BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: CLAIMANT, vs. WESTSIDE REGIONAL CENTER, Service Agency.	OAH No. 2017100119

DECISION

This matter was heard by Eileen Cohn, Administrative Law Judge (ALJ) with the Office of Administrative Hearings, on January 4, 2018, in Culver City, California. Claimant was represented by her mother and was not present.[1] Westside Regional Center (WRC or Service Agency) was represented by Lisa Basiri, Fair Hearing Coordinator.

Oral and documentary evidence was received, and argument was heard. The record was closed, and the matter was submitted for decision on January 4, 2018. On January 16, 2018, the record was reopened for the WRC to submit a complete copy of Ex. 4F, the August 2016 assessment of Cindy LaCost, Ph.D., and to also submit the document memorializing the psychoeducational assessment of WRC's 2017 multidisciplinary team decision meeting in which the team denied Claimant's eligibility. Claimant was given the opportunity to object to the exhibits. The WRC timely submitted the exhibits and Claimant did not object to them. The complete copy of Ex. 4F, which also included Dr. LaCost's raw assessment data, was admitted and replaced the incomplete copy submitted at the

[1] Claimant and her parents are identified by titles to protect their privacy.

hearing. The 2017 multidisciplinary team decision meeting document was marked and admitted as Ex. 9. The record was reclosed and the matter resubmitted on January 30. 2018.

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ISSUE

The parties stipulated to the following issue:

Is Claimant eligible for services under 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, pursuant to the Lanterman Developmental Disabilities Services Act (Lanterman Act)?

EVIDENCE

Documentary: WRC's exhibits 1-8; claimant's exhibits A-L.

Testimonial: Thompson Kelly, Ph.D.; Claimant's mother.

FACTUAL FINDINGS

PARTIES, JURISDICTION AND BACKGROUND

1. Claimant is a 16-year-old young woman who lives at home with her parents and older sibling. She seeks eligibility for regional center services on the basis of the fifth category.

2. Claimant was a client of the Harbor Regional Center's (HRC), early intervention program from about two-months old to three-years old, due to her developmental delays in walking, coordination and speech development. (Ex. 4F, p. 3.) She received occupational and physical therapy and attended a center-based program.

(Ex. 5, p. 3.). HRC evaluated claimant at 2.9 months of age. At that time her cognitive functioning was measured to be within normal limits, her verbal skills measured within her age-range, her expressive skills measured "somewhat" stronger than her receptive language skills, and her social skills "were appropriate." (Ex. 5, p.3). Claimant's regional center services terminated at age three because it was determined that she reached her "developmental milestones in language and motor development." (Ex. 4F, p.3.) Since that time Claimant has not been a client of any regional center.

3. (A) In 2016, Claimant was assessed for eligibility for regional center services, principally under the category of autism. On April 25, 2016, the WRC notified Claimant that she did not qualify for regional center services.

(B) In 2016, the WRC retained the services of Rebecca R. Dubner, Psy.D. to conduct a psychological assessment, and prepare a report, which she did in April 2016. (Ex. 5.) In her report, Dr. Dubner provided the results of various standardized assessments she administered, her review of Claimant's school, educational and medical history, interviews with Claimant and her mother, and previous assessments administered and reports. (*Ibid.*)

(C) Dr. Dubner generally found Claimant to have severe impairments in social communications, along with a variety of learning and psychiatric disorders, but concluded that she did not meet the criteria for either intellectual disability (ID) or autism. (Ex. 5.)

(D) The WRC's multi-disciplinary team, which convened on April 20, 2016, and consisted of a medical doctor, a consulting psychologist, and Dr. Thompson Kelly, WRC's Chief Psychologist and Manager of Intake and Eligibility, recommended Claimant obtain support from the school district and continue ongoing mental health treatment. (Ex. 7.) Claimant did not challenge the WRC's determination that she did not qualify for regional center services.

4. (A) One year later, in April 2017, Claimant reapplied for regional center services based upon her ongoing challenges with adaptive functioning and social

communications impairment, as catalogued by a August 2015 psychoeducational assessment of Dr. LaCost, and a June 2016 diagnosis of partial Fetal Alcohol Syndrome (pFAS), a neurodevelopmental disorder, made by Madelyn M. Laboriel, M.D. (Ex. 4B and Ex. G.)

(B) Dr. Laboriel's diagnosis of pFAS was based upon her finding that Claimant exhibited certain biomarkers of organic brain damage. (Ex. 3B.) The closest category to describe Claimant's condition in the Diagnostic Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)[2] is "Other Specified Neurodevelopmental Disorder, with the specifier of neurodevelopmental disorder associated with prenatal alcohol syndrome. [3] (*Ibid.*, citing

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[2] All citations to the DSM-5 are to the American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, Virginia, American Psychiatric Association, 2013. At hearing, the Administrative Law Judge took official notice of the history and contents of the DSM-5, without objection from the parties, as a highly respected and generally accepted tool for diagnosing mental and developmental disorders. The Diagnostic and Statistical Manual of Mental Disorders (DSM) is a generally-accepted manual listing the diagnostic criteria and discussing the identifying factors of most known mental disorders. Since 1917, the predecessor of the American Psychiatric Association has developed and published standards for and nomenclature of mental disorders. The American Psychiatric Association Committee on Nomenclature and Statistics developed and published the first edition of Diagnostic and Statistical Manual: Mental Disorders (DSM-I) in 1952. Subsequent editions were the DSM-II, DSM-III (1980), DSM-III-R (1987), DSM-IV (1994), and DSM-IV-TR (2000). The most recent edition is the DSM-5, published in May 2013.

[3] Claimant's mother incorrectly cited to the DSM-5, pp. 779-801 based upon the citation provided to her in Dr. Madelyn M. Laboriel's June 8, 2016 report. (Ex. G, p.2.)

DSM-5, 315.8,[F88] at p. [81].)"[4]

> This category applies to presentations in which symptoms characteristic of a neurodevelopmental disorder that cause impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the neurodevelopmental disorders diagnostic class. The other specified neurodevelopmental disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific neurodevelopmental disorder. This is done by recording "other specified neurodevelopmental disorder" followed by the specific reason (e.g., 'neurodevelopmental disorder associated withprenatal alcohol exposure').
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> An example of a presentation that can be specified using the 'other specified' designation is the following:
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> Neurodevelopmental disorder associated with prenatal alcohol exposure: Neurodevelopmental disorder associated with prenatal alcohol exposure is characterized by a range of

[4] The significance of including FAS in the DSM-5 is that for the first time there is a diagnostic code which "triggers payment for services related to the condition as well as helps individuals access needed interventions and treatments." (Ex. H, Chasnoff, Ira J. M.D. Psychology Today, (Posted March 2, 2014) Aristotle's Child. An End to Alphabet Soup: FASD and Changes in the DSM-5.)

developmental disabilities following exposure to alcohol in utero.

(DSM-5, supra, at p. 81.)

(C) Claimant's mother, who identifies herself as Claimant's adoptive mother, testified credibly that Claimant suffered from pFAS as a result of the negligent behavior of her birth mother during her pregnancy with Claimant. Claimant's mother extensively studied the literature and consulted with Dr. Laboriel and other experts who specialize in FAS, and through them confirmed that Claimant exhibits behaviors and the neurodevelopmental markers of pFAS.

