

BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT,

vs.

FAR NORTHERN REGIONAL CENTER,

Service Agency.

OAH No. 2017090189

DECISION

This matter was heard before Administrative Law Judge Susan H. Hollingshead, State of California, Office of Administrative Hearings (OAH), in Chico, California, on October 24, 2017.

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

Claimant was represented by her mother.

Oral and documentary evidence was received. The record was closed and the matter submitted for decision on October 24, 2017.

ISSUES

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

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

FACTUAL FINDINGS

1. Claimant is an eleven-year-old girl who was referred to FNRC by her mother to determine if she was eligible for regional center services on the basis of an intellectual disability or a fifth category disability. Claimant was exposed to drugs in utero and born addicted to methamphetamines. Both biological parents were diagnosed with bi-polar disorder. She has been diagnosed with Reactive Attachment Disorder, Mood Disorder, Attention Deficit Disorder and Auditory Processing Disorder. Claimant has also been the victim of sexual abuse. She has attended approximately five different schools since beginning kindergarten, due to numerous moves by the family. She currently receives special education services from the Oroville City Elementary School District, and WRAP² services from Youth for Change. Claimant lives in the family home with her adoptive parents and six siblings.

2. After comprehensive review, the FNRC Multi-Disciplinary Eligibility Review Team determined that claimant was not eligible for regional center services. A Notice of Proposed Action (NOPA) was issued on August 23, 2017, informing claimant as follows:

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

² WRAP services are provided through a community support program for families with at risk children to offer interagency collaboration and family support with a goal of creating a unified family plan for the future.

Reason for action: [Claimant] does not have intellectual disability and shows no evidence of epilepsy, cerebral palsy, autism, or disabling condition found to be closely related to intellectual disability or to require treatment similar to that required for individuals with intellectual disability. Eligibility Review (multi-disciplinary team) determined [claimant] was not eligible for services based on psychological dated 9/2016 by Oroville City Elementary School District. Behavior Intervention Plan dated 9/29/16 by Butte County SELPA. Behavior assessment report dated 12/15/16 by Beth Madison, School Psychologist, OCESD. WIAT-III report dated 9/27/16 by Laura Marciniak. Intake summary/medical history dated 7/27/17 by Micki Rodstrom, IS. IEPs dated 09/29/16, 04/27/17 & 05/26/17 by Butte County SELPA.

3. Claimant appealed FNRC's decision on or about September 5, 2017, stating, "I disagree with intellectual disability denial."

4. FNRC contends that claimant does not meet the requirements for an intellectual disability. Nor is she eligible under the "fifth category" because her deficits in adaptive functioning are not attributable to global cognitive deficits, thus she does not have a condition closely related to intellectual disability. FNRC opined that claimant does not require treatment similar to that required by persons with intellectual disability.

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

“Developmental disability” means a disability that originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual....[T]his term shall include intellectual disability, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to intellectual disability³ or to require treatment similar to that required for individuals with an intellectual disability [commonly known as the “fifth category”], but shall not include other handicapping conditions that are solely physical in nature.

6. California Code of Regulations, title 17, section 54000, further defines the term “developmental disability” as follows:

(a) “Developmental Disability” means a disability that is attributable to mental retardation, cerebral palsy, epilepsy, autism, or disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation.

(b) The Development Disability shall:

³ Effective January 1, 2014, the Lanterman Act replaced the term “mental retardation” with “intellectual disability.” California Code of Regulations, title 17, continues to use the term “mental retardation.” The terms are used interchangeably throughout.

(1) Originate before age eighteen;

(2) Be likely to continue indefinitely;

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

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

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

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

(3) Solely physical in nature. These conditions include congenital anomalies or conditions acquired through disease, accident, or faulty development which are not associated with

a neurological impairment that results in a need for treatment similar to that required for mental retardation.

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

(l) The existence of significant functional limitation in three or more of the following areas of major life activity, as determined by a regional center, and as appropriate to the age of the person:

(1) Self-care.

(2) Receptive and expressive language.

(3) Learning.

(4) Mobility.

(5) Self-direction.

(6) Capacity for independent living.

(7) Economic self-sufficiency.

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

(a) "Substantial disability" means:

(1) A condition which results in major impairment of cognitive and /or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of

special or generic services to assist the individual in achieving maximum potential; and

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

(1) Receptive and expressive language.

(2) Learning.

(3) Self-care.

(4) Mobility.

(5) Self-direction.

(6) Capacity for independent living.

(7) Economic self-sufficiency.

