BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of the Eligibility of:

CLAIMANT

and

INLAND REGIONAL CENTER, Service Agency

OAH No. 2022030713

DECISION

Abraham M. Levy, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter by videoconference and telephone on August 18 and 24, 2022.

Emily Ikuta, Attorney at Law, Disability Rights California, represented claimant.

Julie A. Ocheltree, Attorney at Law, Enright and Ocheltree, L.L.P., represented Inland Regional Center (IRC).

Oral and documentary evidence was received. On claimant's unopposed motion the record was left open. After consulting with the parties, the record was left open until September 30, 2022, for claimant to submit a closing brief, for IRC to submit a response brief, and for claimant to reply to IRC's brief. The parties submitted their

respective briefs which have been considered and made part of the hearing record. The matter was submitted for decision on September 30, 2022.

SUMMARY

Claimant applied for regional center services under the Lanterman Developmental Disabilities Services Act (Lanterman Act) on the basis of an intellectual disability, or a disability closely related to an intellectual disability or requires treatment similar to that required for individuals with an intellectual disability (the "fifth category"), constituting a substantial disability. After considering the evidence of record in this matter and the parties' arguments, claimant failed to prove by a preponderance of the evidence that she qualifies for regional center services on these bases. Claimant's appeal is denied.

FACTUAL FINDINGS

Jurisdictional Matters

1. On February 10, 2022, IRC notified claimant that she is not eligible for regional center services because she does not have a "developmental disability" as defined under Welfare and Institutions Code section 4512. Claimant timely submitted a Fair Hearing Request, and the matter was set for hearing.

Background and Summary of Claimant's History and the Parties' Assertions Regarding Claimant's Eligibility

BACKGROUND

2. Claimant is 53 years old and resides at Department of State Hospitals-Patton (Patton), a forensic psychiatric hospital in San Bernardino. She was admitted to Patton by the September 2, 1998, order of the Superior Court of California, Los Angeles County, pursuant to Penal Code section 1370, because she was found mentally incompetent to stand trial. Her offenses were four counts of attempted murder in violation of Penal Code section 664/187, subdivision (a). On December 6, 2001, the Office of the Public Guardian was appointed conservator of claimant's person and estate pursuant to Welfare and Institutions Code section 5008, subdivisions (h)(1)(A) and (B), with criminal charges then pending against her. On December 5, 2006, her commitment was changed to Welfare and Institutions Code section 5008, subdivision (h)(1)(A). Her conservatorship was terminated on December 3, 2013.

By court order on January 13, 2010, her type of commitment changed to a Penal Code section 1026 commitment, because she was found not guilty by reason of insanity.[1]

[1] Elsewhere in the record she was reported to have been charged with attempted murder. The court documents were not provided.

Claimant receives Social Security disability benefits with an onset date of October 30, 1985, on the basis of "Schizophrenia Spectrum and Other Psychotic Disorders (Diagnostic Code 2950)."

3. Before her commitment at Patton claimant, claimant had been committed to psychiatric hospitals for most of her life. As one staff psychiatrist at Patton put it in 1998, she has been "extremely psychotic and extremely assaultive." (Exhibit 53, A225, psychiatric evaluation report by Stephen E. Salenger, M.D., October 6, 1998.) In high school she was enrolled in a class for severely emotionally disturbed students. In that class she engaged in bizarre, aggressive, and inappropriate behaviors and assaulted one of her teachers. As recently as January 6, 2021, her target symptoms were identified as mood swings, assaultive behavior, psychotic symptoms, and cognitive deficits. (Exhibit C, B28, DSH Monthly Psychiatric Progress Note, January 6, 2021.) In a monthly report from January 2021, staff psychiatrist Nitin Kulkarni, M.D. described claimant as psychiatrically stable on the medications Clozapine and Divalproex.[2]

PLAN TO TRANSITION TO CONDITIONAL RELEASE PROGRAM AT SYLMAR

4. As her goal, claimant wants to transition to the Conditional Release Program at Sylmar. Her plan to do this requires her to demonstrate continued behavioral stability without assaultive behavior.

5. At Patton claimant attended group therapy, including the Recovery Inspired Skills Enhancement (RISE) group, and was enrolled in the RISE program from

[2] These medications are antipsychotic medications used to treat schizophrenia. < https://www.drugs.com/clozapine.html (Retrieved October 7, 2022)>

April to September 2021. The RISE group is a multifaceted neurocognitive and social cognition training program for individuals with severe cognitive needs and challenges. The program is designed to help participants enhance their neurocognitive functioning and specific behaviors relevant to improve social interactions, social information processing, and emotional regulation. Before she entered the program, claimant was assessed on structured objective measures of cognitive functioning and adaptive measures of her ability to provide self-care and function independently. Mark Williams, Ph.D., a neuropsychologist at Patton, used these structured assessments, in addition to clinical observations of claimant at RISE, to address her potential eligibility for regional center services under the Fifth Category. As detailed below, Dr. Williams prepared two reports and testified on claimant's behalf.

CLAIMANT'S ARGUMENT FOR REGIONAL CENTER SERVICES AND IRC'S RESPONSE

6. Claimant seeks regional center eligibility on two bases: Intellectual disability and the fifth category. Claimant asserts she is eligible for regional center services because she meets the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition ("DSM-5") criteria for intellectual disability and, regardless, qualifies under the so-called "fifth category." She applied for regional center services previously, and the superior court also referred her for an assessment. On December 8, 1987, IRC determined claimant to be ineligible for regional center services based on its diagnostic team's determination that claimant did not have a developmental disability.

