BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: CLAIMANT, Claimant, vs. WESTSIDE REGIONAL CENTER, Service Agency.	OAH No. 2015110817

DECISION

Eileen Cohn, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on January 20 and March 9, 2016, in Culver City, California.

Lisa Basiri, Fair Hearing Coordinator, represented Westside Regional Center (WRC or Service Agency). Claimant's mother and father represented claimant. Claimant was not present.[1]

Oral and documentary evidence was received. After the record was closed and the matter submitted on January 20, 2016, the ALJ re-opened the record and a second hearing day was set to obtain further evidence on the issue of whether attention deficit hyperactivity disorder (ADHD) is a psychiatric disorder. The hearing was held on March 9, 2016, and at the conclusion of the hearing, the matter was submitted and the record

[1] Family and party titles were used to protect the privacy of claimant and his family.

closed.

ISSUE

The parties stipulated to the following issue:

Is claimant eligible for regional center services and supports under the qualifying fifth category, a disabling condition closely related to intellectual disability or requiring treatment similar to that required for individuals with an intellectual disability?

EVIDENCE RELIED UPON

Documents: WRC's exhibits 1-15; claimant's exhibits A-B.

Testimony: Donald A. Meland, M.D., Board Certified, Diplomate American Board of Psychiatry and Neurology; claimant's mother and father; and Thompson J. Kelly, Ph. D., Chief Psychologist and Coordinator, Intake Services, WRC.

FACTUAL FINDINGS

PARTIES AND JURISDICTION

1. Claimant was born in 1993, and is currently 23 years old.

2. Claimant applied to receive services from the WRC under the Lanterman Act for the first time in 2015. In a Notice of Proposed Action dated October 1, 2015, the WRC denied eligibility, asserting that claimant was not eligible for regional center services because she did not meet the criteria set forth in the Lanterman Act. Claimant timely submitted a request for fair hearing and this hearing ensued.

3. Claimant requested services from the WRC under the fifth eligibility category. The parties stipulated that claimant is not eligible under any other category, including autism and intellectual disability (ID). For the reasons set forth below, claimant's appeal is granted.

CLAIMANT'S BACKGROUND AND CURRENT ADAPTIVE FUNCTIONING

4. Claimant was raised by her two parents with her twin sister. She experienced no medical complications at birth, did not experience any head trauma or other chronic or acute medical situations, and reached typical developmental milestones before entering preschool.

5. Claimant has a long history of educational and psychological intervention starting around her fifth birthday when she engaged in inappropriate behaviors including severe temper tantrums, and inappropriate social interactions, such as refusing to answer to her name. Claimant's educational and psychological challenges were evident by kindergarten, and her parents conscientiously monitored her performance, and retained specialists to evaluate her cognitive, academic, developmental and psychological status. Claimant's parents hired academic tutors who worked with claimant daily and guided her through her rigorous private school education. Claimant, educated in the highly competitive general education milieu of private schools, would not have succeeded academically without her tutors. Claimant's mother described her daughter attending the equivalent of two schools daily, one at school and one at home with her private tutors.

6. Claimant's parents provided candid and heartfelt testimony about claimant's academic, social and behavioral history. Her parents enrolled claimant in a rigorous academic program in a private school setting with her twin sister. In addition to daily after-school tutoring, claimant's parents exposed her to tennis lessons, a physical activity also enjoyed by her twin, where claimant excelled. From the documentary evidence and parents' testimony, it is clear that they did everything to identify, to address and to ameliorate claimant's challenges. Claimant's fifth grade teacher recommended special education, but parents elected to retain claimant in private school without special education services. As a result, claimant has never been made eligible or

provided with special education and related services for which she would have most likely qualified given her deficits memorialized in numerous private assessments. In elementary school, claimant consistently received passing grades, A's, B's and C's, but received low marks for work habits and personal development. Her mother offered that claimant's tutors, who worked with her twenty hours a week, were responsible for her passing grades, and that claimant would not have received passing grades without them.

7. In fourth grade, claimant began psychotherapy. Her treatment primarily focused on social skills, social anxiety, home life and choices. Claimant has had consistent difficulties with social interactions.

8(A). Claimant has been assessed numerous times through her school-aged years with the goal of identifying her learning difficulties, improving her academics and addressing her social and behavioral challenges.

8(B). The various assessments administered in 1999, 2003, 2005, and 2010, establish that claimant's cognitive profile cannot be ascertained from her full scale intelligence quotient (FSIQ) because the composite scores and subtests that comprise her average FSIQ vary widely. An early test established a 32 point discrepancy between claimant's average verbal comprehension ability and her impaired perceptual organization. In most assessments, claimant displayed a wide disparity between her verbal and nonverbal skills, and difficulty with visual-spatial processing, particularly with more involved visual material. Where her FSIQ was reported, it was in the average range.

