

BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT,

vs.

FAR NORTHERN REGIONAL CENTER,

Service Agency.

OAH No. 2014100106

DECISION

This matter was heard before Administrative Law Judge Susan H. Hollingshead, State of California, Office of Administrative Hearings (OAH), in Redding, California, on November 17, 2014.

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

Margaret Huscher, Attorney at Law, Shasta County Public Defender, represented claimant.

Oral and documentary evidence was received. The record was closed and the matter submitted for decision on November 17, 2014.

ISSUES

Is claimant eligible to receive regional center services and supports as an individual with intellectual disability pursuant to Welfare and Institutions Code section 4512?¹

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

In the alternative, is claimant eligible under the “fifth category” because he has a condition closely related to intellectual disability, or that requires treatment similar to that required for individuals with intellectual disability?

FACTUAL FINDINGS

1. Claimant is a nineteen-year old young man, currently placed in the Shasta County Juvenile Hall. It is reported that his biological mother raised him for the first seven years of his life, during which time his father was incarcerated. Claimant was exposed to methamphetamine in utero. Claimant has reported that he was sexually molested while in his mother’s care. She had a history of addiction and committed suicide when claimant was seven years old.

2. Claimant received special education services from the time he entered kindergarten. He has been diagnosed with a learning disability and originally qualified for special education as “Other Health Impaired” based on a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD).

3. Claimant has been in placement since the age of fourteen, when he was incarcerated for sexually molesting a seven-year-old boy. He has admitted to numerous acts of sexual offenses, which have been predatory and coercive. He has been unable to successfully complete a sex offender treatment program and he has engaged in sexualized behaviors, defiant behaviors resulting in physical restraint, and eloping from programs. He has seemingly been unable to fully accept responsibility for his behavior throughout his time in placement.

4. Claimant’s position is that he qualifies as either an individual with an intellectual disability or, alternatively, under the “fifth category” because he has a condition closely related to intellectual disability, or that requires treatment similar to that required for individuals with an intellectual disability. He is clearly impaired in his adaptive functioning and lacks the ability to live independently.

5. FNRC contends that claimant is not intellectually disabled and does not meet the requirements for “fifth category” eligibility because his deficits in adaptive functioning are not attributable to global cognitive deficits, thus he 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. They conclude that claimant’s adaptive functioning limitations are solely related to psychiatric disorders and/or learning disabilities and he requires treatment appropriate for an individual with psychiatric and/or learning concerns.

6. Claimant was initially referred for regional center services by his Shasta County Juvenile Probation Officer, Bernard Wolf. As part of the initial intake, Wendy Bell, FNRC Intake Specialist/Service Coordinator, requested that FNRC staff psychologist Robert Boyle, Psy.D, perform a review of claimant’s psychological records. Dr. Boyle reviewed claimant’s records on May 2, 2014, and determined “there is no indication of an intellectual disability,

therefore no reason for us to evaluate.” The probation department sought review due to claimant’s low adaptive functioning.

7. Dr. Boyle considered a triennial evaluation completed by the Shasta Union High School District on September 26, 2011. The evaluation noted that claimant had been receiving special education services since he was in kindergarten when he “originally qualified with a Other Health Impairment due to demonstrating behaviors of inattention that adversely impacted his educational performance.”

Claimant was administered the Wechsler Intelligence Scale for Children, Fourth Edition (WISC-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).

The assessment offered the following score summary and noted that the Standard Scores have a mean of 100 and a standard deviation of 15.

