BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT

vs.

SAN ANDREAS REGIONAL CENTER, Service Agency.

OAH No. 2020080327

DECISION

Administrative Law Judge Michael C. Starkey, State of California, Office of Administrative Hearings, heard this matter on April 4, 6 and 7, 2022, via telephone and videoconference.

Attorneys Marc Buller, Sarah Fairchild, and Devan Brothers represented claimant, who was not present. Claimant's parents were present.

Deputy County Counsel Christi McDonald represented Monterey County Deputy Public Guardian Mayra Calderon, claimant's conservator, who was present.

James Elliott represented San Andreas Regional Center (SARC), the service agency.

The record was held open for written argument. On May 2, 2022, claimant filed a closing brief, which was marked for identification as Exhibit 2.W. On May 9, 2022, SARC submitted an opposition brief, which was marked for identification as Exhibit 13. On May 18, 2022, claimant filed a reply brief, which was marked for identification as Exhibit 2.X.

The matter was submitted on May 18, 2022.

ISSUES

Is claimant eligible for regional center services on the ground that he is substantially disabled by conditions found to be closely related to intellectual disability (ID) or to require treatment similar to that required for individuals with an ID? If not, is SARC required to further evaluate claimant at this time?

FACTUAL FINDINGS

Introduction and Procedural History

1. Claimant is 22 years old.[1] He currently resides at a secure mental health facility in Delhi, California.

2. Claimant sought an intake evaluation for regional center services from SARC in 2020. After a review of some medical records and special education

[1] Claimant and his parents will not be referred to by name in order to protect their privacy.

documents, on May 5, 2020, SARC representatives denied the request for an intake evaluation. On June 12, 2020, SARC issued a Notice of Proposed Action to the same effect. Claimant requested a hearing.

3. On June 9, 2021, after reviewing additional documents, SARC issued a Notice of Proposed Action denying claimant eligibility for regional center services, based on a finding that he did not "demonstrate the presence of a developmental disability and/or substantial handicap in three or more of the seven life domains, as required and defined by law." Claimant timely appealed and this proceeding followed.

4. Claimant contends that he is eligible for regional center services because he is substantially disabled by conditions found to be closely related to ID or to require treatment similar to that required for individuals with an ID. This is known as the "fifth category" of eligibility. Claimant also maintains that SARC's evaluation of claimant was insufficient and that claimant should be fully assessed by SARC if he is not found eligible. SARC concedes that claimant is substantially disabled, but contends that he is not eligible under the fifth category and there is no basis for further evaluation.

Diagnostic Criteria for Intellectual Disability

5. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) was published by the American Psychiatric Association in 2013. It currently serves as the principal authority for psychological and psychiatric diagnoses in the United States.[2]

[2] In its closing brief, SARC cites Welfare and Institutions Code, section 4512, subdivision (a)(1), and argues that the definition of a developmental disability is

6. The diagnostic criteria for ID set forth in the DSM-5 are:

> A. Deficits in intellectual functioning, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing.
>
> B. Deficits in adaptive functioning that result in failure to meet developmental and socio-cultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.
>
> C. Onset of the intellectual and adaptive deficits during the developmental period.

(DSM-5 at p. 33.)

---

defined by the Director of Developmental Services, not the DSM-5. However, SARC proffers no authority establishing that the Director has defined ID differently than the DSM-5 and offers no alternate definition or explanation how such a definition would differ from that of the DSM-5.

7. Intellectual functioning is typically measured using intelligence tests. Individuals with ID typically have intelligence quotient (IQ) scores of 70 or lower. (DSM-5 at p. 37.)

Claimant's Developmental History

8. Claimant was adopted at birth. Claimant's parents met his birth mother approximately six weeks before he was born. Claimant's mother reports that his birth mother had developmental delays and was hearing impaired, but the birth mother reported the hearing impairment was not genetic. A social worker told claimant's mother that the birth mother consumed alcohol and cannabis the night claimant was conceived. Claimant's mother also observed the birth mother with a cigarette in her hand, although she denied smoking.

9. Claimant's mother is an occupational therapist. When claimant was approximately four months old, she noticed that he appeared "really floppy." Claimant's sister is three years older and claimant's mother noticed differences between the development of claimant and his sister, including that his sister was able to hold up her head at a much earlier age. Claimant's mother also noticed differences between claimant and other babies of a similar age.

10. Claimant's grandmother was a pediatric nurse and told claimant's mother that she "knew something was going on" in the first week of claimant's life.

11. At a six-month checkup appointment, claimant's mother mentioned her concerns to claimant's pediatrician. He did not appear "too concerned."

12. At the nine-month checkup appointment, claimant's mother requested and received a different physician, John Rosenfeld, M.D. He asked her about Fetal

Alcohol Syndrome (FAS) and requested an observation of claimant's face. Claimant's mother reports that Dr. Rosenfeld told her that claimant would need help for the rest of his life. That date, Dr. Rosenfeld wrote:

> 1. I am referring him to Dr. McGlaughlin for further evaluation and treatment. 2. I suggested Community Connections for evaluation and treatment. 3. X-rays of his lower extremities especially hips. 4. At this point would suggest chromosomes and fragile X because of the multiple problems. 5. I will see him back at 12 months of age.

13. Dr. Rosenfeld noted hypotonia (low muscle tone) of claimant's extremities. He also noted that claimant was not crawling and could not pull himself up. Claimant's mother confirmed this report.

14. One week later, Dr. Rosenfeld wrote a letter, stating that claimant "has multiple congenital anomalies and is developmentally delayed." He requested chromosome and "fragile X"[3] testing of claimant.

