BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT

vs.

REDWOOD COAST REGIONAL CENTER, Service Agency.

OAH No. 2022010486

DECISION

Administrative Law Judge Michelle Dylan, State of California, Office of Administrative Hearings, heard this matter on June 21, September 13, and December 16, 2022, by telephone and videoconference.

Lauren Gardner, Attorney at Law, represented Redwood Coast Regional Center (RCRC), the service agency.

Jacqueline Snyder, Attorney at Law, represented claimant, who was not present. Claimant's developmental and educational rights holder, Sheryn Hildebrand, was present.

The record was held open for a list of documents reviewed by one of claimant's expert witnesses, and written argument. On January 6, 2022, claimant submitted the list of documents reviewed by their expert, which was admitted as Exhibit T. On

January 20, 2023, RCRC filed a closing brief, which was marked for identification as Exhibit 20. On February 3, 2023, claimant submitted a closing brief, which was marked for identification as Exhibit U. The record was closed and the matter was submitted for decision on February 3, 2023.

ISSUE

Is claimant eligible for regional center services under the Lanterman Act because she is substantially disabled based on autism spectrum disorder, intellectual disability or a condition that is closely related to intellectual disability or that requires treatment similar to that required for individuals with intellectual disability?

FACTUAL FINDINGS

Introduction and Procedural History

1. Claimant is 17 years old. She lives at Birch House, a short-term residential therapeutic placement (STRTP).

2. Claimant was first assessed by North Bay Regional Center (NBRC) for eligibility for regional center services in 2016. NBRC issued a finding that claimant was not eligible for regional center services on November 29, 2016.

3. In 2019, Alta California Regional Center (ACRC) conducted a records review regarding claimant to determine if there was a belief of a developmental disability. Based on their review, ACRC found no indication to suggest that claimant has a developmental disability as defined by California law.

4. In 2020, an eligibility assessment was sought on behalf of claimant from Redwood Coast Regional Center. After reviewing additional information provided by claimant, conducting an intake social assessment, and performing additional testing, RCRC found that claimant was not eligible for regional center services.

5. In 2021, another eligibility assessment was sought on behalf of claimant from RCRC. After reviewing additional information provided by claimant, conducting an updated intake social assessment, and performing additional testing, RCRC once again found that claimant was not eligible for regional center services.

6. Claimant requested a hearing and this proceeding followed.

7. Claimant contends that she is eligible for regional center services due to autism spectrum disorder (ASD), intellectual disability (ID) or conditions found to be closely related to ID or to require treatment similar to that required for individuals with ID, which is known as the "fifth category." RCRC contends that claimant is not eligible for regional center services under autism, ID, the fifth category, or any of the other qualifying developmental disabilities (cerebral palsy or epilepsy). RCRC does not contest that claimant is substantially disabled but, contends that claimant's functional limitations are due to mental health issues, rather than an eligible developmental disability.

Applicable Diagnostic Criteria

AUTISM SPECTRUM DISORDER (ASD)

8. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), describes the modern criteria for diagnosis

of ASD. (DSM-5 at p. 50 and 51.) The diagnostic criteria for ASD set forth in the DSM-5 are:

> A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history . . . :
>
> 1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
>
> 2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
>
> 3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.
>
> [¶]. . . [¶]

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history . . . :

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).

2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).

3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).

4. Hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

[¶]. . . [¶]

C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).

D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay.

9. ASD is a developmental disorder. As diagnostic criterion C reflects, the diagnostic features of ASD are present from early childhood. In addition, and as diagnostic criterion A reflects, its significant symptoms are apparent and persistent in multiple contexts.

INTELLECTUAL DISABILITY (ID)

10. The DSM-5 also sets forth the diagnostic criteria for ID. (DSM-5 at p. 33.) The essential features of ID are deficits in general mental abilities and impairment in everyday adaptive functioning, relative to an individual's age, gender, and socio-culturally matched peers. Three diagnostic criteria must be met for a diagnosis of

intellectual disability[1]. First, there must be deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience. Individuals with ID typically have IQ (intelligence quotient) scores in the 65 to 75 range, representing a threshold score of 70 plus or minus 5 points as a margin for measurement error. Second, there must be deficits in adaptive functioning that result in failure to meet developmental and socio-cultural standards for personal independence and social responsibility. Third, the onset of the intellectual and adaptive deficits must occur during the developmental period.

FIFTH CATEGORY

11. The Lanterman Developmental Disabilities Services Act (Lanterman Act) provides assistance to individuals with five specified developmental disabilities: intellectual disability, cerebral palsy, epilepsy, autism, and the "fifth category" of disabling conditions closely related to an intellectual disability or that require treatment similar to that required for an individual with an intellectual disability. (Welf. & Inst. Code, § 4512, subd. (a).) As with the other specified developmental disabilities, a disability under the fifth category must originate before the age of 18, must continue or be expected to continue indefinitely, and must constitute a substantial disability for the person. (*Ibid.*)

12. The courts have discussed the requirements of the fifth category of regional center eligibility. In *Mason v. Office of Administrative Hearings* (2001) 89

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[1] The term "intellectual disability" has replaced the formerly used term of "mental retardation."

Cal.App.4th 1119, 1129, the court held that the fifth category condition must be very similar to intellectual disability, with many of the same, or close to the same, factors required in classifying a person as intellectually disabled. Another decision has found that fifth-category eligibility may also be based on the established need for treatment similar to that provided for individuals with an intellectual disability, notwithstanding IQ scores within the average range of intellectual functioning. (*Samantha C. v. State Dept. of Developmental Services* (2010) 185 Cal.App.4th 1462, 1492.) However, the court in *Samantha C.* rejected the argument that adaptive functioning impairment standing alone is sufficient for fifth category eligibility. (*Id.* at pp. 1486-1487.)

