BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT,

vs.

SOUTH CENTRAL LOS ANGELES REGIONAL CENTER,

Service Agency.

OAH No. 2021020538

DECISION

Cindy F. Forman, Administrative Law Judge (ALJ), Office of Administrative Hearings, heard this matter by videoconference on December 20, 21, and 22, 2021.

Julie A. Ocheltree, Attorney at Law, Enright & Ocheltree LLP, represented South Central Los Angeles Regional Center (SCLARC or Service Agency).

Christina Bazak and Andrew Tapia, Attorneys at Law, Children's Law Center of California, Los Angeles, Firm 3, and Rose Frihart, Children's Law Center of California, Los Angeles, Firm 4, represented Claimant. (Titles are used to protect Claimant's privacy.) Claimant was not present at the hearing.

The ALJ received testimony and documentary evidence. The record was kept open until February 7, 2022, to allow the parties to submit briefing. Both parties timely filed closing briefs; SCLARC's brief is marked as Exhibit 24, Claimant's brief is marked as Exhibit Z.

The ALJ closed the record and deemed the matter submitted for decision on February 7, 2022.

ISSUES PRESENTED

1. Whether Claimant is eligible for regional center services and supports under the qualifying category of intellectual disability (ID) as provided for in the Lanterman Disabilities Services Act (Lanterman Act), Welfare and Institutions Code (Code) section 4500, et seq.?

2. Whether Claimant is eligible for regional center services and supports under the qualifying category of "disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability," which is commonly referred to as "the fifth category," as provided for in the Lanterman Act?

3. Whether SCLARC is required to conduct an additional eligibility evaluation of Claimant?

EVIDENCE RELIED UPON

Documents: Service Agency Exhibits 1 through 18, 21, and 22; Claimant Exhibits A through U, X, and Y. The ALJ took official notice of the Diagnostic and Statistics

Manual of Mental Disorders, Fifth Edition (DSM-5), which was marked as Service Agency Exhibit 19 and Claimant Exhibit W.

Testimony: On behalf of Service Agency, Laurie McKnight Brown, Ph.D., and Wilhelmina Hernandez, M.D. On behalf of Claimant, Stephen Greenspan, Ph.D., Kenneth L. Jones, M.D., and Wrenn Chais, Claimant's Court Appointed Special Advocate (Court Advocate Chais or Ms. Chais).

SUMMARY

Claimant has appealed SCLARC's denial of eligibility for Lanterman Act supports and services, asserting he presents with either ID or a "fifth category" condition. Alternatively, Claimant seeks another psychological assessment from SCLARC because his most recent evaluation was incomplete and unreliable. Claimant has not proved by a preponderance of the evidence that he presents with ID or has a "fifth category" condition. SCLARC's decision denying eligibility under those two conditions is affirmed. Claimant has also not proved a new assessment for eligibility is warranted at this time.

FACTUAL FINDINGS

Jurisdiction

1. Court Advocate Wrenn Chais requested services for Claimant from SCLARC. By letter and Notice of Proposed Action dated November 12, 2020, SCLARC notified Ms. Chais of its determination Claimant was ineligible for Lanterman Act services and supports. On December 17, 2020, Ms. Chais filed a Fair Hearing Request on

Claimant's behalf, asserting SCLARC's psychological assessment of Curtis was inaccurate and incomplete. On June 2, 2021, SCLARC and Ms. Chais held an informal meeting pursuant to Welfare and Institutions Code (Code) section 4710.7 to discuss the results of a more recent court-ordered psychological assessment of Claimant and Claimant's recent diagnosis of Alcohol Related Neurodevelopmental Disorder. By letter dated June 8, 2021, SCLARC reiterated its position regarding Claimant's ineligibility for Lanterman Act services. This hearing ensued.

2. Ms. Chais contends Claimant is eligible for Lanterman Act services and supports on the grounds he meets the diagnostic criteria for ID or he presents with a disabling condition placing him within the "fifth category." There was no evidence or argument suggesting Claimant suffers from autism spectrum disorder (ASD), cerebral palsy, or epilepsy or that any of these conditions is grounds for deeming Claimant eligible for Lanterman Act services and supports.

Claimant's Background

3. Claimant is a 17-year-old male. He is a dependent of the Juvenile Court. The request for Lanterman Act services and supports giving rise to this proceeding was Claimant's third request for such services.

4. Little is known about Claimant's first four years. Based on descriptions in the numerous evaluations admitted into evidence, Claimant's biological mother either sold or gave Claimant to unknown individuals approximately one month after he was born to avoid removal by the Department of Child and Family Services (DCFS). DCFS issued a warrant for Claimant after discovering he was missing. Claimant's mother was subsequently incarcerated for reasons not pertinent to this matter. When she was

released from prison, she did not know Claimant's whereabouts. During this time, Claimant's father was also incarcerated.

5. DCFS located Claimant after his abductors/caregivers took him to a hospital emergency room. DCFS immediately removed Claimant from their care because there were allegations of physical abuse. Claimant was four years old at the time.

6. DCFS then placed Claimant in child protective services in April 2009. Since that time, Claimant has had at least 15 different residential placements. From April 2009 to June 2010, Claimant was placed in five different foster homes. Some foster homes declined to keep him because of behavioral concerns. Claimant was then placed in several different group homes, but he was frequently moved because of his aggressive and violent behavior and elopement. From February to March 2021, Claimant began living with foster parents; however, in March 2021, Claimant's foster father passed away and Claimant was forced to move to another group home. Although Claimant's father recently has made efforts to reunite with Claimant, Claimant remains a dependent of the court.

Physical Health

7. Claimant's birth was reported to be normal. His onset of developmental milestones is unknown. Claimant has been diagnosed with asthma and is reported to carry the sickle cell gene. He wears glasses, has no problems with hearing, and his gross and fine motor abilities are intact.

8. References in Claimant's records indicate he was first diagnosed with Fetal Alcohol Syndrome Disorder (FASD) in 2009 and two doctors subsequently confirmed the diagnosis. (Ex. 10, p. SCLARC-0074, A74.) Kenneth Lyons Jones, M.D., an

undisputed expert in the FASD field who also testified at hearing, examined Claimant on August 29, 2021, and diagnosed Claimant with Alcohol Related Neurodevelopmental Disorder (ARND), a disorder on the FASD spectrum. (Ex. S.) SCLARC does not dispute Claimant's diagnosis of ARND.

MENTAL HEALTH

9. Claimant has been evaluated multiple times by psychologists, nurses, and therapists in response to requests by different regional centers, the Juvenile Court, the Los Angeles County Department of Mental Health (DMH), DCFS, and the group homes where he has resided. (Exs. 5–15, G, H, J, K, O. R, S.) Those evaluations reveal Claimant has a complex mental health history. Claimant has received inconsistent and different diagnoses from his many evaluators, including Attention Deficit Hyperactivity Disorder (ADHD), Posttraumatic Stress Disorder, Oppositional Defiant Disorder, Bipolar Disorder, Neurodevelopmental Disorder associated with Prenatal Alcohol Exposure, Learning Disorders, Reactive Attachment Disorder, Pervasive Developmental Disorder, Disruptive Behavior Disorder, and Major Depressive Disorder. Evaluators report Claimant has poor impulse control and has exhibited verbal and physical aggression, irritability, defiance, anger outbursts, severe temper tantrums, anxiety, sexually reactive behavior, and inattention. Claimant has provoked peers, physically harmed an animal (he allegedly kicked a dog when he was younger), set fires, destroyed property, lied, stole, and attempted to elope multiple times.