(D) In June 2016, Dr. Laboriel diagnosed Claimant with pFAS, meaning she satisfies most, but not all, of the biomarkers of FAS, including most of the dysmorphic facial features of FAS and head circumference at birth, which showed "microcephaly (a marker of organic brain damage or static encephalopathy." (Ex. G.) "We use the term 'Partial FAS' when a patient's characteristic features are very close to the classic features of FAS and there is a confirmed history of high risk alcohol exposure which is true in this case." (*Ibid.*) Dr. Laboriel stated that the severity of brain damage from pFAS is similar to FAS. Other than her review of records, and certain physical biomarkers, there is no evidence that Dr. Laborial conducted any other neurological testing to confirm Claimant's diagnosis. No foundation was provided of the medical protocols related to such a diagnosis. Nevertheless, her diagnosis is undisputed.

5. (A) In May 2017, Sylvia Young, Ph.D., a California-licensed psychologist was retained by the WRC to review Claimant's file to address whether the file contained enough information to make a recommendation about eligibility for regional center services, to ascertain what, if any, additional information was needed to make that determination, or alternatively, if the information was sufficient, make a recommendation.

(Ex. 4A.)

(B) Dr. Young prepared a short report. She did not make a recommendation to the WRC about Claimant's eligibility. Based upon her review of Claimant's medical records and previous psychological assessments,[5] Dr. Young suggested the WRC review the following issues to determine Claimant's eligibility: Claimant's medications to assess whether they significantly impair her adaptive functioning; the diagnosis of pFAS and its implications for her adaptive functioning and regional center services; whether Claimant's medications are reasonable and if her pFAS "could indicate eligibility if she is substantially disabled, then a detailed assessment of [Claimant's] adaptive functioning deficits at home and at school would be helpful." (Ex. 4A, p. 2.)

6. (A) On August 10, 2017, WRC's multi-disciplinary team met to address Claimant's renewed request for eligibility. (Ex. 9.) In attendance was Dr. Kelly, Ari Zeldin, M.D., a pediatrician and neurologist, and Rita Eagle, Ph.D., a WRC consulting psychologist.

(B) The team concluded that Claimant was not eligible. The following comments were made on the diagnostic/eligibility sheet: "No eligible condition. Following team discussion, client does not present with an intellectual disability, does not [unintelligible] an Autism Spectrum Disorder and would not require treatment similar to a person with an

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[5] Dr. Young reviewed the following exhibits: (Ex. 4B) Claimant's April 11, 2017, reapplication letter; (Ex. 4C), March 27, 2017, progress letter from Julie Sanchez, Psy.D. and Michele-Walker-Bauer, Ph.D. Violence Intervention Program Community Mental Health Center, Inc.(VIP); (Ex.G); February 3, 2015, Psychological Evaluation of Los Angeles County Department of Mental Health (LACDMH) TIES for Family-South Bay, by Brittany Beyerlein, M.A., and Myan Le, Psy.D. with Larisa Litvinov, Ph.D. (Ex. 4E.), supervisor; and August 19, 2015, Psychoeducational Evaluation for the El Segundo Unified School District, by Cindy LaCost, Psy.D. (Ex. 4F.)

intellectual disability." (Ex. 9.) There was no mention as to whether Claimant had a substantial disability.

(C) The team recorded "Follow-up Recommendations" on the diagnostic/eligibility sheet: "Transition planning with the school district to plan for ongoing support past high school."

7. On August 10, 2017, Dr. Kelly sent a letter and a Notice of Proposed Action to Claimant and her parents informing them of the WRC's determination that Claimant is not eligible for regional center services. The letter explained that the WRC's multi-disciplinary clinical team determined, based upon the information provided by Claimant, that the information was "not supportive of an eligible regional center diagnosis which includes [Intellectual Disability], Autistic Disorder, Epilepsy, Cerebral Palsy, or a condition similar to [Intellectual Disability]."[6] (Ex.2.) He explained that Claimant's disability was more consistent with a mental health condition and a specific learning disorder. (Ex. 2.)

> A review of records revealed [Claimant] to have a significant scatter with many academic and cognitive scores appearing within the average range of abilities. In addition behavioral descriptions did not appear consistent with an autism spectrum disorder and there were no medical records supporting the presence of either epilepsy or cerebral palsy...[¶]
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> (*Ibid.*)

8. On August 14, 2017, Claimant's mother timely filed a fair hearing request on

[6] The term "Intellectual Disability" has replaced the "Mental Retardation" in statutes and regulations, as well as the DSM-5.

her daughter's behalf which appealed the eligibility denial and requested a hearing.

9. (A) On September 26, 2017, the parties, including Mary Rollins of the WRC, Claimant, and Claimant's mother, met in an attempt to informally resolve Claimant's appeal of WRC's decision.

(B) Claimant's mother updated the status of Claimant's behaviors. She described claimant as having difficulty with understanding and conducting personal relationships, aggressively pursuing individuals, including becoming sexually active with one 17-year-old camp counselor during summer camp and failing to understand why he was cold to her the next day. "[Claimant] has difficulty relating to peers, exhibits poor boundaries, is unable to read social cues, and often makes her peers feel uncomfortable." (*Id.*). Claimant's mother explained that Claimant cannot "conceptualize many normal social situations."

(C) According to her mother, Claimant has trouble with many aspects of daily living:

(1) She cannot use the stove without supervision because if the (gas) stove does not light right away she will leave it on/or keep trying;

(2) She cannot turn the right knob of the stove;

(3) She can only make a sandwich or a bowl of cereal for herself and she gets frustrated when her mother tries to teach her to cook;

(4) She has poor hygiene, does not bathe on a regular basis, and when asked or reminded to bathe, she says she will do it later or ask "at bedtime when it is too late";

(5) She lets her dirty clothes pile up and only washes them once a month "if we are lucky," does not "separate her laundry before washing" and "stuffs the washer with as many clothes as possible";

(6) She is not allowed to have her own phone or use the computer without supervision because she makes poor social decisions about interacting with people, believing what they say, or stalking them;

(7) She does not manage money well. She gets confused with numbers easily, often reaches the cashier only to discover she does not have enough money to make a purchase because she could not count accurately or estimate the tax. She does not know how to swipe a debit card, forgets her passcode or pushes buttons which cancel a passcode by mistake. A customer behind her got so frustrated he paid for her purchase.

(8) She has difficulty with organization and planning and executing simple tasks. (Ex. 3B.)

(D) Mother's latest report of Claimant's behavior was consistent with her previous reports to the WRC, as well as her report to Claimant's assessors in interviews and in response to rating scales (Ex. 4F, p. 26-27). As part of Claimant's last request for eligibility, Claimant's mother participated in an intake interview with the Service Agency on January 26, 2016, where she reported the following social-emotional behaviors: (Ex. 6.)

(1) Claimant has little understanding of social cues and boundaries. She was sexually molested at school on December 5, 2015 by another student who lured Claimant off campus. Claimant still wants him to be her friend because: "That was last year." (Ex. 6.) As a result of her sexual assault, the school district assigned her a one-on-one aide to accompany her throughout the school day. Claimant did not do well with the one-on-one aide for reasons that were not fully explained in the evidence provided. Beginning on a date unknown but on or about the beginning of the 2016-2017 school year, the school district placed Claimant in an NPS.

(2) Claimant has no friends, has never been invited to a birthday party, and has never had friends come over to her family home.

(3) Claimant "has an emotional shut down about four times a week where she cries, throws objects, yells/screams obscenities, becomes silent and often escalates to physical aggression."(Ex. 6.)