15. When claimant was just a couple weeks past his first birthday, Dr. Rosenfeld referred him to "the genetic clinic," and wrote that claimant has developmental delay, some mild facial anomalies, and also a "few of the traits of FAS."

16. Claimant did not start crawling on his hands and knees until he was 14 months old.

---

[3] Fragile X syndrome is a genetic disorder and one of the most common causes of inherited ID.

17. In late 2001 and early 2002, when claimant was 20 and 21 months old, respectively, a speech and language pathologist, a physical therapist, and an occupational therapist from the Community Connections organization conducted a developmental evaluation of claimant. They used a number of clinical assessment measures and issued a report. This team found that claimant's gross motor skills were that of an average 12-month-old child; his fine motor skills were at age level; he "demonstrated strong cognitive skills through 18 months except for stacking cubes and completing circle and square in puzzles"; his self-help and socio-emotional skills were age-appropriate; and his receptive and expressive language skills, and sound and syllable development were at the 15-month level. The team concluded:

> [Claimant] has continued to master new skills in all areas of development. Although [claimant] continues to demonstrate delays in communication, he has made the important jump into symbolic communication and understands quite a bit of language in context. [Claimant] demonstrated areas of significant delay in gross motor skills. He also has a moderate delay in fine motor skills and cognitive skills and a mild delay in self help skills and social emotional development.

The team recommended: continued enrollment in an early learning program; physical therapy services; continued occupational therapy; and language therapy or language stimulation to address communication development.

18. Claimant's mother noticed that claimant had sensory processing challenges—sensitivity to loud sounds and physical sensations. For example, claimant

did not want to touch grass when he first encountered it and did not enjoy swings or sledding.

19. Claimant did not start walking until he was 23 months old.

20. Claimant started receiving speech therapy at 18 months of age, but his mother could not understand his speech without visual context until he was approximately four or five years old.

21. Claimant attended day care, then preschool, then a charter school for kindergarten. He then completed a second year of kindergarten at a private school.

22. At age six years and two months, claimant was evaluated by an occupational therapist, Lisa Carter. Carter concluded:

> [Claimant] demonstrates strengths in the areas of being pleasant, perceptual skills, and upper limb speed. [Claimant] presented with difficulties in the areas of motor coordination, visual motor skills, bilateral coordination and hypotonia. [Claimant] shows sensory processing issues in some areas stated above, which may interfere with his ability to learn and effectively interact with his environment. [Claimant] will benefit from Occupational Therapy services at this time.

23. Because claimant needed special education services, he was moved to public schools in the Monterey Peninsula Unified School District (MPUSD).

24. At some point, claimant received a psychoeducational assessment from MPUSD and was found eligible for and began receiving special education services.

Claimant's Individualized Education Program (IEP) documentation states that he had a "mild, developmental articulation disorder" and that claimant's language development had been measured in the "below average" to "average" ranges on specific subtests. It was also reported that claimant's academic skills were within the "very low range" and his ability to apply academic skills was low, although his level of academic knowledge was average. Testing showed varying achievement deficits in all categories except picture vocabulary.

DECOULOS PSYCHOEDUCATIONAL ASSESSMENT

25. At age six years and six months, claimant received another psychoeducational assessment. Cognitive tests were administered by Dennis J. Decoulos, a school psychologist. Claimant scored in the average range on measures of verbal memory and attention/concentration. He scored in the low average range on a measure of general memory and in the borderline range (eighth percentile) on a measure of visual memory.

26. Achievement tests were also administered. Claimant's scores ranged from the 1st to 79th percentile, but most of the scores were in the 8th percentile or lower. He scored in the 79th and 39th percentiles in picture vocabulary and academic knowledge, respectively. He scored in the first, second, third, and fifth percentile in writing samples, academic skills, academic applications, letter-word identification, and passage comprehension, respectively.

27. Perceptual/motor tests were also administered to claimant. His scores were low, ranging from 1st percentile (several measures) to 14th percentile. He scored in the 5th percentile on a test of visual-motor integration.

28. Decoulos reported that claimant's testing scores were valid.

29. Decoulos concluded that claimant remained eligible for special education services. He opined that there was significant discrepancy between claimant's intellectual ability and achievement in the area of language arts, which he attributed to "a disorder in the basic psychological process of" visual processing and sensory motor skills. Decoulos opined that this disability was not due to environmental or cultural factors, limited English proficiency, economic disadvantage, maladaptive behavior, social adjustment problems, or limited school attendance. He reported suspicion that claimant had a specific learning disability and recommended a program placement of "Learning Handicap- Resource Specialist."

DR. HUNTLEY REPORT

30. At approximately 6 years, 11 months of age, claimant was evaluated for mood disorder or attention deficit disorder by David T. Huntley, M.D., a pediatric neurologist. Dr. Huntley performed a physical and neurological examination. He noted that claimant had recently been placed in a new classroom under a behavioral psychologist and had a "complete turnaround in attitude towards school" as well as diminished temper tantrums. He opined that a diagnosis of hypotonic cerebral palsy with bilateral athetosis "should be considered" and that claimant also had some dysmorphic features which could suggest fetal alcohol spectrum disorder. Dr. Huntley further opined:

> As far as a diagnosis of mood disorder or attention deficit disorder, I do not feel these are good primary diagnoses. They may be considered in comorbidity. Clearly, to me his acting out is more situational and possibly related more to anxiety disorder relative to school and **borderline mental retardation**. As the environment changes and behavior

> improve. I see no point in medicating him. If we were to give him a stimulant under a presumed diagnosis of attention deficit disorder, it would only increase his anxiety and possibly improve his homework. The odds are very light that it would in any way affect his academic or learning disability. Probably less than 5%. His mother is very much against any medication so the issue is rather moot and not worth pursuing, given his improvement. [Emphasis added.]