REACTIVE ATTACHMENT DISORDER (RAD)

13. The diagnostic criteria for Reactive Attachment Disorder (RAD) set forth in the DSM-5 (DSM-5 at p. 265 and 266) are:

A. A consistent pattern of inhibited, emotional withdrawn behavior towards adult caregiver, manifest by both of the following:

    1. The child rarely or minimally seeks comfort when distressed.

    2. The child rarely or minimally responds to comfort when distressed.

B. A persistent social and emotional disturbance characterized by at least two of the following:

    1. Minimal social and emotional responsiveness to others.

    2. Limited positive affect.

3. Episodes of unexplained irritability, sadness, or tearfulness that are evidence even during nonthreatening interactions with adult caregivers.

C. The child has experienced a pattern of extremes of insufficient care as evidenced by at least one of the following:

    1. Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation, and affection met by caregiving adults.

    2. Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care).

    3. Rearing in unusual settings that severely limit opportunities for form selective attachments (e.g., institutions with high child-to-caregiver ratios.)

D. The care in criterion C is presumed to be responsible for the disturbed behavior in criteria A.

E. The criteria for autism spectrum disorder are not met.

F. The disturbance is evident before age 5 years.

G. The child is the developmental age of at least 9 months.

Developmental, Social, and Educational History

14. Claimant was born at full term after an uneventful pregnancy. She remained in the hospital for a week due to jaundice. Claimant contracted viral meningitis and pneumonia when she was two months old. Claimant's mother reported that she met her developmental milestones on a typical schedule except for toilet training. Claimant was the victim of severe abuse as an infant that led to her father's conviction for felony child abuse. The family moved to Utah and for the next five years, claimant's living conditions were described as poor with multiple calls to Child Protective Services (CPS) being made. Claimant's family then moved to Arizona, Nevada and finally California. In March of 2012, claimant was removed from her mother's care and entered the foster system after a CPS report was made alleging sexual abuse had occurred by claimant's older cousin (also noted as her brother in other reports).

15. Claimant had a number of failed foster home placements due to problematic behavioral problems. In 2014, claimant was diagnosed with Post Traumatic Stress Disorder (PTSD) and Anxiety Disorder at the Mendocino Community Health Clinic in Lakeport, and medication was prescribed.

16. Claimant was placed in several group homes from December 2015 through 2020, with continuing emotion dysregulation and physical aggression. In March 2020, claimant was placed at Birch House, a treatment home setting where she receives therapeutic behavioral services (TBS), general counseling, group therapy, and medication support.

17. Due to frequent family moves, early school records were not available.

POMO ELEMENTARY PSYCHO-EDUCATIONAL ASSESSMENT

18. In September 2014, Pomo Elementary School conducted a psycho-educational assessment of claimant. She was nine years old. Claimant was referred for assessment by her mother due to "academic and behavioral concerns and suspicion of a possible disability." It was noted that claimant did not attend preschool and that she had been retained in kindergarten. During the assessment claimant was reportedly engaged but became easily frustrated when she perceived a task to be difficult and would "shut down" at times, although she responded well to short breaks and small rewards.

19. Results of cognitive functioning tests placed claimant within the Low Range of general intellectual ability (also noted as Below Average in the records), however claimant did not qualify for special education services at the time. On the Kauffman Assessment Battery for Children-Second Edition (KABC-II) claimant obtained a full-scale IQ of 77, 6th percentile. Other scores included Sequential (91; 27th percentile); Planning (90, 25th percentile), Simultaneous (81; 10th percentile); Verbal Knowledge (87; 20th percentile); and Learning (67; 1st percentile). It was noted that due to the large amount of diversity in scores across domains, claimant's full-scale IQ of 77 may not be an accurate representation of her true cognitive abilities and should be interpreted with caution.

20. On the Woodcock-Johnson Test of Achievement-Third Edition (WJ-III) claimant's standard scores included Broad Reading (80; 9th percentile); Broad Math (87; 20th percentile); and Broad Written Language (79; 8th percentile). Claimant was not diagnosed with a specific learning disability since there did not appear to be a severe discrepancy between her ability and achievement. Claimant was placed on a

504 Plan to ensure additional school support based on her diagnoses of PTSD and anxiety.

MARYSVILLE JOINT UNIFIED SCHOOL DISTRICT PSYCHO-EDUCATIONAL ASSESSMENT

21. Claimant was once again referred for multidisciplinary re-evaluation after demonstrating her inability to succeed in a regular school program with the support of a 504 Plan. Claimant had a psychoeducational assessment in February 2016 when she was 10 years old by the Marysville Joint Unified School District. An interview of claimant's third grade teacher noted disruptive behaviors at the beginning of claimant's third grade school year including hitting and kicking other students and talking back in class. Claimant's behavior improved after the teacher developed a relationship with her. By the second half of the year, claimant was able to work in small groups, was respectful, got along with her peers, and sought out hugs from her teacher; and over the course of the year she developed friendships with two other students. The assessment report was not completed because claimant moved.

22. In fourth grade, after changing schools, claimant had difficulty establishing friendships, and it was noted that claimant was academically more than two years behind her peers. The Wechsler Individual Tests of Achievement – Third Edition (WIAT-III) was administered to determine her academic functioning. On the WIAT-III, her composite standard scores ranged from a high of 77 (6th percentile) in Basic Reading to a Low of 57 (<1st percentile) in Math Fluency. Furthermore, claimant scored very low on all facets of the Adaptive Behavior Assessment System (ABAS-3).

SANTA ROSA CITY SCHOOL DISTRICT PSYCHO-EDUCATIONAL ASSESSMENT

23. Claimant had a psychoeducational assessment completed in March 2016 when she was 10 years old by the Santa Rosa City School District. Her cognitive skills were assessed with the Wechsler Abbreviated Scales of Intelligence-Second Addition (WASI-2), an abbreviated measure for assessing intellectual ability, and the Test of Nonverbal Intelligence-Fourth Edition (TONI-4). On the WASI-2, she obtained a full-scale IQ Standard Score of 89 (23rd percentile), which fell in the Low Average Range. On the TONI-4 a122 she obtained a Standard Score of 90 (25th percentile), which placed her at the lowest point of the Average Range. It was noted that claimant was making very slow progress in the acquisition of basic academic skills. Claimant received extremely elevated scores on the Behavior Assessment System for Children-Third Edition (BASC-3), suggesting that she had difficulty in many areas of executive functioning including problem solving, attentional control, behavioral control, and emotional control.