8(C). In fourth grade, claimant began treatment with Donald A. Meland, M.D., Board Certified, Diplomate American Board of Psychiatry and Neurology. Dr. Meland provided expert testimony at hearing. Dr. Meland diagnosed claimant with attention deficit hyperactivity disorder (ADHD). Under the Diagnostic Statistical Manual, Fifth Edition (DSM-5), ADHD is considered a neurodevelopmental disorder, not a psychiatric

disorder. Claimant and WRC agree with the characterization of ADHD as a neurodevelopmental disorder. [2]

8(D). Claimant's struggles with ADHD were noted by her assessors. In her 2003 psychoeducational evaluation, the assessor attributed claimant's difficulties distinguishing between material and immaterial information, or making saliency determinations, to her ADHD. (Exhibit 10.) He predicted claimant would continue to struggle with academics, especially as material became more complex. (*Ibid.*) In her 2006 neuropsychological education evaluation, her low cognitive scores were attributed to her ADHD. (Exhibit 9). ADHD-related deficits affect claimant's long-standing difficulties in properly attending to information, comprehending serial and multi-step instructions and memorizing and retrieving information from memory. Claimant has to be taught several times new information for her to retain it as long-term memory. (*Ibid.*)

8(E). Claimant has been diagnosed with various psychiatric disorders. Assessors also attributed her variations in her cognitive scores to her psychiatric disorders. At a young age, claimant displayed inappropriate sexualized and oppositional behaviors, and anxiety. In fifth grade, at the insistence of claimant's school, she was shadowed by a one-on-one aide to address her attentional issues, negative behaviors, and unpredictable moods. In various assessments, claimant has been diagnosed with a mood disorder, not otherwise specified (NOS), depression and anxiety, and even bi-

[2] The parties stipulated to official notice of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), published in May 2013, a generally-accepted manual listing the diagnostic criteria and discussing the identifying factors of most known mental disorders, developed and published by the American Psychiatric Association (APA). Previous versions relied upon in claimant's earlier assessments include the DSM-IV (1994), and DSM-IV-TR (2000).

polar disorder, under the criteria set forth in the DSM-IV. (Exhibit 9.)

8(F). Claimant has social communication deficits which were apparent during her school-age years. During her evaluations, claimant reported her discomfort with peers, her feeling of being misunderstood and excluded, and her social anxiety. (Exhibit 8.) Claimant was diagnosed with Asperger's Disorder under the DSM-IV diagnosis, a diagnosis similar to Communication Disorder under the DSM-5. (Exhibits 5, 9.) Claimant's pragmatic language is weak in that she misses or misunderstands language subtleties, multiple meanings of language, language-based humor and figurative language.

9(A). Claimant's expert, Dr. Meland, principally relied upon the more discrete testing administered by neuropsychologist John M. Watkins, Ph.D., in 2010 when claimant was 17- years old. (Exhibit 8.) As a neuropsychologist, he considered Dr. Watkins qualified to provide the level of detail necessary to understand claimant's complex cognitive profile.

9(B). Dr. Watkins' extensive testing of claimant's cognitive profile established delayed abilities in the area of oral language, which involves listening ability and oral comprehension. Her overall oral language skills are in the low average and mildly-delayed range, similar to an individual between nine and ten-years old. Her story recall, which measures claimant's language development and meaningful memory using previously presented stories is extremely delayed, in the one percentile rank, and comparable to an individual under five-years old. On measures of auditory memory, claimant's ability to listen to oral information and repeat it immediately, and then recall the information after a 20 to 30 minute delay is in the extremely low range, surpassing only two percent of her peers. Her ability to recall complex details from previously presented information was mildly delayed; tasks requiring skills above the level of an eight-year old are difficult for her.

9(C). Claimant performed in the severely impaired range on measures of social cognition, which measures recognition of emotion in faces, memory of faces and the ability to match faces and names, and the ability to interpret emotion. Claimant's ability to recognize faces after a few minutes is only above the level of one percent of her peers. She performed above only nine percent of her peers on the Social Perception Test.

9(D). Dr. Meland discounted Dr. Watkins's summary and diagnostic impressions, which he considered too general. Dr. Meland relied instead on Dr. Watkins' testing results. Dr. Watkins diagnostic impressions were similar to other assessors. Dr. Watkins also observed claimant's anxiety and depression during claimant's assessment. Using the DSM-IV, Dr. Watkins diagnosed claimant with Asperger's Disorder, Mood Disorder NOS, and a range of learning disorders, including a Mathematics Disorder, Reading Disorder and Learning Disorder NOS (Nonverbal Learning Disorder).

10. Claimant's challenges persisted after high school and as she entered adulthood, her challenges intensified to such a degree that it became uncertain whether she could adequately care for herself, live independently and retain a job.

11(A). Claimant graduated high school and was accepted to Goucher College due to her exceptional tennis skills. She was released from the tennis team because she could not adhere to the practice schedule or would show up to practice without her uniform.

11(B). Claimant could not navigate college, academically or socially. She performed poorly in class and was placed on academic probation at the end of her freshman year because of her low grade point average of 1.89. She was informed she would be removed from academic probation when she achieved a grade point average of 2.0.

11(C). Claimant behaved oddly with her roommates and peers, e.g., in the middle

of the night she appeared uninvited in a male student's room.

11(D). Claimant exhibited emotional problems, texting people that she did want to live. After the resident assistant was informed she wanted to "give up," claimant was placed on a 72 hour psychiatric hold and hospitalized. (Exhibit 5.)

11(E). Claimant withdrew from Goucher College and returned to her parents' home. Claimant explained: "I just did not want to be there anymore. I was severely depressed and I wanted to go to this wilderness program." (Exhibit 8.)

12(A). After returning home from college, claimant made several additional attempts at post-high school education and behavioral programs, without success.

12(B). Claimant participated in an austere wilderness program, where she could not navigate the basic elements of self-care, even after instruction.

12(C). Claimant enrolled in a residential program designed to address behavior, which was unsuited to an individual, like claimant, who was noncompliant, but not otherwise defiant.