10. In a letter dated September 26, 2017, Mary E. Rollins of WRC informed Claimant's mother that based upon their meeting, the information she provided, and the review of the case file, WRC had determined Claimant was not eligible for services under the Lanterman Act. The parties generally agree that Claimant's behavior fits the category of pFAS or FAS. Nevertheless, Ms. Rollins acknowledged that Claimant "has some challenges and could benefit from therapeutic intervention[s] but those challenges are more consistent with mental health issues, a learning disability and fetal alcohol syndrome." (Ex. 3A.) This current fair hearing ensued.

CLAIMANT'S BACKGROUND, BEHAVIORAL AND SOCIAL-EMOTIONAL PROFILE

11. Claimant was born prematurely under significant distress and remained in the neonatal care unit for several days prior to placement in her first foster home. At ten months old, Claimant came to live with her adoptive parents. Little is known of her biological mother, except that she exposed Claimants to toxins in utero, cocaine and/or alcohol, and her mother had "mental health issues, including Bipolar Disorder." (Ex. 4F, p. 3.) Claimant also suffered from ocular muscle problems in her right eye, known as "lazy eye," and underwent three corrective surgeries at one, three and four years of age. (*Ibid.*) She has no other health problems.

12. (A) Claimant's school profile was characterized by shifts between home schooling, and private and public schools, and ongoing social and behavior issues. Claimant did not attend preschool and was home-schooled from kindergarten to third grade. After one year in public school, she attended an independent study school, California Virtual Academies (CAVA), through sixth grade.

(B) Claimant's first psychoeducational assessment was conducted when she attended CAVA and in the report dated March 29, 2013, it was recommended that Claimant be made eligible for special education under the categories of other health impairment (OHI) and emotional disturbance (ED). Claimant enrolled in public middle

school in May 2013, and as a result of the school district's intake assessment, Claimant was made eligible for special education services under the category of OHI only.

(C) In October 2014, at the beginning of Claimant's eighth grade year in the school district, her eligibility was changed from OHI to ED, where it remains.[7] (Ex. D, p. 3.)

13. (A) Claimant experienced some academic challenges, but it was unclear to what extent her grades were determined solely by her cognitive ability or were also impacted by her social-emotional issues. She had passing grades in sixth grade at CAVA, one A, two Bs, and one C; but by spring her grades fell to one C and three Ds. After she transferred to another public school at the end of sixth grade, her grades improved. Between the end of sixth grade through eighth grade, she received special education supports, which included not only special education for math and electives, but also counseling to address her social-emotional challenges, where she was guided in developing strategies to address anger, disappointment and frustration, and in social skills building. (Ex. 4F, p. 4; Ex. 4E. p. 2.)

(B) In 2016, the school district placed Claimant in a nonpublic school (NPS), Beach Cities Learning Center, which she still attends. According to Claimant's mother, she is

[7] ED "means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance. (A) An inability to learn that cannot be explained by intellectual, sensory, or health factors. (B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers. (C) Inappropriate types of behavior or feelings under normal circumstances. (D) A general pervasive mood of unhappiness or depression. (E) A tendency to develop physical symptoms or fears associated with personal or school problems. (F) Emotional disturbance includes schizophrenia." (Cal. Code Regs., title 5, § 3030, subd. (b)(a)(B)(4).)

doing well in that setting and is planning to graduate with a general education degree.

14. Claimant has a history of social emotional issues.

(A) Claimant has a history of difficulties with peer relations during public school. She has had difficulty relating to same-aged peers. She could not build or maintain friendships, primarily due to her inability to interpret social cues. She experienced bullying and on one occasion, sexual assault, which resulted in her being assigned a one-on-one aide throughout the school day. Even with the assistance of an aide, Claimant could only interpret social "nuances" in about 50 percent of occurrences, according to an October 2014 individual education plan (IEP) report. (Ex. 4E, p. 2.) During group therapy at TIES for Families-South Bay (TIES), Claimant "often demonstrates social skills that are of a lower level than her peers." (*Ibid.*)

(B) Claimant was extensively tested to ascertain whether she met the criteria for autism. She did not. Nevertheless through testing for autism, Claimant performed in the borderline range for recognizing the emotions of others, and in the below expected level for what is referred to as "Theory of Mind," the ability to understand mental functions such as deceptions, belief or intentions, and other's perceptions. (Ex. 4E, p. 2, using the Neuropsychological Test for Children-Second Edition (NEPSY-II); and Ex. J). Consistent with Claimant's social deficits, she obtained an overall composite score of "extremely low" on the Developmental Test of Visual Perception for Adolescents (VM-II), administered by Dr. LaCost. (Ex J., p.3.) She also obtained a score of "high probable" on the Gilliam Asperger's Disorder Scale (GADS) administered by Dr. LaCost. Asperger's Disorder is not recognized under the DSM-5, but her percentile rank on the social interaction subscale was the lowest of the four subscales at the 16th percentile. (Ex. J, p. 6.)

15. Claimant has a history of psychiatric, and behavior issues, including psychiatric hospitalizations.

(A) Claimant was hospitalized in January and February 2013 for psychiatric

problems and evaluation. She was hospitalized on March 9 through 15, 2015, and it was reported that she pretended to have Schizophrenia in an effort to go back to the hospital. (Ex. 5, p. 9.) On April 4 and April 12, 2015, just before her 14th birthday, Claimant attempted suicide by scratching herself with fingernails and glass. (Ex. 4F, p. 5.)

(B) Claimant has been diagnosed with various psychiatric conditions. In the February 3, 2015 assessment report of Brittany Beyerlain, M.A., Myan Le, PsyD. and Larisa Litvinov, Ph.D. for LACDMH, TIES, Claimant was diagnosed with Mood Disorder, Not Otherwise Specified and Anxiety Disorder, Not Otherwise Specified. These diagnoses were based on Claimant's strong and consistent history of depression and anxiety.

(C) Claimant's depression and anxiety are ongoing. Dr. LaCost, in her 44-page report of August 19, 2015, declined to confirm the appropriateness of Claimant's psychiatric diagnoses. (Ex. 4F, p.41). Instead, she confirmed that Claimant's "situation is very complicated," and remarked about the various presentations of FASD "for different children", including "intellectual disability, poor academic achievement, learning differences, processing deficits, attention problems, autistic-like symptoms, behavior problems, social maladjustment, etc." (*Ibid.*) Dr. LaCost also confirmed Claimant suffered from "moderate to severe" depression and anxiety. (*Id.*, p. 43.) She concluded that Claimant's depression and anxiety were "affecting her academic performance, her relationships, with family members, teachers and peers, her self-perception, and her problem-solving ability." (*Id.*)

(D) Dr. LaCost also administered multiple rating scales, which required Claimant, her mother, and her teacher, to catalogue her social emotional status and behaviors. From this data, Dr. LaCost confirmed Claimant's struggles with "thought, aggression, and externalizing problems; however she appears to 'hold herself together' more effectively at school than at home. Her struggles may be rooted in obsessive-compulsive problems, endorsed by all three respondents." (*Id.* p. 23-24.) Claimant also demonstrated pervasive

difficulty in managing behaviors and emotions. (*Id.*, p. 25.) However, Dr. LaCost found from the executive function measure which assesses self-control, the Behavior Rating Inventory of Executive Function (BRIEF) that Claimant's teacher's responses found elevated behaviors in fewer areas than Claimant's mother due to the extensive executive function support she received in her school environment. Dr. LaCost concluded "data were insufficient to support a significant and debilitating executive function impairment, which adversely affects academic performance and behavioral adjustment, and requires intensive intervention across settings." (*Id.* 4F, p. 25.)