24. In the fourth grade, she was made eligible for special education services under emotional disturbance (ED) based on her scores on the BASC-3, her diagnosis of PTSD, and low achievement scores; and speech language impairment (SLI).

25. Claimant's current education is being conducted in the home. She only tolerates sessions in increments of 15 minutes or less, and she refuses work that she does not understand. Her academics are reportedly taught at the second-grade level.

Assessment by NBRC in 2016

26. Claimant was referred to NBRC with concerns about autistic-like symptoms. It was reported that claimant had not formed bonds with any staff or

residents in her current placement, has difficulty attaining and maintaining relationships, has rigid thinking, has demonstrated sudden aggression, and has difficulty expressing emotions and understanding the emotions of others.

27. In October 2016, claimant was evaluated by Kathryn Pedgrift, Psy.D, and Daniel Silva, Ph.D., Staff Psychologist at NBRC, who wrote a psychological evaluation report. Evaluators reviewed claimant's records, interviewed claimant and her house manager, and administered several testing instruments. Claimant was 11 years old at the time. A developmental history was based on records from Pomo Elementary School which indicated that claimant's mother reported that claimant met developmental milestones within normal limits with the exception of toilet training which was delayed; and that claimant was exposed to significant physical abuse as a baby. Shortly after meeting claimant, the assessment team determined that a comprehensive evaluation for ASD was not warranted. It was noted that claimant's use of nonverbal communication was typical, her use of language appeared appropriate with integrated gestures and facial expressions, she did not demonstrate any fixated or unusual interests, nor any repetitive body movement, language, or habits. While it was reported that claimant enjoyed the attention of the evaluators, she appeared distracted and disinterested in assessment tasks.

28. The Wechsler Intelligence Scale for Children, Fifth Edition (WISC-V) was administered to assess claimant's intellectual functioning. Again, although claimant seemed to enjoy the attention of the evaluators, she appeared distracted and disinterested in assessment tasks, and at times appeared to "playfully antagonize" the examiner. Claimant's scores indicated verbal comprehension in the borderline range (70; 2nd percentile), visual spatial reasoning in the low average range (81; 10th percentile), fluid reasoning in the borderline range (79; 8th percentile), working

memory in the extremely low range (67; 1st percentile), and processing speed in the extremely low range (69; 2 percentile). A full-scale IQ score of 65 was calculated, which is in the 1st percentile, in the extremely low range of intellectual functioning. However, because claimant's performance was markedly lower than previous measures of her intellectual functioning, and claimant appeared distracted and lacked focus during testing, the evaluators noted that the current results were likely an underestimation of her actual ability. Nevertheless, it was recommended that due to her poor performance on the current testing, her intellectual functioning should be monitored carefully throughout her development.

29. Claimant's house manager, Sharon Laplander, was interviewed for the purpose of the evaluation, and completed the Adaptive Behavior Assessment System, Third Edition (ABAS-3) Caregiver Form. The ABAS-3 consists of three domains including conceptual, social, and practical that are comprised to create the General Adaptive Composite that represents overall adaptive functioning across the three domains. Claimant was reported to have significant and global delays in her adaptive functioning. It was reported that her hygiene is very poor, she does not seem motivated to please adults and requires all chores, grooming tasks and good behavior to be associated with a reward or personal privilege, and her food has to be restricted to prevent her from eating everything. Based on her ratings, claimant's general adaptive composite score of 50, which is less than 1st percentile, fell in the extremely low range.

30. Claimant was diagnosed with PTSD, attention deficit/hyperactivity disorder (ADHD) inattentive type, with a rule out for RAD. Although not an expert in RAD, the psychologist opined that claimant displays many known symptoms of RAD including detachment, difficulty connecting with others, inappropriate emotional

reactions, undeveloped conscience, problems with anger; and recommended that claimant be evaluated and/or treated by someone with expertise in RAD.

31. NBRC issued a determination that claimant was not eligible for regional center services on January 26, 2017.

MERCED OFFICE OF EDUCATION PSYCHO-EDUCATIONAL EVALUATION

32. Claimant had a psychoeducational evaluation completed in March 2019 when she was 13 years old by the Merced Office of Education. It was noted that since her arrival, claimant had several reported behavioral incidents which included work refusal, profanity, ripping work, kicking and hitting school property, threatening staff and walking out of class; and that she had a history of maladaptive behavior. The Woodcock-Johnson Tests of Cognitive Ability, Fourth Edition (WJ-JV; COG) was administered. Claimant's general intellectual ability standard score was 47, in the low range. On the Woodcock Johnson Tests of Achievement (WJ IV ACH), claimant's standard scores were within the low range for Broad Reading (52) and Broad Math (less than 40.) However, the assessor opined that the overall results of the assessments are not an accurate measure of claimant's true abilities because she was constantly inattentive and distracted, uncooperative at times and gave up easily on tasks she found difficult, needed frequent breaks and had difficulty sustaining attention for extended periods of time, and had a lot of difficultly paying attention and staying motivated throughout the assessment.

ACRC DOCUMENT REVIEW IN 2019

33. In 2019, at the request of claimant's representative, Alta California Regional Center (ACRC) conducted a records review regarding claimant to determine if

there was a belief of a developmental disability. ACRC's intake specialist and staff psychologist reviewed psychological/mental health records, including the medication service plan from Charis Youth Center; educational records including but not limited to two psychoeducational evaluation reports dated March 19, 2019, and March 2, 2016; and NBRC ineligibility determination as of November 29, 2016. Based on their review, ACRC issued a letter stating that it found no indication to suggest that claimant has a developmental disability as defined by California law.