10. Claimant has been hospitalized five times in psychiatric facilities because of suicidal threats and gestures and dangerous behavior towards others. He has had over 38 mental health episodes documented in Los Angeles County since 2009. Claimant has received individual, group, and behavioral therapy. He has been prescribed psychiatric medication since age four. (Ex. 6, p. SCLARC-0027, A27.) Those

prescriptions have included Ritalin, Risperidone, Risperdal, Adderall, Concerta, Seroquel, Thorazine, Lithium, Prozac, Abilify, Guanfacine, Benadryl, and Tenex.

EDUCATION

11. Claimant is currently in the 12th grade at a nonpublic school for children with special education needs. Claimant attended half-day therapeutic pre-school and has been in a special education program since first grade. Claimant's original Individualized Education Program (IEP), dated December 1, 2010, indicates Claimant qualified for special education services under "Other Health Impairment." At the time, Claimant could not comprehend what he read and had difficulties writing and speaking sentences as well as carrying on a full conversation. (Ex. 7, p. SCLARC-003, A33.) Sometime later, Claimant also qualified for special education services under the category of Emotional Disturbance.

12. The parties offered no other IEP's or current academic performance assessments into evidence. Academic performance testing administered as part of Claimant's psychological assessments demonstrates inconsistent results. In 2012, Claimant tested in the average to superior range in reading, spelling, and math. (Ex. 9, SCLARC-0067, A67.) However, in 2016, when Claimant was 11-years-old, notes by Debra Lagenacher, staff psychologist at San Gabriel Pomona Regional Center, indicate Claimant tested in the borderline range on academic achievement tests. (Ex. 13, p. A94.) Forensic psychologist V. Inez Gonzalez, Ph.D., who had access to Claimant's educational records as part of her Juvenile Competency Evaluation, reports in 2021 Claimant did not attend school in-person or online during most of the COVID-19 pandemic. (Ex. R.) Reports Dr. Gonzalez reviewed also indicate Claimant attended four different special education schools in the past four years and was repeatedly suspended from school for behavioral issues. (*Id.*, p. 2, B128.) In 2019, Claimant's school vice-principal reported

Claimant was below grade level academically. (Ex. K, p. 3, B81.) In her interviews with assessing psychologists, Court Advocate Chais indicated Claimant is functioning at a third-grade level but gets good grades and is on track to graduate from high school. (Ex. 18, A127, SCLARC-0127.)

Criminal History

13. Claimant was recently detained in Central Juvenile Hall in Los Angeles for attempted second-degree robbery. The circumstances of his arrest and the disposition of the matter were not made known in the record. It was also unclear whether this was his first or second arrest, as some records refer to a separate arrest for a physical altercation with another group home resident. On September 26, 2021, Claimant was found incompetent to stand trial on the attempted second-degree robbery charge. (Ex. R, p. 5, B131.) V. Inez Gonzalez, Ph.D., the forensic psychologist who conducted the competency evaluation, found Claimant's "mental health symptoms and developmental delays make it difficult for him to process, interpret, understand, and retain new and complex information, and also impacts his reasoning and decision-making abilities." (*Ibid.*)

Psychological Evaluations of Claimant

14. Claimant has undergone multiple psychological evaluations because of his complex mental health and cognitive issues. Three of these evaluations were the result of referrals to regional centers to determine Claimant's eligibility for Lanterman Act services and supports. (Exs. 5, 14, 17.) The assessments reflect a wide variance in scores on cognitive and academic achievement tests but consistently demonstrate Claimant's substantial adaptive skill deficits. None of the assessments diagnosed

Claimant with ID. Those evaluations conducted by psychologists who administered formal testing are described in more detail below.

2007 Evaluation

15. SCLARC first evaluated Claimant to determine his eligibility for Lanterman Act supports and services on October 9, 2007, when he was 2 years, 11 months old. Claimant was receiving Early Start services at the time. Licensed psychologist Lisa Doi, Ph.D., noted in her report previous testing conducted by Developmental Dynamics, a preschool which Claimant attended, suggested Claimant's nonverbal cognitive functioning, language development, and motor skills were within normal limits. (Ex. 5, p. SCLARC-20, A20.)

16. Test results reported by Dr. Doi showed Claimant's cognitive abilities to be in the low average range, with verbal skills measured in the average range, and adaptive deficits in the moderately low to adequate range. Based in part on Dr. Doi's test results, SCLARC determined Claimant did not present with ID or a "fifth category" condition. Claimant was therefore found ineligible for Lanterman Act services and supports.

2012 Evaluation

17. On September 11 and October 23, 2012, licensed psychologist Eva Turner, Psy.D., performed a comprehensive evaluation of Claimant at the request of Claimant's wraparound therapist. (Ex. 9.) According to Dr. Turner, Claimant was referred for evaluation because he was experiencing emotional and behavioral problems that were affecting him at home and school. Because of his extreme behaviors, Claimant was at high risk of losing his foster home placement. Claimant was seven years, 10 months

old, and in the second grade at a special education school at the time of the evaluation. (*Id.*, p. SCLARC-0052, A52.)

18. Dr. Turner reported Claimant was extremely oppositional during the assessment and only performed tasks when his Child Specialist was present. When his Child Specialist was absent, Dr. Turner found Claimant to be manipulative, disruptive, and destructive. She wrote Claimant demonstrated a "very fluid" ability to turn his behaviors on and off, with "very entrenched manipulative patterns of behavior." She deemed much of his testing invalid because of his low efforts. However, in a second meeting with Claimant's Child Specialist present, Claimant was compliant and completed the testing. (Ex. 9, p. A53-A54, SCLARC-0053–0054.).)

19. Dr. Turner administered the Wechsler Intelligence Scale for Children, Fourth Edition (WISC-IV) and the Wide Range Achievement Test – Revision 3 (WRAT-III) to Claimant to assess his cognitive abilities. It was not known when the tests were administered, i.e., on the first day when Claimant was noncooperative, on the second day when he was cooperative, or on both days. Dr. Turner reported Claimant received a full scale IQ score of 90 on the WISC-IV, which places him in the "average" range of general intelligence. (Ex. 9, p. SCLARC-0065, A65.) On the WRAT-3, Claimant obtained scores showing his reading and spelling were average and his arithmetic was superior. (*Id.*, p. SCLARC-0067, A67.) Dr. Turner did not conduct any testing to evaluate Claimant's adaptive skills.

20. Dr. Turner diagnosed Claimant with Severe Reactive Attachment Disorder, Ambivalent Type, and Enuresis, Not Due to a General Medical Condition. Apparently unaware of Claimant's FASD diagnosis in 2009 (see Factual Finding 8), Dr. Turner ruled out FASD, although she acknowledged the diagnosis should be made by a medical practitioner. She concluded Claimant's issues were the result of severely

disrupted caregiver-child attachments. Dr. Turner opined Claimant's scores did not suggest borderline intellectual functioning, ID, or the presence of a learning disorder. She maintained his poor performance on academic tasks and tests "may be based solely on his choice not to apply himself and keep other's expectations of him low so less is demanded of him." (Ex. 9, p. A55, SCLARC-0055.) When Claimant chose to apply himself, Dr. Turner pointed out he effectively doubled his scores and demonstrated average intelligence. (*Ibid.*) However, it was unclear whether Claimant's improved test scores were the result of his earlier test-taking attempts during his first meeting with Dr. Turner.