7. IRC again asserts that claimant is not eligible for regional center services because she falls under an exclusion for regional center services: Claimant has a solely psychiatric condition, schizophrenia or schizoaffective disorder, which was first assessed when she was a child. IRC further argues claimant's cognitive and social

declines are due to this condition, and these declines are documented in the evidence of record. IRC also argues that claimant does not meet the fifth category criteria because of the aforementioned exclusion and because she does not have a condition that requires similar treatment to that of intellectual disability.

Testimony of Ruth Stacey, Psy.D., and Mark Williams, Ph.D.

8. IRC relies for its position on the opinion of Ruth Stacy, Psy.D., IRC staff psychologist, who testified in this hearing. Dr. Stacy reviewed claimant's application and medical and psychiatric records as part of IRC's Interdisciplinary Team review of claimant's application. IRC also called Pravin Kansagra, M.D., who is board certified in psychiatry and neurology.

9. Claimant principally relies on the opinion of Mark Williams, Ph.D., a neuropsychologist who testified in this matter.

TESTIMONY OF RUTH STACY, PSY.D.

10. Ruth Stacy, Psy.D., is a staff psychologist at IRC and has held that position since October 2015. Dr. Stacy received her Doctor of Psychology (Psy.D.) degree from Trinity College of Graduate Studies in 2008. Her responsibilities at IRC include performing psychological assessments of children and adults to determine eligibility for regional center services.

11. Dr. Stacy was part of IRC's eligibility team that reviewed claimant's recent application for regional center services. The team consisted of Dr. Stacy, Holly Miller-Sabouhi, Psy.D., a licensed clinical psychologist, and Janessa James, M.D., a pediatrician. The records the team reviewed included medical records from 1982 through 1988, records before she turned 18 years old, claimant's educational records,

reports from teachers, and records from Patton. Dr. Stacy also reviewed claimant's submissions, including Dr. Williams's report, and mental health progress records from Patton. In her analysis, Dr. Stacy was guided by the DSM-5 criteria for intellectual disability and guidelines established by the Association of Regional Center Agencies (ARCA) to determine fifth category eligibility.

12. As documented in two eligibility determination forms the team completed and signed, the team considered whether claimant may be eligible under any qualifying categories and determined that claimant is not eligible for regional center services under any, including intellectual disability and the fifth category. The team noted that IRC had determined, as mentioned above, that it had found her ineligible when she turned 20, she was found to suffer from severe emotional disturbance, she had a long history of psychiatric hospitalizations starting as a young child, and her first admission to Patton was in 1986, when she was 18 or 19 years old.

13. In her testimony, Dr. Stacy discussed in detail the extensive medical records, psychiatric records, educational records, and other information that make up the evidence of record in this matter. These records document claimant's psychiatric condition before she turned 18 years old.

14. Based on her review of these records Dr. Stacy concluded that claimant does not qualify for regional center services because she falls under the excluded category per California Code of Regulations, title 17, section 54000, subdivision (c)(1). Dr. Stacy found that claimant's condition, schizophrenia or schizoaffective disorder, was solely psychiatric in nature, and her cognitive functioning and adaptive functioning declined due to this condition. She further concluded that these records do not support a fifth category finding and claimant did not meet the criteria for intellectual disability under the DSM-5.

15. Dr. Stacy described claimant's history as follows: Per her sister's and mother's reports, claimant did not have prenatal or perinatal problems. Claimant's developmental milestones were outside of the normal range; and she had significant language delays. She did not start articulating words until she was two years old and full sentences until she was five, and she did not start walking until she was eighteen months. Dr. Stacy stated that claimant had been hospitalized for psychiatric disturbance since she was 7 years old and was in special education classes for emotional disturbance as opposed to intellectual disability. Claimant was frequently admitted for psychiatric hospitalizations at Patton, Camarillo, and University of California, Irvine for aggressive behaviors and psychotic symptoms. Dr. Stacy said these repeated hospitalizations would "absolutely" have interfered with her cognition, intellectual development, and adaptive development.

16. Dr. Stacy found it clinically significant that claimant began to show the signs of severe mental illness when she turned three years of age. Claimant's mother told a school psychologist for the Oceanside Unified School District, as recorded in the psychologist's report dated November 15, 1979, that claimant had to be removed from a preschool program due to behavioral problems. As discussed later in this decision, IRC called Pravin Kansagra, M.D., a psychiatrist, to discuss claimant's thought disorder. Dr. Kansagra found that, in his opinion, her display of behavioral problems at such a young age constituted, together with other indications in the record, a "prodromal" symptom of schizophrenia and persons with such a prodromal condition had poor prognoses.

17. In 1987, when claimant was 20 years old, a social assessment of claimant was done at Edgemont Hospital. She was placed at Edgemont from Patton while criminal charges were pending against her for stabbing a fellow patient. The court

found she was not competent to stand trial for the offense and she required psychiatric hospitalization. The court referred her to IRC for an assessment. Per the December 4, 1987, social assessment report done at the court's request, claimant was described as having a long history of mental health treatment with a diagnosis of "atypical psychosis."

18. As a result of this court referral, William Clover, M.D., then chief of medical services at IRC, wrote a report dated December 8, 1987. Dr. Clover visited claimant at Edgemont and interviewed her to determine her eligibility for regional center services. In addition to meeting with her, Dr. Clover obtained her medical history and cited the findings of IRC's staff psychologist Larry Sheffield, Ph.D., who wrote a contemporaneous report.

