# BEFORE THE
# OFFICE OF ADMINISTRATIVE HEARINGS
# STATE OF CALIFORNIA

## In the Matter of:

## CLAIMANT

## v.

## INLAND REGIONAL CENTER

## Service Agency

## OAH No. 2018061194.1

## DECISION

Kimberly J. Belvedere, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, originally heard this matter on June 3, 2019, and July 29, 2019, in San Bernardino, California. Jennifer Cummings, Program Manager, Fair Hearings and Legal Affairs, represented Inland Regional Center (IRC). Jeanie Min and Pilar Gonzalez Morales, Attorneys at Law, Disability Rights California, represented claimant, who was not present. Oral and documentary evidence was received. The record was closed and the matter submitted for decision on July 29, 2019.

On November 6, 2019, claimant filed a writ petition in the Superior Court of California, County of Sacramento, which was heard by the Hon. James P. Arguelles. Claimant raised multiple issues in the writ. The court denied most of the issues that

were raised, finding no abuse of discretion. However, with respect to three issues pertaining to eligibility under the "fifth category," the court granted the writ and remanded the matter for further consideration and clarification, as to those issues, instructing that the decision on remand comport with the following directives:

> 1. A determination whether claimant has a condition closely related to an intellectual disability shall include findings tethered to claimant's deficits in cognitive and adaptive functioning. Such a determination shall be made without regard to whether claimant has been diagnosed with a medical condition.
>
> 2. A determination whether claimant has a condition requiring treatment similar to that required for individuals with an intellectual disability shall not depend on a determination that any treatment required for individuals with an intellectual disability is required for such individuals and no others. Further, to the extent any comparison is made to treatment for attention deficit hyperactivity disorder (ADHD), an explanation for the comparison shall be provided.
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> 3. A determination whether claimant is substantially disabled shall be supported with findings referencing the major life activities contained in Welfare and Institutions Code section 4512, subdivision (l), and California Code of Regulations, title 22, section 54001.

The parties were afforded the opportunity to file briefs following remand. Oral argument was scheduled, and heard, on January 15, 2021. IRC was represented by Julie A. Ocheltree, Enright & Ocheltree, LLP. Claimant was represented by William Leiner, Attorney at Law, Disability Rights California.

The record was closed and matter submitted for decision on January 15, 2021.

## ISSUES TO BE DECIDED

1. Is IRC's original determination finding claimant eligible for regional center services in 2014 under a provisional diagnosis of intellectual disability clearly erroneous in light of IRC's recent comprehensive reassessment and additional information obtained since the time of that original determination?

2. Does claimant have a disabling condition closely related to, or that requires treatment similar to, a person with an intellectual disability (fifth category), so as to render her eligible for regional center services under the Lanterman Developmental Disabilities Services Act (Lanterman Act)?

## FACTUAL FINDINGS

### Background and Jurisdictional Matters

1. Claimant is a nine-year-old girl.[1] Claimant was adopted by her maternal grandparents after she was removed from the care of her biological mother by social

[1] At the time of the original hearing in this matter, claimant was seven years old.

services. Claimant was exposed to methamphetamine, cocaine, cannabis, tobacco, and alcohol in utero.

### EARLY START SERVICES AND RECORDS PRIOR TO CLAIMANT'S THIRD BIRTHDAY

2. Claimant began receiving services from IRC under the Early Start program on April 21, 2014, due to her delays in communication, fine motor, and cognitive skills. According to claimant's April 21, 2014, Early Start Individualized Family Service Plan (IFSP), completed when claimant was approximately 31 months old, claimant loved to dance and was independent in using a napkin to wipe her mouth. Claimant would put her dirty dishes in the sink. Claimant could drink from a straw; play with toys; and wash and dry her hands with assistance. Claimant would show strong periods of independence in social and emotional interactions. Claimant could turn pages of a book, release a raisin into a bottle, and place six pegs into a pegboard without assistance. Claimant was oriented to her name, looked at the appropriate person when that person was named, and inhibited her activity in response to being told "no." Claimant's gross motor skills were shown to be age appropriate. Notes also described claimant as a "friendly energetic girl" who communicates with "gestures and facial expressions." It was also noted that claimant did not chew her food and engaged in self-injurious behaviors, like biting her fingers or purposely falling to the floor, when asked to do something she did not want to do.

3. According to claimant's August 28, 2014, Individualized Education Program Plan (IEP), claimant qualified for special education services at school under the category of intellectual disability. Claimant was placed in a moderate-severe

special day class with services that included specialized academic instruction and speech/language therapy.[2]

4. A September 11, 2014, IFSP progress report, completed when claimant was one-day shy of 36 months old, showed: claimant's cognitive development exceeded her chronological age (37 months); claimant's social-emotional development exceeded her chronological age (46 months); and claimant's expressive and receptive language skills were about age appropriate (34 months old and 35 months old, respectively). Claimant's fine and gross motor skills were shown to be the equivalent of a 29-month-old child, just below her chronological age.

## IRC'S ORIGINAL ELIGIBILITY DETERMINATION

5. Eligibility for the Early Start program is different than eligibility for services under the Lanterman Act. In other words, eligibility for the Early Start program does not mean that a person automatically qualifies for services under the Lanterman Act. A child is eligible for services under the Early Start program until he or she turns three years old. For a child to continue being eligible for regional center services beyond three years old, a child must meet the more stringent criteria for services under the Lanterman Act.

6. On August 5, 2014, when claimant was just under three years old (approximately 34 months old), Tracy Dern, Psy.D., conducted a psychological assessment to determine whether claimant was eligible for regional center services

[2] The criteria for special education services is governed by the Education Code, and differs significantly from the criteria for eligibility under the Lanterman Act, which is governed by the Welfare and Institutions Code and California Code of Regulations.

under the Lanterman Act. Dr. Dern conducted two assessments: the Wechsler Preschool and Primary Scale of Intelligence – Fourth Edition (WPPSI-4), and the Vineland Adaptive Behavior Scales, which is a subjective reporting scale that was completed by claimant's grandmother. Dr. Dern also reviewed claimant's records, although her report does not state what records she reviewed. Dr. Dern also conducted a diagnostic interview. Dr. Dern did not testify at the hearing.

Following the assessment, Dr. Dern diagnosed claimant with global developmental delay. According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5), a diagnosis of global developmental delay is reserved for individuals under the age of five years because the clinical severity of their delay cannot be reliably assessed during early childhood. This category is diagnosed, among other things, when an individual fails to meet expected developmental milestones in several areas of intellectual functioning and when children who are too young to participate in standardized testing. This category requires reassessment after a period of time because global developmental delay is not a qualifying condition for regional center services under the Lanterman Act.

In order to render claimant eligible, Dr. Dern noted that claimant "is in the borderline range with her adaptive skills, but given her cognitive scores on the [WPPSI-4] and past developmental history, a provisional diagnosis of intellectual disability is warranted." Accordingly, claimant was deemed eligible for regional center services due to that provisional diagnosis, with the recommendation that claimant be reassessed in three years to determine if she remained eligible for regional center services.

## ADDITIONAL REPORTS

7. On April 27, 2017, claimant's school district completed a Transition to Kindergarten report, which noted that claimant had good disposition in the classroom; was cooperative and fun to teach; had a good sense of humor; enjoyed interacting with teaching staff and peers; engaged in cooperative play; did well in small group activities; engaged in tasks with minimal re-direction; and was easily re-directed, when needed. The report also noted claimant was able to express her wants and needs and had good social skills.

8. On May 18, 2017, claimant's school district completed a Speech and Language Evaluation Report over a two-day period. The report noted claimant had "clear speech intelligibility" at the conversation level. Claimant's vocabulary skills were shown to be "slightly below average" and her oral and written language skills were shown to be average. Other observations noted in the report showed claimant's expressive and receptive language skills to be "age appropriate." The report then outlined the eligibility criteria for special education eligibility under the category of speech and language impairment, as set forth in Title 5 of the California Code of Regulations. The school determined that claimant did not meet the criteria for special education services because claimant had speech and language skills that were age-appropriate. The report further noted claimant functioned "well above" the level that would qualify a child for special education services in the category of speech and language impairment.

