more below the population mean, including a margin for measurement error (generally +5 points. On tests with a standard deviation of 15 and a mean of 100, this involves a score of 65-75 (70 ± 5). Clinical training and judgment are required to interpret test results and assess intellectual performance.

[¶] . . . [¶]

IQ test scores are approximations of conceptual functioning but may be insufficient to assess reasoning in real-life situations and mastery of practical tasks. For example, 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. Thus, clinical judgment is needed in interpreting the results of IQ tests.

Deficits in adaptive functioning (Criterion B) refer to how well a person meets community standards of personal independence and social responsibility, in comparison to others of similar age and sociocultural background. Adaptive functioning involves adaptive reasoning in three domains: conceptual, social and practical. The *conceptual (academic) domain* involves competence in memory, language, reading, writing, math reasoning, acquisition of practical knowledge, problem solving and judgment in novel situations, among others. The *social domain* involves awareness of others' thoughts, feelings and experiences; empathy; interpersonal communication skills; friendship abilities; and social judgment, among others. The *practical domain* involves learning and self-management across life settings, including personal care, job responsibilities, money management, recreation, self-management of behavior, and school and work task organization, among others. Intellectual capacity, education, motivation, socialization, personality features, vocational opportunity, cultural experience, and coexisting general medical conditions or mental disorders influence adaptive functioning.

Adaptive 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. Scores from standardized measures and interview sources must be interpreted using clinical judgment . . .

Criterion B is met when at least one domain of adaptive functioning—conceptual, social or practical—is sufficiently

impaired that ongoing support is needed in order for the person to perform adequately in one or more life settings at school, work, at home, or in the community. To meet diagnostic criteria for intellectual disability, the deficits in adaptive functioning must be directly related to the intellectual impairments described in Criterion A. Criterion C, onset during the developmental period, refers to recognition that intellectual and adaptive deficits are present during childhood or adolescence.

77. Several evaluations to be considered in this matter referred to a diagnosis of Borderline Intellectual Functioning, which is defined as follows:

DSM-IV-TR: Borderline Intellectual Functioning (V62.89):
This category can be used when the focus of clinical attention is associated with borderline intellectual functioning, that is, an IQ in the 74-84 range. Differential diagnosis between Borderline Intellectual Functioning and Mental Retardation (an IQ of 70 or below) is especially difficult when the coexistence of certain mental disorders (e.g., schizophrenia) is involved.

DSM-V: Borderline Intellectual Functioning (V62.89)
This category can be used when an individual's borderline intellectual functioning is the focus of clinical attention or has an impact on the individual's treatment or prognosis. Differentiating borderline intellectual functioning and mild intellectual disability (intellectual developmental disorder) requires careful assessment of intellectual and adaptive functions and their discrepancies, particularly in the presence of co-occurring mental disorder that may affect patient compliance with standardized testing procedure (e.g., schizophrenia or attention-deficit/ hyperactivity disorder with severe impulsivity).

78. Claimant contends that she is qualified to receive services under the fifth category because her impaired cognitive and adaptive functioning demonstrates that she either has a condition closely related to intellectual disability, and/or that she requires treatment similar to that required by individuals with intellectual disability. Claimant contends that she requires substantial treatment, particularly in adaptive skills and supports, similar to those required for individuals with intellectual disability. Therefore, she is focusing on her significant limitations in adaptive functioning and need for treatment similar to that provided to individuals with intellectual disability.

The DSM-IV-TR explains that “adaptive functioning refers to how effectively individuals cope with common life demands and how well they meet the standards of personal independence expected of someone in their particular age group, sociocultural background, and community setting.” Adaptive functioning may be influenced by various factors, including education, motivation, personality characteristics, social and vocational opportunities, and the mental disorders and generic medical conditions that may coexist with intellectual disability.

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

“Treatment” and “services” have separate meanings. Individuals without developmental disabilities may benefit from many of the services and supports provided to regional center consumers. Section 4512, subdivision (b) defines “services and supports” as follows:

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

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

It is the intent of the Legislature that regional centers assist persons with developmental disabilities and their families in securing services and supports which maximize opportunities and choices for living, working, learning, and recreating in the community. (Welf. & Inst. Code, § 4640.7, subd, (a)).

80. Fifth category eligibility must be based upon an individual requiring “treatment” similar to that required by individuals with intellectual disability. The Legislature clearly intended that an individual would have a condition similar to mental retardation, or would require *treatment* that is specifically required by individuals with mental retardation, in order to be found eligible.

While fifth category eligibility has separate condition and needs-based prongs, the latter must still consider whether the individual’s condition has many of the same, or close to the same, factors required in classifying a person as mentally retarded. (*Mason v. Office of Administrative Hearing, supra*, 89 Cal.App.4th 1119.) Furthermore the various additional factors required as designating an individual as developmentally disabled and substantially handicapped must apply as well. (*Id.* at p. 1129.) *Samantha C.* must therefore be viewed in context of the broader legislative mandate to serve individuals with developmental disabilities only. A degree of subjectivity is involved in determining whether the condition is substantially similar to mental retardation and requires similar treatment. (*Id.* at p. 1130; *Samantha C. v. State Department of Developmental Services, supra*, 185 Ca.App.4th 1462, 1485.) This recognizes the difficulty in defining with precision certain developmental disabilities

81. Dr. Root testified that treatment for individuals with Intellectual Disability consists, in part, of breaking information into small segments, slowing the rate of information, and repetition. She opined that claimant already knows how to do her chores, but for whatever reason does not do them. No amount of repetition or breaking information into smaller segments is going to help. Therefore, she concluded that there was no indication that claimant needed treatment similar to an individual with Intellectual Disability.