19. Dr. Clover concluded that claimant's diagnosis was Schizophrenia, Chronic, Undifferentiated Type, and she did not qualify for regional center services. He further found claimant did not have a handicapping condition to be closely related to mental retardation (now intellectual disability) or required treatment similar to that required for persons with intellectual disability. He also determined that claimant did not qualify for services under the autism category.

20. As part of IRC's assessment of claimant, as Dr. Clover noted in his report, Dr. Sheffield conducted a psychological evaluation. Dr. Stacy found Dr. Sheffield's psychological assessment particularly important for analyzing claimant's intellectual functioning for several reasons.

21. Dr. Sheffield administered the Wechsler Adult Intelligence Scale-Revised test (WAIS) to claimant, but he questioned the accuracy of the test results as a matter of evaluating claimant's true intellectual functioning due to what he described as

claimant's thought disorder, chronic schizophrenia, which interfered with her test taking. He wrote that it was apparent to him this thought disorder impaired claimant's ability to concentrate and pay attention. In addition, the subtest results showed that claimant's reading was in the average range, spelling in the borderline range, and arithmetic in the extremely low range.

22. In her analysis of these scores, Dr. Stacy emphasized that these test results were extremely wide ranging, or scattered. In her view, such wide ranging scatter are inconsistent with an intellectual disability and more consistent with the thought disorder, schizophrenia. Dr. Sheffield, she commented, reached the same conclusion, noting that the hospital chart reflected that claimant's reading and writing skills supported the view that she did not have intellectual disability.

23. In contrast to the results he obtained at Edgemont, Dr. Sheffield found, and Dr. Stacy further emphasized in her analysis, the test results obtained when claimant was 12 years at Oceanside Unified School District did not indicate she had intellectual disability, rather these test results more accurately reflected her intellectual functioning. Dr. Stacy explained that unless there was a head injury or a traumatic insult to the head, a person's intellectual functioning as measured when a person is 12 would not deteriorate.

24. Per the results of the testing done at Oceanside, claimant attained scaled scores on the Wechsler Intelligence Scale for Child of 4 on information, 8 on similarities, 6 on vocabulary, 4 on comprehension, 11 on digit span, 8 on picture completion, 4 on picture arrangement, 8 on block design, 10 on object assembly, and 15 on mazes. These scores placed claimant in the high borderline range, her non-verbal skills in the low average range, and her overall mental abilities in the low average range.

25. Dr. Stacy added that the test results of the Woodcock-Johnson Psychoeducational Battery administered at Oceanside were particularly noteworthy in terms of understanding claimant's intellectual functioning before she turned 18. Per these results, she was reading at the 3.4 grade level; her math skills were at the 3.5 grade level; and her written language skills at the 3.6 grade level. Her aptitude grade level for reading was 4.2; math 5.1; and written language 4.5; which placed her in the percentile range of 8 to 12 percent. Dr. Stacy stated these scores indicated a delay, but a delay not considered to be within a range indicating a developmental disability. With an intellectual disability, Dr. Stacy said you would typically see her at 2 percent for her age. Claimant's scores were slightly below average and not consistent with an intellectual disability.

26. Dr. Stacy concluded, based on these scores, that at age 12 claimant did not meet the DSM-5 criteria for intellectual disability, or had a condition closely related to intellectual disability, or that required treatment similar. Dr. Stacy said it is evident that claimant could learn and retain information; a person with intellectual disability reaches a "ceiling." The records indicate that claimant was able to learn and had skills as other children her age. At this age it would be known whether a person has an intellectual disability, and in Dr. Stacy's opinion, claimant did not have intellectual disability at that time.

27. In addition to the test results Dr. Sheffield obtained, Dr. Stacy cited other information Dr. Sheffield obtained in his report as indications claimant suffered from a thought disorder, schizophrenia, that interfered with her intellectual functioning as opposed to an intellectual disability. First, a staff person, claimant's personal attendant at Edgemont, told Dr. Sheffield it appeared to him that claimant was often "delusional" or appeared to be hallucinating. (Claimant's response to a question from Dr. Sheffield

seems to support this. In her interview with Dr. Sheffield, in response to the question why she was at Edgemont, claimant said that she was upset because "Khadafy was trying to blow up Lybia [*sic*]."

28. In her review of the record, Dr. Stacy also found significant a January 19, 1990, psychological assessment, which Patton staff psychologist Helen M. Courtney, Ph.D., conducted when claimant was 22 years old. Dr. Stacy testified that Dr. Courtney's assessment is significant in terms of understanding claimant's intellectual functioning and cognitive functioning between 12 and 22 years old.

29. Dr. Courtney, in her review of claimant's records, noted that claimant had been tested at age 12, using the WISC and the Bender, as noted above, and again in 1984 using the WAIS and the Bender. Her performance on the tests done when she was 17 showed her verbal IQ at 80, her performance IQ at 74, and full scale IQ (FSIQ) at 76, which Dr. Courtney wrote was in the borderline range. Claimant, Dr. Courtney noted, had no problem with the Bender test. Claimant's performance on the testing Dr. Courtney administered to her on January 19, 1990, showed that she had a verbal IQ of 69, performance IQ of 67, and FSIQ of 71, which again placed her in the borderline intellectual functioning range. Dr. Courtney noted that there were problems with claimant's performance on the Bender indicating carelessness and poor planning.