31. Dr. Huntley recommended an MRI scan of claimant's brain.

DR. HEIDLER'S ASSESSMENT

32. At age seven years, two months, claimant received a psychological evaluation from Elizabeth S. Heidler, Ph.D., of the Kinship Center in Salinas. Dr. Heidler administered an intelligence test to claimant. She reported that claimant had a difficult time staying focused and attentive; easily gave up on tasks that were difficult; was "oblivious" to testing time constraints; and she had to administer the assessment in one-hour sessions, rather than the typical two-hour sessions.

33. Claimant's subtest scores were: 98 (average) verbal comprehension; 71 (borderline) perceptual reasoning; 91 (average) working memory; and 62 (extremely low) processing speed. His full-scale IQ score was 76 (borderline). Dr. Heidler reported that there was a 95 percent chance his IQ was somewhere between 72 and 82, but "[m]ore than likely this is an underestimation of his true intellectual functioning." (Emphasis in original.) She opined that the 27-point difference between claimant's verbal comprehension and perceptual reasoning scores "could easily" be accounted for by a learning disability. Dr. Heidler also reported that due to claimant's ethnicity—

he is described as half African-American—his IQ score could not be used to classify him for special education services. The schools were also not allowed to measure claimant's IQ.

34. Dr. Heidler administered an achievement test and reported that claimant scored at grade level (first grade).

35. Dr. Heidler administered a developmental neuropsychological assessment. Claimant scored in the "below expected" range on three measures; and an 82 (slightly below expected) on visuospatial. Claimant scored a 67 (well below expected) on memory and learning. His score on the memory-for-faces subtest was in the slightly below expected range, but his score on the memory-for-names subtest was in the well below expected range. Dr. Heidler reported that this discrepancy was consistent with the performance of children with FAS.

36. Dr. Heidler also noted that claimant "appears to have issues related to sensory processing." She also administered several other psychological tests.

37. Dr. Heidler diagnosed claimant with: Axis I: Anxiety Disorder Not Otherwise Specified (NOS), Oppositional Defiant Disorder, Parent Child Relational Problems (Attachment Difficulties), Expressive Language Disorder; and Attention Deficit Hyperactivity Disorder (ADHD); Axis II: no diagnosis; Axis III: Effects of FAS exposure in utero, and sensory integration disorder; Axis IV: problems with social support, primary support, and educational problems; and Axis V: present GAF score of 56.[4]

[4] The DSM-IV-TR was the diagnostic manual in effect at the time of this assessment. It utilized a five-axis diagnostic system as follows: 1. primary diagnoses, 2.

38. Dr. Heidler made numerous recommendations for claimant, including continued psychotherapy; consultation with a psychiatrist with expertise in prenatal drug exposure; continued occupational therapy; extracurricular physical activities; a school education plan that included limited amounts of material at one time and "ample opportunities for repetition and review" and "overlearning"; eliminating timed tasks at school; and minimizing distractions when learning.

39. When claimant was nine years old, an FAS facial photographic analysis report was prepared. The finding was "FAS features mild." Claimant was diagnosed with fetal alcohol spectrum disorder.

40. Several months later an addendum to claimant's IEP was executed after his mother expressed concerns that he was falling further behind and becoming too frustrated in his general education setting. Claimant was placed in a smaller classroom.

RESIDENTIAL PLACEMENTS AND FURTHER ASSESSMENTS

41. It appears that claimant's parents applied to SARC for eligibility on his behalf in 2014 and 2016, but the applications were denied and there was no request for fair hearing.

---

personality disorders and/or ID, 3. medical and/or neurological problems impacting the individual's psychological concerns, 4. nine categories of environmental and psychosocial stressors impacting the person's psychological functioning, and 5. Global Assessment of Functioning (GAF), rating the person's overall level of functioning on a scale of 0-100.

42. At age 14, claimant was assessed for placement in Edgewood Center's Hospital Diversion Program (Edgewood) "following a 5150 hold where [he] expressed suicidal ideation reporting that he had a plan to stab himself with a knife, or run into traffic." The records noted a history of suicidal ideation/plan, anger problems, assaulting others, engaging in self-harming behaviors such as biting himself and banging his head against the wall, and three hospitalizations since age 12. Claimant was also susceptible to manipulation by other students.

43. Claimant was placed at Edgewood approximately 10 months later. While there, he received a three-year psychoeducational re-evaluation, including testing. He was reportedly "cooperative off and on" during the testing as well as anxious and "distracted often." During a break, claimant reported a need to cut himself, located a kitchen knife and expressed a desire to kill himself. It took the team approximately one hour to convince him to relinquish the knife, but he did not harm himself.

44. On cognitive ability tests, claimant's scores ranged from 55 (processing speed) to 99 (analysis/synthesis). His overall intellectual ability was scored as 68, with a 95 percent confidence interval of 62 to 73. However, it was noted that his "behavior may have contributed to his low scores." Claimant's academic achievement scores ranged from 67 (quantitative concepts) to 106 (writing samples), with total achievement score of 77. Claimant's visual perception skill scores were significantly below average, with an overall score of 67 (less than first percentile). The examining school psychologist reported that the test scores were valid and that claimant did not demonstrate a "significant discrepancy" between cognitive ability and academic achievement (which would be a sign of a specific learning disability).