ASSESSMENTS AND EVALUATIONS

9. Oroville City Elementary School District Psychologist, Dawn Stalter, conducted a Psycho-Educational Evaluation of claimant in September 2016, during claimant's fifth grade year. As part of the evaluation, Ms. Stalter utilized the following:

Assessment Methods and Psycho-Diagnostic Tools:

Wechsler Individual Achievement Tests-III (WIAT-III)

Wechsler Intelligence Scale for Children-V (WISC-V)

Adaptive Behavior Assessment System-2nd Ed. (ABAS-II)

Behavior Assessment System for Children 2 (BASC-2)

Burk's Behavior Rating Scale-2nd Edition (BBRS-2)

Record Review

Student, Teacher and Parents Interviews

Observation

10. The WIAT-III was used to assess academic achievement. The assessment was conducted by Laura Marciniak, RST, and provided the following scores:

Index	Standard Score	Description
Oral Language	90	Average
Total Reading	90	Average
Basic Reading	91	Average
Reading Comprehension and Fluency	94	Average
Written Expression	79	Below Average
Mathematics	83	Below Average
Math Fluency	69	Low
Total Achievement	85	Average

11. Ms. Stalter administered the Wechsler Intelligence Scale for Children, Fifth Edition, as a measure of claimant's cognitive functioning, with the following results:

Factor Scores	Standard Score	Range	Classification
VERBAL COMPREHENSION	86	79-95	Low Average
VISUAL SPATIAL	84	78-93	Low Average
FLUID REASONING	76	70-85	Very Low
WORKING MEMORY	88	81-97	Low Average
PROCESSING SPEED	69	64-82	Extremely Low
FULL SCALE	76	71-83	Very Low

Ms. Stalter's report noted the following:

[Claimant] performed at the overall very low range of intellectual functioning as assessed by the WISC-V, and there is a 95% percent chance her Full Scale IQ lies in the 71-83 range (5th %tile). A relative weakness was identified in the area of processing speed. Statistical differences were indicated between visual spatial and processing speed, fluid reasoning and working memory, and working memory and processing speed. There was no significant discrepancy evidenced between other domains of the WISC-V. Overall she has somewhat stronger abilities for responding to and recalling auditory information than visual information.

¶ . . . ¶

PRIOR COGNITIVE ASSESSMENT

When previously tested in the cognitive domain in May 2013, the WISC-IV results indicated all average results in all domains. Standard scores ranged from 91 to 106 (85-115 being the average range). It is unclear why there is such a difference in the overall results other than it could be the day, an updated version of the test, alertness, focus, among other possibilities. It is safe to say that her ability is likely mostly average with some low average areas.

12. The ABAS-II is an adaptive behavior measure used to assess adaptive skills functioning utilizing rating forms. Claimant's mother and teacher were the informants.

Based on their responses, claimant obtained scores that were within the Extremely Low range. Ms. Stalter stated in her report that “this examiner feels this is a reliable estimate of her adaptive skills given the challenges and behaviors reported from home.”

GENERAL ADAPTIVE COMPOSITE

	Standard Scores (Parent)	Standard Scores (Teacher)
Conceptual	60	55
Social	61	61
Practical	60	57

The Conceptual Scale includes receptive and expressive language, reading and writing, money concepts and self-direction. The Social Scale includes interpersonal relationships, responsibility, self-esteem, gullibility, naiveté, following rules, obeying laws and avoiding victimization. The Practical Skills portion includes basic maintenance, activities of daily living skills with occupation skill and the maintenance of a safe environment.

13. The BASC-2 was administered to assess claimant’s socio-emotional functioning. Claimant, her parent and her teacher completed rating scales. Ms. Stalter reported:

Parent ratings suggested [claimant] demonstrates clinically significant difficulties in all domains except for average score conduct problems, and “at risk” results for attention problems and social skills.

Teacher ratings suggest [claimant] demonstrates significant difficulties in the areas of learning problems, social skills, leadership, school living and functional communication. Developing problems are noted in the areas of withdrawal, attention problems, and adaptability.

The self-report results suggest that [claimant] perceives herself with difficulty in the areas loss of control, anxiety and sense of inadequacy. Her sense of inadequacy may contribute to some of her low adaptive skills because she doesn't have the confidence to do things independently.

14. The BBRS-2 "addresses 7 areas of student behavior associate[d] with participation in school and community activities." Based on the parent and teacher results, Ms. Stalter noted, "The parent results are far more significant than the teacher results. The only areas elevated on the teacher results are in the area of ability deficits. Parent results indicate concerns in every domain. At school [claimant] has been having a good year and has been able to regulate while at school."

15. Ms. Stalter made the following determination:

SUMMARY:

[Claimant] is a ten-year-old youngster with estimated cognitive abilities in the low average to average range. Her adaptive skills are exceptionally low for her age. It isn't clear if she really doesn't know how to handle every skill or if she lacks confidence to exercise her independence. [Claimant] has strengths in the area of reading and weaknesses in math.