Assessments by RCRC in 2020 and 2021

34. In 2020, claimant was referred by her court appointed special advocate and social worker for an eligibility assessment due to concerns of ASD. RCRC reviewed NBRC's eligibility assessment, as well as additional information, including educational records, a social intake assessment of claimant done by an intake specialist, additional testing and a psychological evaluation of claimant performed by Michael Wright, Ph.D., on October 6 and October 14, 2020, memorialized in a report dated October 28, 2020.

35. On November 3, 2020, the RCRC eligibility assessment team found that claimant was not eligible for regional center services based on their determination that she did not have ASD, ID nor a condition similar to ID. The eligibility determination noted a history of abuse and neglect, and a diagnosis of PTSD and possibly RAD.

36. In late 2021, claimant was referred for another eligibility assessment due to concerns of ID. RCRC reviewed the additional information provided by claimant, a social database report pertaining to claimant, and Dr. Wright conducted another psychological evaluation of claimant on October 27, 2021, and November 11, 2021, and authored a report dated November 23, 2011.

37. The RCRC eligibility assessment team in 2021 included client services manager Dwayne Nelson, intake specialist for Lake and Mendocino Counties Morgan Knight, pediatrician John Sullivan, M.D., and psychologist Robin Kissinger, Psy.D. The assessment team reviewed claimant's school records, current and past psychological evaluations, and a social database report completed by Knight.

TESTIMONY OF MORGAN KNIGHT

38. Knight conducted two social intakes regarding claimant on September 9, 2020, and July 8, 2021; completed a social database report; and testified persuasively at hearing. Knight has conducted intake and eligibility assessments with the Regional Center for the last four years; and has a background in developmental screening. Claimant was not present during the first social intake, because her house manager opted not to have her present. Instead, Knight interviewed claimant's house manager for two hours by telephone. Knight was also a member of claimant's eligibility team in 2020.

39. On July 8, 2021, Knight conducted the second intake social assessment and wrote a report. Knight's role is to collect basic information regarding claimant's current living situation and family dynamics, family, medical and developmental history which is generally limited in foster care, and claimant's current functioning and adaptive skills. Knight reviewed medical records and academic records. Knight noted that due to claimant's experiences within the foster systems across states, it is unknown when concern regarding her development was first expressed.

40. Knight noted that claimant had previously been diagnosed with depression and anxiety; as well as ADHD, PTSD and RAD by NBRC in October 2016. Claimant was prescribed medications which included Fluoxetine, Guanfacine for ADHD,

Propranolol, Gabapentin for anxiety and agitation and Quetiapine for depression. Claimant was enrolled in an independent study program through the local school district.

41. Knight interviewed claimant at Birch House, a residential foster placement home where she had been living for approximately a year and a half. The meeting took place approximately a half hour after claimant returned to the facility upon her return from an involuntary hospitalization and lasted approximately two hours. Claimant gave Knight a tour of her living environment. Knight reported that claimant was relatively calm and was able to provide adequate responses and engage in dialogue. Claimant took breaks as needed, and at times wandered around the house engaged in different activities, such as conversing with staff and looking at earrings that she had purchased. Knight also interviewed the house manager to gather information about her functioning.

42. Knight noted that the house staff feels that claimant's presentation is not always consistent. They state that some days she presents similar to a child of seven or eight years old and other days she presents closer to a child of 13 years old. Staff reported that claimant is capable of making appropriate eye contact when initiating interaction and attempting to get her needs met. Staff did not observe mimicking, parroting nor repetitive speech. It was reported that claimant is sensitive to loud sounds and background noise, paces when she is frustrated, and would rock after intense escalation. Claimant's motivation reportedly varies greatly depending on the task and individuals involved; and claimant was described as being desperate for friends.

43. Knight noted that when claimant first came to the treatment home, she required frequent restraints and refused all hygiene and showering, however as of 2021, she is managing her own hygiene needs. Tantrum behaviors have reduced to three times per week and restraints have been reduced. Claimant has been cleaning her room independently and learning to cook simple foods and is more engaged in mealtimes. She has developed bonded relationships with her preferred house staff whom she will now engage in dialogue regarding her emotions; but at times will engage in "mean" behavior to distance herself from others. Staff reported that claimant has engaged in aggressive physical altercations with other youth residents in the household resulting in the other residents having their placement moved, and she has physically attacked staff.

44. Claimant was enrolled in an independent study program through Willits School District at the time of the intake. Her academic functioning is well below grade level, and she demonstrates very limited attention maintenance. There was an Individualized Education Plan (IEP) in place.

45. Knight testified that fifth category eligibility was considered during both RCRC assessments.

TESTIMONY OF DR. KISSINGER

46. Based upon a review of all of the information provided by claimant, the RCRC eligibility assessment team determined that claimant was not eligible for regional center services based on ASD, ID nor a condition similar to ID.

47. Robin Kissinger is a clinical psychologist in private practice that acts as a consultant to RCRC. Dr. Kissinger was a member of the assessment team that

determined claimant's eligibility for services and testified credibly at hearing. The assessment team members reviewed claimant's school records, current and past psychological evaluations, and the social database completed by the intake specialist, and then met to discuss the case with the eligibility team. The team does not conduct an oral interview.

48. In her report, Dr. Kissinger opined as follows: "Recent reassessment of 16-year-old female with significant history of physical and sexual abuse, removed from biological family as a young child and currently living in a residential placement, rules out ASD and ID. [Claimant's] significant mental health symptoms related to diagnosis of RAD and PTSD, interfered with her performance, but more importantly tremendously impact [her] functioning and quality of life. [Claimant] does not present with a Lanterman disability, rather significant mental health disorders that require intensive, consistent, and high-quality mental health treatment."