9. On June 5, 2017, following the determination that claimant did not meet the criteria for special education services under the category of speech and language impairment, the school conducted a Triennial Psycho-Educational Assessment of claimant. The school administered several measures, including the Vineland Adaptive

Behavior Scales, Third Edition; the Beery Visual-Motor Integration test, Sixth Edition (VMI), and the Developmental Profile 3. The school also reviewed other psychological records, reviewed claimant's medical records, sought parent input, sought teacher input, and observed claimant. The report showed claimant exhibited "strength in the area of visual-motor integration" and tested in the average range. The Vineland tests adaptive skills, and is comprised of four domain scores, including communication, daily living skills, socialization, and motor skills, as well as multiple subsets within each domain. Claimant's scores varied widely. Claimant's scores were as follows: motor skills (moderately high); socialization (moderately high); daily living skills (adequate); and communication (adequate). Claimant's scores in the subsets within each domain included scores that were high, moderately high, and adequate. Claimant had only one "moderately low" score in numeric expression. Overall, claimant's adaptive composite behavior score was determined to be moderately high.

Because an intelligence quotient (IQ) test could not be administered (claimant is African American), the school report concluded claimant's cognitive skills are likely within the average range, based on her moderately high levels of adaptive functioning levels. Accordingly, claimant did not qualify for special education under the category of intellectual disability, which, according to the report, required claimant to have "significantly sub-average intellectual functioning" concurrent with deficits in adaptive behavior.

### COMPREHENSIVE REASSESSMENT AND DETERMINATION THAT CLAIMANT IS NO LONGER ELIGIBLE FOR REGIONAL CENTER SERVICES

10. On March 22, 2018, Ruth Stacy, Psy.D., conducted a comprehensive reassessment of claimant to determine whether claimant remained eligible for regional center services. Dr. Stacy administered the Wechsler Scale of Intelligence for Children,

Fifth Edition (WISC-5); the Adaptive Behavior Assessment System, Third Edition (ABAS-3); reviewed claimant's records; and conducted a diagnostic interview. Dr. Stacy diagnosed claimant with ADHD, which is not a qualifying disorder for regional center services. Dr. Stacy also concluded claimant did not meet the diagnostic criteria for intellectual disability or any other qualifying disorder. Dr. Stacy's testimony and psychological assessment will be discussed more fully below.

11. On May 2, 2018, IRC's eligibility team, which was comprised of a medical doctor, Dr. Stacy, and a Program Manager, reviewed claimant's records and Dr. Stacy's psychological assessment. The IRC eligibility team concluded claimant was no longer eligible for regional center services.

12. On May 14, 2018, IRC sent claimant a Notice of Proposed Action stating that the original determination that claimant was eligible for regional center services under the diagnosis of intellectual disability is clearly erroneous in light of the comprehensive reassessment.

13. On June 25, 2018, a Fair Hearing Request was filed on claimant's behalf challenging IRC's determination.

14. Leigh-Ann Pierce, a Program Manager at IRC, and claimant's father attended a telephonic conference on July 11, 2018, to discuss claimant's eligibility. Following the meeting, IRC adhered to its determination, and the matter was set for hearing. The letter also indicated claimant was not eligible for regional center services under any other qualifying category.

15. In the ensuing months, the matter was continued eight times for various reasons, mostly, to permit claimant an opportunity to obtain an additional assessment and/or documentation. Those documents included a psychological assessment report

completed by Colette D. Sinclair, M.A., L.E.P. in December 2018, who did not testify at the hearing, did not provide a curriculum vitae, and who is not a licensed clinical psychologist. Thus, this report was given little weight in reaching this decision.

16. Also submitted was a March 15, 2019, Multidisciplinary Teacher's Report completed by claimant's school district that showed claimant did not meet the special education criteria for intellectual disability because, although her adaptive skills showed some challenges, her cognitive skills were very high. Most important, this report concluded claimant's cognitive and adaptive skills were consistent with ADHD, Combined Type, which is precisely what Dr. Stacy diagnosed claimant with in March 2019. Moreover, the report noted claimant suffered from encopresis (a bowel disorder). Thus, claimant qualified for special education services under the category of "other health impairment" due to her encopresis[3] and ADHD.

17. Finally, a May 10, 2019, Neuropsychological Evaluation completed by Sarah Mattson, Ph.D., was also submitted. That assessment, discussed more fully below in Dr. Mattson's testimony, concluded claimant suffered from fetal alcohol spectrum disorders (FASD), which includes alcohol-related neurodevelopmental disorders (ARND). Dr. Mattson concluded claimant's ARND qualified claimant for regional center services under the fifth category because claimant had cognitive and adaptive

[3] According to Dr. Stacy, encopresis is a bowel disorder wherein a person cannot tell when they need to have a bowel movement. It is not a condition that causes a deficit in intellectual functioning but can lead to the need for assistance in toileting.

challenges, and "would benefit" from treatment like the treatment given to those who have a diagnosis of intellectual disability.

18. After reviewing all information, and convening an eligibility team on two additional occasions (May 2, 2019, and May 22-23, 2019), IRC again determined that claimant was no longer eligible for regional center services under the category of intellectual disability and did not qualify for regional center services under the fifth category.

19. At hearing, the issues that were presented were 1) whether the original determination that claimant qualified for regional center services is clearly erroneous in light of the comprehensive reassessment and additional information since claimant originally became eligible for regional center services in 2014, and 2) whether claimant is eligible for regional center services under the fifth category.

## Burdens and Standards of Proof

### ARGUMENTS

20. Claimant contended that, since IRC's May 15, 2018, Notice of Proposed Action identified that claimant is no longer eligible for services under any of the categories contained in the Lanterman Act (i.e. autism, epilepsy, intellectual disability, cerebral palsy, and the fifth category), IRC has the burden of proving that claimant is not eligible under either intellectual disability or the fifth category.

21. IRC contended that claimant was originally eligible for regional center services under the provisional diagnosis of intellectual disability found by Dr. Dern, and based on its comprehensive reassessment required with the provisional diagnosis (which included review of all claimant's records), claimant no longer qualifies under

that provisional diagnosis. IRC does not dispute that it has the burden of proving by a preponderance of the evidence that its original determination is now clearly erroneous in light of the comprehensive reassessment. However, IRC contended that the assertion that claimant is eligible for regional center services under the fifth category is a new claim for eligibility, and thus, claimant has the burden of proving her eligibility under the fifth category.

## DETERMINATION

22. As claimant was never before deemed eligible for regional center services based on the fifth category, eligibility under the fifth category constitutes a new claim. Thus, while it is determined, and IRC does not dispute, that it has the burden of proving by a preponderance of the evidence that claimant is no longer eligible for regional center services under a diagnosis of intellectual disability because the original eligibility determination is clearly erroneous in light of the comprehensive reassessment[4], claimant has the burden of proving by a preponderance of the evidence that she qualifies for regional center services under the fifth category.

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[4] Welfare and Institutions Code section 4643.5, subdivision (b), provides:

> An individual who is determined by any regional center to have a developmental disability shall remain eligible for services from regional centers unless a regional center, following a comprehensive reassessment, concludes that the original determination that the individual has a developmental disability **is** clearly erroneous. [Emphasis Added].

## Applicable Diagnostic Criteria

### INTELLECTUAL DISABILITY

23. The DSM-5 contains the diagnostic criteria used for intellectual disability. The essential features of intellectual disability are deficits in general mental abilities and impairment in everyday adaptive functioning, as compared to an individual's age, gender, and socio-culturally matched peers. Intellectual functioning is typically measured using intelligence tests. Individuals with intellectual disability typically have IQ scores in the 65-75 range. In order to have a DSM-5 diagnosis of intellectual disability, three diagnostic criteria must be met. The DSM-5 states in pertinent part as follows:

> Intellectual disability (intellectual developmental disorder) is a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains. The following three criteria must be met:
>
> A. Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment,

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Thus, it is important to note that the determination is not whether the original eligibility determination "was" clearly erroneous (i.e. that the original eligibility determination, in this case by Dr. Dern, was in error). Rather, the determination is whether the original eligibility determination "is" now clearly erroneous in light of the required comprehensive reassessment (and other information) obtained since the original eligibility determination.

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 sociocultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.