Academic achievement results suggest that [claimant] is functioning about 2 to 3 years below grade level based on standardized testing. There is not a discrepancy between ability and achievement, however, [claimant] does meet eligibility for special education services under Emotional Disturbance, suggesting her emotional and behavioral state interferes with her learning. Placement and services will be determined by joint decision of the IEP team.

EDUCATIONAL RECORDS

16. An initial Individualized Education Program (IEP) meeting was held for claimant on September 29, 2016. The IEP team determined that she was eligible for special education based on a primary disability of Emotional Disturbance. No secondary disability was noted. In describing how her disability affects involvement and progress in the general curriculum, the IPP states, "[Claimant] may need reteaching of key concepts and modification of GE work to access the GE curriculum due to anxiety and behavioral issues."

The team discussed claimant's behaviors and noted, "the school has not observed any tantrums or patterns of behavior." The team determined that "should difficulties surface team members will collaborate and consider a behavior goal or plan whatever the case may be."

Claimant's mother was concerned that claimant is in the "honeymoon phase" at this new school. The IEP states, "[claimant's mother] is primarily concern[ed] about how [claimant's] behavior interfere[s] with her progress and worries that she will get further and further behind. [Claimant's mother] is also concerned that sometimes her behavior in the morning interferes with getting the children to school on time."

17. Claimant subsequently began to exhibit behaviors at school that “interfered with her learning or the learning of her peers.” A Functional Behavior Assessment⁴ (FBA) was completed by School Psychologist Beth Madison, General Education Teacher Lori Maturino, and Resource Specialist Laura Marciniak, to determine how best to assist claimant with her behaviors. The FBA report, dated December 15, 2017, stated behaviors of concern were:

- (1) eloping (leaves class without permission; hides; screams and verbally protests when staff encourage her to return to class)
- (2) off task (out of seat; plays with objects; watches teacher help peers)

18. The IEP team met on January 10, 2017, and agreed to a Behavior Intervention Plan (BIP) to assist with claimant’s behaviors. The BIP looks at prevention, alternatives and reactive strategies for the behaviors, and specifies behavioral goals.

MEDICAL RECORDS

19. A Youth for Change⁵ (YFC) letter from Miguel Alvarelllos M.D., dated March 8, 2017, provided “information about claimant’s medical diagnosis.” The letter explained that claimant “has a history of in-utero exposure to methamphetamines, which is associated with the development of static encephalopathy and frontal lobe development impairment.

⁴ An FBA is an analytical process based on observations, review of records, interviews, and data analysis to determine the function the behavior serves for the student, how that function can be met more appropriately and how the environment can be altered to better support general positive behaviors.

⁵ Youth for Change defines itself as “a non-profit, public benefit organization licensed by the State of California to provide comprehensive treatment, education and support services in our community.”

This has manifested in learning problems and difficulties with impulse control. In addition, her prior sexual abuse at the age of 8 has also affected her self-esteem and may be associated with her intermittent struggles with sleep. The following diagnosis and information was given:

DSM V⁶_diagnosis:

Axis⁷ I: Disruptive Mood Dysregulation Disorder (F34.8)

⁶ The Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition (DSM-5) was released in May 2013. Most notably, it changed the diagnosis of Mental Retardation to Intellectual Disability (Intellectual Development Disorder) and no longer uses a multi-axial system. The new classification system combines the axes together and disorders are rated by severity. The DSM-5 states that it “has moved to nonaxial documentation of diagnosis (formerly Axis I, Axis II, and Axis III), with separate notations for important psychosocial and contextual factors (formerly Axis IV) and disability (Axis V) . . . Clinicians should continue to list medical conditions that are important to the understanding or management of an individual’s mental disorder(s).”

⁷ The Diagnostic and Statistical Manual of Mental Disorders, Forth Edition, Text Revision (DSM-IV-TR) was the previous standard for diagnosis and classification. It was a multiaxial system which involves five axes, each of which refers to a different domain of information as follows:

Axis I	Clinical Disorders
	Other Conditions That May Be a Focus of Clinical Attention
Axis II	Personality Disorders
	Mental Retardation
Axis III	General Medical Conditions

Attention-deficit/hyperactivity disorder,
Predominantly inattentive presentation (F90.0)
History of Reactive Attachment Disorder (F94.1)
r/o Unspecified Anxiety Disorder(F41.9)
r/o Specific Learning Disorder, with impairment
in reading comprehension (F81.0)

Axis II: None
Axis III: Static Encephalopathy
Axis IV: Problems with primary social group, school
difficulties
Axis V: Current GAF 46

The patient certainly has elements of the axis I diagnosis mentioned above. [Claimant] has a history of well-established severe recurrent temper outbursts manifested verbally (e.g., verbal rages) and/or behaviorally (e.g., physical aggression toward people or property) that are grossly out of proportion in intensity or duration to the situation or provocation. The temper outbursts are inconsistent with developmental level and the temper outbursts occur, on average, three or more times per week.