2016 Evaluation

21. When Claimant was 11 years, four months old, his court-appointed special advocate referred him to the San Gabriel/Pomona Regional Center (SGPRC) for psychological evaluation. On February 23, 2016, at SGPRC's request, Edward G. Frey, Ph.D., conducted an assessment of Claimant to determine whether he presented with ID or ASD. Claimant was then 11 years old, four months old at the time. (Ex. 14).

22. Dr. Frey administered the Wechsler Intelligence Scale for Children, Fifth Edition (WISC-V), the Vineland Adaptive Behavior Scales, Second Edition (VABS-2), and several tests for ASD. On the WISC-V, Claimant achieved a full scale IQ score of 76, which is low borderline. Claimant's scores on the subtests of the WISC-V showed significant scatter. Claimant demonstrated a mild delay in his verbal comprehension scores; low average abilities on visual spatial skills; low borderline abilities in fluid reasoning; and average abilities on working memory and processing speed.

23. According to Dr. Fry, Claimant's test results suggest a "possible significant discrepancy between [Claimant's] verbal and non-verbal skills . . . [that]

would suggest the possibility of deficits in verbal and auditory processing, such as seen in certain types of learning disabilities." (Ex. 14, p. SCLARC-0099, A99.) However, Dr. Fry noted Claimant was in the average range in terms of memory, processing speed, and visual spatial skills. Thus, Dr. Fry opined Claimant's borderline full scale IQ score was "likely" to be "somewhat of an under-estimation." *(Ibid.*)

24. On the VABS-2, according to Claimant's therapist, who served as the primary informant, Claimant showed mild deficits in most adaptive areas. The therapist reported significant delays both in socialization and communication. She reported Claimant could not point to five minor body parts, listen to a story for 15 minutes, and could only partially or sometimes write brief essays for school. Claimant only sometimes brushed his teeth and washed his face, and he could not tell time on an analog clock. He only sometimes understood the value of money. Dr. Frey opined Claimant's delays were associated more with willful refusal or motivational issues rather than lack of capability as evidenced by a predominance of responses in the sometimes or partially area of the individual sub-domains. Dr. Frey erroneously noted Dr. Turner's assessment indicated probable FASD, even though she expressly ruled out any FASD diagnosis. (Ex. 9, A60.). Nonetheless, Dr. Frey makes no mention of the impact of FASD on Claimant's cognitive or adaptive deficits.

25. Based on the results of the evaluation and his observations of Claimant, Dr. Frey found Claimant did not meet the diagnostic criteria for ASD or ID. "While mild delays are noted adaptively, cognitive functioning appears in the high borderline to more probably low average range." (Ex. 14, p. SCLARC-0104, A104.) Dr. Fry cited the absence of any ID diagnosis in Claimant's prior records to support his conclusion. Dr. Frey deferred any psychiatric or mental health diagnoses to Claimant's treating mental

health professionals but stated he believed a diagnosis of bipolar disorder is "probably accurate." (*Ibid.*)

2020 EVALUATION

26. Sometime in 2020, Court Advocate Chais requested SCLARC assess Claimant's eligibility for Lanterman Act services and supports. On July 28, September 2, and September 11, 2020, Robert Koranda, Psy.D., at SCLARC's request, performed a remote telephone and video assessment of Claimant. The assessment focused on whether Claimant presented with ID. Claimant was 15 years old at the time.

27. Although Dr. Koranda's discussions with Ms. Chais regarding Claimant's background and current functioning appeared to be thorough, his evaluation of Claimant was short and incomplete. According to Dr. Koranda's report, his video session with Claimant lasted 30 minutes; Ms. Chais indicated the session lasted only 10 to 15 minutes. (Ex. 17, p. SCLARC-0118, A118.) At hearing, SCLARC acknowledged Dr. Koranda's report was not thorough and "SCLARC did not rely on it in determining Claimant's ineligibility." (Brown Test.)

28. Dr. Koranda was only able to administer several subtests of the WISC-V because of the video testing format. Claimant scored in the very low range on the Verbal Comprehension Index and the Fluid Reasoning Index, in the low average range on a subtest assessing his visual processing abilities, and in the average range on a short-term working memory subtest. (Ex. 17, p. SCLARC-0119, A119.) Dr. Koranda reported Claimant was not invested in the testing, and many of his answers were given impulsively. Dr. Koranda therefore believed Claimant's scores were "likely to be an underrepresentation" of Claimant's abilities because Claimant "gave minimal indication that he was interested in performing to the best of his ability." (*Ibid.*)

29. Claimant scored in the mild deficit range on the Vineland Adaptive Behavior Scales, 3rd Edition (VABS-3), with Ms. Chais as the informant. He scored in the mild deficit range in the Communication, Daily Living Skills, and Socialization domains. (Ex. 17, p. SCLARC-0120, A120.)

30. Based on his review of the records, the VABS-3 results, and his limited observation and testing of Claimant, Dr. Koranda diagnosed Claimant with ADHD by history and Unspecified Disruptive, Impulse-Control Disorder. Dr. Koranda found there was insufficient evidence to support the presence of deficits in Claimant's general mental abilities, notwithstanding a prior diagnosis of FASD, because of Claimant's earlier test scores, Claimant's scores on the tests Dr. Koranda was able to administer, and Claimant's motivational limitations. (Ex. 17, p. A121–A122, SCLARC-0121-0122.). Dr. Koranda acknowledged Claimant's low adaptive skill scores but found there was insufficient information to conclude these low scores are attributable to the presence of deficits in general mental abilities, especially considering Claimant's current and previous performance on measures of cognitive ability." (*Id.*, p. A122; SCLARC-0122.) Based on these findings, Dr. Koranda concluded Claimant did not meet the criteria of ID, but he opined that it was "likely that [Claimant's] adaptive functioning abilities are negatively impacted by characteristics related to other mental disorders that are not sufficiently managed." (*Ibid.*)

2021 Evaluation

31. Court Advocate Chais was dissatisfied with Dr. Koranda's evaluation and requested Juvenile Court to order another evaluation. In response to the court order doing so, DCFS requested Jenifer Goldman, Psy.D., to conduct a neuropsychological evaluation of Claimant to "better understand" Claimant's "intellectual, speech, language, executive, academic, and personality/emotional functioning." (Ex. 18.). That

evaluation occurred on March 8 and March 12, 2021, and involved both in-person and remote testing and assessment. As part of her evaluation, Dr. Goldman reviewed the assessments by Dr. Turner and Dr. Koranda and obtained extensive background information from Claimant's social worker and Ms. Chais. She also administered several cognitive, personality, and adaptive skills tests, including the WISC-V and the VABS-3.

32. Dr. Goldman observed Claimant was grossly oriented to person, place, and time. His thought processes appeared logical and coherent. Dr. Goldman reported Claimant was uncooperative with testing at first; however, after some discussion, Claimant completed the first two items of cognitive testing without issue. Claimant then refused to do further testing, left the testing room, and disappeared for 10 to 15 minutes. Dr. Goldman left the room to look for him. Claimant then returned to the room, and after discussions with Dr. Goldman and Ms. Chais, he cooperated and completed the test. However, after Claimant left for the day, Dr. Goldman discovered he had stolen four debit cards and cash from her wallet when he was alone in the room while she had been out looking for him. She then terminated Claimant's in-person testing. (Ex. 18, p. A129; SCLARC-0129.)