45. Claimant was discharged from Edgewood after just 13 days. The discharge report contains references to a psychiatrist's report that claimant appeared

to be significantly developmentally delayed and presented with no insight into his actions. Claimant reportedly "adhered minimally with all programming and activities needing one-on-one staff support throughout the day and in the evenings." Claimant engaged in self-harming behaviors and attempted to assault staff members. He "was in the process of having his psychotropic medication adjusted (adding Tenex) [Generic Name: guanfacine, used to lower blood pressure] when he was placed on a 5150 hold for suicidal ideation and self-harm." Among other things, the Edgewood team recommended referral to a regional center for testing for "developmental delay."

46. Katie Rivera, director of special education for the MPUSD, testified at hearing. She holds a master's degree in psychology and school psychology. She knew claimant for years and participated in multiple IEP meetings for him. Once, she visited claimant in the hospital while he was hospitalized. She reports that claimant's primary disability in his IEP's was listed as the category other health impairment (OHI), which in his case was FAS, with a secondary listing of emotional disturbance.

47. Rivera reports that claimant was transferred to Edgewood because he was physically aggressive, was ingesting inedible objects, expressing suicidal ideation, making inappropriate statements, and regarded as a safety threat. She believes Edgewood was not a good fit because claimant did not have the ability to be as independent as that program requires. Rivera is familiar with pica (persistently and compulsively eating nonfood substances). She opines that claimant's ingestion of inedible objects is not consistent with pica.

48. After Edgewood, claimant was placed in another residential facility with a different approach. However, he again did not fare well and he was shortly thereafter transferred to a residential facility called South Bay High School, also known as

Starview Residential (Starview). Claimant attended Starview for approximately two years. At Starwood, claimant received 24-hour support and supervision.

49. Approximately two weeks before his 18th birthday, Eugenie Adams, a school psychologist, conducted a triannual psychoeducational assessment of claimant. Adams reported that claimant had been at Starview for almost two years, was in 11th grade, and was "on a diploma track." His medical, health, and developmental concerns were reported as asthma, mood disorder (unspecified), and ADHD. Claimant was regularly receiving a variety of medications for these conditions. Adams reported interviews with claimant's teachers. The consensus was that claimant lacked motivation and could perform the assigned work when he tried.

50. Adams administered a variety of assessments to claimant. Adams reported that the "results appeared to be valid measures of his current abilities."

51. On an assessment of memory ability, claimant scored within the below average range, with subtest scores ranging from the 1st to 63rd percentile (most 12th percentile or below). His general index memory score was 70 (2nd percentile). However, Adams reported that these "scores must be interpreted with caution as his General Index memory score may not be a true reflection of his current abilities," citing the large amount of variation (also known as "scatter") in claimant's scores.

52. Claimant scored within the below average range for phonological awareness. Claimant scored between the 2nd (low) and 37th (average) percentile on subtests of a test of visual and motor abilities. Tremors were noted.

53. On an assessment of academic achievement, claimant's subtest scores ranged from the 3rd to 93rd percentile, with scores at or below the 5th percentile in sentence writing fluency, reading fluency, oral reading, sentence reading fluency, and

academic fluency and much higher scores in letter word identification (83rd percentile and word attack (93rd percentile). Claimant's reading comprehension was scored as just below fifth-grade level (4.9).

54. Claimant was also assessed for autism and the results were negative.

55. Adams concluded that claimant at that time continued to need special education services as a student with an emotional disturbance and as a student with OHI.

56. In an undated letter, Kira Williams, M.D., claimant's treating physician since his admission to Starview, wrote in support of claimant's father's efforts to have claimant conserved. Dr. Williams reported that claimant was being treated for ADHD and "Unspecified Episodic Mood Disorder" and explained that:

> His symptoms manifest as extreme lability of mood, impulsivity, hyperactivity, explosive and often unprovoked anger which he takes out on himself by trying to choke himself or by ingesting foreign bodies (including metal screws and pieces of glass). Even in a highly supervised setting, he has struggled to maintain safety and he has required several admissions to acute care psychiatric facilities as well as 3 extended re-admissions to our higher acuity unit in order to keep him safe.
>
> [Claimant] often refuses to participate in the therapeutic activities aimed at helping him develop appropriate coping and independent living skills. At times, he has required prompting to participate in basic self-care (grooming and

> hygiene). He has intermittently refused his medications and has recently been restricting his food intake.
>
> . . .
>
> His ongoing engagement in self-injurious behaviors has been interfering with his ability to access the care that he requires. As he approaches his 18th birthday, consideration needs to be given to how to best help him meet his mental health needs. I do not believe that he has the capacity to make decisions in his own best interest at this time and he will require a great deal of assistance for the foreseeable future. He would benefit from having a conservator until such time that he has better judgment and demonstrates that he is able to willingly engage in the treatment that he needs to help him achieve some measure of stability and independence.

57. Claimant was asked to leave Starview a few months after his 18th birthday and he moved in with his father. He was tasked with taking care of dogs and doing limited chores, but often did not complete these tasks. Claimant attended adult school for approximately six months. He was picked up from and returned to his home and had one-on-one care the entire time. Other than that period, he mostly stayed home and played video games.

58. Claimant's father reports that claimant ingested dangerous inedible objects and then immediately called "911" or a suicide hotline approximately 60 times in the approximately 18 months after he left Starview. Claimant reported that he

ingests these items impulsively and sometimes when he is upset and feels like he has no other alternative.