12(D). Claimant enrolled in local colleges, including one program expressly designed for regional center clients. Claimant could not complete the academic work or achieve passing grades without a tutor who completed her assignments. In one instance, claimant never delivered the assignment to the teacher as required. Instead, claimant went for coffee with a friend. When she finally arrived at class, the class was over.

13. Claimant does not have the requisite skills to maintain employment. After returning home from college, claimant attempted, without success, steady employment at one retail juice bar, and several retail clothing establishments. Her job experience followed a similar pattern: claimant was hired, and within a very short time, fired for failing to learn or follow instructions, or being too slow. (Exhibit 5.) Claimant could not understand or follow instructions and became confused and overwhelmed.

14(A). Claimant is currently capable of performing some self-care and independent tasks, but not very well and requires reminders.

14(B). Claimant can toilet, bathe, dress and eat independently, but needs prompting. She will go days without bathing and fails to wash her hands after toileting. When asked about her hygiene, she responded that she "doesn't think about it." (Exhibit 8.)

14(C). Claimant can make a simple cold sandwich. She can make only two items of hot food on the stove, eggs and pasta. Claimant cannot properly measure ingredients using a measuring cup, even after being told the quantity required and being shown how to measure.

14(D). Claimant's mother attempted to teach her how to launder and use the washing machine, but claimant never learned. Claimant does not know how to use a sponge.

14(E). Claimant drives, but has an extensive history of accidents and parking violations. Claimant is willing to make simple purchases but cannot grocery shop on her own.

14(F). Claimant cannot independently manage her finances, and is completely reliant upon her parents for financial support, including shelter and food. Claimant cannot budget, timely pay bills, or select the best value or price for purchases. Before claimant's mother terminated her credit card, claimant charged $8,000 for nonessential items over a period of a few months.

14(G). Claimant does not demonstrate age-appropriate awareness about her health or sexual relations. Claimant does not demonstrate age-appropriate awareness about the consequences of unprotected sex. Claimant has assured her mother she will not get pregnant because she urinates immediately after coitus. (Exhibit 8.) Claimant sometimes forgets to take her medication, and does not refill them as needed. (*Id.*)

15. There was persuasive evidence of claimant's deficient functioning and no dispute that she would benefit from coordinated regional center services, if she qualifies. If found eligible, the regional center's intake coordinator recommended assistance for claimant to: enroll in the state Medi-Cal and federal SSI programs, obtain independent living skills training, participate in assisted living programs, secure housing, and develop academic or vocational goals. Claimant considered applying to the Department of Vocational Training and Rehabilitation but did not. Her parents maintain that claimant's needs are not limited to training and are not rehabilitative, but are related to her "inability to carry out instructions and being self-directed." (Exhibit 6.) At hearing, it became clearer that claimant desired the regional center's comprehensive services and that claimant would benefit from the regional center's coordinated services.

WRC'S 2015 ASSESSMENT AND ELIGIBILITY DETERMINATION

16. The WRC updated claimant's adaptive profile after claimant requested services. The WRC retained Karen E. Hastings, PsyD., to conduct a comprehensive psychological evaluation of claimant to assist in determining eligibility. Dr. Hastings diagnosed claimant with a Learning Disorder (with impairment in reading written expression and mathematics, respectively, by history), ADD (inattentive type), Other Specified Depressive Disorder, and Generalized Anxiety Disorder. (Exhibit 7.) Dr. Hastings' diagnoses are not disputed and are consistent with past assessments. However, claimant disputes that Dr. Hastings' diagnosis is comprehensive or fully considers her complete profile, which does not consist exclusively of learning or psychiatric disorders excluded from WRC eligibility.

17. After reading Dr. Hastings' report, claimant's parents met with her for two hours to clarify claimant's cognitive and functioning deficits, which they believe Dr. Hastings failed to fully appreciate. Based upon the additional information provided by claimant's parents, Dr. Hastings requested permission from Thompson J. Kelly, Ph. D.,

Chief Psychologist and Coordinator, Intake Services, WRC to amend claimant's summary.. The majority of Dr. Hastings' report focused on eligibility under the category of autism, a category not in dispute. Dr. Hastings intended to include additional information so that the WRC could consider the fifth category. Dr. Hastings had never asked Dr. Kelly to amend a report before. Dr. Kelly denied Dr. Hastings' request. Dr. Hastings did not testify at the hearing to fully explain her analysis, especially with regard to information about claimant's current adaptive functioning which parents contend was not fully included. Without a meaningful analysis of the fifth category from Dr. Hastings, her report was given less weight in determining fifth category eligibility than any contrary testimony from claimant's expert, Dr. Meland.

18(A). Dr. Hastings performed the most recent cognitive testing. Dr. Hastings administered the Wechsler Adult Intelligent Scale – IV (WAIS-IV) to measure claimant's cognitive ability. Claimant achieved an average Full Scale Intelligence Quotient (FSIQ) of 94, with substantial scatter in the composite scores consistent with previous testing. Claimant's scores on the verbal comprehension index (VCI), which provided information about verbal abilities utilizing reason and comprehension and conceptualization, were in the average range. In contrast, claimant's scores on the perceptual reasoning index (PRI), which provided information about nonverbal thinking and reasoning, were in the upper end of the borderline range. Claimant scored in the below average rank on the test of visual puzzles in the perceptual reasoning composite.

18(B). Dr. Hastings found a difference between measures of verbal and nonverbal thinking and reasoning skills which were "statistically significant and rare," such that her cognitive ability was better understood by comparing subtests under the individual indices that comprised the FSIQ, where there was appreciable scatter. (Exhibit 8.) Claimant's FSIQ of 94 was not a true measure of claimant's abilities.