Composite Score Summary

<u>Scale</u>	<u>Composite Score</u>	<u>Percentile Rank</u>	<u>Confidence Interval</u>
Verbal Comprehension	VCI 89	23	83-96
Perceptual Reasoning	PRI 90	25	83-98
Working Memory	WMI 68	2	63-78
Processing	PSI 83	13	76-94
General Abilities Index	GAI 89	23	83-95

School Psychologist Lanelle Dowling, M.A., PPS, determined that claimant’s Full Scale IQ (FSIQ) could not be interpreted due to the degree of variability in his index scores; however, his General Abilities Index (GAI)² could be interpreted. “This score differs from the Full Scale

² *Essentials of WAIS-IV Assessment (Essentials IV)*, authored by Alan S. Kaufman and Elizabeth O. Lichtenberger, offers a guide to interpretation of WAIS-IV scores. *Essentials IV* explains:

score in that it does not include the Working Memory and Processing Speed Indices. [Claimant's] General Abilities Index was in the Low Average range (SS=89).

8. Claimant was also administered the Woodcock Johnson III, Tests of Achievement (WJIII), "which measures general academic skills in many areas including reading, math and writing. His total Overall Achievement score was in the Extremely Low range (SS=53). He scored in the Extremely Low range in Reading Skills. In Math Skills, he scored in the Borderline range. In Writing, he demonstrated a relative strength in writing samples, writing grammatically and punctuated correctly sentences. He demonstrated a relative weakness in the area of Spelling."

9. To assess social emotional functioning, claimant was administered the Behavior Assessment System for Children, Second Edition (BASC-II) which utilized rating scales completed by claimant, his teacher and a house staff member. "Any score in the clinically significant range suggests a high level of maladjustment and may need formal treatment. Scores in the at risk range identify either a significant problem that may need formal treatment or that has the potential of developing into a problem that needs careful monitoring." The following information was provided as a summary of test results:

[Claimant's] rating indicated atypicality, or feelings of unusual thoughts or perceptions, as a clinically significant concern. Areas that were rated in the "At Risk" range included Attitude towards teachers, Attitude towards school, Locus of control, Social Stress, Anxiety, Hyperactivity, Relations with parents, interpersonal relations, and Self Reliance.

[Claimant's] teacher, Mrs. Grissom, rated him on classroom behavior. This rating suggested that [claimant] demonstrates Significant concerns in the areas of Hyperactivity, Aggression,

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 IV 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.

Conduct Problems, Depression, Somatization, and Learning Problems. Further she rated him as being in the “At Risk” range in Anxiety, Attention Problems, Atypicality, Withdrawal, Adaptability, Study Skills, and Functional Communication.

Home staff, Kirk Marshlain, also rated [claimant’s] behavior. This rating indicated several areas of difficulty. It is important to note that cautionary F scale³ was indicated on his rating suggesting that Mr. Marshlain may have taken a highly negative view of [claimant] and these results should be interpreted with extreme caution. *However*, it may also indicate that [claimant’s] behaviors and feelings are extreme and have been correctly reported. This rating indicated that [claimant] demonstrates a significant difficulty in the areas of Hyperactivity, Aggression, Conduct Problems, Depression, Atypicality, Withdrawal, and Attention Problems. Further, he indicated that adaptability, leadership, activities of daily living, and functional communication as [sic] a significant problem. He rated him “At Risk” in the areas of Anxiety and Social Skills. Areas that were consistently indicated as significant concerns across raters included Hyperactivity, Aggression, Conduct Problems, Anxiety, Depression, Attention Problems, Atypicality, and Withdrawal.

10. Dr. Boyle also reviewed the results of a Psychological Testing Evaluation completed by Clinical Psychologist J. Reid McKellar, Ph.D., on August 7 and 9, 2013. The evaluation was based on a court ordered referral initiated by Shasta County probation officer Bernard Wolf. The stated reason for the referral was claimant’s “history of sexually inappropriate behavior, his inability to successfully complete a residential treatment program, and his seeming inability to accept responsibility for his behavior.” Dr. McKellar reviewed court and placement records, interviewed claimant’s father, consulted with Officer Wolf, and administered testing instruments. Claimant was evaluated at the Shasta County Juvenile Justice Center.