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

[¶] . . . [¶]

Intellectual functioning is typically measured with individually administered and psychometrically valid, comprehensive, culturally appropriate, psychometrically sound tests of intelligence. Individuals with intellectual disability have scores of approximately two standard deviations or more below the population mean, including a margin for measurement error (generally +5 points). On tests with a standard deviation of 15 and a mean of 100, this involves a score of 65-75 (70 ± 5). Clinical training and

judgment are required to interpret test results and assess intellectual performance.

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

Deficits in adaptive functioning (Criterion B) refer to how well a person meets community standards of personal independence and social responsibility, in comparison to others of similar age and socio-cultural 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 tasks 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. . . .

[¶] . . . [¶]

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, at work, at home, or in the community. To meet the diagnostic criteria for intellectual disability, the deficits in adaptive functioning must be directly related to the intellectual impairments described in Criterion A.

## DIAGNOSTIC CRITERIA FOR ADHD[5]

24. Sometimes, ADHD may be comorbid with a diagnosis of intellectual disability; or, it may exist separately. ADHD is a neurodevelopmental disorder defined

[5] ADHD is not a qualifying diagnosis for regional center services. However, since both experts in this case referenced ADHD, and claimant's adaptive challenges were

by impairing levels of inattention, disorganization, and/or hyperactivity-impulsivity. Inattention and disorganization entail inability to stay on task, seeming not to listen, and losing materials, at levels that are inconsistent with age or developmental level. Hyperactivity-impulsivity entails overactivity, fidgeting, inability to stay seated, intruding into other people's activities, and the inability to wait. ADHD often persists into adulthood, with resultant impairments of social, academic, and occupational functioning.

The DSM-5 diagnostic criteria for ADHD includes: persistent pattern of inattention and/or hyperactivity that interferes with functioning or development, as characterized inattention, hyperactivity, or both.

In order to meet the diagnostic criteria under inattention, a person must have six or more of the following symptoms that persist for at least six months in a manner that impacts social and academic/occupational activities: often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or with other activities; often has trouble holding attention on tasks or play activities; often does not seem to listen when spoken to directly; often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., loses focus, side-tracked); often has trouble organizing tasks and activities; often avoids, dislikes, or is reluctant to do tasks that require mental effort over a long period of time (such as schoolwork or homework); often loses things necessary for tasks and activities (e.g. school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones); is often easily distracted; and is often forgetful in daily activities.

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ultimately determined to be attributable to ADHD, this diagnostic criteria is mentioned here.

In order to meet the diagnostic criteria under hyperactivity and/or impulsivity, a person must have six or more of the following symptoms that persist for at least six months in a manner that is inconsistent with his or her developmental level and negatively impacts social and academic/occupational activities: often fidgets with or taps hands or feet, or squirms in seat; often leaves seat in situations when remaining seated is expected; often runs about or climbs in situations where it is not appropriate (adolescents or adults may be limited to feeling restless); often unable to play or take part in leisure activities quietly; is often "on the go" acting as if "driven by a motor"; often talks excessively; often blurts out an answer before a question has been completed; often has trouble waiting his/her turn; and often interrupts or intrudes on others (e.g., butts into conversations or games).

In addition, the following conditions must be met: several inattentive or hyperactive-impulsive symptoms were present before age 12 years; several symptoms are present in two or more settings (home, school or work; with friends or relatives; in other activities); there is clear evidence that the symptoms interfere with, or reduce the quality of, social, school, or work functioning; the symptoms do not happen only during the course of schizophrenia or another psychotic disorder; and the symptoms are not better explained by another mental disorder (e.g. Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

A diagnosis of ADHD Combined Presentation is appropriate if a person meets the criteria for both inattention and hyperactivity/impulsivity.

### DIAGNOSTIC CRITERIA FOR FIFTH CATEGORY

25. Under the fifth category, the Lanterman Act provides assistance to individuals with disabling condition closely related to an intellectual disability or that

requires similar treatment as an individual with an intellectual disability but does not include other handicapping conditions that are "solely physical in nature." (Welf. & Inst. Code, § 4512, subd. (a).) A disability involving the fifth category must also have originated before an individual attained 18 years of age, must continue or be expected to continue indefinitely, and must constitute a substantial disability.

In *Mason v. Office of Administrative Hearings* (2001) 89 Cal.App.4th 1119, the appellate court held that 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. Another appellate decision has also suggested, when considering whether an individual is eligible for regional center services under the fifth category, that eligibility may be based largely on the established need for treatment similar to that provided for individuals with an intellectual disability, 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 intellectual disability. The court understood and noted that the Association of Regional Center Agencies had guidelines (ARCA 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 intellectual disability.

The ARCA Guidelines provide criteria to assist regional centers in determining whether a person qualifies for services under the fifth category. The ARCA Guidelines

provide that the person must function in a manner similar to a person with an intellectual disability or who requires treatment similar to a person with an intellectual disability.

## Functioning Similar to a Person with an Intellectual Disability

26. A person functions in a manner similar to a person with an intellectual disability if the person has significant sub-average general intellectual functioning that is accompanied by significant functional limitations in adaptive functioning. Intellectual functioning is determined by standardized tests. A person has significant sub-average intellectual functioning if the person has an IQ of 70 or below. Factors a regional center should consider include: the ability of an individual to solve problems with insight, to adapt to new situations, and to think abstractly and profit from experience. If a person's IQ is above 70, it becomes increasingly essential that the person demonstrate significant and substantial adaptive deficits and that the substantial deficits are related to the cognitive limitations, as opposed to a medical or some other problem. It is also important that, whatever deficits in intelligence are exhibited, the deficits show stability over time.

Significant deficits in adaptive functioning are established based on the clinical judgements supplemented by formal adaptive behavioral assessments administered by qualified personnel. Adaptive skill deficits are deficits related to intellectual limitations that are expressed by an inability to perform essential tasks within adaptive domains or by an inability to perform those tasks with adequate judgement. Adaptive skill deficits are not performance deficits due to factors such as physical limitations, psychiatric conditions, socio-cultural deprivation, poor motivation, substance abuse, or limited experience.

## Treatment Similar to a Person with an Intellectual Disability

27. In determining whether a person requires treatment similar to a person with an intellectual disability, a regional center should consider the nature of training and intervention that is most appropriate for the individual who has global cognitive deficits. This includes consideration of the following: individuals demonstrating performance based deficits often need treatment to increase motivation rather than training to develop skills; individuals with skill deficits secondary to socio-cultural deprivation but not secondary to intellectual limitations need short-term, remedial training, which is not similar to that required by persons with an intellectual disability; persons requiring habilitation may be eligible, but persons primarily requiring rehabilitation are not typically eligible as the term rehabilitation implies recovery; individuals who require long-term training with steps broken down into small, discrete units taught through repetition may be eligible; and the type of educational supports needed to assist children with learning (generally, children with an intellectual disability need more supports, with modifications across many skill areas).

## Substantial Disability

28. The ARCA Guidelines also refer to California Code of Regulations, title 17, sections 54000 and 54001 regarding whether a person has a substantial disability. This means the person must have a significant functional limitation in three or more major life areas, as appropriate for the person's age, in the areas of: communication (must have significant deficits in both expressive and receptive language), learning, self-care, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

## Dr. Stacy's Testimony

29. Dr. Stacy testified on behalf of IRC. Dr. Stacy is a staff psychologist at IRC. She has also held positions at IRC such as Senior Intake Counselor, Senior Consumer Services Coordinator, and Consumer Services Coordinator. In all of those capacities, she dealt directly with individuals who either had or were suspected of having developmental disabilities, among other challenges. She has been involved in assessing individuals who desire to obtain IRC services under the Lanterman Act for over 29 years. In addition to her doctorate degree in psychology, she also holds a Master of Arts in Counseling Psychology, a Master of Arts in Sociology, and a Bachelor of Arts in Psychology and Sociology. Dr. Stacy qualifies as an expert in the diagnosis of intellectual disability, and in the determination of eligibility for IRC services based on intellectual disability and the fifth category. Dr. Stacy reviewed reports pertaining to claimant. Those reports included those identified previously in this decision. The following is a summary of Dr. Stacy's testimony and the documentary evidence.