49. Dr. Kissinger testified that claimant's test results were not consistent with an ID diagnosis because they did not demonstrate a flat or uniform pattern across subtests, but rather were scattered in different areas with peaks and valleys, which was more consistent with a learning disability. (Claimant has not been diagnosed with a learning disability). For example, claimant had scores on subtests of the WISC-V which was administered by NBRC in 2016 which were as high as 8 and 9, where the average is 10, and as low as 3. In addition, although claimant's overall performance on the testing was in the extremely low range with a full scale IQ of 65, Dr. Kissinger pointed out that when claimant was tested in September of 2014 by Pomo Elementary, in the Kaufman Assessment Battery for Children-II (KABC-II) she scored mostly within the broad average range (Low Average or Average) with several tests in the Average range, including Planning with a score of 90 at 25 percentile, and Sequential with a

score of 91 at 27 percentile. Dr. Kissinger opined these scores are not consistent with ID.

50. Furthermore, Dr. Kissinger opined that typically, with ID, one can see problems with functioning very early in development, as opposed to in the teenage years, unless a traumatic brain injury occurs.

51. Dr. Kissinger testified that the team did not review the assessment conducted by the University of California, Davis Child and Adolescent Abuse Resource and Evaluation (CAARE) Diagnostic and Treatment Center submitted on claimant's behalf because it was prepared after their review.

Testimony of Dr. Wright

52. Dr. Wright earned his Ph.D. degree in Clinical Child Psychology from the University of Kansas in 2004. Dr. Wright also holds a master's degree in Clinical Child Psychology from University of Kansas and a bachelor of arts degree in psychology from the University of California, Berkeley. Dr. Wright is a licensed clinical psychologist in California and a board certified behavioral analyst. Dr. Wright has worked in the field of autism for several decades. Since 2017, he has worked as chief clinical officer and co-owner of Ascend Behavior Partners, overseeing diagnostic and applied behavioral analysis (ABA) services. From 2010 through 2017, he worked as the Regional Director Southern California at Trumpet Behavioral Health, providing quality oversight of all ABA services provided and overseeing five offices that provided services for ASD clients. From 2001 through 2010, he was employed as a behavioral consultant for two different companies. In these roles, he treated children with ASD, supervised paraprofessionals performing ABA services, consulted with school personnel, psychiatrists, and community members, and developed treatment plans.

53. Dr. Wright testified at hearing regarding his review of claimant's assessments, his own evaluation of claimant, and his opinions about her claim for eligibility. He reviewed claimant's records, including but not limited to the psychoeducational assessment done in February 2016 by Marysville Joint Unified School District when claimant was ten years old, a psychoeducational assessment completed in March 2016 by Santa Rosa City Schools District, and the psychological evaluation completed by NBRC in October 2016, administered testing, interviewed claimant's caregivers and personally met with claimant twice, once in October 2020 and once in October 2021. When claimant sought eligibility again in 2021, RCRC conducted another evaluation of claimant and Dr. Wright evaluated claimant for ID, but not for autism.

54. Dr. Wright noted that reasons for the 2020 referral to RCRC included that when claimant first started living in her treatment home in March 2020, she required frequent restraints, and would frequently run away. Claimant was placed in juvenile hall for assault and was subject to a 5150 hold for dangerous behavior. Claimant's program manager reported that at time she acts like a seven-year-old, and other times she acts like a 55-year-old; and that claimant is processing at a second-grade level and her academics are taught at a second-grade level. Further, claimant's tablet time needs to be limited because she will look up Pennywise the clown from the horror novel, and say she is the devil.

55. During his October 2020 evaluation, Dr. Wright immediately noted that claimant did not want to participate in the examination. Dr. Wright first administered the Wechsler Intelligence Scale for Children, Fifth Edition (WISC-V) to assess claimant's cognitive functioning. During the assessment, claimant was antagonistic and noncompliant with testing, sometimes not attempting responses at all. During the

block design subtest, she did not attempt the tasks, rather saying "I only see red," and later saying red is the color of demons. During other subsets she said "I am not doing anymore," or simply gave up. Claimant also made rude comments during the testing.

56. Due to claimant's behavior, Dr. Wright opined that a number of the subtests were invalid, an overall score could not be obtained, and testing could not be completed. Dr. Wright only reported on the tests that claimant completed while appearing most motivated. Dr. Wright explained that a scaled score of 10 on a subset is average; and on the subsets that claimant appeared to have better motivation, she obtained scaled scores of 5 and 6, which were in the 5th and 9th percentile, falling in the Low Average to Borderline Range, which Dr. Wright opined was not in the range of an individual in the intellectual disability range. Dr. Wright also opined that claimant's prior testing was not indicative of ID. He explained that for an ID diagnosis, one would need a full-scale IQ of 70 or lower, although up to 75 could be considered. Dr. Wright opined that a person can test lower than his or her true cognitive ability due to a lack of effort. However, the only instance when a person could score higher than their actual ability would be if they were given the same test before within one year, which was not the case for claimant.

57. In his October 28, 2020, report, Dr. Wright opined: "While cognitive testing completed in 2011 resulted in her Full Scale IQ (Standard score 65; 1st percentile) falling in the Extremely Low Range, this appeared to be an underestimate of her cognitive abilities due to her not being compliant. When she was 10 years old, she obtained a Full Scale IQ (Standard Score 89; 23rd percentile) that fell in the Low Average Range. At the time of testing, she was being taught in a typical classroom in the third grade. While at the beginning of third grade she was having behavioral difficulties by the end of the year she was participating in school, developed

friendships, and completing work. Her performance was such that IEP was not needed that year. Claimant clearly did not have evidence of an intellectual disability in grade school. Given that one of the criteria, for an intellectual disability is the requirement of delays in the developmental period, claimant does not meet criteria for an intellectual disability. Based on results, claimant's capacity most likely falls in the Low Average to Borderline Range."

58. At hearing, Dr. Wright noted that IQ scores stay fairly stable after the age of 6. He opined that the fact that claimant was falling in the average range at the age of 10 years old, and then then appeared to steeply decline in the next six months typically will not happen unless there is a traumatic brain injury or a genetic cause. Dr. Wright attributed claimant's decline in academic function after age 10 to a lack effort and refusal to engage in testing. He opined that this apparent decline is not consistent with ID.