33. Notwithstanding Claimant's initial resistance and elopement, Dr. Goldman noted Claimant was motivated and engaged throughout the majority of cognitive testing, and she found the test scores to be an accurate estimate of his intellectual ability. (Ex. 18, p. A137; SCLARC-0137.) She reaffirmed her belief in the accuracy of the tests in an undated email sent to Claimant's counsel sometime after March 2021. (Ex. U.) Ms. Chais confirmed Claimant spent two uninterrupted hours with Dr. Goldman; she also noted Dr. Goldman remarked to her that Claimant remained focused during the test after Claimant completed the testing.

34. Dr. Goldman found Claimant demonstrated "significant" cognitive deficits, with his full scale IQ based on the WISC-V to be 71, in the very low range, indicating overall weak intellectual functioning abilities. (Ex. 18, p. A137, SCLARC-0137.) Claimant's cognitive skills across verbal abilities, fluid reasoning, and working memory fell in the very low range; his processing speed fell in the extremely low range; and his understanding of visual information fell in the low average range. As with Claimant's previous tests, Claimant's performance on the subtests showed "significant variability" as he received at least one average to low average score within each Index. (*Ibid.*) Dr. Goldman observed Claimant's "weaknesses appear strongly influenced by language and executive functioning demands." (*Ibid.*)

35. Ms. Chais was again the informant on the VABS-3. The VABS-3 results placed Claimant's communication, daily living skills, and socialization below the first percentile and in the low range. (Ex. 18, p. SCLARC-0134, A134.) Ms. Chais rated Claimant as "exhibiting clinically significant aggression, conduct problems, attention problems, atypicality, and difficulties across adaptability, functional communication, and activities of daily living. (*Id.* p. SCLARC-0137, A137.) According to Dr. Goldman, these ratings indicate Claimant is likely to struggle with "receptive, expressive, and written language; personal, domestic, and community-based daily living skills; and interpersonal relationships, play/leisure, and coping skills." (*Ibid.*) Dr. Goldman also concluded Claimant demonstrated difficulty meeting "community standards of personal independence and social responsibility." (*Ibid.*)

36. Dr. Goldman diagnosed Claimant with Neurodevelopmental Disorder Associated with Prenatal Alcohol Exposure; ADHD, Combined Presentation; Unspecified Communication Disorder; and Unspecified Trauma- and Stressor-Related Disorder. (Ex. 18, p. SCLARC-0137, A137.) She found Claimant did not meet the full criteria for an ID

diagnosis, notwithstanding Claimant’s IQ low score and poor adaptive functioning. She did not explain the basis of her finding. Nevertheless, Dr. Goldman recognized the need for services and supports to address Claimant’s cognitive and adaptive deficits, stating:

> [I]t is very clear that [Claimant] exhibits areas of cognitive weakness (particularly as they relate to language and executive functioning) and resulting adaptive functioning deficits. He should be provided with the maximum available services to prevent further conduct challenges. He requires substantial support for learning and adaptive functioning.

(Ex. 18, p. A138.)

37. Dr. Goldman recognized the potential impact of FASD and trauma on Claimant’s cognitive and adaptive functioning deficits. In her report summary, Dr. Goldman states:

> Neurodevelopmentally, it is important to note that [Claimant's] exposure to inconsistent caregiving as a young child has been quite impactful on him. Children who are exposed to such trauma at a young age often have underdeveloped limbic systems neurologically, which, in turn, results in a heightened arousal state and less developed emotion regulation and emotional functioning skills. Additionally, Curtis's prenatal exposure to alcohol makes him further vulnerable to dysexecutive symptoms, intellectual challenges, academic achievement trouble, and emotion regulation difficulties.

(Ex. 18, p. A136.)

38. Dr. Goldman recommended Claimant receive a follow-up evaluation because children with FASD tend to fall behind their peers over time. Dr. Goldman reported her belief Claimant's cognitive abilities were in a pattern of decline, and when re-tested, she recommended the administration of an adult scale (WAIS-IV) to evaluate Claimant's cognitive status. (Ex. 18, p. A138, SCLARC-0138.) Dr. Goldman also noted Claimant's limited self-awareness and awareness of others, combined with his limited intellectual abilities, placed him at risk to be exploited and manipulated by others. (*Id.,* p. A139, SCLARC-0139.) As a result, she recommended supervision of Claimant in social and interpersonal environments to ensure others did not exploit or take advantage of him and for reinforcement of his personal safety. She additionally recommended placement in a maximally supportive residential setting, individual therapy, relaxation techniques and learning more appropriate adaptive coping skills, empathy and life skill training, neurofeedback, pro-social activities, verbal skill development, extra tutoring, technical training allowing for hands-on engagement, and medication management. (*Id.,* p. A138–A140, SCLARC-0138-0140.)

Testimony at Hearing

WILHELMINA HERNANDEZ, M.D.

39. Wilhelmina Hernandez, M.D., testified on SCLARC's behalf. Dr. Hernandez is a developmental pediatrician. She has completed a fellowship in neurodevelopmental pediatrics, she has engaged in psychological assessments, and she has treated and assessed children with FASD during her medical training and practice. Since 2019, Dr. Hernandez has been a consultant to SCLARC on eligibility issues, and she consulted on

this case. Her opinions are based on a review of Claimant's assessments and academic records. She has never met Claimant, and she did not interview him.

40. Dr. Hernandez testified Claimant does not present with ID and does not function like a person presenting with ID. She noted none of the psychologists who examined Claimant diagnosed him with ID. She observed the medications prescribed for Claimant did not treat ID.

41. Dr. Hernandez testified Claimant's adaptive deficits do not result from ID but rather from past trauma, attention issues, and psychiatric illness. Dr. Hernandez acknowledged a person with ID could have maladaptive behaviors, poor impulse control, attentional issues, and difficulties forming relationships, but the presence of such behaviors and issues did not signify ID. She asserted it would be rare for a person with ID to be diagnosed with Reactive Attachment Disorder because the disorder is based on an inability to form relationships and stems from an unstable environment, not cognitive deficits.

42. Dr. Hernandez described Claimant as having a psychiatric disorder with impaired intellectual functioning. She testified Claimant's cognitive declines were due to problems with language and executive functioning. She maintained Respondent's maladaptive behaviors interfered more with his functioning than with his capabilities. She found Claimant's mental health had worsened over time because of constant stressors, which includes physical abuse, separation from caregivers, multiple foster care placements, and his mother's use of alcohol. She also maintained mental health supports from schools, treaters, and care providers were provided to Claimant in a fragmented way and have not been as comprehensive as recommended.

43. Dr. Hernandez testified Claimant would not benefit from treatment provided for ID. She noted individuals with ID are taught differently than persons with mental health issues. She explained persons with ID have a lower ability to learn and process information so information has to be presented in a more basic manner, sometimes with an emphasis on visual instead of verbal learning. She opined Claimant might take offense to being taught as a person with ID. Dr. Hernandez also testified individuals with ID are taught life skills to become functional and independent. However, she opined Claimant's behavior would interfere with him benefitting from such teaching because of his lack of interest and motivation and his attention problems.