11. In addition to the background information set forth above, Dr. McKellar provided the following pertinent information:

[Claimant] was discharged from his most recent placement, Martin’s Achievement Place[,] after it was determined that [claimant] presented as being too high risk for the level of care he was placed in. In addition, a sexual offender risk assessment evaluation indicated that [claimant] continues to be at high risk for sexual re-offending.

³ The F scale looks at perceived validity of given responses.

[Claimant] has been unable to exhibit advancement in the treatment of his sexual issues. [Claimant] has made comments to his father that he believes he is a woman, that he wants a sex change operation, and [claimant] frequently presents as obsessed with sex.

[Claimant] has a lifelong history of poor impulse control, deficits in judgment, emotional immaturity and sexual identity issues. [Claimant] wore girls underwear during latency, and he continues to voice concerns about his sexual identity. Despite years of intensive treatment, primarily focused on [claimant's] sexual deviancy, [claimant] continues to present as an impulsive, sensation seeking, emotionally immature and sexually deviant young man.

[Claimant's] father has expressed the opinion that [claimant] cannot function outside of an institution at this time, and he feels that [claimant's] disturbance is far more pervasive than his sexual behavior may suggest.

12. Dr. McKellar administered the Wechsler Abbreviated Scale of Intelligence (WASI), a test that has a high validity coefficient with the full scale Wechsler Intelligence Tests.

On this measure, [claimant] obtained the following scores:

Verbal Standard Score	79 (74-85 at the 95% confidence interval)
Performance Standard Score	96 (91-102 at the 95% confidence interval)
Full Scale Score	86 (82-90 at the 95% confidence interval)

Dr. McKellar opined that claimant's "obtained Full Scale score of 86 likely represents a valid estimate of [claimant's] intellectual potential. The obtained Full Scale score is in the low average range, with a significant discrepancy between verbal and performance scores. [Claimant's] scoring pattern suggests he is likely an action oriented problem solver and he is capable of fair reasoning skills. The fact that [claimant's] cognitive scores fell within the average range suggests the continued presence of a learning disorder, given his history of special Education and past educational evaluations."

13. Dr. McKellar used the Stroop Color Word Test, an instrument that provides diagnostic information on brain dysfunction, cognition, and psychopathology. He suggested that claimant's Stroop profile suggests "the potential presence of neurological (organic) impairment. Stroop scoring patterns in which all of the obtained scores are low suggest the potential presence of mental retardation, and/or left hemisphere or diffuse brain injuries."

14. On the Minnesota Multiphasic Personality Inventory-A (MMPI-A), Dr. McKellar concluded that claimant's "profile indicates the presence of poor reality testing, the potential for psychotic symptoms, paranoid ideation and passive dependency. Given the MMPI-A scale elevations, [claimant's] interpersonal struggles, deficits in self-image, transient paranoid thinking and poor impulse control suggest the presence of Borderline Personality Disorder.

15. Dr. McKellar's report offered the following:

Clinical Diagnoses: ⁴

Axis I-311 Depressive Disorder NOS
314.9 Attention Deficit Hyperactivity Disorder
315.9 Learning Disorder NOS
Axis II-301.83 Borderline Personality Disorder
Axis III-R/o/Organic Impairment
Axis IV-I
Axis V-40

Recommendations:

1. [Claimant] may benefit from a program that emphasizes instrumental conditioning and positive reinforcement.
2. [Claimant] may benefit from a trial of an anti-psychotic and or a mood stabilizer, due to his tendencies for Paranoid thinking and inability to restrain his impulses.

⁴ Dr. McKellar used The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) as 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

It should be noted that the fifth edition of the manual (DSM-5) was released in May 2013 and practitioners began transitioning to its use after that time.

3. [Claimant] may benefit from components of Dialectical Behavior Therapy, in a more concrete form than is traditionally utilized.

4. Despite [claimant's] deceptive verbal skills, he is likely to obtain more benefit from a program geared toward offenders with developmental disabilities than a traditional program.