59. Karel Routhier, M.D., is a clinical psychiatrist and was claimant's treating physician from April 6, 2020, through October 26, 2020. In a letter dated August 24, 2021, Dr. Routhier reported that claimant's diagnoses were: "Intellectual disability, mild (in setting of fetal alcohol syndrome)"; major depressive disorder (MDD), recurrent; "Other Specified Impulse control disorder (leading to repetitive foreign body ingestions)"; and "Traits of Borderline Personality Disorder." Dr. Routhier further reported:

> [Claimant's] therapist at the time and myself, worked closely with client to find ways to help him learn new skills but were quick to uncover that in [the] setting of his intellectual disability, despite receiving psychotherapy and medication management services, client remained unable to apply coping skills and learn how to tolerate distressful stimuli.
>
> In my opinion, [claimant] does not appear to be able to compute and mobilize taught coping skills and could benefit greatly from a higher level of care (group home or locked facility) and SARC.
>
> In my experience, with clients suffering solely from depression, impulse control disorder and personality disorders, there is typically at least some improvement with medication trials and individual/group therapy, whether or not they engage fully in their treatment plan. In [claimant's]

> case, I believe that his intellectual disability precludes him from reaching such improvement because of his cognitive impairment, limited insight and [judgment] and clear inability to function independently in the community in a safe manner that allows him to meet most of his basic needs.

60. In September 2020, claimant underwent surgery at Stanford University Hospital to remove two batteries he ingested. He received care on multiple occasions over a period of weeks from Andrea Erika Ament, M.D. Dr. Ament consistently reported claimant's diagnoses as unspecified depression disorder, impulse control disorder, and intellectual disability.

61. Mayra Calderon, Deputy Public Guardian of the Public Guardian Office, Monterey County Health Department, was appointed as conservator of claimant, under an LPS conservatorship (also known as Lanterman-Petris-Short or Mental Health Conservatorship). Calderon testified at hearing. Calderon's mission is to work with claimant's medical team, place him in the least restrictive setting appropriate, and ensure he receives benefits for which he is eligible.

62. Claimant has been placed in a mental health unit for over a year, despite the fact that the unit is designed for short-term care. Calderon reports that claimant really wanted to leave the mental health unit for a less restrictive placement in the facility. She explained that he needed to demonstrate enough self-care (attending to personal hygiene, eating his meals, cleaning his area, etc.) to justify such a placement, but he was unable. She reports the staff then made a rule that they would not interact with him more than necessary (e.g. play games, or have conversations) unless he showed improvement. Calderon reports that he was then able to progress to a lower

level of care than one-on-one, but he is still at the level where he is checked every 15 minutes and has not made appreciable improvement in personal hygiene, eating his meals, and cleaning his area.

Expert Opinion Evidence

DR. KELLER

63. Jennifer Keller, Ph.D., conducted a neuropsychological evaluation of claimant on February 3, 2020, issued a report that same date, and testified at hearing.

64. Dr. Keller has been licensed as a psychologist since 2001. She holds bachelor's, master's, and doctoral degrees in psychology. She is a clinical professor at the Stanford University School of Medicine (Stanford) and co-director of the neuropsychology clinic in Stanford's department of psychiatry. She conducts and supervises neuropsychological assessments and supervises psychology students, doctoral interns, and post-doctoral fellows. She is the author or co-author of 41 peer-reviewed research publications.

65. At the time of Dr. Keller's evaluation, claimant was being held in Stanford's inpatient psychiatry unit, approximately three weeks after being admitted to Stanford after he had swallowed a computer cable in an attempt to harm himself. Claimant was discharged the day after Dr. Keller's evaluation.

66. Prior to issuing her report, Dr. Keller interviewed claimant and his parents; reviewed claimant's Stanford medical records and his 2015 and 2018 school psychology assessment records; and administered several assessment tests to claimant over a period of approximately four hours. Dr. Keller reports that claimant appeared to put forth good effort and attempted most tasks, although he did stop at some points,

saying the tests were too difficult for him. Dr. Keller provided claimant with numerous breaks. She believes that most of the tests "were clearly challenging for him," but he persisted. Dr. Keller also administered one implicit effort test (reliable digit span) to claimant and reports that he scored above the cutoff, suggesting reasonable effort.

67. Claimant was on several medications at the time of the assessment. However, Dr. Keller does not believe these medications had a negative effect on claimant's test scores. She opined that, in her experience, such medications are often mildly helpful for subjects, leveling mood and perhaps improving concentration. However, she admitted that she was unfamiliar with two of the medications. Prior to testifying at hearing, Dr. Keller reviewed additional medical and assessment records of claimant.

68. Dr. Keller administered a standard IQ test to claimant, measuring his overall capacity to reason, solve problems, and learn useful information. Claimant's full-scale IQ score was 66, in the first percentile (extremely low range).

69. Claimant received the following subtest scores:

Verbal comprehension:	76 (5th percentile) (borderline)
Perceptual reasoning skills:	69 (2nd) (extremely low)
Working memory index:	77 (6th) (borderline)
Information processing speed:	62 (1st) (extremely low)
General ability:	70 (2nd) (borderline)

70. Dr. Keller reports that if a subject's subtest scores differ too much (scatter), the full-scale IQ score may not be accurate. However, she opines that the

conventional view is that subtest score differences of less than 1.5 standard deviations do not invalidate the full-scale IQ score. She reports that one standard deviation on this test is 15 points, therefore the validity threshold for subtest score variation is approximately 23 points. Because the differences between claimant's highest and lowest subtest scores was much less (15 points), Dr. Keller opines that claimant's full-scale IQ score (66) is a valid measure of his IQ on the date of testing.

71. Dr. Keller also attempted to administer a standard assessment of claimant's learning and memory. He was shown a complex figure and asked to copy it. He reported it was too difficult and did not attempt it.

72. Dr. Keller administered portions of an executive functioning test. Claimant scored extremely low (trail making test; verbal fluency test; color-word interference test) to low average (tower test).