59. In order to determine whether claimant meets the criteria for an ASD diagnosis, Wright reviewed claimant's developmental history, conducted interviews, and administered the Autism Diagnostic Observation Schedule – Second Edition (ADOS-2), a standardized assessment tool for ASD. The (ADOS-2) is widely regarded as the most reliable tool for assessment of ASD and considered the "gold standard." Dr. Wright used Module 4, for adolescents and adults who speak fluently. Dr. Wright and claimant did not wear masks during the administration of the ADOS-2 because it is necessary to observe facial expressions and eye contact to fully score the test. Dr. Wright testified that claimant was cooperative during the ADOS-2. Claimant scored in the Non-Spectrum Range.

60. During the ADOS-2, Dr. Wright did not observe enough behaviors that Dr. Wright considered consistent with ASD to warrant a diagnosis. To the contrary, claimant spoke in full sentences, followed the conversation and was able to add to topics. Her rate, rhythm, tone, and inflection of speech were all typical. At times she initiated interactions with the examiner. While she easily engaged in activities such as telling a story from a book, she often refused to answer questions, frequently saying "Nunya," meaning "none of your business." She maintained eye contact and used integrated gestures. During the exam, she did not display repetitive behavior nor restrictive interests, nor did she speak of highly specific topics or engage in any rituals. She independently labeled "happy", "mad" and, "upset" during activity-based interactions, demonstrating an understanding of emotion. He opined that her antagonistic behavior during testing was also not consistent with ASD.

61. Dr. Wright set forth the DSM-5 diagnostic criteria for ASD and opined that claimant does not meet any of the diagnostic criteria for ASD summarized in Factual Findings 8 and 9. Dr. Wright noted that claimant has integrated gestures, has a history of making friendships, and understands emotions. Dr. Wright also noted that twirling of hair is not considered repetitive behavior for an ASD diagnosis in his opinion.

62. Dr. Wright also opined that symptoms of ASD would show up in early development, in the toddler or preschool year, and noted that he did not see an autism diagnosis in early school records, and in fact noted behavior contradictory to ASD in her records, such as engaging with others. Dr. Wright noted that claimant exhibited a sudden change in behavior after third grade, however he attributed this to the fact that her adoption placement failed, and she was placed in a group home

setting. Dr. Wright also opined that the criteria for an autism diagnosis in the educational system is less stringent than for a medical diagnosis.

63. Dr. Wright opined that claimant did not meet the DSM-5 criteria for ASD or ID and instead her behavior was more consistent with RAD which is characterized by a lack of attachment or overattachment; and aggressive, volatile and destructive behavior. He opined that claimant met all of the diagnostic criteria for RAD which is not an eligible condition under the Lanterman Act. Dr. Wright noted that claimant has difficulty forming relationships and has odd and strange behaviors; has a physical and sexual abuse history, and CPS reports indicating possible neglect; and had frequent changes in homes after being removed from her mother's care when she was six years old. RAD is characterized by a pattern of markedly disturbed and developmentally inappropriate attachment behaviors. The child rarely turns to an attachment figure for comfort, support, protection, and nurturance. Children with RAD are believed to be able to form selective attachments, however they may fail to show behavioral manifestations of attachments. Their emotional regulation capacity is compromised, and they display episodes of negative emotions of fear, sadness, or irritability that are not readily explained. They have a history of neglect, repeated changes in primary caregivers. The care is presumed to be responsible for the disturbed behavior. They do not meet diagnostic criteria for ASD, the disturbance was evident before age five, and they have a developmental age of at least nine months. According to Dr. Wright, claimant also met the requirements for PTSD, including an abuse history, negative cognitions and mood, and marked alterations in reactivity.

64. In 2021, claimant's social worker made the next referral to RCRC. Reasons for the referral noted in Dr. Wright's psychological evaluation dated November 23, 2021, included behavior resulting in nine emergency room visits and two 5150

hospitalizations, problems reading social cues from others, and interest in content that is younger than her age.

65. Dr. Wright did not administer the ADOS again because he had administered valid testing the year before that had ruled out ASD in his opinion. Dr. Wright explained that ASD occurs in the early developmental period, and one would not see changes between the ages of 15 and 16 years old. Dr. Wright opined that an interview with claimant's caregiver and claimant's presentation continued to indicate that ASD is not present.

66. In November 2021, Dr. Wright administered the Stanford Binet Intelligence Scales-Fifth Edition (SBS) to assess claimant's intelligence and cognitive abilities. Dr. Wright thought that claimant may be more compliant during the SBS than she was during the WISC-V the year before. Claimant did not appear happy to do the testing. She did engage in the first two tasks, Non-Verbal Fluid Reasoning and Verbal Knowledge. For tasks she seemed to enjoy, she paid more attention to the material. When she was unsure how to do a task, and later during testing, she did not show any persistence and frequently gave flippant answers. Dr. Wright believes that claimant's performance during the last tests of the Verbal Domain, especially Quantitative Reasoning and Visual Processing, should be considered a low estimate of her abilities; and that overall, the results of the assessment are an underestimation of her overall skills. The complete scale, the Full Scale IQ, consists of 10 subtests. Claimant's Full Scale IQ was 72, 3rd percentile, Borderline Impaired. Claimant's Abbreviated Battery IQ, which consists of the first two subtests, one verbal and one nonverbal, was 85, 16th percentile, Low Average. Dr. Wright opined that the difference between scores may be due to less motivation as testing continued and difficulties with visual spatial skills.

67. The subtest score for Fluid Reasoning was 94, 35th percentile, Average, Knowledge was 77, 6th percentile, Borderline Impaired, Quantitative Reasoning was 64, 1st percentile, Mildly Impaired, Visual Spatial was 68, 2nd percentile, Mildly Impaired, Working Memory was 77, 4th percentile, Borderline Impaired. Dr. Wright opined that claimant did not meet criteria for intellectual disability, specifically that she did not meet Criteria A relating to deficits in intellectual functioning confirmed by both clinical assessment and standardized testing, and Criteria C, relating to onset of intellectual and adaptive deficits during the developmental period. Criteria B, relating to adaptive functioning, was met.