44. Dr. Hernandez did not dispute Claimant's diagnosis with ARND. However, she noted children with ARND present with an array of developmental issues, from mild symptoms of attentional deficits to full ID. Thus, children presenting with ARND do not necessarily meet the criteria for ID, and such children needed to be evaluated on an individual basis with cognitive testing and frequent assessments throughout their development to determine the full impact of prenatal alcohol exposure. Dr. Hernandez further testified psychiatric issues and ADHD could cause cognitive decline over time. She was unfamiliar with any articles or studies concluding ARND had similar consequences.

LAURIE MCKNIGHT BROWN, PH.D.

45. Laurie McKnight Brown, Ph.D., testified on behalf of SCLARC. Dr. Brown holds a doctorate in psychology and has been a licensed clinical psychologist since 2015. She has been the lead psychologist consultant for SCLARC since 2017. She participated in SCLARC's multidisciplinary decision finding Claimant ineligible for Lanterman Act services and supports and in the informal meeting with Court Advocate

Chais following the multidisciplinary decision. Dr. Brown never met or examined Claimant.

46. Dr. Brown's testimony is consistent with Dr. Hernandez's testimony regarding Claimant's ineligibility for Lanterman Act services and supports based on ID or a "fifth category" condition. Dr. Brown admitted Claimant was substantially disabled. However, Dr. Brown did not find Claimant presented with ID or a "fifth category" condition. She cited Claimant's high IQ scores as a basis for Claimant's disqualification based on a diagnosis of ID. She dismissed Dr. Goldman's findings of low IQ score and adaptive deficits because of Claimant's uncooperative and defiant conduct during the assessment. Dr. Brown acknowledged Claimant had substantial adaptive deficits but she attributed those deficits to his psychiatric conditions and inadequate care during his childhood, not to any cognitive issues.

47. Dr. Brown cited the diagnostic criteria for ID set forth in the DSM-5 to buttress her conclusion Claimant did not present with ID. A DSM-5 diagnosis of ID requires satisfaction of three components: deficits in intellectual functions, deficits in adaptive functioning, and the onset of those deficits during the developmental period. (Ex. 19, A155, SCLARC-0155.) Under the DSM-5, individuals with ID have IQ scores "of approximately two standard deviations or more below the population mean, including a margin for measurement error (generally +5 points)," or "a score of 65–75." (*Id.,* p. A159, SCLARC-0159.) However, invalid scores may result from the use of "highly discrepant individual test scores." (*Ibid.*) Additionally, an individual's deficits in adaptive functioning must be "directly related" to cognitive deficits. (*Id.*, A160, SCLARC-A160.) Dr. Brown found Claimant did not meet the DSM-5 diagnostic criteria for ID because his overall IQ scores were at times higher than 75, the scores on his IQ subtests were

highly discrepant, and his adaptive deficits were not “directly related” to his cognitive deficits.

48. Dr. Brown testified her conclusions regarding Claimant’s eligibility under the “fifth category” were guided in part by the Guidelines for Determining “5th” Category” Eligibility for the California Regional Centers, published by the Association of Regional Center Agencies (“ARCA Guidelines”). (Ex. 21.) The ARCA Guidelines describe factors to be considered in determining whether an individual functions like a person with ID or requires treatment similar to a person with ID.

49. According to the ARCA Guidelines, to be considered functioning in a manner similar to a person with ID, the individual’s general intellectual functioning should be in the low borderline range. (Ex. 21, p. SCLARC-0179, A179.) As an individual’s IQ score rises, an individual must present with substantial adaptive deficits that are “clearly related” to cognitive limitations. When there is a significant difference between cognitive skills, particularly when an individual has some scores in the low average range, the ARCA Guidelines state it is more difficult to describe the individual’s general intellectual functioning as being similar to that of a person with intellectual disability. (*Ibid.*) The ARCA Guidelines further state that an individual’s borderline intellectual functioning needs to show stability over time.

50. Dr. Brown testified application of the ARCA Guidelines demonstrated Claimant did not function in a manner similar to a person with ID. Except for Dr. Goldman’s test scores which Dr. Brown found unreliable, Claimant’s test scores were above the low borderline range. Claimant’s educational records also do not reflect an ID diagnosis. Although she acknowledged Claimant has substantial adaptive deficits, it was her opinion the deficits are not “clearly related” to cognitive limitations. She also found that Claimant did not meet the ARCA Guidelines because some of his cognitive

skills had at times tested in the average range and therefore he did not evidence borderline intellectual functioning over time.

51. To determine whether a person suffering a disabling condition requires treatment similar to that required by a person with ID, the ARCA Guidelines urge consideration of the "nature of training and intervention that is most appropriate for the individual who has global cognitive deficits." (Ex. 21, p. SCLARC-0180, A180.) According to the ARCA Guidelines, individuals with ID require long term training, "with steps broken down into small, discrete units taught through repetition." (*Ibid.*) They may require the teaching of basic living skills, not the re-teaching of previously acquired skills. Persons presenting with ID also may need additional educational supports, across many skill areas to assist with learning. (*Id.,* p. SCLARC-0180-0181, A180-181.) The ARCA Guidelines noted such training was not required by individuals demonstrating performance based deficits who often need treatment to increase motivation or by individuals with skill deficits secondary to cultural deprivation, but not secondary to intellectual limitations, who need short-term remedial training. (*Id.*, p. SCLARC-180, A180.)

52. Dr. Brown testified Claimant did not require treatment similar to that required by a person with ID. Dr. Brown opined Claimant would not benefit from the repetitive and closely supervised method of teaching persons with ID require. She testified Claimant needed treatment to address his lack of focus, medication for hyperactivity, behavior management, and therapy for himself and the family caring for him.

53. Dr. Brown did not attribute Claimant's cognitive deficits to Claimant's ARND. She testified an ARND diagnosis does not necessarily result in ID.

Kenneth Jones, M.D.

54. Dr. Jones is a board-certified pediatrician and currently a Distinguished Professor of Pediatrics at the University of California San Diego School of Medicine. Dr. Jones discovered FASD and is an internationally acknowledged expert on FASD.

55. Dr. Jones testified individuals with ARND suffer from a range of neurodevelopmental problems including intellectual deficiency, aggressive behavior, difficulties expressing their thoughts and ideas to others, hyperactivity, attention deficits, impulse control, and self-regulation. These problems also include poor executive functioning, learning difficulties, impaired short-term memory, and visual and spatial impairment. Individuals diagnosed with ARND also have problems with hygiene and taking care of themselves. They often have no friends. According to Dr. Jones, an individual can present with ID and ARND, and approximately 15 percent of people who have ARND present with co-occurring ID.

56. Dr. Jones diagnosed Claimant with ARND after examining Claimant on August 29, 2021. (Ex. S.) Dr. Jones based his diagnosis on neurodevelopmental deficits reflected in Claimant's Full Scale IQ score of 71 on the WISC-V administered by Dr. Goldman; Claimant's problems related to hyperactivity, aggression, attention, and impulsivity; Claimant's serious problems with adaptive function, specifically in the communication, daily living skills, and socialization realms; certain of Claimant's physical features that were consistent to meet the criteria for an FASD diagnosis; and a written statement by Claimant's father disclosing Claimant's mother drank alcohol excessively during her pregnancy with Claimant. (Ex. S, p. 2–3, B134–B135.) Dr. Jones did not conduct any independent cognitive testing.