73. Dr. Keller administered a standard psychological inventory to claimant to measure psychological distress and personality structure and relevant diagnosis data. It also contains a brief validity scale. Dr. Keller reports that claimant's responses appeared to be valid and his approach to this inventory reflects a possibility of magnifying illness, an inclination to complain, and feelings of extreme vulnerability. Claimant's most prominent clinical symptoms were generalized anxiety and depression, both persistent and acute. His profile also suggested ineffective coping mechanisms. His highest personality scores included dependent and melancholic traits. He scored both as dependent and also resentful towards those upon whom he must depend. His scores indicated that he is invariably pessimistic.

74. Dr. Keller also had claimant's father complete an adaptive behaviors scale questionnaire, which yielded a score in the low range (1st percentile) for general adaptive functioning, consistent across domains.

75. Dr. Keller also assessed claimant for autism and opines that he does not meet criteria for that condition.

76. Dr. Keller opines that claimant meets the DSM-5 criteria for ID. In her report, she wrote:

> He demonstrates deficits in intellectual functions, including reasoning, abstract thinking, and learning, as demonstrated by the cognitive testing (FSIQ [full-scale IQ]=66). Similar intellectual functioning levels have been found in past assessments. [Claimant] also has significant deficits in adaptive functioning (per the Vineland III) that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility. Similar low ratings per [claimant's] teachers were seen in previous assessments. Without ongoing support, the adaptive deficits limit functioning in terms of communication, social participation, and independent living across settings. It is clear from his history in [claimant's] medical and educational files that such deficits have been present since early childhood.
>
> Current testing also demonstrated several executive functioning difficulties, including poor inhibition and

difficulty switching between tasks. In addition, previous testing by the Monterey School District consistently demonstrates deficits in other cognitive areas. In 2018, [claimant] demonstrated significant difficulty with learning and memory, visual perceptual and visual motor tasks, and lower levels of academic achievement. Though his memory was low across modalities, [claimant] performed best when information was presented verbally (Low average range, mild impairment) compared to visually presented information (Very Low range, moderate impairment). This suggests that in order for [claimant] to learn new information (such as new coping strategies) verbally mediated strategies (such as role playing, repetition) may be the most effective learning strategy. [Claimant] also demonstrated significant impairments in visual perceptual skills and visual motor integration tasks. These visual skills may lead to difficulties in understanding whole-part relationships and understanding an object in relation to others/other objects. Similar results were seen in 2015 testing.

Per [claimant's father] and previous assessments, [claimant] has a previous diagnosis of Fetal Alcohol Syndrome Disorder. Due to the range of deficits and variability in degree of each deficit within the diffusely damaged brain, FASD can present as functionally different in each individual that is affected. However, certain cognitive, behavioral, and

> adaptive functioning problems are common across the spectrum, including lower intellectual functioning, impaired learning ability, and difficulty processing information (such as not being able to remember or follow instructions). Other functional issues regularly observed in FASD include attention deficit, decreased proficiency in cognitive planning, reduced working memory, reduced response inhibition, socially inappropriate behaviors and deficits in fine motor and visual-spatial functions. Individuals with an FASD often require more intensive and personalized services. [Claimant's] cognitive challenges, evidence in the current and past testing, are consistent with the patterns seen in adults with fetal alcohol syndrome.

77. In addition to ID, Dr. Keller opines that claimant meets the diagnostic criteria for persistent depressive disorder (dysthymia), with intermittent major depressive episodes; and ADHD (by history).

78. Dr. Keller opines that the reasons that claimant ingests inedible objects are varied, but she believes that executive function deficits—his impulsivity and lack of inhibition—may be factors. Dr. Keller opines that treatment for this problem will need to be modified for claimant due to his ID and FAS history. She recommends structure and consistent, frequent feedback about the behaviors, with features such as: structured living environment; simple rules, repeated often; consistent boundaries; social skill training; basic living skill training as insight-oriented and cognitive behavioral therapy "are likely too abstract for him"; and small, achievable goals.

DR. CHAMBERS

79. Gerard Chambers, Jr., Psy.D., Ph.D., attempted to conduct a neuropsychological evaluation and diagnostic interview of claimant in 2021; issued a letter dated August 18, 2021; and testified at hearing.

80. Dr. Chambers has been licensed as a psychologist since 2010. He holds a bachelor's, master's, and two doctoral degrees in psychology. He has worked in private practice as a clinical and forensic psychologist since 2010.

81. Dr. Chambers reviewed claimant's medical and school records. He reports that when he visited claimant in a locked facility to assess and interview him, claimant appeared too sedated for a valid assessment. Dr. Chamber's letter is based upon his review of claimant's records. Dr. Chambers acknowledged claimant's psychiatric conditions, but after summarizing numerous childhood records regarding claimant that cited FAS, developmental delays, or "borderline intellectual functioning," wrote:

> Clearly, there have been numerous indications of a developmental disability throughout the aggregate of [claimant's] history prior to the age of 18, and prior to being assigned a major depression diagnosis with subsequent hospitalization. He possesses borderline intellectual functioning, mild FAS facial dysmorphia, and numerous practitioners have referred to him as developmentally delayed and conclude that the consequences of his very clear adaptive difficulty may be explained by poor brain development, and not mental health alone.

> In conclusion, it is the formal opinion of the undersigned that a psychiatric condition is not the sole cause of his current level of adaptive dysfunction, and [claimant] displays clear clinical characteristics of a developmentally delayed and substance exposed patient.

82. Dr. Chambers reviewed Dr. Keller's report. At hearing he opined that claimant's cognitive function was borderline and Dr. Keller's report did not clearly explain how she came to a diagnosis (ID) ostensibly more severe than he had previously received. However, he opined that Dr. Keller's diagnosis of ID could be supported by claimant's poor adaptive function. Dr. Chambers opined that his opinion that claimant's intellectual functioning is "borderline" is based on the fact that claimant scored greater than 70 on "some indices." Dr. Chambers emphasized his opinion that claimant's medical records show that his FAS and intellectual deficits arose prior to age 18.