(E) From the assessments she administered, Dr. LaCost reported that Claimant has "problems with auditory inattentiveness associated with a high likelihood of having a disorder characterized by attention deficits, such as AD/HD [attention deficit hyperactivity disorder, or ADHD]." (Ex. 4F, p. 34.) However, Dr. LaCost cautioned that Claimant's ADHD symptoms could be caused by "other psychological and/or neurological conditions." (*Ibid.*) She concluded that "[w]hatever the source, she is likely to have an impaired ability to attend to classroom lectures and extended social discourse." (*Id.*)

(F) Beginning July 1, 2015, Claimant has been receiving outpatient treatment from VIP, which includes individual therapy with Julie Sanchez, Psy.D., and psychiatric services by Scott Sweet, M. D. In a progress letter dated March 27, 2017, Dr. Sanchez and Clinical Supervisor, Michele Walker-Bauer, Ph.D., reported that Claimant displayed "defiance, anger, irritability, impulsivity, verbal and physical aggression, poor concentration, poor judgment, poor insight and difficulties with peer and family relations." (Ex. 4C, p. 1.) They described Claimant as having particular challenges, manifested by verbal and aggressive outbursts, when she transitioned from structured to unstructured time, or is forced to deviate from previous plans. (*Ibid.*)

(G) VIP reported Claimant's "unusual fixations on people, particularly boys" and her pattern of creating relationships "in her mind." (*Id.*) Claimant exhibited stalking behaviors.

Specifically, she would "flood" the targeted individual with "e-mails, messages, and text messages," and become "highly agitated and aggressive if it is suggested that the relationship is not genuine." (*Id.* p. 1-2.)

(H) Beginning on January 5, 2016, Dr. Sweet of VIP prescribed Claimant a variety of medications to address her anxiety, mood, attention, depression and sleep challenges. As of VIP's March 27, 2017 progress letter, Claimant has been taking Focalin XR 20mg, Ritalin 40mg, Depakote 2000mg, Abilify 25mg, and Zoloft 100mg.

(I) Since January 2016, Claimant has been regularly attending individual therapy with Dr. Julie Sanchez, also of VIP, where she addresses Claimant's challenges with peer rejection, social isolation, her pattern of seeking out attention with male peers, and her failure to understand how she is placing herself at risk. (Ex. D.)

(J) Claimant's placement in the NPS was clearly the result of Claimant's social-emotional and psychiatric challenges. In VIP's April 27, 2016 progress letter, Dr. Sanchez and Dr. Michele Walker-Bauer, referring also to Dr. Sweet's and Dr. LaCost's opinions, recommended placement in a NPS for "increased supervision, appropriate therapeutic support, and opportunities for positive interaction with peers who are similar to her in terms of developmental functioning." (Ex. D.)

(K) Dr. Dubner, in her April 2016 report for the WRC, concluded that Claimant's "symptoms are more mental health in nature." (Ex. 5, p. 10.) She rejected the diagnosis of Autism Spectrum Disorder using the DSM-5, but in so doing, pointed to Claimant's mental health issues and recommended intervention from a community mental health agency for "diagnostic clarification and treatment planning." (*Ibid.*) She recommended group therapy for social skills to connect with her peers, a psycho-diagnostic assessment, and continued mental health therapy.

EVALUATIONS OF COGNITIVE AND ADAPTIVE FUNCTIONING

16. (A) As part of Dr. LaCost's August 19, 2015 psychoeducational evaluation,

she assessed Claimant's cognitive ability by administering the widely used and valid Wechsler Intelligence Scale for Children – Fifth Edition (WISC-V). (Ex 4F, pp.10-11.) Cognitive ability is measured by performance in a range of index scales including Verbal Comprehension Index (VCI), Visual Spatial Index (VSI), Fluid Reasoning Index (FRI), Working Memory Index (WMI) and Processing Speed Index (PSI). Claimant achieved a full scale intelligence quotient (FSIQ), derived from these five indices, of 82, which represents a "true FSIQ" between 77 and 88, and a rank of 12th percentile, a low average score, meaning that she scored the same as or higher than 12 percent of her same-aged peers on the sample. (Ex. 4F, pp. 10-11.)

(B) Claimant obtained inconsistent or scattered scores on the various indices and subtests within the indices. The VCI measures verbal knowledge and the application of verbal skills. Claimant obtained an average score of 100, and a rank of 50th percentile. Claimant obtained a score of 64, and a rank of the first percentile, or extremely low range, on the VSI which measures her ability to evaluate visual details and spatial relationships. Claimant obtained a score of 79, and a rank of the eighth percentile, or very low range, on the FRI. The FRI measures her ability to detect underlying conceptual relationships among visual objects and to use inductive and quantitative reasoning, broad visual intelligence, simultaneous processing, and abstract reasoning. Within the FRI, claimant obtained scattered scores. Specifically, she scored in the average range in Arithmetic, but obtained scores in the two other subtests in the low average range. As a result of this scatter, Dr. LaCost considered the FRI a less valid measure of Claimant's ability. (Ex. 4F, p. 12.) On the WMI, Claimant obtained a score of 103 and a rank of the 58th percentile, or the average range, but there was considerable variability in the subscores, and as such, Dr. LaCost considered the WMI a less valid measure of her ability. On the PSI, Claimant obtained a score of 72 and a rank of third percentile, or the very low range. The PSI measures Claimant's speed and accuracy of visual identification, decision making, and decision

implementation, visual discrimination, short-term visual memory, coordination and concentration. The PSI correlates to intellectual ability and is sensitive to clinical conditions such as autism and specific learning disorders. Dr. LaCost considered the PSI reliable because there was no significant difference between the subtests.

(C) Dr. LaCost administered ancillary indices of the WISC-V and carefully analyzed and compared disparities within indices to determine the best measure of Claimant's cognitive ability. Dr. LaCost concluded that Claimant's FSIQ score of 82 was the best measure of her ability.

(D) Dr. LaCost did not find a significant discrepancy between Claimant's cognitive ability and achievement for the diagnosis of a learning disorder. The diagnosis of a learning disorder requires a discrepancy between Claimant's performance on achievement tests of one-and-one-half standard deviations below her cognitive ability measured by her FSIQ and her performance on achievement tests. (Ex. 4F, p. 16.) In the area of reading, based upon the results of her performance on the Woodcock-Johnson IV Tests of Achievement (WJ-IV ACH) and the Gray Oral Reading Test, Fifth Edition Gort-5) Claimant's achievement was consistent with her cognitive ability. In the area of written expression, Claimant achieved scores on the WJ-IV ACH in the high average and average range, or 110 and 109, respectively, which were "significantly higher than expected," based upon Claimant's cognitive ability. (*Ibid.*) Overall, Dr. LaCost found Claimant's academic achievement scores in the W-J IV ACH across all areas, including written language, reading and math, consistent with her cognitive ability as measured by her FSIQ.