30. Dr. Stacy found claimant's test performance at age 17 "crucial" to understand claimant's intellectual functioning before she turned 18 because the test results clearly showed no evidence of intellectual disability at age 17. Claimant's verbal score was in the low average range and her FSIQ at the borderline range. But her performance on the testing also showed her intellectual functioning declined from when she was 12, which Dr. Stacy also viewed as important. In her opinion this decline was consistent with the effects of schizophrenia.

31. Dr. Stacy reviewed and discussed Dr. Williams's finding that claimant is eligible for regional center services under the fifth category of eligibility and claimant has an intellectual developmental disorder. Based on claimant's performance on the WAIS-IV test Dr. Williams administered, and claimant's psychological clinical history, Dr. Stacy disagrees with Dr. Williams's conclusions.

32. Dr. Stacy stated that the WAIS-IV test results are not suggestive of moderate intellectual disability, as Dr. Williams found. She dismissed the FSIQ of 63 in light of claimant's performance on subtests. These results suggest claimant has a lot higher ability. Dr. Stacy cited the 79 score for processing speed and coding, which were in the borderline and low average range, respectively. Dr. Stacy also cited the visual spatial test results, which ranged from average for picture completion to impaired.

33. Dr. Stacy commented that Dr. Williams himself recognized the discrepancies in claimant's test results indicating a higher level at processing that in her view are inconsistent with intellectual disability. Dr. Stacy stated you cannot look at the FSIQ of 63 without using clinical judgment to get a complete and accurate understanding of claimant's intellectual functioning. In this respect, Dr. Stacy cited Dr. Williams's comment in his report, in which he wrote the following:

> There was some heterogeneity among her performance scores across indices that comprise the FSIQ; thus, a more accurate reflection of her intellectual functioning can be obtained by examining each of these indices separately.

34. Dr. Stacy also stressed that, regardless of his diagnosis, there is no evidence of intellectual disability during the developmental period. A review of the evidence of record supports Dr. Stacy's assessment.

In various reports from clinicians during and shortly after claimant's developmental period, clinicians raised the possibility of a mild mental retardation diagnosis (mental retardation is the former term for intellectual disability), but these clinicians did not make that diagnosis. Claimant's psychiatrist, Charles Adams, M.D., in a letter dated December 28, 1982, wrote that claimant's diagnosis was "pervasive developmental disorder with delusions and auditory hallucinations, DSM III 299.7." (Exhibit O, B100.) Dr. Adams then stated claimant "suffers from poor impulse control, poor object relations and possible mild mental retardation." Claimant was being treated with major tranquilizers and she required continual psychiatric treatment, including hospitalization. (*Ibid.*) In a report dated May 30, 1986, Patton staff psychiatrist Nenita Deiparine, M.D., wrote that claimant had in the past been diagnosed with mild mental retardation. Dr. Deiparine did not, however, diagnose her with this. In a letter dated July 15, 1986, in response to a court order, O. L. Geiricke, M.D., at a forensic psychiatric clinic where claimant was sent, Dr. Geiricke noted that a question arose whether her diagnosis was mental retardation. Dr. Geiricke was not able to reach a diagnosis based on the information the doctor had. But Dr. Geiricke wrote that claimant's false ideas about being a Bulgarian, marriage, and tangential speech suggested a "schizophrenia pattern." The doctor concluded, notwithstanding the inability to reach a formal diagnosis, that claimant "continued to be psychotic to the point of being legally insane." In a letter dated August 5, 1986, Arnaldo Moreno, M.D., Chief of Medical Services at San Bernardino County Department of Mental Health, and David R. Sena, Ph.D., Mental Health Clinician, interviewed claimant and diagnosed her with chronic undifferentiated schizophrenia, not in remission. They did

not mention mental retardation in their assessment. In their report, they noted that claimant appeared delusional telling them that she had conversations with her hero, Abraham Lincoln. In a report dated January 14, 1988, Patton staff psychiatrist Talat Khan, M.D., noted that past psychological testing showed mild mental retardation, but he noted that claimant's cooperation with the testing was poor and discarded it. He diagnosed claimant with atypical psychosis and childhood onset of pervasive developmental disorder.

In a letter received by IRC on June 17, 1986, psychiatrist Trevinder Ahluwalia, M.D., who was claimant's treating psychiatrist, diagnosed her with Atypical Psychosis and gave her a guarded prognosis. In a letter dated February 24, 1986, Dr. Ahluwalia described claimant's behavior as bizarre with poor impulse control, and claimant had the potential to severely injure someone else.

35. In her testimony, Dr. Stacy repeated that before claimant turned 18, her verbal skills were assessed at the low range when she was 17 with a FSIQ in the borderline range. As she put it, this in "no way" indicated she met the criteria for intellectual disability before she turned 18 years old.

36. Dr. Stacy noted further that Dr. Williams emphasized in his report claimant's limited adaptive skills as a basis for his conclusion that claimant may qualify for regional center services. But claimant's adaptive skills were "absolutely" affected by schizophrenia. Since she was six or seven years old, claimant was hospitalized multiple times in psychiatric facilities and has been institutionalized most of her life. As a result, claimant has not developed adaptive skills and her adaptive skills have declined. Claimant has lacked the opportunity to learn these skills and practice them.