DR. QUITON

83. Rhiyan Quiton, Psy.D., has been a licensed psychologist for 12 years and works for the Monterey County Health Department's Behavioral Health Bureau, on the adult placement team. He holds bachelor's, master's, and doctoral degrees in psychology. He has worked as part of claimant's care team for more than a year.

84. Dr. Quiton reports that in October 2021, claimant was briefly placed in a less restrictive level of care, but again ingested a foreign body. Dr. Quiton authorized claimant's return to the disturbed behavior unit, where claimant receives supervision at least every 15 minutes and must remain in the facility at all times. Dr. Quiton reports that the facility is intended for short-term care and progression to lower levels of care,

but the county has no other facility in which to safely place claimant due to his self-injurious and occasionally assaultive behaviors. Dr. Quiton reports that claimant's past diagnoses included borderline personality disorder (BPD), but now he is diagnosed with BPD traits, meaning claimant has some of the symptoms of BPD, but does not meet the full criteria or further time is needed for observation. Dr. Quiton reports that claimant's current diagnoses are: major depressive disorder (MDD), recurrent severe, partial remission; BPD traits, and FAS. Dr. Quiton opines that MDD does not typically interfere with a patient's cognition.

85. Dr. Quiton reports that claimant has shown no improvement since October 2021, despite medication and group therapy. Dr. Quiton attributes this to claimant's FAS, which he believes prevents claimant from absorbing and processing treatment information. Dr. Quiton reports that claimant appears to be able to take in verbal information, but cannot retrieve this information to use as coping skills or strategies.

86. Dr. Quiton opines that claimant's prognosis is poor and he will need support services and supervision for the rest of his life. He believes that claimant, if placed in a board and care facility (large or small), would quickly end up in the emergency department because such facilities require clients to be at least somewhat self-directed.

DR. ELLIS

87. Azelin A. Ellis, Psy.D., has been a staff psychologist for SARC for almost seven years. For the last year, she has been SARC's Autism Spectrum Disorder clinical manager and supervisor of SARC's board-certified behavioral analysts. She conducts eligibility evaluations for SARC. Dr. Ellis earned her doctor of psychology degree in

2013 and also holds two master's degrees and one bachelor's degree in psychology. Before working at SARC, Dr. Ellis directed mental health treatment at a children's clinic and worked at a children's hospital.

88. On October 27, 2021, Dr. Ellis and SARC hearing representative James F. Elliott, M.S.W., met with claimant via videoconference for approximately 45 minutes. Dr. Ellis issued a written summary of the clinical interview. Dr. Elis also relied upon a June 7, 2021, report of remote interview of claimant, his father, and his social worker, conducted by Ashley Berry, Psy.D. (Dr. Berry did not testify at hearing.)

89. Dr. Ellis reports that claimant:

> was cooperative and ready to participate when we started the meeting. [Claimant] demonstrated good verbal skills; he took time to pause and think after questions. His speech was somewhat slow at times but seemed to reflect him taking the time to think through his responses. He smiled and chuckled appropriately at various times throughout the interview.
>
> . . .
>
> [Claimant] knows who his conservator is and how long he has been in his current placement [secure mental health facility]. He stated he was at Natividad Hospital for 8-months prior to coming to this placement. He notes he has had one arrest but asked not to talk about it. He knows he takes Prozac and Risperdal but did not know any others ("I take so many medications"). He cannot administer

medications himself due to his history of overdosing. He is cooperative with taking his medication.

90. Dr. Ellis reports that claimant:

> noted that the staff "pester" him to wake up. He goes to bed between [9:00 p.m. and 10:00 p.m.] but has a hard time getting up due to feeling groggy. Currently, it appears the grogginess is due to medication, and [claimant] noted the psychiatrist is going to lower the medication he takes that causes sedation. [Claimant] was able to walk us through his day; he needed some verbal prompts to state the next step. He noted that he does not like attending the groups at his placement but is aware he has to in order to "get anywhere" in moving up on the level system. He was asked to explain the levels, and he was able to state what each level meant in terms of privileges. He asked a staff member for clarification when he could not remember what a certain level was called. He is looking forward to moving to the level where he can go to the store; he did not have anything in mind to purchase but would like to go "look around."

91. Dr. Ellis reports that the IQ cutoff score for ID is 70. She opined that a claimant needs an IQ test prior to age 18 and "can't use later tests." Dr. Ellis emphasized that claimant was not diagnosed with ID until Dr. Keller diagnosed him with ID when he was almost 20 years old. Dr. Ellis opines that claimant does not meet criteria for ID or the fifth category of eligibility.

92. Dr. Ellis acknowledges that FAS can cause impairment that qualifies some individuals for fifth category eligibility, but she opines that FAS is also associated with non-eligible conditions that can cause impairment, such as MDD. Dr. Ellis acknowledges that determining the cause of impairment can be difficult.

93. Dr. Ellis opined that a person can test lower than his or her natural capability, for example if severely depressed or having a psychotic episode. However, a person is unlikely to test significantly better than his or her capability. Dr. Ellis cited examples in previous assessments of claimant in which assessors or teachers noted that insufficient motivation and effort were factors in claimant's academic struggles. She opines that claimant's poor effort could have been a factor in Dr. Keller's assessment. Dr. Ellis also emphasized that claimant, when motivated by staff's deprival of one-on-one play, was able to improve on certain tasks.