Axis IV	Psychosocial and Environmental Problems
Axis V	Global Assessment of Functioning

There is still widespread use of the multiaxial system as a reporting method.

It should be noted that children with in utero exposure to illicit substances have a much higher rate of ADHD and learning disabilities. Given the history presented, and the Vanderbilt scales, [claimant] has ADHD inattentive type. Despite this, she may also have a learning disability, but this will need to be reevaluated once ADHD is treated.

A GAF score of 50-41 indicates a moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area such as might result from, for example, suicidal preoccupations and ruminations, school refusal, anxiety etc.

20. Deborah Touchette, Au.D., CCC-A saw claimant for an auditory processing evaluation at Paradise Hearing and Balance Clinics, Inc. Dr. Touchette's report dated April 25, 2017, explained that claimant "was seen to determine if an auditory processing disorder is a contributor to her social and academic difficulties. She has learning difficulties with focusing, organizing and impulse control. [Claimant] has verbal temper outbursts and aggression."

Dr. Touchette's determined as follows:

Impressions

Auditory processing may be viewed as those processes involved in taking in information via the auditory channel prior to the signal or message being given meaning. Systems theory dictates that this process does not occur in isolation but is a culmination of numerous interactions. Internal systems (e.g.,

CNS, cognitive system, language system, and auditory system) as well as external systems (e.g., environment, culture, and society) influence how a child will process information. In order for an Auditory Processing Disorder (APD) to be identified, it must be established that (1) one or more underlying auditory processes are disordered or delayed, and (2) the disorder or delay, in all likelihood, has a significant impact on the child's ability to function and learn.

The results of this auditory processing evaluation are consistent with **prosodic deficit**. Although this right hemisphere based auditory processing disorder can significantly impact communication, it may be just one portion of a more global right hemisphere deficit that results in far more pervasive and severe non-auditory difficulties. This would appear to be the case for [claimant] and it is important to note that her other associated symptoms (ADD, anxiety, aggression, low cognitive ability) should not be considered to arise from the auditory processing deficit but rather be considered as co-morbid conditions.

Primary auditory complaints associated with a prosodic deficit include:

- Difficulty comprehending the intent (rather than the content) of communications.

- Frequent misunderstandings, complaints of hurt feelings, and perceptions of others' communication is abrupt, rude, sarcastic, or negative in some other way.
- Difficulty perceiving jokes, sarcasm, and other messages that rely on subtle prosodic cues.
- Possible difficulty understanding messages in which subtle changes in stress alter the meaning (e.g., "Look out the window" versus "Look out! The window!")

Related sequelae:

- Poor pragmatic and social communication abilities.
- Poor sight word reading and spelling abilities, combined with good word attack or phonological decoding skills.
- Poor gestalt patterning abilities.
- May have difficulty staying on topic during conversation.
- Poor visual spatial abilities.

Many children with prosody difficulties exhibit difficulty in sequencing, following directions and understanding complex messages. [Claimant] may hear message simply as a string of equally stressed words, so that remembering the message for follow-through purposes becomes a task of memory rather than comprehension. Memory is best conceptualized as a higher-order, supra-modal cognitive skill that interacts with incoming sensory input to affect retention of information. When a deficit exists in the processing of the incoming auditory information, so much effort is expended in hearing

and understanding the information that very little energy may be left over for remembering it.

Recommendations

Bold and aggressive management must be undertaken knowing that neuromaturational development and neural plasticity depend on stimulation. Presenting stimulation in an organized manner that progressively challenges [claimant] with the proper gradation of difficulty level, as well as integrating that stimulation into everyday activities, will facilitate change.

Dr. Touchette concluded her report with "Suggestions for school time" listing many ideas to consider for the school setting.

21. Claimant's IEP team met on May 26, 2017, to review results of an Assistive Technology (AT) assessment, as well as the Auditory Processing Assessment. The IEP addendum states:

Also reviewed was the Auditory Processing Assessment completed by Deborah Touchette, audiologist on April 25, 2017. It is noted that [claimant] often has difficulty comprehending the intent rather than the content of what has been said. It is important to make gentle good eye contact with [claimant] as she may or may not appropriately interpret a person's facial expression in the right way. Given her issues with talking about personal things, the team discussed using the Circles program to help establish the boundaries she

needs. She will need prompting to remind her of guidelines and boundaries on a regular basis. Additionally, she needs extra response time when asked questions.

TESTIMONY

22. Robert Boyle, Ph.D. is a FNRC Staff Psychologist with extensive experience assessing and diagnosing individuals with developmental disabilities. Dr. Boyle testified that, in his capacity as a FNRC staff psychologist, one of his responsibilities is participating in the eligibility review process. He was a member of claimant's Multi-Disciplinary Eligibility Review Team.