19(A). As part of her evaluation, Dr. Hastings assessed claimant's adaptive

functioning through interviews with claimant and her parents, observations during testing and standardized assessments. Dr. Hastings' report is the only source of claimant's recent statements about her social, emotional, educational and adaptive status, and to the extent claimant's statements provided insight into her adaptive status, they were given great weight.

19(B). Claimant told Dr. Hastings, , "I do not have a lot of motivation which makes me feel lazy. I feel as if I do not want to do things for myself." (Exhibit 8.) She admitted to being uncomfortable with peers, with her difficulties and anxieties increasing as she transitioned to middle school. (*Id.*) Claimant acknowledged being anxious on a daily basis whenever outside the home. Additionally, claimant indicated she was sad daily, and most of the day, and guilty for what she put her mom through, stating "[s]he should not be going through this right now." (*Id.*)

19(C). Dr. Hastings' testing established claimant's low adaptive functioning. Dr. Hastings administered the Vineland Adaptive Behavior Scales-II (VABS-II), which measured claimant's communication, daily living and socialization skills. Claimant was borderline delayed in all areas, and achieved an overall adaptive behavioral composite score in the fourth percentile.

19(D). With respect to communication, claimant can follow instructions or directions heard five minutes before, sometimes listen to an informational talk, but not for 30 minutes, and she claimed she cannot remember to do things.

20(A). Dr. Hastings' opinion regarding claimant's functioning was contrary to her standardized testing and history. Dr. Hastings partially attributed claimant's low scores to her psychiatric issues, particularly her anxiety and depression.

20(B). Dr. Hastings' conclusions that claimant's emotional difficulties, particularly her anxiety and depression, "in all likelihood contribute some variance to her low adaptive functioning," did not fully explain claimant's adaptive deficits. (Exhibit 5.) Dr.

Hastings' opinion was based on claimant's report that she had agreed to run errands for her mother so that she could get the car, and once she was given the car keys, elected to shop for herself instead of fulfilling her mother's request. Claimant admitted she lied because her mother would not otherwise have permitted her to take her car. This one instance of willfulness was impressive, but did not fully negate the overwhelming evidence of claimant's adaptive deficits.

21(A). At hearing, the WRC relied upon the expert opinion of Dr. Kelly to explain Dr. Hastings' evaluation and WRC's determination that claimant was not eligible under the fifth category.

21(B). Dr. Kelly is a well-qualified psychologist. As the WRC's chief psychologist, he leads the team responsible for making all eligibility determinations for the WRC, including claimant's eligibility determination. Dr. Kelly has extensive experience in reviewing eligibility for regional center services.

21(C). Dr. Kelly did not dispute that claimant could benefit from regional center services. He agreed that ADHD is properly classified as a neurodevelopmental disorder. He agreed that a learning disorder can also be a cognitive disorder. He disputed claimant's conclusion that claimant's profile qualified her for eligibility under any category, including the fifth category.

22(A). Based upon his review of Dr. Hastings evaluation, Dr. Kelly concluded that claimant did not satisfy the criteria of the Lanterman Act. According to Dr. Kelly, claimant's profile was consistent with the excluded categories of learning and psychiatric disorders, and did not reflect the consistent pattern of global and cognitive delays apparent in regional center clients eligible under the category of intellectual disability. Claimant's scores fluctuated between measures, and in different evaluations. Individuals with global developmental delays score consistently across measures and over time. Claimant's scores have decreased from her earliest assessments, indicating that factors

were interfering with measures of her cognition or academic achievement levels. Dr. Kelly agreed with Dr. Hastings' assessment that her psychiatric disorders impacted her scores.

22(B). According to Dr. Kelly, under the Lanterman Act, a developmental disability must be the source of the claimant's adaptive deficits. To determine fifth category eligibility it is essential to "tease" out the source of impairment as a cognitive impairment, learning impairment or psychiatric impairment. Claimant's learning and psychiatric disorders can result in severe, adaptive functioning deficits. Claimant's psychiatric disorders make her vulnerable to environmental and other stressors, and affect her adherence to a medication regime. Unlike individuals with intellectual disabilities, claimant's adaptive functioning can vary depending on her psychiatric condition.

22(C). According to Dr. Kelly, learning disorders are distinguishable from the more global cognitive impairment associated with intellectual disabilities. Learning disorders can be treated and improvements made though remedial measures, including educational strategies and teaching methods. Individuals with profound learning disorders make tremendous gains. Individuals with intellectual disabilities do not improve despite interventions. Dr. Kelly agreed that an individual can have a learning disorder and a co-occurring cognitive disorder.

22(D). Dr. Kelly explained that claimant's psychiatric disorders affect her functioning. Claimant's psychiatric disorders have a variable impact on her cognitive and adaptive functioning, including test performance.

22(E). According to Dr. Kelly, ADHD is a condition that can be controlled with medication. The adaptive functioning of an individual with ADHD can improve over time. Many of the symptoms of ADHD disappear with age.

22(F). Dr. Kelly agreed with claimant that she suffered from social interaction

deficits similar to those individuals diagnosed with autism.