Dr. Stacy correctly related the diagnostic criteria for both intellectual disability and the fifth category. She explained that for a diagnosis of intellectual disability, a person must have intellectual deficits, as typically measured by an IQ of below 75, before adaptive deficits are even considered. With respect to the fifth category, Dr. Stacy explained that as a person's IQ exceeds 70, it becomes increasingly important for that person's adaptive deficits to be very low, and it must also show that the adaptive deficits are attributable to the lower cognitive skills as opposed to something else. This is precisely why, in young children, they are very rarely qualified under the fifth category because their cognitive and adaptive skills are still developing. The test as to whether a person is eligible for regional center services under the fifth category is also not simply whether they can "benefit" from services provided by a regional center;

rather, it is whether they require treatment similar to a person with an intellectual disability.

Typically, when a child is diagnosed with Global Developmental Delay or provisionally qualified for regional center services under intellectual disability, IRC will reassess the child around age five. In claimant's case, she had a history of her mother using drugs and alcohol in utero, being in foster care, being left at a "drug house," and many other negative factors. Nobody can really be sure what claimant was exposed to in her early developmental years. However, not every child exposed to such conditions or substances automatically equates with having an intellectual disability.

Claimant has been diagnosed by Dr. Mattson with FASD, or more specifically, ARND. The treatment options for these disorders is medication, which is not used to treat individuals with an intellectual disability. Other treatments that may help or benefit persons with ARND are parent training, behavioral training, and specialized learning environments.

In claimant's early years, especially the records pertaining to when claimant was under three years old, there were cognitive and adaptive delays present. However, Dr. Stacy explained that the delays appeared to be very mild (closer to a 33 percent). Thus, when Dr. Dern evaluated claimant, Dr. Dern felt claimant met the criteria for Global Developmental Delay, and claimant should be provisionally qualified for regional center services. Dr. Stacy did not disagree that claimant met the diagnostic criteria for Global Developmental Delay, but felt that since claimant's adaptive skills were not bad and her cognitive skills were in the borderline range, claimant should not have been qualified for regional center services under the category of intellectual disability. In other words, the qualification for services was erroneous.

Further, in reviewing the documents after claimant became eligible for regional center services, a diagnosis of intellectual disability or qualification under the fifth category is not warranted. Claimant's April 17, 2017, transition to kindergarten report, did not show any major concerns in either claimant's intellectual or adaptive skills. The May 18, 2017, Speech and Language Evaluation Report completed by claimant's school district determined claimant was functioning at an age appropriate level and did not qualify for special education services under speech and language impairment. Similarly, the June 5, 2017, Triennial Psycho-Educational Assessment showed claimant's cognitive skills were in the average range and her adaptive skills were moderately high. Thus, prior to Dr. Stacy conducting her March 22, 2018, psychological assessment, claimant did not present as a child who was either intellectually disabled or someone who exhibited substantial disabilities in three or more major life activities, as appropriate for her age.

Dr. Stacy conducted her psychological assessment on March 22, 2018. She utilized the Wechsler Scale of Intelligence for Children, Fifth Edition (WISC); Adaptive Behavior Assessment System (ABAS), and also conducted a diagnostic interview, observed claimant, and reviewed records. On the WISC, which tests cognitive functioning, claimant had a wide range of abilities. Overall, claimant's cognitive abilities fell within the low average range. On the WISC, which tests cognitive functioning, claimant scores ranged from the low to high average across 10 domains. As Dr. Stacy noted, however, low average skills are simply at the lower end of the "average" range. Thus, claimant was not functioning at a deficit.

Claimant's scores on the ABAS showed her adaptive skills to range from extremely low to average. The ABAS is a form completed by claimant's parent or caregiver. Dr. Stacy noted that the unusually low results yielded on the ABAS appeared

to be a gross underestimation of claimant's adaptive skills. The results of the ABAS were simply inconsistent with claimant's cognitive functioning, which was tested by using an objective measure.

Dr. Stacy also concluded, because of her low average cognitive abilities, claimant did not qualify for regional center services under the fifth category. Dr. Stacy diagnosed claimant with ADHD, Combined Presentation, and opined that claimant's adaptive challenges are attributable to her ADHD, as opposed to any cognitive deficit.

Regarding the December 2018 report completed by Ms. Sinclair, Dr. Stacy explained that a licensed educational psychologist is not the same as a licensed clinical psychologist. A licensed clinical psychologist is a person licensed by the Board of Psychology. A licensed educational psychologist is a person with a Master of Arts degree, not a Ph.D., who obtains some additional training and becomes licensed by the Board of Behavioral Sciences. Dr. Stacy did not agree with the conclusion in Ms. Sinclair's report that claimant's cognitive and adaptive deficits were attributable to claimant's brain function.

Regarding the March 15, 2019, Multidisciplinary Report completed by claimant's school district, Dr. Stacy pointed out that, yet again, claimant's school concluded she did not meet the special education criteria for intellectual disability.

Dr. Stacy reviewed Dr. Mattson's May 10, 2019, psychological evaluation. She noted that claimant's scores on the WISC were very similar to when she administered the WISC just a few months prior. Again, there was a lot of variability among the different subsets, which is not consistent with a person who has an intellectual disability. Claimant's scores on the Vineland Adaptive Behavior Scales (Vineland) showed claimant had low adaptive skills, in fact, much lower than what she observed in

her ABAS assessment. Dr. Stacy therefore questioned the accuracy of the Vineland because she noted it would not be normal for a person to regress in their adaptive skills in only two months. What would explain the variability, however, other than an over-reporting adaptive challenges by claimant's father, is ADHD. In other words, cognitive deficits are not causing claimant's adaptive challenges; a person with an intellectual disability has consistent deficits over a long period of time. Claimant has not exhibited consistent deficits over a long period of time – even between when Dr. Stacy conducted her assessment and when Dr. Mattson conducted her assessment. Finally, with respect to Dr. Mattson's evaluation, Dr. Stacy pointed out that in order to find claimant intellectually disabled, Dr. Mattson used 1.5 standard deviations below the normal expected cognitive functioning level as opposed to 2 standard deviations, which is what is supposed to be used.

Dr. Stacy testified that the nature of training and intervention (as opposed to treatment) most appropriate for a person with an intellectual disability is as follows: typically a person needs a lot of repetition broken down into small steps, a person does not necessarily need mental health services; a person with an intellectual disability would need assistance in all areas of life - such as money management, making decisions, and in getting employment; things would have to be modified for a person with an intellectual disability to make it easier for the individual to understand; and a person with an intellectual disability may have behavioral challenges. Intellectual disability is a substantial lifelong disability that is the direct result of cognitive limitations. For example, a person who is blind might benefit from the same interventions as a person with an intellectual disability (i.e. money management, cooking meals, etc.), but they would need that assistance because of their physical limitations and not any cognitive deficit. In that same vain, claimant may benefit from interventions similar to a person with an intellectual disability, like a person who is

blind, but it would not be because of her cognitive limitations, because claimant simply does not have the cognitive deficits expected of a person who is intellectually disabled.

Accordingly, even if claimant has ARND as diagnosed by Dr. Mattson, claimant no longer qualifies for regional center services under a diagnosis of intellectual disability and similarly does not qualify for regional center services under the fifth category.

## Evidence Presented by Claimant

### TESTIMONY OF DR. MATTSON

30. Dr. Mattson is currently a professor of psychology at California State University, San Diego (SDSU). She also serves as an adjunct professor at the University of California, San Diego, and is a co-director at the Center for Behavioral Teratology and center for Clinical and Cognitive Neuroscience, both located at SDSU. Dr. Mattson holds a Ph.D. in Clinical Psychology with a Neuropsychology Specialty, an M.A. in Psychology, and a B.A. in Biology. She is licensed with the Board of Psychology. Dr. Mattson's clinical research experience is focused on alcohol-related neurodevelopmental disorders, and she has a current research grant in the field of FASD. She also has had many prior grants in the area of pre-natal alcohol and drug exposure. Dr. Mattson is published in many peer-reviewed academic journals in the area of fetal alcohol and drug exposure and has written chapters in books regarding the same. Dr. Mattson is an expert in the area of FASD.

Dr. Mattson conducted a neuropsychological evaluation of claimant on May 10, 2019. The following is a summary of Dr. Mattson's testimony and the report she completed concerning that evaluation.