68. In his November 23, 2021, report, Dr. Wright opined that "[claimant] [also] does not meet criteria for intellectual disability. Current testing placed her Abbreviated Battery IQ (Standard Score 85; 16th percentile) in the Low Average Range. While her Full Scale IQ (Standard Score 72; 3rd percentile) fell in the Borderline Impaired Range her behavior during testing indicates that her Full Scale IQ is most likely an underestimate of her abilities. Claimant had previous testing completed after she was nine years old that placed her outside the intellectual disability range. In 2014 when she was nine years old, she obtained a Full Scale IQ (77; 6^{th} percentile) on the KABC-II that fell in the Low Range and in 2015 when she was 10 years old she obtained a Full Scale IQ (Standard Score 89; 23^{rd} percentile) on the WASI-2 that fell in the Low Average Range. Thus, [claimant] does not meet diagnostic criteria for deficits in intellectual functioning. Claimant was taught in a regular education classroom in third grade. Her achievement testing placed her reading and math in the Low Average Range. Thus, claimant does not meet criteria for symptoms being present in early developmental period. [Claimant's] Adaptive Behavior Composite (Standard Score 68;

2nd percentile) fell in the Low Range. [Claimant's] difficulty with adaptive behaviors is not due to capacity issues but due to emotional and behavioral difficulties."

69. At hearing, Dr. Wright acknowledged that a Full Scale IQ of 72 could be considered in the upper end of ID, however he noted that claimant's motivation was variable during testing and opined that the score underestimated her abilities. Dr. Wright also opined that her Abbreviated Battery IQ of 85 was a better estimate of claimant's abilities because it was made up of the first two tests which were performed at her highest level of motivation. Dr. Wright further opined that the Abbreviated Battery IQ score of 85 and claimant's score of 94 on Fluid Reasoning, were not consistent with ID. Dr. Wright opined that claimant's lower scores appeared to be a result of her lack of effort. Dr. Wright opined that claimant meets diagnostic criteria for RAD and PTSD and should be considered to have a severe and persistent mental health disorder that will require intensive mental health supports throughout her lifetime.

70. Dr. Wright testified that he does not specifically assess the fifth-category condition.

71. Dr. Wright testified that the CAARE report from claimant's experts (discussed below) did not change his opinion that claimant does not meet the diagnostic criteria for ASD and ID. Dr. Wright's opinion is based on detailed history of cognitive scores and variability in the testing on the Stanford Binet. Dr. Wright noted that claimant's experts failed to review a detailed history of cognitive scores and school records and opined that they failed to provide an explanation for why the CAARE assessment test results would differ significantly from all previous testing. Dr. Wright also pointed out that most of the assessments with the exception of the CAARE

report state that test results are probably not an accurate reflection of her actual abilities due to her lack of cooperation and his opinion is that her scores are in all likelihood higher. Dr. Wright agreed with the CAARE assessment that claimant's adaptive functioning would meet the criteria for ASD; but that alone is not sufficient for the diagnosis.

72. Dr. Wright was critical of Dr. Kidwell's[2] diagnosis of ASD because in his opinion it was not substantiated either by a documented history or by the use of the ADOS-2 which is widely regarded as the most reliable tool for assessment of ASD. Rather, she relied on Gilliam Autism Rating Scale (GARS) and the SRS2, which are screening tests completed by others. Dr. Wright also opined that there was no evidence of symptoms of ASD early in claimant's life; that claimant's behavior and functioning appeared to decline after her foster placements failed; and that claimant's attachment to her therapeutics skills coach (see below) was not consistent with ASD.

Testimony of Zobeyda Bojorquez

73. Zobeyda Bojorquez, claimant's therapeutics skills coach and behavioral aid at Birch House since claimant's arrival in March 2020, testified at hearing. Bojorquez noted a history of being an ABA worker. Bojorquez has spent over 40 hours per week with claimant since she arrived. Bojorquez completed the Vineland Adaptive Behavior Scales III (VABS-III) for Dr. Wright in 2020, and an additional VABS-III, the Gilliam Autism Rating Scale – Third Edition (GARS-3), and the Social Responsiveness Scale, Second Edition (SRS-2) as part of the CAARE assessment. Bojorquez was also present at the 2020 evaluation by Dr. Wright, and present during parts of claimant's

[2] Dr. Kidwell's testimony is discussed in Factual Findings 85-113.

interaction with Dr. Kidwell for the CAARE assessment. Bojorquez also provided a statement for the CAARE assessment.

74. Claimant has just turned 17 years old, but Bojorquez reports that she behaves like a nine-year-old, which Bojorquez believes impacts her functioning substantially. Claimant reportedly does not understand her own emotions or those of others, nor does she understand verbal and nonverbal cues, often interrupting Bojorquez. Most days, she reportedly spends time coloring, playing children's games and role playing. She is particularly interested in Barbies, My Little Pony and Pennywise the clown from a horror novel; and often acts like a younger child or an animal. Bojorquez reported that if claimant "doesn't understand or if she thinks people are overexplaining, she escalates." Claimant avoids things that she cannot understand.

75. Bojorquez reported that claimant continues to struggle with adaptive functioning, including following through on daily living activities, like brushing her teeth without instruction, doing laundry, cleaning, gathering ingredients for simple dishes like macaroni and cheese and understanding the value of money. Claimant would love to have friends, but she does not know how to engage with children her own age. She is more likely to engage with much younger children in the nine- to 11-year-old range. Even then, claimant can only engage for short periods of time.

76. Bojorquez helps claimant with her schoolwork which currently consists of walking her through steps on several pages of worksheets involving math and reading per day. Other days, she may have claimant read aloud from children's books. Claimant can only read one paragraph at a time.