57. Dr. Jones testified Claimant presented with ID based on his overall IQ score of 71 set forth in Dr. Goldman's report. Dr. Jones also testified Claimant presented with significant problems with communication. Claimant did not respond to many of the questions asked of him and "just sat there." (Dr. Jones Test.) Dr. Jones testified, however, Claimant acknowledged having problems interacting with other people and his challenging behaviors.

STEPHEN GREENSPAN, PH.D.

58. Stephen Greenspan, Ph.D. is a Nebraska-licensed psychologist with a Ph.D. in Developmental Psychology and a post-doctoral certificate in developmental disabilities from UCLA. He is an Emeritus Professor of Educational Psychology at the University of Connecticut. He is the most-cited authority in the ID section of the DSM-5. He has written extensively on ID and FASD.

59. Dr. Greenspan testified Claimant was eligible for Lanterman Act services and supports because he presents with ID and a "fifth category" condition. His testimony expanded upon his report. (Ex. T.) Dr. Greenspan's opinions were based on his review of Claimant's prior assessments and other records. Dr. Greenspan has never met with Claimant.

60. Dr. Greenspan opined Claimant meets the diagnostic criteria for ID set forth in the DSM-5, citing Claimant's full-scale IQ score of 71 based on Dr. Goldman's testing and the borderline scores on tests administered by Dr. Koranda and Dr. Frey. Dr. Greenspan asserted Claimant's low scores were not due to lack of effort, as some assessors suggested, and noted the absence of effort tests to support those claims. Dr. Greenspan also challenged the relevancy of Claimant's early testing results because "[t]ests given in early childhood generally are poor predictors of scores from tests given

in adolescence." (Ex. T, p. 12, B148.) He testified Dr. Turner failed to perform adaptive skill testing and her report's discussion of ID suggested she did not specialize in ID. Dr. Greenspan further noted IQ scores are variable and Claimant's declining cognitive scores were consistent with FASD because individuals with FASD show declines in intelligence as they age.

61. Dr. Greenspan maintained Claimant's low adaptive skills were a more valid indicator of ID than his cognitive scores under the DSM-5. Under the DSM-5, a person like Claimant with an IQ score above 70 "may have such severe adaptive functioning that the person's actual functioning is comparable to that of individuals with a lower IQ score." (Ex. 19, p. A159.) According to Dr. Greenspan, an individual need only demonstrate a significant deficiency (below the second percentile) in the Social, Practical, and Conceptual Domains to meet the criteria for ID, and Claimant far exceeded this standard by demonstrating deficiencies in the first percentile in all three diagnostic domains. Dr. Greenspan also maintained Claimant's diagnosis of ARND established his disability began during early childhood.

62. Dr. Greenspan asserted Claimant functioned similarly to a person presenting with ID based on Claimant's diagnosis of ARND and his significant adaptive deficits. According to Dr. Greenspan, ARND involves brain damage affecting a child's cognitive and everyday functioning. Dr. Greenspan opined ARND in and of itself qualifies as a developmental disability because it is characterized by the same level of deficits and support needs as people with ID. He maintained Claimant's inability to benefit from the mental health services and medication he has received since age 4 suggests he suffers from a neurodevelopmental disability.

63. Dr. Greenspan acknowledged Claimant's past traumas, neglect, and attachment disruptions also contributed significantly to his cognitive and adaptive

deficits. However, according to Dr. Greenspan, brain damage resulting from ARND was the primary cause of those deficits. He maintained Claimant was best characterized as someone with a developmental disorder who also presents with emotional and attentional problems. Dr. Greenspan cited the concerns expressed by Dr. Lyn Laboriel, M.D., of the LAC+USC Violence Intervention Program, who confirmed Claimant's FASD diagnosis in 2016 after examining him and reviewing his assessments. (Ex. J, p. 2, B77; T, p. 16, B152.) In her report, Dr. Laboriel notes:

> It is impossible with current data to differentiate disability due to the history [of] severe trauma and neglect noted in this case from disabilities that are rooted in brain damage. In fact, the severe environmental stressors reported to have been part of [Claimant's] first 4–5 years of life have also been associated with brain-based disabilities. Assessment done by Dr. Edward Frey in February 2016 for purposes of assessing for Regional Center eligibility concluded that the child . . . did not meet the criteria for Intellectual Disability, thus not being eligible for Regional Center services. My concern in reviewing the data is that this child may indeed ultimately be found to have an Intellectual Disability. There was quite a bit of scatter in his scores on the WISC-V . . . . His Adaptive scores were very poor and it could be argued that with the cognitive scores, this child is in fact Intellectually Disabled. I understand Dr. Frey's explanation of the Adaptive scores as likely reflecting motivation rather than capability. I would point out, though, that Individuals with Fetal Alcohol issues almost always present with

adaptive scores much worse than would be predicted by
their cognitive abilities.

(Ex. J, p. 2, B77.)

64. Dr. Greenspan found Claimant would benefit from the services and supports specified in *Samantha C. v. State Department of Developmental Services*, (2010) 185 Cal.App.4th 1462 (*Samantha C.*), including self-contained classes, one-on-one services, residential supports, independent living skill training, service coordination and management information, special education until he attains the age of 21, social or recreational services, rehabilitative or vocational training, supported employment, supported living arrangements, day activity programs, mobility training, and financial oversight. He stressed the importance of self-help and life skills training and observed only people with chronic schizophrenia receive these supports within the mental health system. He noted Claimant required specialized training and skill development, i.e., "micro-teaching," to learn basic life skills, including how to make a bed and clean a bathroom. Dr. Greenspan also maintained Claimant required complex information to be translated into manageable units. (Ex. T, p. 17–18, B153–B154.)

65. Dr. Greenspan noted several reasons why he believed Claimant had been found ineligible for Lanterman Act services and supports. He asserted FASD was initially unrecognized and misunderstood. He also asserted while ADHD might have been an appropriate diagnosis for Claimant when he was younger, it is an inappropriate diagnosis given Claimant's many academic and behavioral difficulties. Dr. Greenspan opined Claimant is a victim of "diagnostic (or psychiatric) overshadowing'' in which Claimant's "very salient" symptoms of his mental health disorders cause the less salient symptoms of his ID to "be missed entirely or given less diagnostic weight than they should." (Ex. T, p.19, B155.) According to Dr. Greenspan, this was understandable given

the severity of Claimant's emotional and behavioral dysfunction and the lack of training on FASD provided to clinicians conducting assessments and evaluations. Dr. Greenspan also opined Claimant is a victim of "environmental overshadowing," meaning Claimant's brain damage was overlooked because Claimant's deviant upbringing is typically associated with maladjusted outcomes. (*Ibid.*)

WRENN CHAIS

66. Court Advocate Chais has been Claimant's Court Appointed Special Advocate and co-holder of Claimant's Educational and Development Rights since June 2019. As part of her duties, Ms. Chais advocates for Claimant within the court system and communicates with Claimant's group home, his social workers, his therapists, and his teachers on his behalf. Ms. Chais is also familiar with Claimant's entire court file, which includes his medical records. She is unpaid for her work. Ms. Chais has been a CASA for eight years and has experience working with teenagers through the CASA program and nonprofit organizations.