As a neuropsychologist, Dr. Mattson's practice is to focus on how fetal alcohol exposure affects cognition and behavior. FASD is a diagnosis that encompasses people who may still show the cognitive effects of fetal alcohol exposure even though they lack the physical markers. ARND is included in the diagnosis of FASD. People with ARND are likely to have cognitive and adaptive deficits throughout their lifetime. Approximately 60 to 90 percent of people with ARND also have diagnoses of ADHD. Cognitive behavioral impairment is determined if the person is 1.5 standard deviations below the normal range. People with ARND typically have higher intellectual functioning than a person with intellectual disability, so it is very common for them to not get services they need.

Dr. Mattson explained that the purpose of her assessment was to determine whether claimant met the diagnostic criteria for intellectual disability or the fifth category. She opined that ARND is similar to intellectual disability because ARND is characterized by significant impairment in cognitive and adaptive functioning. Based on her assessment, claimant probably does not meet the criteria for intellectual disability. However, some children with ARND have adaptive impairments that exceed cognitive impairments, which is the case with claimant. Treatments for FASD or ARND are also similar to treatments that a person with an intellectual disability would receive.

Dr. Mattson administered the following tests: WISC; the NEPSY II; NIH toolbox; Wechsler Individual Achievement Test, third edition (WIAT-3); California Verbal Learning Test (CVLT); Child Behavioral Checklist (CBCL); two versions of the Vineland Adaptive Behavior Scale, Third Edition (Vineland); Delis Rating of Executive Function (DREF); Behavior Rating Inventory of Executive Function, Second Edition (BRIEF 2); and the Behavior Assessment System for Children, Third Edition (BASC 3).

During the testing, Dr. Mattson observed claimant to be fidgety but "not overly inattentive." An assistant who was helping conduct the assessment noticed claimant "was easily distracted and needed to be redirected . . . ."

Claimant's full-scale IQ score was determined to be 76. On the WISC, claimant scored in the low average to average range of cognitive abilities. These scores differed from her executive functioning scores on the NEPSY II, which showed claimant to be significantly challenged in the area of executive functioning.

On the Vineland, claimant's adaptive skills were shown to be significantly lower than her overall cognitive abilities. On the BASC 3, fewer than 5 percent of the children in the general population had scores as low as claimant. On the BRIEF 2, all scores were in the "clinically elevated" range. Concerns were noted with claimant's ability to resist impulses, be aware of her functioning in social settings, adjust well to changes in her environment, get going on tasks, and problem solving, among other things. Dr. Mattson explained that "these difficulties likely relate to fundamental behavioral and emotional regulation difficulties and suggest that more global problems with self-regulation are having a negative effect on active cognitive problem solving . . . ." On the D-REF, all of claimant's scores as determined by the parent reporting form showed difficulties in behavioral, emotional, and cognitive functions. The NIH Toolbox and CVLT showed claimant's memory to be "relatively intact" while her "verbal and visual memory" are impaired. On the WIAT-3, claimant's academic functioning was determined to be below average. On the CBCL, which was filled out by claimant's father, claimant was shown to have both behavioral and emotional problems.

Dr. Mattson provided an ARND checklist to claimant's father, which contained 35 items. Claimant's father checked off two items, which is above the cutoff and suggests impairment consistent with ARND. Items endorsed included "seems unaware

of consequences of actions, socially inept, easily manipulated by others, and requires constant supervision."

Dr. Mattson provided an ADHD checklist to claimant's father, which contained 18 items relating to behaviors consistent with ADHD. Claimant's father checked off nine symptoms that cause moderate to severe problems at home and school and nine hyperactive/impulsive symptoms, which cause moderate to severe problems at home and school.

Dr. Mattson diagnosed claimant as follows:

> ARND is characterized by cognitive impairment or behavioral impairment. Cognitive impairment is defined as impairment at least 1.5 standard deviations (SD) below the norm on a measure of global ability or on tests of 2 other cognitive domains. Claimant has a FSIQ of 76 which is more than 1.5 standard deviations below the norm. She also demonstrated impairment more than 1.5 standard deviations from the norm on academic functioning . . . . While cognitive impairment supersedes behavioral impairment diagnostically, in the absence of documented cognitive impairment claimant would also meet the criteria for ARND based on her behavioral scores . . . .

Dr. Mattson concluded claimant has "many features consistent with FASD including a history of significant prenatal alcohol exposure, low IQ score, behavioral impairment, adaptive function deficits, and deficits in executive function, attention, and learning." Although claimant also likely met the criteria for ADHD, that condition

"is not sufficient in and of itself to cause the difficulties she is having." In summary, Dr. Mattson concluded that the "most parsimonious explanation is that claimant's difficulties in learning, executive function, attention, overall cognition, problem behavior, and adaptive behavior are related to fetal alcohol spectrum disorder." Dr. Mattson feels that ARND, as opposed to ADHD, is a more global diagnosis that explains claimant's cognitive and adaptive deficits.

Dr. Mattson correctly identified the diagnostic criteria for the fifth category, and said it is her opinion that ARND is a condition similar to an intellectual disability because it "shares characteristics with intellectual disability and a person can benefit from treatment similar to" treatment provided to a person with an intellectual disability. For example, repeated exposure, alternative testing strategies, breaking things down into smaller steps, checklists, putting claimant in a smaller classroom, and helping to teach her better impulse control and safety awareness. Further, Dr. Mattson felt that even if one were to ignore the cognitive deficits, claimant's adaptive abilities are so low that she would still meet the criteria for the fifth category.

### TESTIMONY OF CLAIMANT'S FATHER

31. Claimant's father testified at the hearing. The following is a summary of his testimony: A typical day for claimant begins waking up at approximately 5:30 a.m. to get her ready for school. Getting claimant up is difficult. They structure claimant's activities such as dressing, brushing teeth, and having breakfast, so she can be ready for the bus. Claimant can eat by herself with supervision. She can use utensils. Claimant plays with her food and sometimes does not chew appropriately. She sometimes shoves large pieces of food in her mouth.

Claimant cannot bathe by herself. Claimant has encopresis (a bowel disorder) so she wears pull-ups and requires hourly changing.

When claimant gets home from school she is like the "energizer bunny." She literally runs all over the house. She goes to the kitchen and indiscriminately grabs whatever she wants. She runs around, having no direction in particular. It is very difficult to get her to settle down. It is as if she wants to do something but just doesn't know what she wants to do. Claimant will go into the family room and then the kitchen and start going through cabinets. When they try to calm claimant down, she will launch into full-blown tantrums.

Communication is difficult because claimant is driven by whatever is in her head at the moment you are speaking with her. Thus, claimant always has to have instructions repeated for her.

Claimant is currently in first grade. In the 2018-2019 school year, claimant was in the general education setting. She did not do well. As soon as she started in a general education class, the school was calling him almost daily because the general education teacher really had no clue how to deal with claimant. Sometimes claimant would engage in self-injurious behaviors at school and exhibited behavioral issues. Claimant would take objects from the classroom, cut her hair, eat glue sticks, tear paper, take things apart and not put them back together, and disrupt the class. The school always characterized claimant as being uncooperative.

At home, claimant will tear up plants and eat the leaves. She is "harsh" with the family dogs. When out in the community, claimant will characterize everyone as her friend and thinks everyone likes her but whenever she engages with anyone it always becomes a problem. Claimant's father said they need to keep claimant on a tight leash.

At present, he receives financial assistance from the government since claimant is adopted, and those financial benefits will go down quite significantly if claimant is no longer an IRC consumer. Claimant does not receive any services from regional center. IRC did offer respite but he declined. IRC did offer behavioral services, but the providers would come into the home and their schedules did not work with the family schedule. It has always been a source of frustration that IRC is the "payor of last resort." Claimant's father said he does not really feel claimant needs any services at the moment but feels she may need services in the future as she ages.

Claimant's father feels that ADHD is a "scapegoat diagnosis" for claimant and her three siblings and it is insulting when anyone suggests that they have ADHD when there is something out there that provides a more complete diagnosis.

## LEGAL CONCLUSIONS

### Applicable Law

1. The Legislature enacted a comprehensive statutory scheme known as the Lanterman Developmental Disabilities Services Act (Welf. & Inst. Code, § 4500 et seq.) to provide a pattern of facilities and services sufficiently complete to meet the needs of each person with developmental disabilities, regardless of age or degree of handicap, and at each stage of life. The purpose of the statutory scheme is twofold: To prevent or minimize the institutionalization of developmentally disabled persons and their dislocation from family and community, and to enable them to approximate the pattern of everyday living of nondisabled persons of the same age and to lead more independent and productive lives in the community. (*Assn. for Retarded Citizens v. Dept. of Developmental Services* (1985) 38 Cal.3d 384, 388.) Welfare and Institutions

Code section 4501 outlines the state's responsibility for persons with developmental disabilities and the state's duty to establish services for those individuals.