Dr. Boyle testified that claimant demonstrates deficits in adaptive functioning, however having adaptive impairments does not establish that she has a qualifying disability making her eligible for regional center services and supports. Adaptive deficits can exist without a developmental disability. They must be attributable to one of the five eligible conditions. Solely psychiatric disorders and/or learning disabilities are specifically excluded. FNRC concluded that the evidence failed to establish regional center eligibility. Although claimant has deficits in adaptive skills, Dr. Boyle agrees that she does not have an eligible condition causing those deficits.

Dr. Boyle testified that claimant does not have an intellectual disability (ID) and that testing has rendered scores within the average to low average range. He explained that it was important to consider subtests scores; an individual with ID would show uniformly low scores over indices demonstrating global deficits in cognitive functioning. Claimant's scores showed concern in the area of Processing Speed which lowers her IQ index and may also be indicative of other difficulties, but did not support a finding of globally impaired cognitive functioning.

23. Dr. Boyle opined that the family is seeking eligibility based upon a contention that claimant's condition is ID or fifth category, because of the impairments

under which she struggles. He testified that the evidence did not demonstrate intellectual functioning at the level of or similar to ID. Her IEP provides for special education services based on a diagnosis of emotional disturbance. She was not identified as a student with intellectual disability. ID has never been diagnosed. Dr. Boyle testified that claimant does not have impaired cognitive functioning but does have struggles with various psychiatric diagnoses and learning disabilities, and that her adaptive skills deficits could be related to those diagnoses.

To have a condition which requires treatment similar to that required by an individual with ID is not simply determining whether the services provided to such persons would benefit claimant. It is whether claimant's condition requires such treatment. Dr. Boyle testified that the treatment for an individual with global deficits in cognitive functioning would be unlike those for someone functioning in the normal range. Claimant has scored in the average/low average range on standardized intelligence tests. She exhibits adaptive deficits which are best explained by other diagnoses such that services required would most appropriately be provided from the treatment perspective of mental health and/or a learning disability rather than intellectual disability.

24. Claimant's mother testified to her concerns with claimant's adaptive functioning and is extremely concerned for her safety. Claimant often puts herself in danger, by eloping when she is anxious and/or misinterprets comments made by others. She will "leave until she resets herself and calms down." In these situations, claimant will cross a road without looking or take other actions placing her safety in jeopardy. According to claimant's mother, in March 2016, claimant allegedly attempted to commit suicide when she was holding a knife and stating that she wanted to kill herself.

Claimant's mother explained that claimant misinterprets others and may think they don't like her or are mad at her. This causes her to become anxious and she elopes to calm herself. If her mother is present, she will ask claimant "Did you breathe?" Her mother

believes that her deficits in adaptive functioning are related to her APD, and that “processing speed is the issue.” “When the processing part of her doesn’t work, she becomes anxious.” She contends that the regional center’s concern should “not be claimant’s IQ but her behaviors and functioning.” Claimant needs reminders for hygiene, can be inappropriate socially telling anybody anything,⁸ and exhibits poor judgment and decision-making.

Claimant’s mother questioned whether claimant has a learning disability and she is attempting to determine “what’s causing [claimant] not to learn.” She explained that claimant has a new IEP offer from her school district, with which she disagrees and is appealing. She also clarified that the “Prior Cognitive Assessment Data” included in Ms. Stalter’s psychoeducational report, was appealed with the previous school district through an OCR (Office of Civil Rights) complaint, and should not be considered.

Claimant is currently administered Abilify in a “low dosage.” Vivance was attempted and discontinued when claimant experienced an adverse reaction.

Claimant’s mother desires regional center services for her daughter and contends that claimant is eligible due to an intellectual disability or under the fifth category due to her “perception, memory and reasoning.” She believes claimant “cannot do the adaptive functioning that an eleven year old should do.”

ELIGIBILITY BASED ON INTELLECTUAL DISABILITY

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

⁸ The purpose of the “circles” program in claimant’s IEP is to address this issue. It is a method for assisting her in learning what is appropriate to share with various individuals within each circle.

Intellectual Disability (intellectual developmental disorder)⁹ is a disorder with onset during the developmental period that includes both intellectual and adaptive functioning¹⁰ deficits in conceptual, social, and practical domains. The following three criteria must be met:

- A. Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing.
- B. Deficits in adaptive functioning that result in failure to meet developmental and socio-cultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social

⁹ The DSM-V states, "The diagnostic term *intellectual disability* is the equivalent term for the ICD-11 diagnosis of *intellectual developmental disorders*. Although the term intellectual disability is used throughout this manual, both terms are used in the title to clarify relationships with other classification systems."