94. Dr. Ellis opined that a large variance in IQ subtest scores is not typical of ID, and one would expect to see consistently low (not low average) scores across multiple domains. In reference to claimant's scores on the IQ test administered by Dr. Keller, Dr. Ellis opined that if claimant had ID, she would expect to see a majority if not all scores in the extremely low range. Dr. Ellis did not offer any information about the valid threshold for variation in subtest scores, or explain why claimant's full-scale IQ score of 66, if valid, would not support a diagnosis of ID.

95. Dr. Ellis also opined that some of claimant's statements in the records demonstrate a cognitive level inconsistent with someone with a substantially impairing developmental disability. Dr. Ellis further opined that some of claimant's deficits, such as processing speed, are more consistent with ADHD—not an eligible condition—than ID.

Ultimate Findings

96. A preponderance of the evidence shows that claimant has ID or a disabling condition that is closely related to ID or that requires similar treatment as an individual with an ID, and that claimant's disabling condition arose prior to the age of 18 and is expected to continue indefinitely. Claimant does not dispute that he also suffers from non-eligible conditions, including depression. SARC concedes that claimant has FAS and that it occurred before the age of 18. SARC does not dispute that claimant is substantially disabled. However, SARC contends that claimant's FAS is not similar to, nor requires treatment similar to ID. Implicitly, SARC contends that claimant also does not suffer from ID itself.

97. The opinions of Dr. Keller were most persuasive. She is the most experienced and most qualified of the experts who testified in this proceeding. She spent the most time with claimant and her interactions with claimant were in person, not remote. Dr. Keller administered a standard IQ test to claimant and his full-scale IQ score was 66, in the first percentile and extremely low range, and below the 70-point cutoff for ID. Dr. Keller credibly and persuasively testified that claimant put forth good effort and his medications did not have a negative effect on his test scores. Dr. Keller persuasively explained that the scatter in claimant's subtest scores did not invalidate his full-scale IQ score. Dr. Keller also measured deficits in claimant's executive functioning and he scored extremely low on three of four subtests. Dr. Keller's psychological testing and adaptive behaviors questionnaire indicated that claimant has psychological distress, ineffective coping mechanisms, and general adaptive functioning at the 1st percentile, consistent across domains. Dr. Keller persuasively opined that these deficits were seen in assessments of claimant prior to age 18 and his deficits limit his functioning across settings, as they have since early childhood.

Additionally, she and Dr. Quiton persuasively opined that claimant's intellectual deficits prevented him from effectively implementing treatment he has received and that he needs treatment similar to that of individuals with ID. Further, the fact that claimant was not diagnosed with ID prior to age 18 can be partially attributed to the fact that the schools were not allowed to administer IQ tests to him and to the presence of comorbid conditions, including FAS, the symptoms of which vary and overlap with many other diagnoses. Also, when claimant's IQ was assessed at age 7, his score was 76 (borderline).

98. Dr. Ellis's testimony raised significant questions as to the sophistication of some of claimant's language, and his ineligible conditions such as depression and ADHD, but was ultimately not persuasive. Dr. Chambers's opinion that claimant's cognitive function was borderline conflicted with Dr. Keller's opinion that claimant has ID, but weighs in favor of a finding of fifth-category eligibility. The preponderance of the evidence established that claimant is disabled by ID or a condition that is closely related to ID.

LEGAL CONCLUSIONS

1. The State of California accepts responsibility for persons with developmental disabilities under the Lanterman Act. The purpose of the Act is to rectify the problem of inadequate treatment and services for the developmentally disabled, and to enable developmentally disabled individuals to lead independent and productive lives in the least restrictive setting possible. (Welf. & Inst. Code, §§ 4501, 4502; *Association for Retarded Citizens v. Department of Developmental Services* (1985) 38 Cal.3d 384 [All further statutory references are to the Welfare and Institutions Code unless stated otherwise.].) The Act is a remedial statute; as such it

must be interpreted broadly. (*California State Restaurant Association v. Whitlow* (1976) 58 Cal.App.3d 340, 347.)

2. As claimant is seeking to establish eligibility for government benefits or services, he has the burden of proving by a preponderance of the evidence that he has met the criteria for eligibility. (*Lindsay v. San Diego Retirement Bd.* (1964) 231 Cal.App.2d 156, 161 [disability benefits]; *Greatorex v. Board of Admin.* (1979) 91 Cal.App.3d 54, 57 [retirement benefits]; Evid. Code, § 500.)

3. A developmental disability is 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." (§ 4512, subd. (a).) The term "developmental disability" includes ID, cerebral palsy, epilepsy, and autism. (*Ibid.*) Under the fifth category, an individual is also eligible for services if he or she has a disabling condition that is closely related to ID or that requires similar treatment as an individual with an ID. (*Ibid.*) Such condition must also have originated before the individual attained 18 years of age, and must continue or be expected to continue indefinitely. (Cal. Code Regs., tit. 17, § 54000, subd. (b).) Claimant has an eligible disability, either ID or a closely related condition under the fifth category. (Factual Findings 96–98.)

4. A qualifying disability must be "substantial," meaning that it causes "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; [and] (G) Economic self-sufficiency." (§ 4512, subds. (a), (l)(1); Cal. Code Regs., tit. 17, § 54001, subd. (a)(2).) Claimant's

eligible disability has rendered him pervasively disabled across all these domains. (Factual Findings 96–98.) Claimant's qualifying disability is substantial.

5. Claimant has established eligibility for regional center services.

ORDER

The appeal of claimant from the service agency's denial of regional center eligibility is granted. Claimant is eligible for regional center services.

DATE:

MICHAEL C. STARKEY
Administrative Law Judge
Office of Administrative Hearings

NOTICE

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