2. The Department of Developmental Services is the public agency in California responsible for carrying out the laws related to the care, custody and treatment of individuals with developmental disabilities under the Lanterman Act. (Welf. & Inst. Code, § 4416.)

3. The Lanterman Act is set forth at Welfare and Institutions Code section 4500 et seq. Welfare and Institutions Code section 4501 provides:

> The State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge. Affecting hundreds of thousands of children and adults directly, and having an important impact on the lives of their families, neighbors and whole communities, developmental disabilities present social, medical, economic, and legal problems of extreme importance . . .
>
> An array of services and supports should be established which is sufficiently complete to meet the needs and choices of each person with developmental disabilities, regardless of age or degree of disability, and at each stage of life and to support their integration into the mainstream life of the community. To the maximum extent feasible, services and supports should be available throughout the

state to prevent the dislocation of persons with developmental disabilities from their home communities.

4. Welfare and Institutions Code section 4512, subdivision (a), defines developmental disability as a disability that "originates before an individual attains 18 years of age; continues, or can be expected to continue, indefinitely; and constitutes a substantial disability for that individual." A developmental disability includes "disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability." (*Ibid.*) Handicapping conditions that are "solely physical in nature" do not qualify as developmental disabilities under the Lanterman Act. (*Ibid.*)

5. California Code of Regulations, title 17, section 54000, provides:

> (a) "Developmental Disability" means a disability that is attributable to intellectual disability[6], cerebral palsy, epilepsy, autism, or disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with intellectual disability.
>
> (b) The Developmental Disability shall:
>
> (1) Originate before age eighteen;

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[6] Although the Lanterman Act has been amended to eliminate the term "mental retardation" and replace it with "intellectual disability," the California Code of Regulations has not been amended to reflect the currently used terms.

(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 intellectual disability, 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 intellectual disability."

6. 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 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.

(b) The assessment of substantial disability shall be made by a group of Regional Center professionals of differing disciplines and shall include consideration of similar qualification appraisals performed by other interdisciplinary bodies of the Department serving the potential client. The group shall include as a minimum a program coordinator, a physician, and a psychologist.

(c) The Regional Center professional group shall consult the potential client, parents, guardians/conservators, educators, advocates, and other client representatives to the extent that they are willing and available to participate in its deliberations and to the extent that the appropriate consent is obtained.

(d) Any reassessment of substantial disability for purposes of continuing eligibility shall utilize the same criteria under which the individual was originally made eligible.

7. Welfare and Institutions Code section 4643.5, subdivision (b), provides:

An individual who is determined by any regional center to have a developmental disability shall remain eligible for services from regional centers unless a regional center, following a comprehensive reassessment, concludes that the original determination that the individual has a developmental disability is clearly erroneous.

## Evaluation

8. If this case were simply about whether claimant has a diagnosis of ARND, or whether claimant could benefit from certain interventions to assist her in her daily life because of that condition, the analysis would be simple. There is no doubt, according to Dr. Mattson, that claimant meets the criteria for an ARND diagnosis and that claimant benefits from various interventions to assist her in her daily life. However, this case is not about whether claimant suffers from ARND or whether claimant benefits from certain interventions to assist her in her daily life. Rather, this case is about whether claimant is intellectually disabled, and whether ARND - as it manifests in claimant - is a condition similar to, or that requires treatment similar to, a person with an intellectual disability.

9. It is also of the utmost importance to consider that a person must have **both** a qualifying condition and a substantial disability (significant functional limitations in three or more areas of a major life activity) to qualify for regional center services under the Lanterman Act. In other words, if the evidence does not establish that claimant is intellectually disabled or meets the criteria under either prong of the fifth category, it is irrelevant if she has significant functional limitations in three or more areas of a major life activity. The Legislature specifically requires both a qualifying condition and a substantial disability.

10. Along with the documentary evidence submitted for review in this case, two experts testified: Dr. Stacy and Dr. Mattson. Both experts were exceptionally qualified, and both experts had a firm grasp of the evidentiary record. Dr. Stacy concluded claimant does not qualify for regional center services under intellectual disability or the fifth category; Dr. Mattson agreed claimant "probably" does not meet

the criteria for intellectual disability but believed claimant meets the criteria for the fifth category.

11. A person is qualified to testify as an expert if he or she has special knowledge, skill, experience, training, or education sufficient to qualify as an expert on the subject to which the testimony relates. (*Chavez v. Glock, Inc.* (2012) 207 Cal.App.4th 1283, 1318-1319.) An expert witness may give opinion testimony based on matter (including his special knowledge, skill, experience, training, and education) perceived by or personally known to the witness or made known to him at or before the hearing, whether or not admissible, that is of a type that reasonably may be relied upon by an expert in forming an opinion upon the subject to which his testimony relates, unless an expert is precluded by law from using such matter as a basis for his opinion. The trial court's determination that a witness qualifies as an expert is a matter of discretion that will not be disturbed absent a showing of manifest abuse. (*People v. Brown* (2014) 59 Cal.4th 86, 100, quoting *People v. Jones* (2012) 54 Cal.4th 1, 57.)

12. The trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke Davis & Co.* (1973) 9 Cal.3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected material." (*Id.* at pp. 67-68, quoting from *Neverov v. Caldwell* (1958) 161 Cal.App.2d 762, 767.) Further, the fact finder may reject the testimony of a witness, even an expert, although not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.)

13. In resolving any conflict in the testimony of expert witnesses, the opinion of one expert must be weighed against that of another. In doing so, consideration

should be given to the qualifications and believability of each witness, the reasons for each opinion, and the matter upon which it is based. The testimony in this case by Dr. Stacy with respect to whether claimant continues to be eligible for regional center services under intellectual disability and whether claimant is eligible for services under the fifth category is determined to be more persuasive than the testimony of Dr. Mattson. While both are licensed clinical psychologists, Dr. Mattson is a professor and expert in FASD and ARND. Dr. Stacy has devoted virtually her entire career to assessing individuals specifically for the presence of developmental disabilities such as intellectual disability, assessing individuals for regional center eligibility under the fifth category, and other aspects of the Lanterman Act. Although Dr. Mattson's opinion is not completely discounted, with respect to weight, Dr. Stacy's opinion in this case was given more weight and relied upon more heavily when rendering a conclusion in this case.

## CLAIMANT DOES NOT MEET THE DIAGNOSTIC CRITERIA FOR INTELLECTUAL DISABILITY

14. IRC established by a preponderance of the evidence that its original determination finding claimant eligible for regional center services based on a provisional diagnosis of intellectual disability is clearly erroneous in light of the comprehensive reassessment conducted by Dr. Stacy, and other evidence presented at the hearing.

15. Claimant's August 28, 2014, IEP, September 11, 2014, IFSP progress report, and Dr. Dern's August 5, 2014, psychological assessment, showed claimant presented with some mild challenges in her adaptive and cognitive abilities. However, as claimant developed in age, her intellectual and adaptive functioning also

developed, to a point where claimant was performing either at an age-appropriate range or very close to it.

16. Claimant's April 17, 2017, transition to kindergarten report, did not show any major concerns in either claimant's intellectual or adaptive skills. The May 18, 2017, Speech and Language Evaluation Report completed by claimant's school district determined claimant was functioning at an age appropriate level and did not qualify for special education services under speech and language impairment. Similarly, the June 5, 2017, Triennial Psycho-Educational Assessment showed claimant's cognitive skills were in the average range and her adaptive skills were moderately high. Thus, prior to Dr. Stacy conducting her March 22, 2018, psychological assessment, claimant did not present as a child who was either intellectually disabled or someone who exhibited substantial disabilities in three or more major life activities, as appropriate for her age.