(E) Dr. LaCost also administered the Developmental Test of Visual Perception, Adolescents and Adults (DTVP-A) and confirmed Claimant's significant challenges in activities involving visual motor integration which require Claimant to utilize both her visual and motor systems in tandem. On the subtest that measures visual perception only, Claimant obtained an average range score; on the subtest that measures visual-motor

integration, she obtained a score in the extremely low range. Her disparate scores explains her learning difficulty in the classroom where copying from the board, working with maps, using a touch screen, typing a computer or any other visual-motor task is involved.

(F) Dr. LaCost also obtained information through standardized testing (Differential Screening Test for Processing (DSTP)). Her results on the DSTP revealed that Claimant's acoustic-linguistic processing was less well-developed, which Dr. LaCost explained would account for Claimant's misunderstanding of "the intent of more complex social language," and having "difficulty 'reading between the lines'." (Ex. 4F, p 22.)

(G) At the conclusion of her report, Dr. LaCost made the following diagnoses under the DSM-5: Specific Learning Disorder (SLD) in Accurate Math Reasoning, Moderate (315.1); SLD in Sentence Reading Fluency and Comprehension, Mild (315.00); and Other Specified Neurodevelopmental Disorder (Visual-Motor Integration, Auditory Processing, Auditory Attention, Activities of Daily Living) (315.9). (Ex. 4F, p. 43.)

(H) Without making a psychiatric diagnosis, Dr. LaCost reported that Claimant's "depression and anxiety are moderate to severe," and have a global effect on her relationships, self-perception and problem-solving. (Ex. 4F, p.43.) Dr. LaCost recommended a learning environment, like an NPS, which would cater to her "learning style," and would also have "less stress, more support and positive feedback, and structured opportunities for identity development, responsibility, success and growth." (*Id.*, p. 44.) She recommended encouragement of Claimant's "artistic and verbal/written strengths, so she can feel better about herself." (*Id.*) To address Claimant's visual-motor and processing weaknesses, Dr. LaCost recommended an evaluation and treatment by a developmental optometrist. Dr. LaCost also emphasized Claimant's strengths, describing her as "musical, creative, social and expresses herself beautifully in writing." (*Id.*) She did not conclude that Claimant was an individual with ID. She maintained that with "appropriate supports in place, she will make it through these difficult adolescent years to

the relative calm of adulthood." (*Id.*, p. 42.)

(I) Dr. LaCost's assessment report was funded by the school district as an independent educational evaluation (IEE) and administered for the purpose of determining Claimant's appropriate school placement and services. Dr. Laboriel's medical diagnosis was also used to support Claimant's school placement, not eligibility for regional center services. Dr. Laboriel confirmed her diagnosis of pFAS by reviewing the psychological testing of Dr. LaCost. Dr. Laboriel commented that Claimant's adaptive skills measured at the bottom one percentile, and her low average cognitive skills, with marked strength in verbal areas and clear deficits in nonverbal areas, were typical of individuals with FAS. (Ex. G, p. 2.) Dr. Laboriel explained that Claimant's adaptive functioning was similar to a seven or eight year old, not her same-aged peers. She recommended a nonpublic school (NPS) setting "which can help her to maintain her learning while having considerable assistance with coping with her adaptive deficits, especially in the areas of social skills and self-regulation." (*Ibid.*)

(J) Dr. Laboriel only examined Claimant once, and relied on Claimant's previous psychological testing. Dr. Laboriel did not observe claimant at school or at home. Dr. Laboriel did not testify at hearing. She relied upon her interpretation of Dr. LaCost's report, but the evidence did not establish any foundation for her expertise in the area of psychological assessment and diagnosis, and her conclusions, based upon her review of records, were not given much weight. As such, the basis of her broad opinion that Claimant operates as someone with the adaptive skills of a much younger person, or an individual with ID under the DSM-5, was not established, and, aside from her diagnosis of pFAS, which was not disputed, the weight given to her report was limited.

17. (A) In January 2016, when Claimant was 14 years old and enrolled in ninth grade at her district public school, WRC's consulting psychologist, Dr. Dubner, completed a psychological evaluation of Claimant. Dr. Dubner prepared a written report of her findings

and conclusions. The purpose of the evaluation was to determine Claimant's current level of cognitive, adaptive and social functioning to clarify her diagnosis and to assist the WRC with determining whether she was eligible for services under the Lanterman Act. (Ex. 5, p.1). Dr. Dubner's assessment was limited to intellectual disability and autism, and was not intended to fully diagnose Claimant's emotional or mental disorders, although she provided several DSM-5 diagnoses by history, including Mood Disorder, Anxiety Disorder, FAS and Other Specified Neurodevelopmental Disorder. (Ex. 5.)

(B) To determine Claimant's cognitive ability, Dr. Dubner administered a variety of standardized assessments, interviewed Claimant and her mother and father, and observed Claimant during testing and at school. In Dr. Dubner's assessment, Claimant's full scale intelligent quotient (FSIQ) measured by the Wechsler Abbreviated Scale of Intelligence Scale-2nd Edition (WASI-II) was 87, the upper end of the low average range. (*Id.*, p. 4.) Her performance on the Verbal Comprehension Index of the WASI-II was in the average range, and her performance on the Perceptual Reasoning Index of the WASI-II was in the low average range. Dr. Dubner administered to Claimant the Kaufman Test of Educational Achievement, Third Edition (KTEA-3), which measures core academic skills. In the area of Math Computation and Reading Comprehension, Claimant performed in the average range. (*Id.*, p. 5.). Her score on measures of visual-motor integration on the Beery Developmental Test of Visual-Motor Integration (Beery), showed scores in the below average range, and established that she had "slightly" underdeveloped visual-motor integration skills. (*Id.*, p.5). Dr. Dubner found relative strength in Claimant's verbal comprehension skills and a relative weakness in her perceptional reasoning skills, and her academic performance in reading and math computation to be average. Overall, Dr. Dubner did not find Claimant to be an individual with "significant deficits in intellectual functioning, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning and learning from experience." (*Id.*, p. 10.)

(C) To determine Claimant's adaptive ability, Dr. Dubner administered the Vineland Adaptive Behavior Scales, 2nd Edition, Parent/Caregiver Rating Form (VABS-II), which measures Claimant's "practical everyday skills" in 11 skill areas. (Ex. 5, p.8.) Based upon the rating form completed by Claimant's mother, Claimant's overall adaptive functioning fell within the low (mild) range. Claimant achieved composite scores between 68 and 71, just below the moderately low range of 71-85, above the deficit ranges of 50-55 (but well below the adequate score of 86 and above). Based upon the results of the VABS-II, from her mother's perspective, Claimant presented "with significant impairment in all areas of adaptive functioning; namely communication, daily living, and socialization skills. She continues to require a significant amount of prompting to carry out many of her basic activities of daily living (e.g., eating, grooming, hygiene). She also requires a high degree of supervision and prompting to carry out her instrumental ADL [activities of daily living] (e.g., cooking managing money). Her deficits in adaptive functioning as well as difficulties in judgment, decision-making, and attention appear to be long-standing." (*Id.*, p. 10.)

(D) Dr. Dubner also observed Claimant's social interaction and behavior at her public school. Dr. Dubner observed Claimant wearing a track suit for a track meet that day, appearing very happy, dancing in her seat in the courtyard at lunch time, greeting other students approaching her seat, and speaking with other students. She respected her peer's social space, and when lunch was over, she transitioned to her next class without a problem. Dr. Dubner was told by the school psychologist that accompanied her that Claimant hadn't had the "easiest start of the week" and that she "was glad she was having such a good day." (Ex. 5, p. 4.) At the time of Dr. Dubner's observation, Claimant had been assigned a one-on-one aide throughout the school day, but the aide was not present.