37. Dr. Stacy, in addition, discussed Dr. Williams's citation of a 2010 "Focused Neuropsychological" report prepared by Albert Yee, Psy.D., to support his findings. Dr. Williams referenced Dr. Yee's finding specifically that claimant has "Mild Mental Retardation." In his report Dr. Yee diagnosed claimant with "Borderline Intellectual Functioning." In the body of his report referred to the diagnosis as "Borderline Intellectual Functioning or Mild Mental Retardation." (Dr. Yee did not diagnose claimant with mild mental retardation or what is now known as mild intellectual disability. As he wrote, "without collateral information . . . about her past adaptive skills . . . it would be somewhat difficult to give this diagnosis." Dr. Williams recognized Dr. Yee's qualification but referenced that "collateral information" shows claimant's adaptive functioning difficulties and developmental disabilities.)

38. In her evaluation of Dr. Yee's report, Dr. Stacy noted that the "Current Diagnosis," when Dr. Yee assessed her, was Schizoaffective Disorder, not intellectual disability. (Dr. Yee added Borderline Intellectual Functioning to the diagnosis.) As with her performance on other psychological testing, her performance on the WAIS-IV showed a wide array of scores. Such a wide array of scores, in Dr. Stacy's opinion, was not consistent with a diagnosis of intellectual disability for a diagnosis to be made when she was under 18. She cited claimant's FSIQ of 70, which was in the borderline range, and her working memory core of 80, which placed her in the low average range. Many of the scores fell within the low average range. Her performance on the WAIS-IV Processing Speed Index score was 86, which was in the low average range, and her symbol search performance was average based on a scaled score of 8. Claimant also achieved a score of 84 on the WRAT-4 word reading, which was in the low average range. Dr. Stacy testified that due to this wide range of test results, the FSIQ of 70 needed to be viewed with caution.

39. In her analysis, Dr. Stacy addressed whether, based on these test results, claimant met the fifth category eligibility criteria. In her view these test results did not support such a finding. She also cited the "Association of Regional Center Agencies Guidelines for Determining 5th Category' Eligibility (ARCA Guidelines)." The Guidelines provide that the farther the scores are from 70, "the less similar to a person with mental retardation is the person likely to appear." (Exhibit 62, A323.)

DR. WILLIAMS'S TESTIMONY

40. Claimant, as noted, called Mark Williams, Ph.D., to testify on her behalf. Dr. Williams obtained his Ph.D. in neuropsychology from the State University of New York at Binghamton and completed an internship at Patton. He also completed an additional year of postdoctoral training in neuropsychology at Patton, has published articles in the field of neuropsychology, and done numerous presentations in neuropsychology.

41. Dr. Williams serves as Senior Psychologist Specialist, Neuropsychologist, for the State Hospital and is on the State Hospital advisory team. At Patton, as a clinical neuropsychologist, he assesses the cognitive strengths of individuals and the neuropsychological effects on the brain due to disease.

Dr. Williams has served on the specialty team at Patton where he works with patients who have behavioral problems that affect their cognitive functioning and adaptability. These persons include persons with schizoaffective disorder and/or who have cognitive problems above their psychiatric diagnoses. Dr. Williams estimates he has performed close to 200 neuropsychological assessments including persons with intellectual disability.

42. Dr. Williams is familiar with claimant through her involvement in the RISE group program where he served as a facilitator or co-facilitator for the one-hour group sessions. These group sessions met weekly over a six-month period. In that role Dr. Williams had the opportunity to observe claimant, and his observations factored into his integrated assessment of his cognitive functioning.

43. Dr. Williams is also familiar with DSM-5 criteria for intellectual disability which he stated involves three key factors: the demonstration of cognitive impairment, deficits in adaptive functioning such as the ability to navigate responsibilities regarding work and caring for themselves, and persons must demonstrate these deficits arose before they turned 18 during the developmental period. Dr. Williams further considered the DSM-5 criteria for intellectual disability and the fifth category criteria.

44. Dr. Williams reviewed the evidence of record in this matter and prepared a detailed report and an addendum report summarizing his conclusions. As part of his assessment, he administered the following psychological profile tests to claimant: The WAIS test, which he described as the gold standard test to measure overall cognitive functioning and is widely used to measure cognitive functioning; the DOT Counting Test, which measures a person's motivation to take a test and also tests for malingering; the Peabody Picture Vocabulary Test, a language-based test, which measures a person's ability to respond verbally; the Texas Functional Living Scale which measures adaptability; and the California Verbal Learning Test, which measures a person's ability to remember information. His testimony is consistent with the reports he prepared.

45. Based on claimant's test scores, his observations of claimant, and the records he reviewed, Dr. Williams found that claimant demonstrated impairment in

various domains in cognitive functioning, deficits in adaptive functioning, and she had a history of cognitive functioning impairment before she was 18 years old. Dr. Williams recognizes that claimant has schizoaffective disorder which has affected her cognitive functioning and this psychiatric condition goes well back into her history. He stated this condition, in his view, is superimposed upon a compromised intellectual foundation, a clinical feature that is set upon a compromised cognitive function based on the hypoxic event and Pervasive Developmental Disorder that was already present.

46. In his testimony Dr. Williams explained that claimant's intellectual disability presentation is consistent with the DSM-5 criteria for intellectual disability with deficits in reasoning, problem solving, academic learning, and learning from experience.

47. Claimant further has adaptive functioning deficits that limit her functioning in one or more activities of daily living. He stated claimant does not have the ability to complete tasks in cooking, doing laundry, shopping for groceries, paying bills, and accessing public transportation without guidance. Dr. Williams said he saw during the six months of group sessions that claimant needs prompting and assistance to perform activities of daily living. Claimant is not able to be economically self-sufficient, and requires assistance out of concern she may be victimized.