67. Ms. Chais has observed Claimant while interacting with him and during his interactions with others. She credibly described Claimant's issues as aggression, difficulty in social situations, particularly when dealing with authority and staff, behavior problems at school, difficulties understanding the causal relationship of his behavior and consequences, and poor hygiene practices. Ms. Chais reported Claimant oftentimes refuses to bathe and needs prompting from residential staff to maintain his hygiene. Claimant also needs encouragement to attend doctor and dentist appointments. At hearing, Ms. Chais gave examples of Claimant's impressionability and his failure to understand the consequences of his actions. She testified Claimant has major communications problems; his answers are generally limited to 'yes," "no," and "I don't

know." Claimant also has a hard time discussing his wants and needs with others and cannot advocate for himself.

68. Ms. Chais is familiar with Claimant's mental health issues and the mental health services he has received. Currently, Claimant participates in individual and group therapy and takes medication to manage his mental health. She believes Claimant continues to take his medication; she testified she was only aware of a short period when he stopped doing so. Ms. Chais testified that despite these mental health interventions, Claimant's cognitive and behavioral problems have continued.

LEGAL CONCLUSIONS

1. An administrative hearing to determine the rights and obligations of the parties, if any, is available under the Lanterman Act to appeal a contrary service agency decision. (Code, §§ 4700–4716.) Claimant requested a hearing to contest SCLARC's denial of Claimant's eligibility for services and supports under the Lanterman Act and therefore jurisdiction for this appeal was established.

2. Claimant has the burden of establishing his eligibility for Lanterman Act services and supports by a preponderance of the evidence. (*Lindsay v. San Diego Retirement Bd.* (1964) 231 Cal.App.2d 156, 161; Evid. Code, §§ 115, 500.) "Preponderance of the evidence means evidence that has more convincing force than that opposed to it.[Citations] . . . [T]he sole focus of the legal definition of 'preponderance' in the phrase 'preponderance of the evidence' is the *quality* of the evidence. The *quantity* of the evidence presented by each side is irrelevant." (*Glage v. Hawes Firearms Co.* (1990) 226 Cal.App.3d 314, 324–325 (emphasis in original).)

3. The Administrative Law Judge is guided by the decisional law acknowledging that fact finders are permitted to “accept 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); to “reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected material” (*Id.*, at pp. 67-68, quoting from *Neverov v. Caldwell* (1958) 161 Cal.App.2d 762, 777); and even to reject testimony that is not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.)

Relevant Statutes and Regulations

4. To be eligible for Lanterman Act supports and services, Claimant must present with a qualifying developmental disability. Code section 4512, subdivision (a), defines “developmental disability” as:

> [A] disability that originates before an individual attains 18 years of age; 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 an intellectual disability, but shall not include other handicapping conditions that are solely physical in nature.

5. CCR section 54000 similarly defines “developmental disability" as a disability attributable to intellectual disability, cerebral palsy, epilepsy, autism, or disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for intellectually disabled individuals. The disability must originate before age 18, be likely to continue indefinitely, and constitute a substantial handicap.

6. CCR section 54000 specifically excludes three conditions from the definition of “developmental disability." First, solely psychiatric disorders involving impaired intellectual or social functioning which originated as a result of the psychiatric disorders would not be considered developmental disabilities. "Such psychiatric disorders include psycho-social deprivation and/or psychosis, severe neurosis or personality disorders even where social and intellectual functioning have been seriously impaired as an integral manifestation of the disorder." (CCR, § 54000, subd. (c)(1).)

7. Second, an individual would not be considered developmentally disabled if his or her only condition was a learning disability, ''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, [or] psychiatric disorder . . . ." (CCR, § 54000,subd. (c)(2).) Third, solely physical conditions, such as faulty development not associated with neurological impairment, which result in a need for treatment similar to that required for intellectual disability are also excluded.

8. For an individual with a developmental disability to qualify for regional center services, his or her developmental disability must also function as a "substantial disability." An individual with a "substantial disability'' must demonstrate significant functional limitations in three or more of the following areas of major life activity, as

determined by a regional center, and as appropriate to the age of the person: [¶] (1) Self-care. [¶] (2) Receptive and expressive language. [¶] (3) Learning. [¶] (4) Mobility. [¶] (5) Self-direction. [¶] (6) Capacity for independent living. [¶] (7) Economic self-sufficiency." (CCR, § 54001, subd. (a)(2).)

Analysis

9. Claimant is substantially disabled. The evidence shows Claimant has significant functional limitations in self-care, receptive and expressive language, learning, self-direction, and capacity for independent living. (Factual Findings 46, 67.) Because of the presence of ARND and environmental stressors, Claimant's cognitive and adaptive deficits cannot be solely attributed to a psychiatric disorder. (Factual Findings 36, 37, 63.) His disabilities are not solely physical conditions, and his conditions are not limited to a learning disability.

10. Claimant does not present with cerebral palsy, epilepsy, or ASD. (Factual Finding 2.) Claimant's eligibility for Lanterman Act services and supports therefore rests solely on whether he presents with ID or a "fifth category" condition.

INTELLECTUAL DISABILITY

11. A preponderance of the evidence establishes Claimant does not present with ID. As Dr. Hernandez and Dr. Brown credibly noted, no therapist or clinician has ever diagnosed Claimant with ID. (Factual Findings 14–47.) Even Dr. Goldman, who found Claimant presented with significant intellectual deficits, did not diagnose Claimant with ID. (Factual Finding 36.) Additionally, none of Claimant's academic records offered at hearing reflect an ID diagnosis. (Factual Findings 11–12.) Claimant's scores on academic achievement tests administered by Dr. Turner were in the average to superior ranges. (Factual Finding 20.) Dr. Jones' conclusion Claimant presented with

ID was not creditable. He conducted no independent cognitive assessment of Claimant and appeared to rely exclusively on the full scale IQ score reported by Dr. Goldman without any discussion addressing Claimant's discrepant subtest scores. (Factual Findings 56–57.)

12. Dr. Greenspan's criticisms of Claimant's early childhood assessments raise questions about the reliability of those assessments. However, even if Claimant's earlier test scores are not credited, Claimant's discrepant scores on the cognitive subtests administered by Dr. Goldman and Claimant's acknowledged communication difficulties call Claimant's overall IQ scores into question under the DSM-5 diagnostic criteria for ID. (Ex. 19, p. SCLARC-0159, A159.) Dr. Greenspan failed to address these discrepant subtest scores or the impact of Claimant's communication difficulties on Claimant's overall test scores in his testimony and his report.

13. SCLARC does not dispute Claimant suffers substantial adaptive skill deficiencies across every domain. Dr. Greenspan contends these substantial adaptive skill deficits should be sufficient by themselves to support an ID diagnosis according to the DSM-5. However, the presence of substantial adaptive deficits does not eliminate the DSM-5 requirement that such deficits be "directly related" to cognitive deficits. (Ex. 19, p. A160 [to meet criteria of ID, "deficits in adaptive functioning must be directly related to [] intellectual impairments"].) Dr. Greenspan presumes Claimant's adaptive deficits are related to Claimant's cognitive deficits based on Claimant's ARND diagnosis. But Dr. Hernandez and Dr. Brown credibly explained the effects of ARND differ in every individual, and it was more likely, given Claimant's variant cognitive scores, that his adaptive deficits were caused by his history of trauma, unstable living situations, ADHD, and psychiatric conditions. Dr. Jones also confirmed prenatal exposure to alcohol can

cause a spectrum of defects and that a majority of adults presenting with ARND do not have ID.