17. Dr. Stacy conducted a comprehensive assessment on March 22, 2018. Dr. Stacy explained that intellectual disability is a substantial lifelong disability that is the direct result of cognitive limitations. Dr. Stacy's assessment showed claimant's cognitive abilities were higher than the level required for intellectual disability, and although claimant's adaptive skills were low on some assessments, the low result likely flowed from the over-reporting of adaptive challenges on the ABAS. She opined claimant's adaptive skills were much higher than what was reported on the ABAS, and based on claimant's cognitive abilities, her adaptive abilities had to be higher. Finally, regardless of what adaptive challenges claimant may have had, they were more likely attributable to ADHD.

18. Following Dr. Stacy's evaluation in 2018, and the determination that claimant was not eligible for regional center services, additional documents were

submitted to IRC by claimant. Those documents included a psychological assessment report completed by Ms. Sinclair in December 2018, who did not testify at the hearing, did not provide a curriculum vitae, and who is not a licensed clinical psychologist. Thus, this report was given little weight in reaching this decision.

19. A March 15, 2019, multidisciplinary teacher's report completed by claimant's school district showed claimant did not meet the criteria for intellectual disability, as her cognitive skills were too high. Of the utmost importance, this report also rendered a diagnosis of ADHD, Combined Type, which is precisely what Dr. Stacy diagnosed nearly three months prior. Claimant was therefore permitted to continue receiving special education services under "other health impairment" despite the lack of cognitive deficits.

Dr. Mattson's background and experience, though very impressive and definitely well-published in the area of FASD and ARND, is not in the area of assessing eligibility for regional center services under the Lanterman Act. Dr. Mattson's battery of tests showed claimant to have cognitive abilities similar to what Dr. Stacy found. Claimant's full-scale IQ score was determined to be 76. On the WISC, claimant scored in the low average to average range of cognitive abilities. These scores differed from claimant's executive functioning scores on the NEPSY II, which showed claimant to be significantly challenged in the area of executive functioning. Nonetheless, Dr. Mattson agreed that claimant "probably" did not meet the criteria for intellectual disability.

20. Claimant's IQ in Dr. Stacy's assessment was 80. In Dr. Mattson's assessment claimant's IQ was 76. Claimant's adaptive skills on Dr. Mattson's tests were very low, however, it is noted that many of the adaptive scores are determined by parental reporting. As Dr. Stacy explained, it is not normal for a person to have such a

huge change in adaptive scores in just a few months (i.e. between the time claimant tested with her and the time claimant tested with Dr. Mattson).

21. In sum, the weight of the evidence shows claimant does not meet the criteria for intellectual disability because cognitively, claimant functions in the average to low average range, and although her adaptive skills are somewhat low, they are not reflective of her overall adaptive capabilities. In other words, there was insufficient evidence that claimant's adaptive challenges are the result of cognitive deficits.

## CLAIMANT DOES NOT HAVE A CONDITION CLOSELY RELATED TO INTELLECTUAL DISABILITY

22. Claimant does not qualify for services under the fifth category because a preponderance of the evidence did not establish that she suffers from a condition closely related to an intellectual disability.

23. In *Mason, supra,* 89 Cal.App.4th 1119, the appellate court held that that "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]." (*Id.* at p. 1129 [emphasis added].) Further, the presence of adaptive deficits alone, absent cognitive impairment, is also not sufficient to establish that a person has a condition closely related to an intellectual disability. (*Samantha C., supra,* 185 Cal.App.4th at p. 1486 [intellectual disability "includes both a cognitive element and an adaptive functioning element"].)

24. The evidence as a whole does not support a finding that claimant suffers from cognitive impairment. As such, even though she does have challenges in adaptive skills, she cannot be found to have a condition similar to a person with an intellectual disability under applicable law. Simply put, claimant's cognitive abilities are not the

cause of her markedly variable adaptive skills, which likely are better explained by claimant's diagnosis of ADHD.

25. Claimant does not suffer from the kind of general intellectual impairment found in persons with intellectual disabilities (as described by Dr. Stacy and above in Legal Conclusions paragraphs 8 through 13), nor do any of her adaptive deficits stem from cognitive deficits. Instead, the evidence suggests that claimant's ADHD, Combined Type (characterized by hyperactivity and inattention) is more likely interfering with claimant's ability to remain focused and stay on task. This marked inability to remain focused therefore results in claimant's adaptive capabilities appearing to be much lower than they really are, as Dr. Stacy also explained in her testimony. Indeed, claimant meets every feature of the DSM-5 criteria for ADHD on both the hyperactivity and inattention categories.

26. ADHD is a developmental disorder separate and distinct from intellectual disability in the DSM-5. ADHD is characterized by hyperactivity and inattention, while intellectual disability is characterized by cognitive delays. ARND has features of both.

27. As Dr. Mattson explained, a person with ARND may have a comorbid diagnosis of ADHD. Dr. Mattson believes, however, that ARND is a better *overall* explanation for claimant's overall level of functioning. And, while this may be the case, it does not change the fact that looking at claimant's cognitive and adaptive results over time (as discussed extensively above in Legal Conclusions paragraphs 14 through 21 and below), and also in consideration of applicable law, the way that ARND or ADHD (or both) manifest in claimant, neither one constitutes a condition closely related to a person with an intellectual disability.

28. With respect to the fifth category, Dr. Stacy explained that as a person's IQ exceeds 70, it becomes increasingly important for that person's adaptive deficits to be very low, and it must also show that the adaptive deficits are attributable to the lower cognitive skills as opposed to something else (which is consistent with what the *Mason* and *Samantha C.* courts have held). As shown above in the Legal Conclusions paragraphs 14 through 21, claimant's IQ scores have been anywhere from 80 (on Dr. Stacy's assessment) to 76 (on Dr. Mattson's assessment), rendering her at least to be functioning at the low end of the average range (which is not the same as below average). In Dr. Stacy's assessment, claimant showed significant cognitive variation from very low to high average across 10 domains. Claimant achieved similar cognitive results on the WISC administered by Dr. Mattson just a few months later, which again, showed significant variability. Such variability is not expected in a person who is intellectually disabled – and it follows that such variability would not be expected in a person who has a condition closely related to an intellectual disability.

29. Claimant's adaptive scores have been all over the map, to say the least, which also would not be consistent with a person who has a condition closely related to an intellectual disability. Dr. Stacy, in her 2018 assessment, administered the ABAS, which ultimately showed claimant in the extremely low range. A score of "extremely low" is inconsistent with claimant's cognitive abilities (i.e. claimant's true abilities are much higher). In other words, the impairment in adaptive functioning is an underestimation of claimant's true adaptive skills. The ABAS is based on person's perception of abilities, so it is vulnerable to underestimation. In Dr. Stacy's testing, claimant's mother completed the questionnaire. Just a year or so prior, in the June 5, 2017, Triennial Psycho-Educational Assessment where the questionnaire (on the Vineland) was completed by claimant's teacher, claimant's adaptive skills were moderately high. Again, referring to Dr. Stacy's testimony and the DSM-5, it is not

normal to see such a variability among persons with intellectual disability (i.e. moderately high in one year when reported by the teacher and then extremely low the next when reported by the mother).

30. Finally, claimant's father's testimony also lends support to the conclusion that any of claimant's adaptive challenges do not stem from cognitive impairment (and thus claimant's ARND or ADHD is not a condition closely related to a person with an intellectual disability). Claimant can eat by herself but may from time to time chew a large piece of food. Claimant can use utensils. Because of claimant's inattention – as opposed to any cognitive delay - he and his wife try to structure her activities after school to keep her focused as she acts like "the energizer bunny." At school, according to claimant's father, claimant takes objects from the classroom, cuts her hair, eats glue sticks, tears paper, takes things apart, and disrupts class. Claimant's father's testimony clearly demonstrated that claimant's adaptive and/or behavioral problems stem directly from hyperactivity and inattention, which are the hallmarks of ADHD as set forth in the DSM-5.

31. Accordingly, it is concluded that claimant does not suffer from a condition closely related to intellectual disability.[7]

[7] This conclusion, as requested in the remand order, is made without regard to whether claimant has been diagnosed with a medical condition.

## CLAIMANT DOES NOT HAVE A CONDITION THAT REQUIRES TREATMENT SIMILAR TO A PERSON WITH AN INTELLECTUAL DISABILITY

32. Claimant also does not qualify for services under the fifth category because a preponderance of the evidence did not establish that she suffers from a condition that requires treatment similar to an intellectual disability.