22(G). Dr. Kelly's testimony and opinion was given less weight than the expert opinion of claimant's long-term treating psychiatrist and expert, Dr. Meland. Dr. Kelly did not prepare the report and lacked personal knowledge of claimant. Dr. Kelly is undoubtedly an experienced and knowledgeable clinician. Nevertheless, more weight was given to Dr. Meland, who, as set forth in more detail below, demonstrated a greater understanding of claimant's profile and unique deficits.

CLAIMANT'S EXPERT OPINION

23. Dr Meland has been treating claimant for approximately 15 years, since claimant was eight years old. Dr. Meland provided expert opinion testimony and possesses the necessary qualifications to testify as claimant's expert. Dr. Meland has more than 20 years of experience evaluating and treating children with psychiatric disorders and developmental disabilities. In addition to his professional experience, as claimant's treating psychiatrist, Dr. Meland has personally observed claimant for 15 years, more so than any assessor. Dr. Meland and the WRC were in general agreement about claimant's deficits and needs. Dr. Meland agreed claimant did not satisfy the criteria for autism and did not meet the criteria for intellectual disability. Dr. Meland capably examined the results of claimant's previous assessments in the context of his observations of claimant and his professional experience. Dr. Meland persuasively established that claimant was eligible for regional center services under the fifth category.

24. Dr. Meland recommended that claimant apply to the WRC because her combination of deficits conspired to disable her from meeting the "demands of life." (Exhibit 7.) Dr. Meland maintained that claimant suffered from a complex combination of diagnoses forming a developmental disability, "characterized by impaired social interactions, inattention, mood lability, perseverative thinking, the inability to learn

simple tasks despite seemingly average intelligence, the inability to meaningfully grasp the concept of time, and minimal understanding of the consequences of her behavior." (Exhibit 7.)

25(A). In his decades of experience, Dr. Meland never treated any other patient with claimant's profile. Dr. Meland described claimant's presentation and profile as complex. He maintained claimant's profile was similar to intellectual disability because of her inability to process and retain information, and similar to autism due to her social communication deficits.

25(B). Dr. Meland maintained that Dr. Watson's more discrete testing established a severe cognitive impairment in her memory. Dr. Watson's testing results were consistent with Dr. Meland's observations of claimant and her severe adaptive functioning challenges described in factual findings 10-15. Dr. Meland maintained that Dr. Watson's more general summary and diagnostic impressions did not adequately consider his more specific testing. Dr. Meland's opinion is supported by the scope and purpose of Dr. Watson's assessment. Specifically, in 2010, claimant was still in high school and Dr. Watson's assessment focused on "educational planning and support." His summary was designed to guide claimant's parents in her education. (Exhibit 8.)

25(C). Dr. Meland acknowledged claimant's extensive assessment history. He described the assessments as attempts to understand claimant's extremely complex profile, but considered them inconclusive. Dr. Meland explained there is no diagnostic criteria that fully explained claimant's clinical presentation and profile. The diagnosis of claimant with various learning disorders did not explain her severe adaptive deficits. Dr. Meland did not object to her diagnoses of learning disorders as a useful description for educational interventions, but he did object to it being the exclusive explanation for her severe adaptive deficits. According to Dr. Meland, claimant's cognitive deficit related to her memory was the source of her adaptive deficits. Dr. Meland defined a learning

disorder as a learning deficit in a specific area. Contrary to the profile of a learning disorder as a condition responsive to remediation and educational interventions, due to claimant's cognitive deficit, she was not responsive to educational interventions, and her adaptive deficits remained severe and disabling.

25(D). Dr. Meland further explained that Claimant's ADHD remained a significant impairment, but its symptomology did not fully explain her deficient adaptive functioning. Dr. Meland diagnosed claimant with ADHD when she was in fourth grade, and after a trial with other psychostimulants, prescribed Adderall, which claimant still takes. With advanced medical technolog,y it has become apparent that ADHD is a developmental disorder affecting brain functioning. Claimant's adaptive functioning remains severely deficient despite pharmaceutical interventions. Dr. Meland has treated thousands of children with ADHD who respond to medication and who do not function as individuals with developmental disabilities. Claimant's functioning has not changed due to her cognitive memory impairment.

25(E). Dr. Meland opined that claimant's severe adaptive functioning was not caused by her psychiatric functioning, but was claimant's response to her cognitive deficits. Through the years, Dr. Meland also prescribed Ability for mood lability and Lexapro for depression and anxiety. Dr. Meland observed that claimant's overall adaptive functioning remained significantly impaired despite these medications. According to Dr. Meland, claimant was acutely aware of her functioning deficits. Claimant's psychiatric issues, which included a history of anxiety and depression, were claimant's reaction to her deficits. Dr. Meland's opinion was supported by statements claimant made to various assessors over the years. Contrary to Dr. Kelly's opinion, Dr. Meland determined that claimant's variable scores and decreasing scores were not the result of psychiatric disorders, but were due to material getting more complicated as claimant aged, interfering with her ability to keep up with her peers.

25(F). Dr. Meland experienced claimant's cognitive memory deficit, firsthand. Claimant was deceptive in her initial presentation. In treatment, claimant initially presented as someone who was engaged and responsive, but by the end of a 50-minute session, she did not recall a single recommendation, and was incapable of generalizing her therapy to daily living. Dr. Meland received calls from other treating therapists perplexed and frustrated by claimant's inability to retain information during therapy. He also received a call from her wilderness program director, exasperated about claimant's inability to adhere to a basic outdoor hygiene regime.