"FIFTH CATEGORY" ELIGIBILITY

14. Whether Claimant presents with a "fifth category" condition can be established by either demonstrating Claimant has a disabling condition found to be closely related to ID or a disabling condition requiring treatment similar to that required for individuals with ID. In *Mason v. Office of Administrative Hearings* (2001) 89 Cal.App.4th 1119, the appellate court recognized the language of the Lanterman Act "allows some flexibility so as not to rule out eligibility of individuals with unanticipated conditions, who might need services." (89 Cal.App.4th at p. 1129.) This flexibility is particularly important in the determination of eligibility under the "fifth category" "when developmental disabilities are widely differing and difficult to define with precision." (*Id.* at p. 1130.) Nonetheless, "the fifth category condition must be very similar to [ID], with many of the same, or close to the same, factors required in classifying a person as [ID]. Furthermore, the various additional factors required in designating an individual developmentally disabled and substantially handicapped must apply as well." (*Id.*, at p. 1129.) *Mason* thus requires, in considering "fifth category" eligibility, that the intellectual and adaptive functioning of a person with ID be used as a guidepost for purposes of assessing an applicant's disabling condition. The ARCA Guidelines are consistent with *Mason's* holdings.

Disabling Condition Closely Related to ID

15. A preponderance of the evidence establishes Claimant does not present with a disabling condition closely related to ID for many of the same reasons Claimant does not present with ID. Claimant's discrepant IQ subtest scores, his average scores in

academic achievement, and the absence of evidence establishing clear linkage between Claimant's substantial deficits in adaptive functioning and his cognitive deficits are inconsistent with a person presenting with a disabling condition closely related to ID. Contrary to Dr. Greenspan's claim, Claimant's diagnosis with ARND is not conclusive of whether his condition is similar to ID because ARND does not necessarily cause cognitive dysfunction rising to the level of ID.

16. Claimant's substantial adaptive functioning deficits by themselves also fail to demonstrate Claimant presents with a disabling condition closely related to ID. Contrary to Claimant's contention, simply because ARND causes brain damage is not sufficient to establish Claimant suffers from a condition closely related to ID. The percentage of persons diagnosed with ARND and presenting with ID is only 15 percent. And, as Dr. Laboriel, Dr. Greenspan, and Dr. Goldman all note, it is difficult to parse the source of Claimant's adaptive deficits, i.e., whether they are caused by brain damage resulting from ARND, psychiatric disorders, trauma, or home and relationship instability. However, Claimant's consistent diagnoses based on trauma, ADHD, and communication disorders from Claimant's assessors and clinicians support the opinions of Dr. Hernandez and Dr. Brown that Claimant's psychiatric disorders and environmental stressors are the principal contributors to Claimant's poor adaptive functioning.

Disabling Condition Requiring Treatment Similar To That Required by a Person with ID

17. Under Code section 4512, subdivision (b), the services and supports provided by a regional center for a developmentally disabled person under the Lanterman Act include "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. . . . " The designation of "treatment" in the statute as a separate item is a clear indication that it is not merely a synonym for services and supports. (*Ronald F. v. Dept. of Developmental Services* (*Ronald F.*) (2017) 8 Cal.App.5th 84.) Regional center services and supports targeted at improving or alleviating a developmental disability may be considered "treatment" of developmental disabilities.

18. Claimant has not established he requires treatments similar to those targeted at ID. Dr. Hernandez and Dr. Brown, because of their experience assessing children with developmental disabilities. were credible in describing the treatment a person with ID requires. That treatment is long-term, broken down into small steps, repetitive, and closely supervised. This recommended treatment is aligned with the ARCA Guidelines, specifically referenced by the *Ronald F.* court. The treatment is based on the assumption the individual has limited learning capabilities. Both Dr. Hernandez and Dr. Brown maintained Claimant's functioning was limited because of his mental illness, not because he had limited capabilities. They further maintained Claimant therefore needed behavioral management, medication, classroom and other school accommodations, and therapy.

19. None of the assessors evaluating Claimant noted he required treatment similar to persons presenting with ID. The recommendations by Dr. Goldman, notwithstanding her recognition of Claimant's prenatal alcohol exposure, largely addressed Claimant's mental health and attentional issues and fell more within the realm of services, not treatment. Her recommendations included a maximally supportive residential setting, therapy, neurofeedback, group therapy, involvement in pro-social activities, extra tutoring, verbal skill development, and medication management. She agreed with Dr. Brown's recommendations of classroom

accommodations. Only a few of her recommendations could be construed to be targeting Claimant's cognitive deficits; however, those recommendations largely concerned generic services not treatment, i.e., substantial support for learning and adaptive functioning, life skill training, and extra tutoring.

20. Dr. Greenspan, relying on *Samantha C.*, testified Claimant would benefit from services available to regional center consumers with ID, including training in self-care and independent living skills, residential placement, counseling, supported employment, and behavioral training. For the most part, these recommendations are services, not treatment, and would benefit individuals not presenting with ID. While Dr. Greenspan noted Claimant would benefit from micro-teaching daily living skills and breaking down published materials into subparts, these recommendations are not integral to Claimant's treatment. They also are not directed at Claimant's inability to learn. Dr. Greenspan's contention that anyone presenting with ARND requires treatment similar to a person with ID is based on the assertion that Claimant's ARND is the principal source of his cognitive and adaptive deficits, which is not supported by the evidence.

21. As stated in *Ronald F.,* an individual need not suffer from ID or any developmental disability to benefit from the broad array of services and supports provided by a regional center to individuals with ID. Those services could be helpful for individuals with other disabilities or with mental health disorders, or individuals with no disorders at all. The criterion therefore is not whether someone would benefit from the provision of services, but whether that person's condition requires treatment similar to that required for persons with ID, which has a narrower meaning under the Lanterman Act than services. (*Ronald F., supra,* 8 Cal.App.5th at p. 98.)

22. Claimant has not met his burden of proving by a preponderance of the evidence that he presents with a "fifth category" condition requiring treatment similar to that required by a person with ID.

Request for New Assessment

23. Claimant requests SCLARC be ordered to conduct a new psychological assessment because Dr. Koranda's assessment was inaccurate and incomplete. At hearing, Dr. Brown acknowledged Dr. Koranda's assessment was not thorough. (Factual Finding 27.) She testified SCLARC's eligibility committee consequently did not rely on Dr. Koranda's assessment in determining Claimant's eligibility for Lanterman Act services and supports.

24. Both parties offered into evidence Dr. Goldman's in-person assessment of Claimant, which was more recent and more complete than the assessment submitted by Dr. Koranda. Claimant offers no reason why Claimant requires another assessment. Claimant's request that SCLARC be ordered to conduct another psychological assessment at this time is therefore denied.

ORDER

1. Claimant's appeal of Service Agency's determination Claiman is not eligible for Lanterman Act services and supports under the qualifying category of intellectual disability is denied.

2. Claimant's appeal of Service Agency's determination Claimant is not eligible for Lanterman Act services and supports under the qualifying category of the "fifth category" is denied.

3. Claimant's request SCLARC be ordered to conduct a new psychological assessment for Claimant is denied.

DATE:

CINDY F. FORMAN

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.