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WRC'S FIFTH CATEGORY ELIGIBILITY DETERMINATION

18. (A) Dr. Kelly testified on behalf of the WRC and provided credible and persuasive testimony regarding the qualifications and basis for the multi-disciplinary team's determination that Claimant was not eligible for services under the fifth category.

(B) Dr. Kelly, who is a well-qualified psychologist and clinician, has managed WRC's intake and eligibility determinations for more than a decade. Dr. Kelly has been a clinician for 25 years and is experienced with conducting assessments, overseeing the assessment process and counseling individuals with developmental disabilities. In his current position, Dr. Kelly oversees psychological evaluations of existing and potential clients, WRC's intake department and counselors, and the multi-disciplinary team that makes eligibility determinations. As part of his responsibilities, he participated as a member of the WRC's eligibility team that determined Claimant was not eligible for services.

(C) Dr. Kelly maintained that at each multi-disciplinary team meeting about Claimant, including the team meeting in 2016 and the most recent meeting in 2017, the team considered all possible areas of eligibility, including the fifth category. He testified that Dr. Zeldin, a team member who is a pediatrician and a neurologist, is knowledgeable about FAS, and has many years of experience with eligibility determinations of regional centers statewide, through his participation in the Association of Regional Center Agencies (ARCA).

(D) Dr. Kelly responded to questions regarding the basis for his and the multidisciplinary team's conclusions. Dr. Kelly did not administer any standardized assessments, interview Claimant or her mother, or observe Claimant. His conclusion was based solely upon his analysis of the data provided to him about Claimant, including the assessments and reports her mother provided. Dr. Kelly did not challenge the basis for Claimant's diagnosis of pFAS. Nevertheless, based upon the comprehensiveness of the information available to the multidisciplinary team, and the expertise of the team

members, there was sufficient information for them to reach their determination of ineligibility and for Dr. Kelly to render an opinion at the hearing.

19. In denying Claimant's eligibility under the fifth category, the multi-disciplinary team noted only that Claimant did not require treatment similar to that of a person with an ID. (Ex. 9.) Dr. Kelly went into more detail at hearing as to what that requirement means in the context of Claimant's profile.

20. Dr. Kelly addressed whether Claimant had a disabling condition closely related to ID. Dr. Kelly did not challenge Claimant's diagnosis of pFAS, but maintained that there is insufficient evidence that pFAS, by itself, was predictive of a disabling condition closely related to ID. FAS can manifest in a variety of ways and is not uniform.[8] According to Dr. Kelly, there is no specific diagnosis that determines fifth category eligibility, including FAS, and that the multi-disciplinary team looks at Claimant's overall profile from her assessments and observations. The multi-disciplinary team reviewed Claimant's cognitive profile, her school performance, and the impact of her other deficits, including her psychiatric, attentional and visual acuity issues.

21. (A) Dr. Kelly reviewed Claimant's cognitive profile. Claimant's cognitive profile was inconsistent with the profile of individuals with ID. The assessments scores for individuals with ID are uniformly low, and are consistent with global cognitive delays. Claimant's profile is similar to that of individuals with learning disorders in that she has what Dr. Kelly referred to as "scatter" in her many areas of abilities. Specifically, many of Claimant's cognitive scores demonstrating verbal comprehension were in the average

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[8]. Claimant provided many articles about FAS, but the foundation for these articles was not provided, and in general, while the articles focused on the intersection between FAS and autism, ADHD, and a range of psychiatric issues, they did not shed light on the fifth category, or refute Dr. Kelly's testimony about Claimant's profile.

range, with lower scores in the area of nonverbal cognition, such as visual processing. Dr. Kelly's testimony is consistent with Claimant's assessments, although he disagreed with the assessors' analyses. Dr. LaCost did not find a significant difference between Claimant's overall FISC and her academic achievement, but nevertheless diagnosed her with learning disorders in multiple areas. Dr. Kelly disagreed with Dr. LaCost's use of the FSIQ as the most reliable indicia of cognition because of the amount of scatter in many of the scores in the various domains, particularly the visual-spatial scores. Overall, he found that Dr. Dubner and Dr. LaCost identified a common profile of Claimant's cognition as delayed in certain areas, but having too many average cognitive scores and average achievement to characterize her as an individual with borderline cognition.

(B) Dr. Kelly explained that the team looks at performance over time, and Claimant's profile varied from elementary to high school, which suggested that her performance was consistent with that of an individual with a learning disorder, and was also impacted by other issues, such as her attentional and psychiatric challenges, not just her innate cognitive ability.

(C) Prior to the most recent multi-disciplinary team meeting, Dr. Kelly requested that Dr. Young prepare her report where she raised many questions for the multi-disciplinary team to answer (Factual Finding 5). At hearing, Dr. Kelly did not directly answer Dr. Young's questions, but generally covered the issues she raised. For example, in regard to the effect of Claimant's medications on her functioning, Dr. Kelly generally understood Claimant's regime of medications, knew they could affect her performance in standardized assessments positively in relation to her visual processing deficits, but would not affect her verbal comprehension. Otherwise, Dr. Kelly conceded he could not otherwise render an opinion on the impact of her medication on her adaptive functioning because it was outside his area of expertise. As such, with regard to the reasonableness of her medications, Dr. Kelly had no foundation to render an opinion. However, in regard to the

diagnosis of pFAS and its implications for Claimant's adaptive functioning and regional center services, Dr. Kelly aptly noted that pFAS did not have a uniform effect on every individual, and the multi-disciplinary team looked at her overall functioning, not merely her diagnosis. With respect to whether she was substantially disabled, Dr. Kelly did not specifically address each area of major life activity enumerated under the Lanterman Act, but instead emphasized that Claimant did not have adaptive deficits or require treatment similar to that required of a person with ID.

22. (A) Dr. Kelly insisted that Claimant's adaptive deficits did not qualify her for WRC services under the fifth category. Based upon his review of her assessments and overall profile, Claimant's profile is characteristic of a person with psychiatric challenges which affect her adaptive functioning, and not her ability to perform the various functions. At public school, the teacher reported that Claimant had good and bad days, and Claimant's behavior was not consistent in all environments. For example, Claimant was more controlled at school than at home. Dr. Kelly distinguished between basic functional capabilities arising from cognitive or adaptive limitations similar to that of a person with ID, and limitations arising from a mental health disorder. Based on Claimant's profile as a person with "scattered" cognitive abilities, and significant mental health issues, Dr. Kelly considered Claimant to be capable of functioning, albeit inconsistently due to her emotional and mental health issues. Dr. Kelly used the example of a teenager who knows how to shower and wash the dishes but does not. Claimant understands how to bath, and can, but does not do so consistently, or without reminders.

(B) Dr. Kelly disputed that Claimant's adaptive behavior was similar to that of an individual with ID, despite her low scores on the behavioral rating scales administered by Dr. LaCost. Dr. Kelly observed that it was apparent that Claimant's teacher did not observe the same behaviors consistently as Claimant's mother did. Dr. Kelly conceded that Claimant had a "clearly delayed profile," but that there was insufficient evidence that she

did not have the ability to function at her age level. Dr. Kelly's conclusion was supported by Claimant's psychological assessments and VIP's reports of her psychiatric and mental health challenges. Claimant's psychiatric and mental health issues informed her daily functioning. Undoubtedly from her historical social deficits, Claimant was not functioning at her age level, but according to Dr. Kelly's testimony, these deficits were also due to her psychiatric issues.