LEGAL CONCLUSIONS

Based upon the foregoing Factual Findings, the Administrative Law Judges makes the following Legal Conclusions:

1. The Lanterman Developmental Disabilities Services Act (Lanterman Act) governs this case. (Welf. & Inst. Code, § 4500 et seq. (Code).)[3] An administrative "fair hearing" to determine the rights and obligations of the parties, if any, is available under the Lanterman Act. (Code §§ 4700-4716.) Proper jurisdiction was established by virtue of the WRC's denial of the request for funding and claimant's Fair Hearing Request.

2. Where applicants seek to establish eligibility for government benefits or services, the burden of proof is on them. (See, e.g., *Lindsay v. San Diego Retirement Bd.* (1964) 231 Cal.App.2d 156, 161 [disability benefits].) The standard of proof in this case is the preponderance of the evidence, because no law or statute (including the Lanterman Act) requires otherwise. (Evid. Code, § 115.) In meeting the burden of proof by a preponderance of the evidence, the claimant "must produce substantial evidence, contradicted or un-contradicted, which supports the finding." (*In re Shelley J.* (1998) 68

[3] All further statutory references are to the Welfare and Institutions Code, unless otherwise noted.

Cal.App.4th 322, 339.)

3. With regard to the issue of eligibility for regional center services, "the Lanterman Act and implementing regulations clearly defer to the expertise of the DDS (California Department of Developmental Services) and RC (regional center) professionals' determination as to whether an individual is developmentally disabled." (*Mason v. Office of Administrative Hearings* (2001) 89 Cal.App.4th 1119, 1127.) In *Mason*, the court focused on whether the applicant's expert witnesses' opinions on eligibility "sufficiently refuted" those expressed by the regional center's experts that the applicant was not eligible. (*Id.,* at p. 1137.) Based on the above, claimant in this case has the burden of proving by a preponderance of the evidence that her evidence regarding fifth category eligibility is more persuasive than the WRC's evidence. As set forth below, claimant has established by a preponderance of the evidence that she is eligible for regional center services under the fifth category.

4(A). It is settled that the trier of fact may accept any part of the testimony of a witness and reject another part even though the latter contradicts the part accepted. (*Stevens v. Parke Davis & Co*. (1973) 9 Cal.3d 51, 67.) Furthermore, the trier of fact may reject the testimony of a witness, even an expert, although not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.) The testimony of one credible witness, including that of a single expert witness, may constitute substantial evidence. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.) An expert's credibility may be evaluated by looking to his or her qualifications. (*Grimshaw v. Ford Motor Co*. (1981) 119 Cal.App.3d 757, 786.) It may also be evaluated by examining the reasons and factual data upon which the expert's opinions are based. (*Griffith v. County of Los Angeles* (1968) 267 Cal.App.2d 837, 847.) Further, the weight to be given to expert opinion may be evaluated by its reasoning.

4(B). As set forth in the factual findings, more weight was given to the expert

opinion of claimant's expert and treating psychiatrist, Dr. Meland. As such, claimant's evidence, overall, was more persuasive than the WRC's evidence.

5(A). To be eligible for services under the Lanterman Act, claimant must establish that she is suffering from a developmental disability that is attributable to intellectual disability, cerebral palsy, epilepsy, autism or what is referred to as the fifth category closely related to intellectual disability or to require treatment similar to that required for individuals with intellectual disability. (Code § 4512, subd. (a).) The qualifying condition must originate before one's 18th birthday and continue indefinitely thereafter. (Code § 4512.)

5(B). California Code of Regulations, title 17 (CCR), section 54000 further defines "developmental disability" as follows:

> (a) "Developmental Disability" means a disability that is attributable to [intellectual disability][4], cerebral palsy, epilepsy, autism, or disabling conditions found to be closely related to [intellectual disability] or to require treatment similar to that required for individuals with [intellectual disability].
>
> (b) The Developmental Disability shall:
>
> (1) Originate before age eighteen;
>
> (2) Be likely to continue indefinitely;
>
> (3) Constitute a substantial disability for the individual . . . ;

5(C). Claimant established by a preponderance of the evidence that she suffers from a substantial developmental disability that: originated before her 18th birthday, is likely to continue indefinitely, and is closely related to intellectual disability or requiring

[4] The term mental retardation still appears in the CCR, but to be consistent with the Welfare and Institutions Code and current practice it has been changed to intellectual disability in this Decision.

similar treatment. As set forth in the factual findings, claimant has suffered from a substantial disability from a very young age that has persisted without interruption and is likely to continue indefinitely. Claimant has established by substantial evidence that her low cognitive functioning in certain discrete areas is closely related to an intellectual disability or requires similar treatment and coordinated services.

6(A). CCR section 54000, subdivision (c) excludes the following conditions from the definition of "developmental disability:"

(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) (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 [intellectual disability], educational or psycho-social deprivation, psychiatric disorder, or sensory loss.

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

6(B). Based on the language "solely," a person with a "dual diagnosis," that is, a developmental disability coupled with a psychiatric disorder, a physical disorder, or a learning disability, could still be eligible for services. However, someone whose conditions originate from just the excluded categories (psychiatric disorder, physical

disorder, or learning disability, alone or in some combination), and who does not have a developmental disability, would not be eligible.