Dr. Root also suggested that there was no evidence that claimant required treatment similar to that required by an individual with Intellectual Disability in order to learn.

ACRC does not dispute that claimant has significant deficits in adaptive functioning but asserts that such deficits may have a number of causes, which may occur in the absence of significant deficits in general cognitive ability. Claimant has been diagnosed with various mental health disorders and Dr. Root opined that claimant’s deficits in adaptive functioning are most likely caused by those disorders. She concluded that claimant’s deficits in adaptive functioning are better addressed by continued medication and from the treatment perspective of one with mental health disorders.

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LEGAL CONCLUSIONS

1. Eligibility for regional center services is limited to those persons meeting the eligibility criteria for one of the five categories of developmental disabilities set forth in section 4512 as follows:

“Developmental disability” means 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 [commonly known as the “fifth category”], but shall not include other handicapping conditions that consist solely physical in nature.

2. The statutory and regulatory definitions of “developmental disability” (Welf. & Inst. Code, § 4512 and Cal. Code. Regs., tit. 17, §54000) exclude conditions that are solely physical in nature. California Code of Regulations, title 17, section 54000, also excludes conditions that are solely psychiatric disorders or solely learning disabilities. Therefore, a person with a “dual diagnosis,” that is, a developmental disability coupled with a psychiatric disorder, a physical disorder, or a learning disability, is not excluded from eligibility for services.

3. A person may qualify for services under the fifth category in two ways: (1) a person may have a disabling condition closely related to intellectual disability; or (2) a person may have a disabling condition that requires treatment similar to that required for individuals with intellectual disabilities.

4. Claimant’s presentation is extremely complex. The evidence was overwhelming that she has a substantially disabling condition. She has exhibited behaviors and adaptive functioning deficits since a young age. It was stipulated that claimant exhibits deficits or impairments in her adaptive functioning such that she is not effectively meeting the standards of personal independence expected of a woman of her age in her community. Claimant’s functioning has been characterized as in the range of someone with intellectual disability.

Substantial deficits in adaptive functioning alone are not sufficient for fifth category eligibility; there must be both a cognitive and adaptive functioning component. There was evidence that claimant has impaired cognitive skills reflected in deficits in working memory and processing speed and a relatively consistent diagnosis of Borderline Intellectual Functioning. There were also questions raised regarding the presence of a neurocognitive disorder that was neither substantiated nor ruled out.

The term “cognitive” is defined as “the ability to solve problems with insight, to adapt to new situations, to think abstractly, and to profit from experience.” (Cal. Code Regs, tit. 17, § 54000).

5. While claimant has documented psychological concerns, a need for psychological services does not disqualify an individual for eligibility under fifth category conditions. Disorders where there is accompanying impaired intellectual or social functioning attributable to both psychiatric disorders and developmental disabilities, are not disqualified from regional center eligibility. Claimant has a complex symptomatology which is not fully understood. There was no evidence of a psychodiagnostic evaluation to further explain any psychiatric conditions and their potential impact on adaptive functioning.

6. A preponderance of the evidence demonstrated that claimant’s impairments in adaptive functioning were not caused solely by a psychiatric disorder. Nor are they solely the result of a physical disability or learning disorder. There was evidence of ADHD and other conditions impacting her performance but there was no credible evidence that ADHD and/or any other psychological and/ or learning disabilities were solely the cause of her adaptive functioning deficits.

The most probable inference from the evidence is that claimant’s disabling condition and adaptive deficits require treatment similar to that required for individuals with intellectual disability. Evidence established that treatment required for individuals with intellectual disability might include long-term training with steps broken down into small, discrete units taught through repetition. Training to achieve goals would include component skills broken down and taught with step-by-step instruction for maintenance and retention. Witnesses testified that she requires step-by-step instruction, close supervision, high level of prompts, reminders and redirection. Dr. Lepage concluded that claimant’s supportive services “should be designed at the level of one functioning with intellectual disability.” She requires interdisciplinary planning that may include services including assistance with self-care, housing, independent living and financial management. The only way claimant appears to have demonstrated improvement is through supervised step-by-step instruction. She has a poor capacity for self-direction and needs prompting and direction to accomplish tasks. Accordingly, she has a developmental disability as defined by the Lanterman Act and is eligible for services and supports from the regional center.

7. Neither the Lanterman Act or its implementing regulations (Cal. Code Regs., tit. 17 § 50900 et seq.) assigns burden of proof. California Evidence Code section 500 states that “[e]xcept as otherwise provided by law, a party has the burden of proof as to each fact the existence or nonexistence of which is essential to the claim for relief or defense that he is asserting.” Claimant bears the burden of establishing that she meets the requirements to receive services pursuant to the Lanterman Act. She has met that burden. The standard of proof applied is a preponderance of the evidence (Evid. Code § 115.)