48. In his addendum report, Dr. Williams referenced several factors that contributed to his analysis of claimant's intellectual functioning: He understood claimant suffered a perinatal hypoxic event,[3] a factor he emphasized, she was delayed

[3] Dr. Williams'ss understanding that claimant suffered from hypoxia, as discussed later in this decision, is not supported in the record.

in meeting developmental milestones in walking and speech specifically, she struggled during her academic career, and has been an inpatient in the mental health system for much of her childhood and adult life. He added as a factor that claimant was assessed with childhood onset Pervasive Developmental Disorder. He stated these factors contributed to his analysis that claimant has an intellectual disability as opposed to a learning disability.

49. In summary, Dr. Williams reached the following conclusion:

> Taken together, it appears [claimant] has subaverage intellectual ability that is likely related to developmental causes. Importantly, this is the foundation upon which other psychiatric and neuropsychological influences have been superimposed.

50. Regarding the onset of claimant's intellectual disability, Dr. Williams relied as an important source of his opinion that claimant's onset was before she turned 18, Dr. Sheffield's December 11, 1987, assessment of claimant and the WAIS scores from the test Dr. Sheffield administered, although the test was administered after claimant turned 18. He noted that claimant's FSIQ was measured as 70 in that assessment. Dr. Williams stated that the 70 FSIQ is the standard cutoff for an intellectual disability diagnosis and represents two standard deviations from the average FSIQ of 100 with a margin of error of plus or minus five. At the same time, he cautioned that a FSIQ is not the only measure to assess a person for intellectual disability.

51. Dr. Williams further cited claimant's FSIQ scores from 2010 and 2012 of 70 and 64, respectively. Again, these scores were administered to claimant after she turned 18.

By comparison to the FSIQ scores from 1987, 2010, and 2012, claimant's present day FSIQ was measured by Dr. Williams as 63, in the impaired range; her Verbal score was measured at 68, also in the impaired range; and her Perceptual Reasoning, Working Memory scores, and Matrix Reasoning scores were all in the impaired range. Dr. Williams discounted claimant's processing speed score of 79. He explained that for claimant being able to identify shapes is a strength, but this score was in the borderline range and the score cannot be looked at in isolation considering the results in other areas. Her score was still in the borderline range.

52. Dr. Williams acknowledged the heterogeneity, or scatter, in claimant's WAIS subtest scores, and addressed whether this scatter might mean claimant has a learning disability. He discounted that claimant has a learning disability based on the factors he mentioned earlier. For claimant, he said a learning disability does not account for her performance as a matter of historical formulation. Dr. Williams identified his understanding that claimant suffered a perinatal hypoxic event and was assessed with childhood onset Pervasive Development Disorder. These factors Dr. Williams said argue against a learning disability.

53. Dr. Williams was asked about several intellectual functioning test scores he did not address in his reports. One of these reports is from Patton staff psychologist Dr. Courtney and is dated January 19, 1990, and is discussed above in the context of Dr. Stacy's testimony. In her testimony Dr. Stacy referenced Dr. Courtney's assessment and found it significant as a matter of understanding claimant's cognitive functioning between ages 12 and 22. In her review of claimant's reports and test

results, Dr. Courtney stated that claimant had been tested at age 12 using the WISC and the Bender, as noted above, and again in 1984 using the WAIS and the Bender. Her performance on the tests done when she was 17 showed her verbal IQ at 80, her performance IQ at 74, and FSIQ at 76. Claimant, Dr. Courtney noted, had no problem with the Bender test. In contrast, claimant's performance on the testing Dr. Courtney administered to her on January 19, 1990, showed that she had a verbal IQ of 69, performance IQ of 67, and FSIQ of 71, which again placed her in the borderline intellectual functioning range. Dr. Courtney noted that claimant's performance on the Bender indicated carelessness and poor planning. As discussed earlier, Dr. Stacy found claimant's test performance at age 17 "crucial" to understand claimant's intellectual functioning before she turned 18 because the testing was done before she turned 18, and the test results clearly showed no evidence of intellectual disability at age 17.

54. Dr. Williams acknowledged he had not reviewed Dr. Courtney's report before he wrote his reports. He acknowledged, additionally, that claimant suffered a decline in her scores between ages 12 and 22, but he maintained that the FSIQ still remains consistent with a borderline intellectual functioning diagnosis. He recognized that the Verbal IQ of 80 is not consistent with such a diagnosis, however.

55. Dr. Williams was also asked to address the Oceanside Unified School District assessment of claimant from November 15, 1979, when she was 12 years old. According to the claimant's scaled score, as also discussed earlier, on the WISC claimant placed in the high borderline range, her non-verbal skills in the low average range, with her overall mental abilities in the low average range. She was assessed at reading at the 3.4 grade level; her math skills were at the 3.5 level; and her written language skills at the 3.6 grade level. Her aptitude grade level for reading was 4.2;

math 5.1; and written language 4.5 which placed her in the percentile range of 8 to 12 percent.

Dr. Williams stated he did not review this report before he wrote his reports, but it did not change his final diagnosis. He noted that the scores in Dr. Sheffield's report and his 2021 assessment are consistent.

56. Regarding claimant's eligibility under the fifth category, Dr. Williams felt claimant met the fifth category factors to qualify under this category: she has a cognitive impairment closely related to intellectual disability, or requires treatment similar to intellectual disability.