¹⁰ "*Adaptive functioning* refers to how effectively individuals cope with common life demands and how well they meet the standard of personal independence expected of someone in their particular age group, sociocultural background, and community setting. Adaptive functioning may be influenced by various factors, including education, motivation, personality characteristics, social and vocational opportunities, and the mental disorders and general medical conditions that may coexist with Intellectual Disability.

participation, and independent living, across multiple environments, such as home, school, work, and community.

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

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

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

Criterion A refers to intellectual functions that involve reasoning, problem solving, planning, abstract thinking, judgment, learning from instruction and experience, and practical understanding. Critical components include verbal comprehension, working memory, perceptual reasoning, quantitative reasoning, abstract thought, and cognitive efficacy. Intellectual functioning is typically measured with individually administered and psychometrically valid, comprehensive, culturally appropriate, psychometrically sound tests of intelligence. Individuals with intellectual disability have scores of approximately two standard deviations or more below the population mean, including a

margin for measurement error (generally +5 points. On tests with a standard deviation of 15 and a mean of 100, this involves a score of 65-75 (70 ± 5). Clinical training and judgment are required to interpret test results and assess intellectual performance.

[11] . . . [11]

IQ test scores are approximations of conceptual functioning but may be insufficient to assess reasoning in real-life situations and mastery of practical tasks. For example, a person with an IQ score above 70 may have such severe adaptive behavior problems in social judgment, social understanding, and other areas of adaptive functioning that the person's actual functioning is comparable to that of individuals with a lower IQ score. Thus, clinical judgment is needed in interpreting the results of IQ tests.

Deficits in adaptive functioning (Criterion B) refer to how well a person meets community standards of personal independence and social responsibility, in comparison to others of similar age and sociocultural background. Adaptive functioning involves adaptive reasoning in three domains: conceptual, social and practical. The *conceptual (academic) domain* involves competence in memory, language, reading, writing, math reasoning, acquisition of practical knowledge, problem solving and judgment in novel situations, among others. The *social domain* involves awareness of others'

thoughts, feelings and experiences; empathy; interpersonal communication skills; friendship abilities; and social judgment, among others. The *practical domain* involves learning and self-management across life settings, including personal care, job responsibilities, money management, recreation, self-management of behavior, and school and work task organization, among others. Intellectual capacity, education, motivation, socialization, personality features, vocational opportunity, cultural experience, and coexisting general medical conditions or mental disorders influence adaptive functioning.

Adaptive functioning is assessed using both clinical evaluation and individualized, culturally appropriate, psychometrically sound measures. Standardized measures are used with knowledgeable informants (e.g., parent or other family member; teacher; counselor; care provider) and the individual to the extent possible. Additional sources of information include educational, developmental, medical, and mental health evaluations. Scores from standardized measures and interview sources must be interpreted using clinical judgment . . .

Criterion B is met when at least one domain of adaptive functioning—conceptual, social or practical—is sufficiently impaired that ongoing support is needed in order for the person to perform adequately in one or more life

settings at school, work, at home, or in the community. To meet diagnostic criteria for intellectual disability, the deficits in adaptive functioning must be directly related to the intellectual impairments described in Criterion A. Criterion C, onset during the developmental period, refers to recognition that intellectual and adaptive deficits are present during childhood or adolescence.

27. While the DSM-5 does not rely on IQ scores alone, it does require clinical assessment *and* standardized testing of both intellectual and adaptive functioning. The DSM-V looks to “deficits in general mental abilities.” And, “intellectual functioning is typically measured with individually administered and psychometrically valid, comprehensive, culturally appropriate, psychometrically sound tests of intelligence.” A determination cannot be based solely on claimant’s adaptive deficits, but they must be related to deficits in general mental abilities.

Claimant does have limitations in adaptive skills. The evidence presented at hearing did not establish that claimant, presented with the necessary global deficits confirmed by both clinical assessment and standardized intelligence testing to support a diagnosis of intellectual disability. Consequently, claimant does not qualify for regional center services under the category of intellectual disability.

ELIGIBILITY BASED ON THE “FIFTH CATEGORY” (A DISABLING CONDITION FOUND TO BE CLOSELY RELATED TO INTELLECTUAL DISABILITY OR TO REQUIRE TREATMENT SIMILAR TO THAT REQUIRED FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY)

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

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

29. Fifth category eligibility determinations typically begin with an initial consideration of whether claimant has global deficits in intellectual functioning. This is done prior to consideration of other fifth category elements related to similarities between the two conditions, or the treatment needed.

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

FIFTH CATEGORY ELIGIBILITY-CONDITION CLOSELY RELATED TO INTELLECTUAL DISABILITY

31. Claimant contends that she is eligible for regional center services based upon a condition being closely related to mental retardation due to her impairments in adaptive functioning. The DSM explains that deficits in adaptive functioning can have a number of causes. The fact that claimant has deficits in adaptive functioning alone, is not sufficient to establish that she has a condition closely related to mental retardation. To meet diagnostic criteria for intellectual disability, the DSM-V requires that the deficits in adaptive functioning must be directly related to the intellectual impairments.