23. (A) The determinative issue for the eligibility team is whether Claimant requires treatment similar to an individual with ID. Dr. Kelly addressed the multi-disciplinary team's express finding that Claimant did not require treatment similar to that of an individual with ID. Dr. Kelly generally denied that Claimant's adaptive deficits were rooted in any long-term cognitive or adaptive limitations. Dr. Kelly described treatment similar to that of an individual with ID to require the break down and repetition of the discrete components of each task, a method Dr. Kelly described as "chunking." Consistent with Dr. Kelly's testimony, there was insufficient evidence from Claimant's assessments that she required specialized instruction similar to that of a person with more global developmental delays. For example, Dr. LaCost referred to Claimant's "learning style," recommended encouragement of her artistic and verbal strengths, and recommended an evaluation by developmental optometrist for her visual-motor and processing issues. She explained Claimant's learning difficulties in the classroom where visual-motor tasks are involved, such as copying from the board.

(B) Dr. Kelly recommended mental health and behavioral interventions. Dr. Kelly identified a mental health service through the Los Angeles Department of Mental Health referred to as dialectical behavior therapy (DBT), an evidenced-based practice which addresses mood regulation, conflict resolution and problem solving. The WRC does not fund this service.

24. (A) WRC's multi-disciplinary team determined that Claimant did not have a

qualifying developmental disability because she did not require treatment similar to an individual with ID. The team did not expressly comment on or reach the issue of whether Claimant was "substantially disabled" in three or more areas of major life activity.

(B) Based upon the insufficiency of the evidence as to whether Claimant has a developmental disability, it is not necessary to address the issue of whether Claimant is substantially disabled.

CLAIMANT'S CONTENTIONS

25. Claimant's mother testified credibly and sincerely at the hearing regarding Claimant's background, educational and mental health history, consistent with the behavioral history and information contained in the psychological evaluations, of which she participated. Claimant's mother has clearly been diligent in following the recommendations of the assessors by participating in programs designed for parents with children of pFAS, and learning the appropriate interventions to mitigate behaviors and to provide positive support for Claimant. (Ex. 4B, p2.) She has pursued support from the school district and has convinced the school district to place Claimant in an appropriate highly structured academic and therapeutic environment where she is experiencing success. She has enrolled Claimant in therapy, individual and group, and related organized programs to address her social and peer-to-peer deficits. According to Claimant's mother, despite all the interventions, Claimant's deficits persist, and she requires access to the coordinated services of the WRC to obtain the services she needs to succeed.

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. (Welf. & Inst. Code, §§ 4700-4716.) Claimant's mother requested a hearing, on Claimant's behalf, to contest WRC's proposed denial of Claimant eligibility for services

under the Lanterman Act and therefore jurisdiction for this appeal was established.

2. Generally, when an applicant seeks to establish eligibility for government benefits or services, the burden of proof is on him or her to prove by a preponderance of the evidence that he or she meets the criteria for eligibility. (*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.) Where applicants seek to establish eligibility for government benefits or services, the burden of proof is on them. (See, e.g., *Lindsay v. San Diego Retirement Bd.* (1964) 231 Cal.App.2d 156, 161 [disability benefits].)

ELIGIBILITY CRITERIA

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

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

(a) 'Developmental Disability' means a disability that is attributable to ID[9], cerebral palsy, epilepsy, autism, or disabling conditions found to be closely

[9] The term mental retardation has been changed to intellectual disability.

related to ID or to require treatment similar to that required for individuals with ID.

(b) The Developmental Disability shall:

(1) Originate before age eighteen;

(2) Be likely to continue indefinitely;

(3) Constitute a substantial disability for the individual.

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

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

(2) 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 ID, 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 need for treatment similar to that required for ID.

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

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

7. A developmental disability within the meaning of Welfare and Institutions Code section 4512, a claimant must also suffer a "substantial disability." Pursuant to Welfare and Institutions Code section 4512, subdivision (*l*)(1):

> 'Substantial disability' means the existence of 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:
>
> (A) Self-care.
> (B) Receptive and expressive language.
> (C) Learning.
> (D) Mobility.
> (E) Self-direction.
> (F) Capacity for independent living.
> (G) Economic self-sufficiency.

8. Additionally, CCR, section 54001, states, in pertinent part:

(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 significant functional limitations, as determined by the regional center, in three or more of the following areas of major life activity, as appropriate to the

person's age:

(A) Receptive and expressive language;

(B) Learning;

(C) Self-care;

(D) Mobility;

(E) Self-direction;

(F) Capacity for independent living;

(G) Economic self-sufficiency.

9. California Code of Regulations, title 17, section 54001, subdivision (b), provides, in pertinent part, that the "assessment of substantial disability shall be made by a group of Regional Center professionals of differing disciplines," and the "group shall include as a minimum a program coordinator, a physician, and a psychologist."

DOES CLAIMANT HAVE A FIFTH CATEGORY DISABLING CONDITION?

10. The parties stipulated that the fifth category is the only eligibility category at issue. Claimant contends that the diagnosis of pFAS is predictive of a long-term and profound disabling condition that is closely related to intellectual disability or requires treatment similar to intellectual disability. The WRC maintains that pFAS, by itself, is not a qualifying diagnosis for eligibility under the Lanterman Act, and claimant's scattered cognitive profile, adaptive deficits or pFAS, do not provide support for eligibility under the fifth category.

11. Claimant is not eligible for regional center services as a person with an ID. Not one assessor concluded that Claimant was an individual with ID. Nevertheless, the requirements of eligibility for ID inform the analysis of fifth category eligibility. The "fifth category" is described as "disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for intellectually disabled individuals." (Code § 4512, subd. (a).) A more specific definition of a "fifth category"

condition is not provided in the statutes or regulations. Whereas the first four categories of eligibility are specific (e.g., epilepsy or cerebral palsy), the disabling conditions under this residual fifth category are intentionally broad so as to encompass unspecified conditions and disorders.

12. (A) The Legislature requires that the condition be "closely related" or "similar." "The fifth category condition must be very similar to [intellectual disability], with many of the same, or close to the same, factors required in classifying a person as [intellectually disabled]." [10] (*Mason v. Office of Administrative Hearings*, (2001) 89 Cal.App.4th 1119, 1129 (*Mason*).) Developmental disabilities differ widely and are difficult to define with precision. (*Id.* at p. 1130.)

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

13. Under the DSM-5, a claimant asserting fifth category eligibility is required to establish by a preponderance of evidence significant deficits in cognitive capacity or deficits in adaptive functioning, or both. Fifth category eligibility does not require strict replication of all of the diagnostic features of ID. If this were so, the fifth category would be redundant. CCR, section 54002, defines "cognitive" as "the ability of an individual to solve problems with insight to adapt to new situations, to think abstractly, and to profit

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

from experience."

14. (A) Claimant did not establish by a preponderance of the evidence that she has a disabling condition required for fifth category eligibility. Specifically, Claimant failed to establish that her disabling condition is "closely related to intellectual disability," given her cognitive ability challenges. Claimant has deficits in many areas of cognitive functioning, but the assessments revealed scattered scores on tests of cognitive ability, with deficits in areas affecting social understanding, visual-motor, and auditory processing. Based upon her multiple assessments, school performance, and the conclusions of the multi-disciplinary team, Claimant's deficits were determined to be similar to an individual with a learning disorder, and not an individual with an intellectual disability.