57. Concerning the second prong of the fifth category, Dr. Williams stressed claimant requires the structure or "scaffolding," and interdisciplinary planning and coordination that are most applicable for persons with intellectual disability. This treatment regimen, he said, offers a lot of attention and support for a person with intellectual disability to help that person be more effective. In Dr. Williams's view, these added supports "absolutely" are appropriate and are needed for claimant to maximize a successful treatment modality. At the same time, Dr. Williams stressed that treatment for a psychological disorder alone is not appropriate for claimant.

Dr. Kansagra's Testimony

58. As mentioned earlier, IRC called Pravin J. Kansagra, M.D., as a witness to discuss the effects on claimant's cognition due to her schizoaffective disorder. Dr. Kansagra is board certified in psychiatry. He serves as a staff psychiatrist at Western Medical Center in Orange County, has his own clinical practice, and for fifteen years served in the Court Evaluation and Guidance Unit for the County of Orange. Since

2001 he has conducted psychiatric evaluations and treatment for IRC consumers with dual diagnoses.

Dr. Kansagra reviewed IRC's evidence of record. The following is a summary of his testimony:

Dr. Kansagra stated that claimant has early onset schizophrenia and she displayed compromised intellectual functioning over time. Dr. Kansagra stated that beginning at age 7 he saw in the records evidence of claimant's behaviors which indicated schizophrenia. She was aggressive and found staring off into space. He also cited her problem behaviors at age three as indicating she had "prodromal" symptoms of schizophrenia at a very young age.

For persons with this early onset schizophrenia, the prognosis is poor. Dr. Kanangra testified that for persons with schizophrenia, their cognitive functioning declines over the years by as much as a 20 points per studies in intellectual functioning. Dr. Kansagra cited two articles in support of his opinion on this issue: a 2006 study titled "Intellectual Decline in Schizophrenia: Evidence from a Prospective Birth Cohort 28 Year Study" (Journal of Clinical and Experimental Neuropsychology (Volume 28, 2016-Issue 2)) (Exhibit 75), and a publication titled "Very Early Onset Schizophrenia in a Six-Year-Old Boy," as published on Psychiatry Online on February 10, 2017. (Exhibit 76.)

Closing Arguments

59. The parties as mentioned submitted closing briefs which have been duly considered. Their arguments are summarized as follows:

60. Claimant argued in closing she meets the DSM-5 criteria for intellectual disability citing Dr. Williams's opinions, the evidence of record, and her childhood developmental history. Dr. Williams's opinions, claimant asserted, should be given greater weight than Dr. Stacy's based on his training and experience and the comprehensiveness of his opinions. As an alternative to a finding of intellectual disability, claimant qualifies under the fifth category with a disabling condition closely related to intellectual disability or because she requires treatment similar to that for an intellectual disability. She further argued that her condition is not solely psychiatric in nature, or a learning disorder.

61. IRC argued in closing that the overwhelming evidence from Patton and the testimony of Drs. Stacy and Kansagra shows that claimant suffers from schizoaffective disorder and this condition has integrally manifested itself in her intellectual and social functioning. Accordingly, this condition is excluded from the definition of developmental disability. In addition, IRC argued that claimant does not meet the DSM-5 criteria for intellectually disability citing Drs. Courtney's and Sheffield's psychological assessments and conclusions during and near her developmental period. IRC added that claimant focused on her current functioning and not on psychological assessments made before or near when she turned 18. IRC noted further that the evidence of record does not support the conclusion that claimant suffered from perinatal hypoxia.

Regarding the fifth category issue, IRC does not have a condition closely related to intellectual disability citing the *Mason* decision and the ARCA guidelines. Claimant also does not require treatment similar to that of a person with an intellectual disability. IRC urged that the *Samantha C.* decision (*Samantha C. v. State Dept. of Developmental Services (2010) 185 Cal.App.4th 1462,1471-72*) not be relied upon to

assess what the term "treatment" for someone with intellectual disability means. Instead, IRC urged that the court's reasoning in *Ronald F.* be followed. (*Ronald F. v. Dept. of Developmental Services* (*Ronald F.*) (2017) 8 Cal.App.5th 84.)

62. In her reply, claimant asserted that the evidence shows that she did have a developmental disability before she turned 18, and the schizoaffective disorder was not solely psychiatric in nature but co-occurring as both a psychiatric and developmental disability. Claimant stressed that Dr. Williams's comprehensive assessment and opinions should be given greater weight than Dr. Stacy's. Claimant further argued that claimant meets the fifth category criteria because she has a condition closely related to intellectual disability and because she requires treatment similar to the treatment for persons with intellectual disability. In this regard, claimant noted that the court in *Ronald F.* did not define "treatment," and the court's decision in *Samantha C.* should be followed because the court's reasoning in that case is consistent with the legislature's intent to allow flexibility in determining eligibility under the fifth category and the ARCA guidelines. In any case, claimant argued that the evidence of record shows that claimant requires treatment similar to those required for persons with intellectual disability.

LEGAL CONCLUSIONS

Burden and Standard of Proof

1. In a proceeding to determine eligibility, the burden of proof is on the claimant to establish he or she meets the proper criteria. The standard of proof is a preponderance of the evidence. (Evid. Code, § 115.) Claimant has the burden of proof to establish her eligibility in this matter.

Statutory Authority

2. The Lanterman Act is set forth at Welfare and Institutions Code section 4500 et seq.

3. Welfare and Institutions Code section 4501 states:

> 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 follows:

"Developmental disability" means 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. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include intellectual disability, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability, but shall not include other handicapping conditions that are solely physical in nature.