32. Claimant's general intellectual functioning, based on her IQ scores on standardized, intelligence tests, did not meet the definition of significantly subaverage intellectual functioning under the DSM. Thus, claimant does not have this "essential feature" of mental retardation. The fact that claimant may have deficits in adaptive functioning alone, without global intellectual impairment, does not establish that she has a condition closely related to mental retardation.

33. Over the years, claimant has been diagnosed with a variety of conditions, including: Reactive Attachment Disorder, ADHD, anxiety, mood, behavior, and learning disorders, and APD.

For example, the DSM-5 describes the functional consequences of ADHD, in part, as follows:

ADHD is associated with reduced school performance and academic attainment, social rejection, and, in adults, poorer occupational performance, attainment, attendance, and higher probability of unemployment as well as elevated interpersonal conflict. Children with ADHD are significantly more likely than

their peers without ADHD to develop conduct disorder in adolescence and antisocial personality disorder in adulthood . .

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

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

There was no persuasive evidence presented that any of these conditions resulted from significantly subaverage intellectual functioning or were shown to be closely related to intellectual disability. Dr. Touchette specifically concluded that claimant's APD did not cause her associated symptoms (ADD, Anxiety, aggression, low cognitive ability) and should be considered as co-morbid conditions. There was no evidence presented that claimant qualified for special education as a student with intellectual disability.

FIFTH CATEGORY ELIGIBILITY-CONDITION REQUIRING TREATMENT SIMILAR TO THAT REQUIRED FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY)

34. Fifth category eligibility may also be based upon a condition requiring treatment similar to that required by individuals with mental retardation. "Treatment" and "services" do not mean the same thing. Individuals without developmental disabilities may benefit from many of the services and supports provided to regional center consumers. Section 4512, subdivision (b) defines "services and supports" as follows:

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

Regional center services and supports targeted at improving or alleviating a developmental disability may be considered "treatment" of developmental disabilities. But regional center services and supports go beyond treatment, focusing on improving an eligible individual's social, personal, physical or economic status or assisting the individual in living an independent, productive and normal life. Thus, section 4512 elaborates further upon the services and supports listed in a consumer's individual program plan as including "diagnoses, evaluation, *treatment*, personal care, day care, domiciliary care, special living arrangements, physical, occupational and speech therapy, training, education, supported and sheltered employment, mental health services..." (Welf. & Inst. Code, § 4512, subd. (b). (Emphasis added). The designation of "treatment" as a separate item is clear indication that

it is not merely a synonym for services and supports, and this stands to reason given the broader mission of the Lanterman Act:

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

35. Fifth category eligibility must be based upon an individual requiring “treatment” similar to that required by individuals with mental retardation. The wide range of services and supports listed under section 4512, subdivision (b), are not specific to mental retardation. One would not need to suffer from mental retardation, or any developmental disability, to benefit from the broad array of services and supports provided by ACRC to individuals with mental retardation. They could be helpful for individuals with other disabilities, or for individuals with mental health disorders, or individuals with no disorders at all. The Legislature clearly intended that an individual would have a condition similar to mental retardation, or would require *treatment* that is specifically required by individuals with mental retardation, and not any other condition, in order to be found eligible.

36. In *Samantha C.*, no attempt was made to distinguish treatment under the Lanterman Act as a discrete part or subset of the broader array of services provided to those seeking fifth category eligibility. Thus, the appellate court made reference to individuals with mental retardation and with fifth category eligibility both needing “many of the same kinds of treatment, such as services providing help with cooking, public transportation, money management, rehabilitative and vocational training, independent living skills training, specialized teaching and skill development approaches, and supported

employment services.” (*Samantha C. v. State Department of Developmental Services, supra*, 185 Cal.App.4th 1462, 1493. .) This broader characterization of “treatment” cannot properly be interpreted as allowing individuals with difficulties in adaptive functioning, and who require assistance with public transportation, child care, vocational training, or money management, to qualify under the fifth category without more. For example, such services as vocational training are offered to individuals without mental retardation through the California Department of Rehabilitation. This demonstrates that it is not necessary for an individual to have mental retardation to demonstrate a need for services which can be helpful for individuals with mental retardation.

Individuals with mental retardation might require many of the services and supports listed in Welfare and Institutions Code section 4512, which could benefit any member of the public: assistance in locating a home, child care, emergency and crisis intervention, homemaker services, paid roommates, transportation services, information and referral services, advocacy assistance, technical and financial assistance. To extend the reasoning of *Samantha C.*, an individual found to require assistance in any one of these areas could be found eligible for regional center services under the fifth category. However, it is unreasonable to conclude that any individual that might benefit from a service or support provided by the regional center, which might also benefit an individual with intellectual disability, requires treatment similar to that required by individuals with intellectual disability. This was clearly not the intent of the Legislature.