16. FNRC Intake Specialist Kathleen Hamill completed a FNRC Social Assessment on July 21, 2014 and August 22, 2014. Her Summary noted claimant's psychiatric history and that he is prescribed Wellbutrin, Paxil and Vyvanse to address these concerns. She explained that claimant "spoke openly about his sexual predation on younger children; this began when [claimant] was about twelve years old. He recalled various situations in which he would get a child to trust him and then he would proceed to molest the child. [Claimant] now denies that he has those tendencies. He is in juvenile hall due to his behaviors in several group homes. He can be aggressive and threatening and does not follow rules. He will challenge authority and has been reportedly manipulative with the staff at juvenile hall and other residents living there."

17. Also on August 22, 2014, Dr. Boyle completed a Psychological Assessment of claimant. "The purpose of the evaluation was to gain a clearer sense of [claimant's] intellectual and adaptive functioning, as well as possible eligibility for Regional Center services." Dr. Boyle noted that "while information from the records suggested average/low average intelligence, the report from his Probation Officer suggested very poor adaptives. For this reason, it was decided to evaluate [claimant]."

18. Dr. Boyle administered the Wechsler Adult Intelligence Scale Fourth Edition (WAIS-IV) with the following results:

Verbal Comprehension	81
Perceptual Reasoning	88
Working Memory	66
Processing Speed	76
Full Scale IQ	75
General Abilities Index	84

Dr. Boyle explained as follows:

Two observations need to be made about the configuration of his IQ scores. First, as previously mentioned, [claimant] was easily distracted during the WAIS-IV administration. While he was also easily redirected, it is believed that his attentional difficulties may have spuriously diminished his Full Scale IQ score. In situations like this, it is standard of practice to also compute a "General Ability Index" score. This score is a combination of the Verbal

Comprehension and Perceptual Reasoning scores, and is considered to be more truly representative of the individual's intellectual functioning.

19. Dr. Boyle also utilized the Adaptive Behavior Assessment System-Second Edition (ABAS-II). Claimant's Probation Officer, Mr. Wolf served as the informant. Because claimant is a ward of the court, Mr. Wolf, as legal guardian, completed the parent form of the ABAS-II.

Claimant scored in the deficient range on the following ABAS-II scales: Communication, Community Use, Functional Academics, Home Living, Health and Safety, Leisure, Self. He scored in the borderline deficient range on the following scales: Communication, Self-direction, and Social.

20. Dr. Boyle provided the following:

DIAGNOSTIC IMPRESSIONS

Depressive Disorder NOS, by history
Attention-Deficit/Hyperactivity Disorder, by history
Learning Disorder NOS, by history
Rule out Pedophilic Disorder
Borderline Personality Disorder, by history

In his Summary, Dr. Boyle concluded that claimant does not meet the DSM-5 diagnostic criteria for an intellectual disability, clarifying as follows:

His performance on IQ testing suggests that his intellectual abilities are in the high borderline/ low average range. He performed more poorly when presented with tasks that involved attentional difficulties, and it is hypothesized that his previously diagnosed ADHD and difficulties sustaining attention negatively impacted his scores in those areas. When considering the two most robust IQ Index scores—Verbal Comprehension and Perceptual Reasoning—these scores are both in the high borderline/low average range. While [claimant] appears to have substantial deficits in adaptive functioning in various areas, these appear to be connected to his significant mental health/behavioral difficulties. For these reasons, it does not appear that [claimant] has a developmental disability and would not be eligible for Regional Center services.

21. On September 17, 2014, the FNRC Eligibility Team completed its review and determined that claimant was not eligible for regional center services. The multidisciplinary team concluded as follows:

[Claimant] does not have an intellectual disability and shows no evidence of epilepsy, cerebral palsy, autism, or a disabling condition found to be closely related to intellectual disability or to require treatment similar to that required for individuals with intellectual disability. Psychological records show evidence of Depressive Disorder, Attention Deficit Hyperactive Disorder, Learning Disorder NOS, Borderline Personality Disorder (all by history), but those are not conditions for regional center services.