(B) CCR, section 54000, subdivision (c), also defines a learning disorder (LD) as a significant discrepancy between cognitive ability and educational performance, i.e., educational performance that is significantly below cognitive ability. While Dr. LaCost concluded that the most reliable measure of Claimant's cognitive ability was her FSIQ of 82, Dr. Kelly disagreed, and his opinion was given more weight as it was consistent with Dr. LaCost's designation of Claimant's multiple learning disorders.

15. Claimant failed to prove by a preponderance of the evidence that her adaptive deficits were similar to that of a person with ID. The DSM-5 recognizes that a person with an IQ 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." (DSM-5, p. 37). Claimant has severe deficits in social understanding and her social age is not the same as her same-aged peers, but much younger. However, there is insufficient evidence that her adaptive behavior is similar to that of a person with ID, because her adaptive profile is complicated by her complex mental health and psychiatric history. Dr. LaCost recognized Claimant's psychiatric profile, and both Dr. Dubner and Dr. Kelly attributed Claimant's

adaptive challenges to her mental health issues, and not her cognitive deficits.

16. Claimant did not establish by a preponderance of the evidence that she had a disabling condition requiring "treatment similar to that required for individuals with intellectual disability." (Code, § 4512, subd. (a).) Determining whether a claimant's condition "requires treatment similar to that required for intellectually disabled individuals" is not a simple exercise of enumerating the services provided and finding that a claimant would benefit from them. While many people could benefit from the types of services offered by regional centers (e.g., counseling, vocational training or living skills training), the criterion is not whether someone would benefit. Rather, it is whether someone's condition requires such treatment. Based upon Dr. Kelly's testimony, which was supported by Claimant's assessments, school placement in a NPS, reports from VIP and Claimant's mother, Claimant required a therapeutic school setting, and therapeutic interventions to address her social and behavioral deficits. Claimant failed to provide sufficient evidence that her need for intensive therapeutic interventions to address her psychiatric challenges is similar to the treatment required of a person with ID.

17. (A) Claimant failed to show by a preponderance of the evidence that her diagnosis of pFAS qualifies her under the fifth category.

(B) Claimant provided substantial and undisputed evidence that her deficits are also due to a neurological or medically-related disorder, and as such, eligibility is not barred by the excluded conditions of either a learning disorder or a psychiatric disorder. Claimant's case is distinguishable from *Samantha C. v. Department of Developmental Services* (2010) 185 Cal.App.4th 1462. In that case, a person seeking eligibility for regional center services, Samantha C., was born prematurely and with hypoxia (oxygen deprivation). In elementary school, her cognitive abilities were measured to be in the average range, though she was provided with special education services because she had deficits in auditory processing, language, speech and memory. She was later diagnosed with

attention deficit disorder (ADD), although the condition was present from an early age. She ultimately graduated from high school and enrolled in a junior college. She received SSI disability benefits and qualified for services from the Department of Rehabilitation. During the process of requesting regional center services, Samantha was given cognitive tests, which yielded scores of 92 and 87, with a full-scale IQ score of 90, placing her in the average range. The Vineland Adaptive Behavior Scales assessment revealed Samantha functioned adequately in daily living and social skills, but that she functioned on a moderately low level in the area of communication. While various experts arrived at different conclusions, at least two experts (whom the court found persuasive) opined that Samantha had major adaptive impairments and that she functioned in the range of someone with ID. The same experts opined that Samantha's hypoxia affected her brain and created a neurocognitive disorder explaining her various deficits. One expert diagnosed Samantha with a Cognitive Disorder Not Otherwise Specified.

(C) The court determined that Samantha had a fifth category condition and was eligible for regional center services. First, the court concluded that Samantha had a disabling developmental condition, i.e., she had "suffered birth injuries which affected her brain and that her cognitive disabilities and adaptive functioning deficits stem, wholly or in part, from such birth injuries." (*Samantha C. v. Department of Developmental Services*, *supra*, 185 Cal.App.4th at pp. 1492-1493.) Since the evidence established that her cognitive and adaptive deficits were related to her hypoxic birth episode, there was substantial evidence that her disabilities were *not* solely related to psychiatric or learning disorders. (*Id.*) *Samantha C.* was diagnosed with several psychiatric disorders including depression, anxiety and adjustment disorder. Second, the court concluded that Samantha's disabling condition required treatment similar to that needed by individuals with ID. (*Id.*, at p. 1493.) Specifically, the court found convincing an expert witness's testimony that those with ID and fifth category eligibility needed many of the same kinds

of treatment, such as help with cooking, public transportation, money management, job training and independent living skills, and that Samantha needed those same services. (*Id.*)

(D) *Samantha C.* established that a neurocognitive impairment that is related to a medical condition exempts a Claimant from the bar to fifth category eligibility based upon a diagnosis of a learning disorder or psychiatric disorder. The threshold requirements of fifth category eligibility were satisfied in *Samantha C.* because her disabling developmental condition was caused by a neurocognitive impairment, which was "secondary to a medical condition," not excluded disorders. (*Id.* at p. 1476.)

(E) There are elements of Claimant's case similar to those presented in the *Samantha C.* case. Claimant was diagnosed with pFAS, a neurodevelopmental, not a psychiatric disorder, which also results in a range of deficits including learning and mental health disorders. As such Claimant's disabilities do not solely arise solely from learning or psychiatric disorders, excluded conditions. Claimant's cognitive ability is also above the threshold for ID, but lower than that of *Samantha C.*

(F) However, based upon the specific circumstances of this case, the factual findings and the absence of expert testimony on behalf of Claimant, Claimant did not prove by a preponderance of evidence that her adaptive functioning deficits are closely related or similar to that of an individual with an ID, and not otherwise informed by her mental health issues, or that she requires treatment similar to that of a person with ID. Dr. Kelly provided the only expert testimony regarding Claimant's adaptive functioning and treatment. Claimant's assessments established that she has severe social deficits which are related to her learning and processing deficits. Nevertheless, based upon Dr. Kelly's testimony, which was also supported by Claimant's assessments and mental health profile, her adaptive functioning is driven primarily by her mental health issues. Claimant has not shown she requires anything but therapeutic services to address her adaptive functioning deficits, particularly at her age.

IS CLAIMANT SUBSTANTIALLY DISABLED?

18. Claimant has not proved by a preponderance of the evidence that she has a developmental disability under the fifth category. As such, it is not necessary to reach the issue of whether Claimant has significant functional limitations in three or more of the areas of major life activity specified in Welfare and Institutions Code section 4512, subdivision (*l*), and California Code of Regulations, title 17, section 54001, subdivision (a)(2). Further evaluation of Claimant's functional limitations may be appropriate in the future.

DISPOSITION

19. Based on the foregoing and the totality of the evidence, Claimant failed to establish she has the qualifying fifth category developmental disability. It was not established by a preponderance of the evidence that she is eligible for regional center services under the Lanterman Act at this time. (Factual Findings 1-25; Legal Conclusions 1-18.)

ORDER

Claimant's appeal is denied. Claimant is not eligible for regional center services under the fifth category pursuant to the Lanterman Developmental Disabilities Services Act.

DATED:

EILEEN COHN
Administrative Law Judge
Office of Administrative Hearings

NOTICE

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