33. Determining whether claimant's condition "requires treatment similar to that required" for persons with an intellectual disability is not simply an exercise in reviewing the broad array of services provided by regional centers (*e.g.*, counseling, vocational training, living skills training, supervision) and finding merely that a person would benefit from those services. Indeed, the appellate court has been abundantly clear that "services" and "treatment" are two different things.

> That the Legislature intended the term "treatment" to have a different and narrower meaning than "services" is evident in the statutory scheme as a whole. The term "services and supports for persons with developmental disabilities" is broadly defined in subdivision (b) of section 4512 to include those services cited by the court in Samantha C., e.g., cooking, public transportation, money management, and rehabilitative and vocational training, and many others as well. (§ 4512, subd. (b); Samantha C., supra, 185 Cal.App.4th at p. 1493, 112 Cal.Rptr.3d 415.) "Treatment" is listed as one of the services available under section 4512, subdivision (b), indicating that it is narrower in meaning and scope than "services and supports for persons with developmental disabilities."

> The term "treatment," as distinct from "services" also appears in section 4502, which accords persons with developmental disabilities "[a] right to treatment and habilitation services and supports in the least restrictive environment. Treatment and habilitation services and supports should foster the developmental potential of the person and be directed toward the achievement of the most independent, productive, and normal lives possible. Such services shall protect the personal liberty of the individual and shall be provided with the least restrictive conditions necessary to achieve the purposes of the treatment, services, or supports." (§ 4502, subd. (b)(1).) The Lanterman Act thus distinguishes between "treatment" and "services" as two different types of benefits available under the statute. (Ronald F. v. Dept. of Developmental Services (2017) 8 Cal.App.5th 84, 98-99.)

34. This, claimant must show that she requires "treatment" similar to a person with an intellectual disability as opposed to benefitting from "services" similar to a person with an intellectual disability, which is not the standard.

35. During Dr. Mattson's testing, it was noted that claimant was easily distracted and needed to be redirected. Concerns were noted with claimant's ability to resist impulses, be aware of her functioning in social settings, adjust well to changes in her environment, and start tasks, among other things. Dr. Mattson noted that claimant's difficulties likely related to fundamental "behavioral and emotional" regulation difficulties and suggest that claimant's problems with self-regulation have a

negative effect on her cognitive problem solving. Stripping away the complex language, this appears to be a way of saying that claimant's behavioral and emotional problems (which likely stem from ADHD) interfere with her ability to perform cognitive problem solving. That is not the same as cognitive delays interfering with problem solving. Put another way, a person who is intellectually disabled has difficulties because of their inability to comprehend – their inability to cognitively process – certain things. Claimant, on the other hand, does not have that inability to comprehend or process. Rather, her challenges are due to the inability to remain focused. Thus, claimant's adaptive challenges – which are well documented and not in dispute by IRC – are not attributable to a diminished cognitive ability.

36. As Dr. Stacy explained, in essence, a person with an intellectual disability needs lifelong assistance across all areas of life to learn new skills and make decisions because there is a limit to what they can learn. These individuals have consistent cognitive delays throughout their life. Claimant functions in the low average area of intelligence and has adaptive challenges due to inattention and hyperactivity, and therefore does not need treatment similar to a person with an intellectual disability. Dr. Stacy testified that the nature of training and intervention (as opposed to treatment) most appropriate for a person with an intellectual disability is as follows: typically a person needs a lot of repetition broken down into small steps, a person doesn't necessarily need mental health services; a person with an intellectual disability would need assistance in all areas of life - such as money management, making decisions, and in getting employment; things would have to be modified for a person with an intellectual disability to make it easier for the individual to understand. The things Dr. Mattson described in her testimony that claimant "benefits" from (i.e. repeated exposure, alternative testing strategies, breaking things down into smaller steps), are similar to the trainings and intervention services described by Dr. Stacy but are just

that – services – and not treatments. Moreover, they are necessary because of claimant's inattention and hyperactivity, as opposed to cognitive delays, which she does not have (for the reasons discussed above).

37. Based on the appellate court's distinction between "treatment" and "services," in conjunction with the clear intent of the Legislature to draw a distinction between "treatment" and "services" within the plan language of the statute, on this record, it cannot be found that claimant met her burden of showing that she requires treatment similar to a person with an intellectual disability.[8]

**SUBSTANTIAL DISABILITY**

38. The "substantial disability" standard is set forth in California Code of Regulations, title 22, section 54001. Eligibility for regional center services requires not only a qualifying condition but also a substantial disability. In order to meet this standard, it is not enough to show that claimant merely has general adaptive challenges or requires assistance to meet her full potential. California Code of Regulations, title 17, section 54001, subdivision (a)(1), requires that the qualifying condition result in "major impairment" of cognitive and/or social functioning so as to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential; and the existence of "significant

[8] This conclusion is made without regard to whether any treatment required for individuals with an intellectual disability is required for only those individuals and no others, in accordance with the remand order. Further, a more detailed discussion of why claimant's services assist her due to ADHD (as opposed to cognitive delay), which she does not have, is also explained, as requested in the remand order.

functional limitations" in three or more areas of specified life activities, as appropriate to the person's age. (*Ibid.*)

39. However, it is not enough that someone is "substantially disabled" to qualify for regional center services. The individual must first have a qualifying condition (autism, epilepsy, cerebral palsy, intellectual disability, or fifth category) before the second eligibility prong of substantial disability is reached.

40. Based on the Legal Conclusions above in paragraphs 8 through 30, which determined claimant is not intellectually disabled and does not suffer from a condition similar to or that requires treatment similar to a person with an intellectual disability, an evaluation of whether claimant is substantially disabled is not necessary. In other words, given that claimant has no qualifying condition, whether she is substantially disabled is irrelevant for purposes of eligibility. However, given the remand order requiring a reference to each category, the following findings with respect to each category are made:

41. Capacity for independent living and economic self-sufficiency do not apply to a child and there are no concerns in the record concerning claimant's mobility. That leaves only receptive and expressive language; learning; self-care; and self-direction.

42. Regarding receptive and expressive language, the record does not support a finding that claimant has significant functional limitations in this area. The May 18, 2017, Speech and Language Evaluation completed by claimant's school district documented that claimant had "clear speech intelligibility" at the conversational level, her oral and written language skills were average, and her expressive and receptive language skills were "age appropriate." Claimant does not

receive special education services under the category of speech and language. Nothing in the record suggested claimant has significant deficits in the area of expressive and receptive language specifically, and claimant did not argue that she does.

43. With respect to the remaining three categories, learning; self-care; and self-direction, claimant argued she does have significant functional limitations in those areas. Claimant's father's testimony concerning claimant's challenges with self-care and self-direction certainly indicate as much. More important, IRC does not dispute that claimant has significant limitations in those areas. In other words, that claimant is substantially disabled in those three areas, for purposes of the regulation, is undisputed and supported by the record.

44. However, for the reasons discussed above in the fifth category analysis, claimant's substantial disabilities in these areas stem from ADHD (as also discussed above) and not cognitive limitations. Thus, because claimant does not have a qualifying condition in the first instance (autism, epilepsy, cerebral palsy, intellectual disability, or fifth category), that she is limited in learning, self-care, and self-direction does not change the ineligibility outcome.

## Conclusion

45. IRC established by a preponderance of the evidence that its original determination finding claimant eligible for regional center services under a provisional diagnosis of intellectual disability is clearly erroneous, and accordingly, claimant is no longer eligible for regional center services under this category.

46. A preponderance of the evidence did not establish that claimant is eligible for regional center services under the fifth category because claimant does not

have a condition similar to or that requires treatment similar to an individual with an intellectual disability.

47. These conclusions are based on the Factual Findings and Legal Conclusions as a whole. Evidence and arguments presented by the parties, and not referenced in this decision, have been considered in reaching this decision. All arguments contrary to this decision have been considered and rejected.

48. Claimant's appeal is denied.

## ORDER

1. Claimant's appeal from Inland Regional Center's decision that its original determination finding claimant eligible under intellectual disability is clearly erroneous in light of the comprehensive reassessment is denied.

2. Claimant's appeal from Inland Regional Center's determination that claimant is not eligible for regional center services under the fifth category is denied.

DATE: January 29, 2021

KIMBERLY J. BELVEDERE
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.