22. As a result of the eligibility team determination, A Notice of Proposed Action (NOPA) was issued on September 17, 2014, informing claimant that FNRC determined he was not eligible for regional center services. The NOPA stated:

Reason for action: [Claimant] does not have an intellectual disability and shows no evidence of epilepsy, cerebral palsy, autism, or a disabling condition found to be closely related to intellectual disability or to require treatment similar to that required for individuals with intellectual disability. Psychological records show evidence of Depressive Disorder, Attention Deficit Hyperactive Disorder, Learning Disorder NOS, Borderline Personality Disorder (all by history), but those are not conditions for regional center services. Eligibility Review (multi-disciplinary team) determined on 9/17/14 that [claimant] is not eligible for FNRC services based on Psychological evaluation dated: 8/22/14 by Dr. Boyle, FNRC Staff Psychologist. Intake summary dated; 7/22/14; 8/22/14 by Kathleen Hamill. Parental Input received on 7/21/14 by Kathleen Hamill.

23. Claimant filed a Fair Hearing Request through his attorney, Margaret Husher, Shasta County Public Defender, disputing his ineligibility for regional center services. The request noted the following needs:

- 1) Need to review Dr. Boyle's report which is the basis for denying services and which was not provided to [claimant] or Shasta Co. Probation.
- 2) We believe that [claimant] does have a neurocognitive impairment as suggested by Dr. McKellar's report and is appropriate for services.

24. An Informal Meeting was held at FNRC on October 10, 2014. By letter dated October 14, 2014, FNRC Executive Director Laura Larson informed claimant "after carefully

considering all information provided to me by Dr. Boyle and Ms. Kruse⁵, I have decided to uphold the decision of the Eligibility Review Committee that [claimant] is not eligible for regional center services.”

Ms. Larson explained that:

During the meeting, Ms. Kruse reviewed with you the definition of developmental disability and the eligibility criteria for regional center services . . . Dr. Boyle review [sic] previous evaluations of [claimant], including 9/21/11 testing completed by the Shasta Union High School District, 8/09/13 testing completed by J. Reid McKellar, Ph.D., and 8/22/14 testing completed by Dr. Boyle. He further explained the regional center eligibility criteria and substantial handicapping conditions.

During the informal meeting you questioned why [claimant] functions so poorly and discussed why you believe [claimant] may require treatment similar to that required by an intellectually disabled individual, therefore [sic] should be eligible under the 5th category. You shared characteristics of [claimant] and how he functions throughout his day, including his need for a supervised group home.

25. James Patton is a teacher with extensive experience who has taught claimant at the juvenile hall. Mr. Patton testified that claimant’s social interactions were “odd/weird and other kids want to avoid him.” He described claimant’s learning ability noting that he had “no problem with math” but he believed claimant had issues with reading. No reading tests were given. Mr. Patton testified that claimant passed both sections of the California High School Exit Examination (CAHSEE) and graduated high school with a diploma.

26. Psychologist Kent Caruso, Ph.D. evaluated claimant as part of a criminal matter. He testified that he believes claimant has a “failure to thrive” where his “personality structure is so seriously damaged that he does not have the ability to access his IQ.” He opined that due to abuse, deprivation, lack of parenting, tremendous instability his first five years of life and other factors, claimant’s “intellectual capacity is still there but he can’t access it. He doesn’t make sense of things emotionally.” Due to this “damaged personality,” Dr. Caruso explained that claimant “doesn’t care about or use his intelligence.” He opined that claimant “can learn if you could get ahold of him or he could get control of himself—if he cared, but I don’t think he will care.”

⁵ Judy Kruse is the FNRC Associate Director of Case Management. She participated in the October 10, 2014 informal meeting.

Dr. Caruso testified that claimant “can’t be left alone and needs services to stay out of prison”. He believes that left to his own devices, claimant will be incarcerated and “he needs someone to help make opportunities for him.”