6(C). Claimant established by a preponderance of the evidence that her developmental disability did not originate solely from excluded categories. As set forth in the factual findings, claimant may have had learning disorders, but she also had a cognitive memory impairment which severely affected her adaptive functioning. Dr. Kelly acknowledged that an individual can have both a learning disorder and a cognitive impairment. Due to her cognitive memory impairment, claimant was not responsive to educational interventions and her adaptive functioning deficits remained static. Claimant's developmental disability did not originate solely from her psychiatric disorders. According to the testimony of Dr. Meland, her psychiatric disorders were the consequence of her discrete cognitive memory impairment and her recognition of her deficits. Dr. Meland acknowledged that claimant's ADHD contributed to her complex profile, but he did not agree with various assessors that ADHD was responsible for her impaired intellectual functioning. Nevertheless, both parties agreed that ADHD was a neurodevelopmental disorder, not a psychiatric disorder. As such, ADHD was not an excluded psychiatric disorder and claimant's developmental disability was not the result of solely psychiatric disorders.

7(A). Establishing the existence of a developmental disability within the meaning of Code section 4512, subdivision (a), requires claimant to additionally prove that the developmental disability is a "substantial disability," defined in CCR section 54001, subdivision (a), as follows:

> (1) A condition which results in a major impairment of cognitive and/or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential; and

(2) The existence of significant functional limitations, as determined by the regional center, in three or more of the following areas of major life activity, as appropriate to the person's age:

(A) Receptive and expressive language;

(B) Learning;

(C) Self-care;

(D) Mobility;

(E) Self-direction;

(F) Economic self-sufficiency.

7(B). Claimant established by a preponderance of the evidence that her condition results in a major impairment of both cognitive and social functioning, requiring interdisciplinary planning. Claimant's cognitive memory deficit and social communication deficits have severely affected her adaptive functioning. Claimant supplied substantial evidence of her inability to engage in the world and achieve her maximum potential without coordinated planning and services. Claimant cannot live independently, care for herself, self-direct, learn, or achieve any measure of economic self-sufficiency without assistance. Claimant's efforts to navigate without assistance through daily routines, education, and employment have failed.

7(C). Claimant established by a preponderance of the evidence that she has a substantial disability by demonstrating functional limitations in at least three categories appropriate to her age, including receptive language, learning, self-care, self-direction, capacity for independent living, and economic self-sufficiency. The evidence is clear from claimant's assessments and Dr. Meland's observations that although her language functioning appears average, her ability to remember and interpret communication and related situations, for the purpose of learning, self-direction, retaining employment and living independently, is impaired. Claimant's assessments, parent report, and Dr. Meland

confirm claimant's challenges with receptive language, learning, self-care, self-direction, independent living, and economic self-sufficiency. Dr. Hastings report confirms claimant's borderline adaptive functioning.

DOES CLAIMANT HAVE A FIFTH CATEGORY CONDITION?

8. As claimant is asserting eligibility for Lanterman Act services and supports under the "fifth category," she must establish by a preponderance of evidence a disabling condition "closely related to intellectual disability" or a disabling condition requiring "treatment similar to that required for individuals with intellectual disability." (Code, § 4512, subd. (a).) Furthermore, determining whether a claimant's condition "requires treatment similar to that required for intellectually disabled individuals" is not a simple exercise of enumerating the services provided and finding that a claimant would benefit from them. Many people could benefit from the types of services offered by regional centers (e.g., counseling, vocational training or living skills training). The criterion is not whether someone would benefit. Rather, it is whether someone's condition requires such treatment.

9. Claimant did not claim eligibility for regional center services as a person with an intellectual disability. Nevertheless, the requirements of eligibility for intellectual disability inform the analysis of fifth category eligibility. The "fifth category" is described as "disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for intellectually disabled individuals." (Code § 4512, subd. (a).) A more specific definition of a "fifth category" condition is not provided in the statutes or regulations. Whereas the first four categories of eligibility are specific (e.g., epilepsy or cerebral palsy), the disabling conditions under this residual fifth category are intentionally broad so as to encompass unspecified conditions and disorders. But the Legislature requires that the condition be "closely related" or "similar." "The fifth category condition must be very similar to [intellectual disability], with many of the

same, or close to the same, factors required in classifying a person as [intellectually disabled]." (*Mason v. Office of Administrative Hearings*, (2001) 89 Cal.App.4th 1119, 1129.(*Mason*))[5] Developmental disabilities differ widely and are difficult to define with precision. (*Id.* at p. 1130.)

10. *Mason* was decided before the adoption of the DSM-5. The American Psychiatric Association (APA) notes that the most significant change in diagnostic categorization accompanying the change from DSM-IV-TR to DSM-5 nomenclature of intellectual disability is emphasis on the need for an assessment of both cognitive capacity and adaptive functioning, and that the severity of intellectual disability is determined by adaptive functioning rather than IQ score. (*Id.* at 37.) The APA notes no other significant changes.

11. Under the DSM-5, a claimant asserting fifth category eligibility is required to establish by a preponderance of evidence significant deficits in cognitive capacity or deficits in adaptive functioning, or both. Fifth category eligibility does not require strict replication of all of the diagnostic features of intellectual disability. If this were so, the fifth category would be redundant. Eligibility under the fifth category requires an analysis of the quality of a claimant's cognitive and adaptive functioning and a determination of how well that claimant meets community standards of personal independence and social responsibility in comparison to others of similar age and sociocultural background. CCR, section 54002 defines "cognitive" as "the ability of an individual to solve problems with insight to adapt to new situations, to think abstractly, and to profit from experience." The evidence must establish that the claimant's disabling condition requires treatment similar to the treatment needs of an individual with

[5] As noted above, the DSM-5 has replaced the diagnosis of "Mental Retardation" with "Intellectual Disability."

intellectual disability.