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

(a) "Developmental Disability" means a disability that is attributable to mental retardation, cerebral palsy, epilepsy, autism, or disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation. (Note: The regulations still use the term "mental retardation," instead of the term "Intellectual Disability.")

(b) The Developmental Disability shall:

(1) Originate before age eighteen;

(2) Be likely to continue indefinitely;

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

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

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

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.

Evaluation and Disposition

7. After giving due consideration to the evidence of record in this matter, the testimony of Drs. Stacy, Williams and Kansagra, and the parties' arguments, claimant's appeal is denied. This conclusion is reached for the following reasons:

8. First, a preponderance of the evidence does not show that claimant qualifies for regional center services under the intellectual disability category. Dr. Stacy's opinions here are well supported in the record and found more persuasive than Dr. Williams's opinions. Courts have repeatedly underscored that an expert's opinion is only as good as the facts and reasons upon which that opinion is based. (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 924.) Dr. Williams's opinion that claimant's performance on testing is consistent with the DSM-5 criteria for intellectual disability is not found persuasive because it is not well supported in the record, particularly, with respect to claimant's intellectual functioning before she turned 18. Claimant's performance on the tests done when she was 12 and 17 shows that her intellectual functioning was in the low average to high borderline range, which Dr. Stacy found is not consistent with an intellectual disability. Other test results done during this period are also inconsistent with an intellectual disability diagnosis: claimant's reading level was assessed at the 3.4 grade level; her math skills were at the 3.5 level; and her written language skills at the 3.6 grade level. Her aptitude grade level for reading was 4.2, math 5.1, and written language 4.5, which placed her in the percentile range of 8 to 12 percent, well above what would be expected of a person with intellectual disability. At age 17, her FSIQ was measured at 76, with her verbal IQ

at 80, and her performance IQ at 74. Dr. Stacy testified that absent brain injury or neurological damage her cognitive functioning should remain the same.

But as Dr. Stacy also persuasively concluded, claimant has long suffered from a schizoaffective disorder that has integrally manifested itself and compromised her social and intellectual functioning, and the regulatory exclusion applies. (Cal. Code Regs, title 17, § 54000, subd. (c)(1).) This manifestation of the schizoaffective disorder in claimant's life is detailed in the evidence of record and has resulted in her repeated hospitalizations and State Hospital commitments. The condition itself has caused her intellectual functioning and adaptive capacity to deteriorate as Drs. Stacy and Kansagra testified, which is a feature of the disease. Dr. Courtney's documentation of this decline between the age of 12 and 22 is a notable summary of claimant's cognitive deterioration during the developmental period and shortly thereafter.

Dr. Williams's opinion must also be discounted because in his assessment of claimant's intellectual functioning, he emphasized claimant suffered from perinatal hypoxia. But there is no support in the record for this conclusion.

9. The issue now turns to whether claimant can be deemed to qualify for regional center services under the fifth category either because she has a disabling condition found to be closely related to intellectual disability or a disabling condition requiring treatment similar to that required for individuals with intellectual disability. A preponderance of the evidence does not show that claimant meets the fifth category criteria.

With regard to the first prong, a disabling condition closely related to intellectual disability, Dr. Stacy's testimony as summarized immediately above is found persuasive. At the age of 12 claimant was measured as having low to average

intelligence with school level performance measured in the 8 to 12 percentile range. As also noted, her FSIQ at age 17 was measured at 76, with her verbal IQ at 80, and her performance IQ at 74. The ARCA Guidelines provide that the farther the scores are from 70, "the less similar to a person with mental retardation is the person likely to appear." (Exhibit 62, A323.)

10. Claimant also did not prove by a preponderance of the evidence that she meets the second prong of the fifth category criteria. This conclusion is reached for these reasons: Fundamentally, as discussed above, the regulatory exclusion applies and claimant is not deemed to have a developmental disability because her cognitive limitations are found to be solely a psychiatric disorder. (Cal. Code Regs, title 17, § 54000, subd. (c)(1).)

Regardless, claimant did not prove by a preponderance of the evidence that she requires *treatment* similar to that required of a person with intellectual disability. The designation of "treatment" in Section 4512 as a separate item is a clear indication that it is not merely a synonym for services and supports. (*Ronald F. v. Dept. of Developmental Services* (2017) 8 Cal.App.5th 84.) The appellate court in that case noted that regional center services and supports targeted at improving or alleviating a developmental disability may be considered "treatment" of developmental disabilities. (*Ibid*. at p. 98.). The court then commented that a lot of persons, regardless of whether they are regional center consumers, would "'benefit from the broad array of services and supports provided by a regional center to individuals with [intellectual disability].'" (*Ibid*., citing *Terry C*., Office of Administrative Hearings Decision, Case No. 2010011014.)

Regarding the question of similar treatment in claimant's case, it has not been established that claimant requires treatment similar to that of a person with

intellectual disability to alleviate or improve a developmental disability. Her cognitive cognition is due to the integral manifestation of her psychiatric condition. Dr. Stacy persuasively testified this condition does not require similar treatment to that provided for one with an intellectual disability. That claimant would benefit from the structure of interdisciplinary planning and coordination is accepted, but such services and supports would benefit many persons without developmental disabilities.

ORDER

Claimant's appeal is denied. Claimant is ineligible for regional center services under the Lanterman Act. IRC's determination that she is ineligible if affirmed.

DATE: October 10, 2022

ABRAHAM M. LEVY
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.