Dr. Caruso testified that he did not know if he followed the DSM-V during testing, as he doesn’t “know what it all means.” He stated that he “used clinical intuition more than test scores” due to his experience in the field.

27. Probation Officer Wolf also testified. Claimant was transferred to his caseload in 2009 and Officer Wolf stated that he is concerned about claimant’s ability to live independently. He described claimant’s residential history and the extreme difficulty he has being disruptive and acting out. Claimant requires constant supervision and always is accompanied by staff. Officer Wolf testified that claimant “can’t function out in society--he doesn’t fit. He is only capable of keeping out of trouble if you keep him right with you.” He opined that claimant needs services due to his problems with adaptive deficits.

28. 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 disability⁶ 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.

29. 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:

⁶ Effective January 1, 2014, the Lanterman Act replaced the term “mental retardation” with “intellectual disability.” The terms are used interchangeably throughout.

- (1) Originate before age eighteen;
- (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.

30. 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.

31. 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.

32. The diagnostic criteria for “Intellectual Disability” 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.

33. 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 functioning⁷ 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.

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

34. 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

⁷ 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.”

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.

35. 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)⁸ 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 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.

⁸ The DSM-V further clarifies that the terms intellectual disability and mental retardation, as well as intellectual developmental disorder, are used interchangeably.

C. Onset of intellectual adaptive deficits during the developmental period.

36. 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.

37. 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.

38. Claimant contends that he is qualified to receive services under the fifth category because deficits in his adaptive functioning demonstrates that he either has a condition closely related to intellectual disability, and/or that he requires treatment similar to that required by individuals with intellectual disability.

39. Fifth category eligibility determinations typically begin with an initial consideration of whether claimant had global deficits in intellectual functioning. This is done prior to consideration of other fifth category elements related to similarities between the two conditions, or the treatment needed. Claimant contends that he requires substantial treatment, particularly in adaptive skills and supports, similar to those required for individuals with intellectual disability. His primary need expressed was for a supported living environment.

40. 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. Here, claimant believes he requires treatment similar to that required for individuals with intellectual disability. He also believes that his condition is closely related to intellectual disability.

41. Claimant contends that he is eligible for regional center services based upon a condition being closely related to intellectual disability due to his impairments in adaptive functioning. 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.

42. FNRC 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 and learning disorders and Dr. Boyle opined that claimant's deficits in adaptive functioning are most likely caused by those disorders. He concluded that claimant's deficits in adaptive functioning are better addressed from the treatment perspective of one with mental health and learning disorders.

43. Fifth category eligibility may also be based upon a condition requiring treatment similar to that required by individuals with intellectual disability. The terms "treatment" and "services" have separate meanings under the Lanterman Act. 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 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)).

44. Fifth category eligibility must be based upon an individual requiring "treatment" similar to that required by individuals with intellectual disability. The wide range of services and supports listed under section 4512, subdivision (b), are not specific to intellectual disability. One would not need to suffer from intellectual disability, or any developmental disability, to benefit from the broad array of services and supports provided by FNRC to individuals with

intellectual disability. They could be helpful for individuals with other disabilities, or for individuals with mental health disorders, or individuals with no disorders at all. The Legislature clearly intended that an individual would have a condition similar to mental retardation, or would require *treatment* that is specifically required by individuals with mental retardation, and not any other condition, 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 disable 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. Thus, the *Mason* court determined: "it appears that it was the intent of those enacting the Lanterman Act and its implementing regulations not to provide a detailed definition of 'developmental disability' so as to allow greater deference to the [regional center] professionals in determining who should qualify as developmentally disabled and allow some flexibility in determining eligibility so as not to rule out eligibility of individuals with unanticipated conditions, who might need services." (*Id.* at p. 1129.)

For all the above reasons, the treatment needs of claimant will be viewed within the narrower context of those services and supports similar to and targeted at improving or alleviating a developmental disability similar to intellectual disability. The fact that claimant might benefit from some of the services that could be provided by the regional center does not mean that he requires treatment similar to that required by individuals with intellectual disabilities.