12. The case of *Samantha C. v. Department of Developmental Services* (2010) 185 Cal.App.4th 1462 provides insight into fifth category eligibility. In that case, a person seeking eligibility for regional center services, Samantha C., was born prematurely and with hypoxia (oxygen deprivation). In elementary school, her cognitive abilities were measured to be in the average range, though she was provided with special education services because she had deficits in auditory processing, language, speech and memory. She was later diagnosed with attention deficit disorder (ADD), although the condition was present from an early age. She ultimately graduated from high school and enrolled in a junior college. She received SSI disability benefits and qualified for services from the Department of Rehabilitation. During the process of requesting regional center services, Samantha was given cognitive tests, which yielded scores of 92 and 87, with a full-scale IQ score of 90, placing her in the average range. The Vineland testing revealed Samantha functioned adequately in daily living and social skills, but that she functioned on a moderately low level in the area of communication. While various experts arrived at different conclusions, at least two experts (whom the court found persuasive) opined that that Samantha had major adaptive impairments and that she functioned in the range of someone with [intellectual disability]. The same experts opined that Samantha's hypoxia affected her brain and created a neurocognitive disorder explaining her various deficits. One expert diagnosed Samantha with a Cognitive Disorder Not Otherwise Specified.

13. The court determined that Samantha had a fifth category condition and was eligible for regional center services. First, the court concluded that Samantha had a disabling developmental condition, i.e., she had "suffered birth injuries which affected her brain and that her cognitive disabilities and adaptive functioning deficits stem, wholly or in part, from such birth injuries." (*Samantha C. v. Department of*

Developmental Services, *supra*, 185 Cal.App.4th at pp. 1492-1493.) Since the evidence established that her cognitive and adaptive deficits were related to her hypoxic birth episode, there was substantial evidence that her disabilities were *not* solely related to psychiatric or learning disorders. (*Ibid.*) *Samantha C.* was diagnosed with several psychiatric disorders including depression, anxiety and adjustment disorder. The court did not address whether ADD was a psychiatric disorder. Second, the court concluded that Samantha's disabling condition required treatment similar to that needed by individuals with [intellectual disability]. (*Id.*, at p. 1493.) Specifically, the court found convincing an expert witness's testimony that those with intellectual disability and fifth category eligibility needed many of the same kinds of treatment, such as help with cooking, public transportation, money management, job training and independent living skills, and that Samantha needed those same services. (*Ibid.*)

14. In *Samantha C.* it was undisputed that claimant's diagnosis of a learning disorder and her psychiatric disorders were excluded under the Lanterman Act. Substantial evidence was provided to the court of Samantha's hypoxic birth to distinguish the genesis of her disability from the excluded conditions of learning and psychiatric disorders. The court adopted expert testimony connecting Samantha's hypoxic birth episode to a diagnosis of Cognitive Order Not Otherwise Specified, a neurocognitive disorder. Fifth category eligibility was satisfied in *Samantha C.* because her disabling developmental condition was caused by a neurocognitive impairment, which was "secondary to a medical condition," not excluded disorders. (*Id.* at p. 1476.)

15. There are elements of claimant's case similar to those presented in the *Samantha C.* case. Claimant has FSIQ scores in the average range, but all assessors agreed, including Ms. Hastings, that claimant's FSIQ was not a an accurate reflection of her cognitive profile. Claimant's adaptive scores were borderline. Although claimant graduated from high school and was accepted to college, she never advanced

academically without a tutor shadowing her. Additionally, she demonstrated she was unable to get and maintain a job. Claimant has, and continues to, ignore her hygiene, self-direct, and is unable to manage money or live independently. She also fails to understand the basic health risk of unprotected sex. (Factual Findings 10-15.)

16. Claimant provided expert opinion from Dr. Meland that persuasively established that her particular cognitive deficit in memory was not solely the result of an excluded learning disorder, but a persistent condition, that was not responsive to remediation through educational interventions. The evidence established that claimant's extremely impaired cognitive deficit in the area of language development and memory was primarily responsible for a disabling condition that severely impaired her adaptive functioning. Further, under the DSM-5, claimant's ADHD was not an excluded condition, and it further complicated her profile and impaired her functioning, as described in numerous assessments. Claimant's profile was further complicated by severe social communication deficits formerly referred to as Asperger's Syndrome and under the DSM-5 identified as a Communications Disorder.

17. Under these circumstances, the *Samantha C.* case applies to claimant's situation. Based upon the factual findings in the instant case, claimant established by a preponderance of evidence that her intellectual or adaptive functioning is closely related or similar to that of an individual with an intellectual disability, and not otherwise excluded as a learning disorder or psychiatric disorder under the Lanterman Act. Claimant also provided substantial evidence that due to her adaptive functioning, she would benefit from the types of coordinated services offered by WRC to individuals with intellectual disabilities. Claimant has shown that she can benefit from a range of coordinated services directed at, among other things, self-care, independent living skills, and job training.

18. In sum, based on factual findings 1-25, and legal conclusions 1-17,

claimant is eligible for regional center services under the fifth category.

ORDER

1. Claimant's appeal of the Westside Regional Center's denial of eligibility under the fifth category is granted.

2. Claimant is eligible for regional center services under the fifth category.

DATED: March 23, 2016

EILEEN COHN

Administrative Law Judge

Office of Administrative Hearings

NOTICE

This is the final administrative decision; both parties are bound by this decision. Either party may appeal this decision to a court of competent jurisdiction within 90 days.