Thus, while fifth category eligibility has separate condition and needs-based prongs, the latter must still consider whether the individual’s condition has many of the same, or close to the same, factors required in classifying a person as mentally retarded. (*Mason v. Office of Administrative Hearing, supra*, 89 Cal.App.4th 1119.) Furthermore the various additional factors required as designating an individual as developmentally disabled and substantially handicapped must apply as well. (*Id.* at p. 1129.) *Samantha C.* must therefore

be viewed in context of the broader legislative mandate to serve individuals with developmental disabilities only. A degree of subjectivity is involved in determining whether the condition is substantially similar to mental retardation and requires similar treatment. (*Id.* at p. 1130; *Samantha C. v. State Department of Developmental Services, supra*, 185 Ca.App.4th 1462, 1485.) This recognizes the difficulty in defining with precision certain developmental disabilities. Thus, the *Mason* court determined: "it appears that it was the intent of those enacting the Lanterman Act and its implementing regulations not to provide a detailed definition of 'developmental disability' so as to allow greater deference to the [regional center] professionals in determining who should qualify as developmentally disabled and allow some flexibility in determining eligibility so as not to rule out eligibility of individuals with unanticipated conditions, who might need services." (*Id.* at p. 1129.)

37. The Lanterman Act and Title 17 Regulations do not discuss services and supports available from regional centers in the eligibility criteria. Rather, an individual's planning team discusses services and supports after that individual is made eligible. Section 4512, subdivision (b) explains:

...The determination of which services and supports are necessary for each consumer shall be made through the individual program plan process. The determination shall be made on the basis of the needs and preferences of the consumer or, where appropriate, the consumer's family, and shall include consideration of a range of service options proposed by individual program plan participants, the effectiveness of each option in meeting the goals stated in the individual program plan, and the cost-effectiveness of each option.

There is no mandate that eligibility determinations include consideration of whether an individual might benefit from an available regional center service or support. Rather, services and supports are determined by the planning team based on “needs and preferences” of the consumer. A need or preference for a specific service or support determined by the planning team is not the same as a determination by a qualified professional of what treatment is required for an individual with a specific developmental disability.

38. The evidence was not persuasive that claimant’s treatment needs were targeted at improving or alleviating a developmental disability similar to intellectual disability. The fact that claimant might benefit from some of the services that could be provided by the regional center does not mean that she requires treatment similar to that required by individuals with intellectual disability. Rather, claimant’s recommended treatments are geared toward addressing mental health, communication and social/emotional, learning, and behavior concerns.

DISCUSSION

39. When all the evidence is considered, claimant did not establish that she qualifies for services from FNRC under the Lanterman Act. While claimant has challenges and exhibits a wide array of symptoms, her challenges and symptoms appear to result from her learning and mental health issues, which do not constitute a developmental disability under the Lanterman Act. Claimant functions cognitively at a higher level than an individual with an intellectual disability and she has never been identified as a student with intellectual ability. Global deficits in cognitive functioning are distinguishable from psychiatric and learning disorders.

The possibility of benefiting from regional center services also does not create eligibility. Many people might benefit from the array of services provided by the regional center, whether or not they are diagnosed as Developmentally Disabled.

40. Claimant bears the burden of establishing that she meets the eligibility requirements for services under the Lanterman Act.¹¹ She has not met that burden. The evidence presented did not prove that claimant is substantially disabled by a qualifying condition that is expected to continue indefinitely. She did not meet the diagnostic criteria for an intellectual disability, or a disabling condition found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability. There was no evidence to show that she has epilepsy, cerebral palsy, or autism. Accordingly, claimant does not have a developmental disability as defined by the Lanterman Act. Consequently, claimant's request for services and supports from FNRC under the Lanterman Act must be denied.

LEGAL CONCLUSIONS

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

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

¹¹ California Evidence Code section 500 states that "[e]xcept as otherwise provided by law, a party has the burden of proof as to each fact the existence or nonexistence of which is essential to the claim for relief or defense that he is asserting."

required for individuals with mental retardation [commonly known as the "fifth category"], but shall not include other handicapping conditions that consist solely physical in nature.

2. The statutory and regulatory definitions of "developmental disability" (Welf. & Inst. Code, § 4512 and Cal. Code. Regs., tit. 17, §54000) exclude conditions that are solely physical in nature. California Code of Regulations, title 17, section 54000, also excludes conditions that are solely psychiatric disorders or solely learning disabilities.

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

3. Claimant did not prove that he has a developmental disability as defined by the Lanterman Act. Therefore, she is not eligible for regional center services.

ORDER

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

DATED: November 7, 2017

SUSAN H. HOLLINGSHEAD

Administrative Law Judge

Office of Administrative Hearing

NOTICE

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