45. Dr. Boyle testified that the eligibility team focused on claimant's eligibility under intellectual disability and the fifth category, while considering both the DSM-IV-TR and DSM-V criteria. He 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, he opined that the Full Scale IQ score may not be a true representation of an individuals overall intellectual ability.

He 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 what caused the deficits. Adaptive functioning difficulties may result from behavior and/or personality disorders, or other sources. Claimant definitely has challenges in attending which could be caused or exacerbated by his ADHD diagnosis. He has been diagnosed with Borderline Personality Disorder as well as Depressive and Learning Disorders. It is also

important to consider his history of abuse, deprivation and psychiatric and learning issues, and how those factors might impact his adaptive functioning.

Claimant did not meet the diagnostic criteria for intellectual disability under either the DSM-IV-TR or the DSM-V. Dr. Boyle testified convincingly that claimant's ability was more consistent with an individual with an IQ in the High Borderline/Low Average range. He opined 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. There was no evidence that claimant required treatment similar to that required by an individual with intellectual disability in order to learn.

46. The treatment recommendations made by Dr. McKellar were not based on a condition closely related to intellectual disability and no evidence was presented that these treatments are similar to those required for an individual with intellectual disability. For example, he suggested a trial of an anti-psychotic, and or a mood stabilizer, due to claimant's tendencies for Paranoid thinking and inability to restrain his impulses and/or Dialectal Behavior Therapy. While an individual with an intellectual disability may also exhibit comorbid mental health concerns, that was not proved in this case.

Claimant has been diagnosed with ADHD, Borderline Personality Disorder, Learning Disorder and Depressive Disorder. Testimony was persuasive that claimant's deficits in adaptive functioning are better addressed from the treatment perspective of one with mental health and learning disabilities. No persuasive evidence was presented to demonstrate that claimant required treatment similar to that required by an individual with intellectual disability.

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

Handicapping conditions that consist solely of psychiatric disorders, learning disabilities or physical conditions do not qualify as developmental disabilities under the Lanterman Act.

2. Claimant contends that he exhibits deficits or impairments in his adaptive functioning, is impaired by these limitations, and would benefit from regional center services. However, regional center services are limited to those individuals meeting the stated eligibility criteria. The evidence presented did not prove that claimant has impairments that result from a qualifying condition which originated and constituted a substantial disability before the age of eighteen. There was no evidence to support a finding of intellectual disability or a condition closely related to intellectual disability, or requiring treatment similar to that required for individuals with intellectual disability.

3. Neither the Lanterman Act nor 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 he meets the requirements to receive services pursuant to the Lanterman Act. He has not met that burden. The standard of proof applied is a preponderance of the evidence (Evid. Code § 115.)

4. Claimant’s presentation is complex. The evidence was clear that he has a disabling condition and has exhibited behaviors and adaptive functioning deficits since a young age. He exhibits deficits or impairments in his adaptive functioning such that he is not effectively meeting the standards of personal independence expected of a man of his age in his community. However claimant does not meet eligibility criteria under either the DSM-IV-TR or the DSM-5 for intellectual disability.

Adaptive functioning deficits alone are not sufficient for fifth category eligibility; there must be both a cognitive and adaptive functioning component. A preponderance of the evidence demonstrated that claimant’s impairments in adaptive functioning are most likely the result of mental health and learning disorders.

The most probable inference from the evidence is that Claimant’s disabling condition and adaptive deficits require treatment required for individuals with mental health and learning disorders. Accordingly, he does not have substantially disabling developmental disability as defined by the Lanterman Act and is not eligible for services and supports from the regional center at this time.

ORDER

Claimant's appeal from the Far Northern Regional Center's denial of eligibility for services is denied. Claimant is not eligible for regional center services under the Lanterman Act.

DATED: December 3, 2014

SUSAN H. HOLLINGSHEAD
Administrative Law Judge
Office of Administrative Hearings

NOTICE

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