77. Bojorquez reported that she has noticed that claimant rocks backs and forth, twirls her hair, often avoids eye contact and repeats phrases that she has heard

such as "Aargh! The booty." Bojorquez has heard claimant talking to herself, and reported that claimant told her that she "hears voices" that sound like they are whispering in her ear from the outside that "tell her do things." It was reported that claimant also has a history of believing she has "superpowers."

78. Claimant attended Willits from August 2021 to October 2021, and New Direction from January 2022 through the first week of February 2022. Since then, Bojorquez has been providing her with worksheets. Claimant is unable to be in a classroom setting due to unsafe behaviors. Bojorquez noted claimant's behavior has improved since she first arrived at Birch House and that she has since connected to Bojorquez. However, with the exception of a slight improvement in spelling, her academic skills do not appear to be improving.

79. Bojorquez explained that Birch House is a short-term residential placement designed to house complex clients with behavioral concerns that cannot be addressed within lower levels of care. Birch House is meant to house one to three youth at a time; with a two to one staff to patient ratio. Youth are typically referred to the program through the county or the state. Everything in the house is tailored to meet her needs. Bojorquez does not believe that there are residential placements similar to Birch House for adults.

80. Bojorquez does not believe that claimant has the ability to be employed. She reported that claimant will most likely "give up" if she is told that she is not performing a task correctly.

81. Bojorquez was present with claimant during Dr. Wright's October 2020 evaluation of claimant. Bojorquez testified that they only spent about 30 minutes with

Dr. Wright. Claimant was given a tiara as incentive to perform the testing, however she still needed multiple breaks, and in general was negatively responsive to Dr. Wright.

82. Bojorquez testified that the questionnaire that Dr. Wright provided to her might have been the same questionnaire that Dr. Kidwell provided to her, but in a different format, because the one she completed for Dr. Wright was online.

83. Bojorquez reported that everyone present in the 2020 assessment with Dr. Wright was wearing masks. Her testimony in this regard was less credible than the contrary testimony of Dr. Wright.

84. Bojorquez was present both days that Dr. Kidwell spent with claimant. Claimant initially did not want to answer questions, but eventually connected with her more, showing Dr. Kidwell her room and fish. Her interaction with Dr. Kidwell appeared more positive than that with Dr. Wright. Claimant answered questions, made comments and laughed on occasion. She still required breaks, but often took the breaks with Dr. Kidwell and/or Bojorquez.

University of California, Davis, Child and Adolescent Resource and Evaluation (CAARE) Diagnostic and Treatment Center Assessment and Report

85. Due to claimant's concerning behaviors and potential impairments, Claimant's social worker, Susan Buice, requested an evaluation from the UC Davis CAARE Center. The Center is an outpatient clinic which conducts comprehensive psychological evaluations and outpatient treatment for primarily children between two and eighteen years of age with a history of child abuse or exposure to the foster

system. Mallory Kidwell, Ph.D.[3], a predoctoral intern with a master's degree in clinical psychology from University of Utah earned in 2019, and Anna Washington, Ph.D., Kidwell's supervisor and a licensed psychologist, were assigned claimant's matter. Dr. Kidwell reviewed records including Department of Social Services documents, incident reports, court reports, a Mendocino County Office of Education Individualized Education Program dated February 18, 2021, Dr. Wright's 2021 report and NBRC's 2016 assessment, conducted an assessment of claimant, interviewed sources close to claimant, generated a report and testified at hearing. Dr. Kidwell reviewed additional evidence at the time of her testimony.

Dr. Kidwell's Testimony

86. Dr. Kidwell noted that claimant has a mental health history of severe emotion dysregulation, physical aggression, verbal aggression and bullying, noncompliance and oppositionality, disruptive behavior, posttraumatic stress symptoms, disassociation, self-harm and suicidal ideation, possible psychosis, and problematic sexual behaviors within the context of exposure to a number of traumatic experiences and numerous home placements throughout her development. It was also noted that claimant has previously been diagnosed with PTSD, RAD, ADHD and "unspecified psychosis."

87. Susan Buice, Amanda's CPS social worker reported to Dr. Kidwell that claimant "presents much younger than she is. She's 16 and her problem-solving skills, how she processes information, her manner of speech, and demeanor are that of an 8

[3] Dr. Kidwell obtained her post-doctorate degree in August 2022.

to 10 year old." Buice believes that these challenges result in impairment to her academic, behavioral, and social functioning.

88. Buice also reported that claimant has a history of testing refusal across settings and would likely be "more amenable" to participating in testing if it took place in her "own setting."

89. On February 7, 2022, Dr. Kidwell traveled to Birch House, claimant's STRTP, to complete psychological testing, collateral interviews, and observations of claimant over two full days. Dr. Kidwell was aware of claimant's prior diagnoses and history of emotional and behavioral difficulties and considered how they may affect testing. In order to build rapport, she offered claimant a small gift that was provided to Dr. Kidwell by Buice, who reported that claimant responds to concrete rewards and physical objects. Although claimant accepted the gift, she was initially physically guarded, turning her body away from Dr. Kidwell. Over time claimant became more comfortable and welcomed Dr. Kidwell into her room. Dr. Kidwell spent five to six hours in Amanda's presence building rapport and conducting a limited clinical interview with claimant. Although claimant largely refused to answer direct questions, Dr. Kidwell was able to ask her some questions as she showed Dr. Kidwell her room. Claimant reported that she enjoys drawing, playing with Barbies, and watching funny videos. Dr. Kidwell noted that claimant presented much younger than her age, wearing child-like jewelry, hair accessories and clothing.

90. Dr. Kidwell also provided standardized assessment questionnaires to have completed by Bojorquez.

91. The next day, Dr. Kidwell administered the WISC-V, a standardized measure of cognitive functioning. Although claimant exhibited some oppositionality

throughout testing, she appeared to demonstrate adequate effort on testing when she agreed to participate. She also appeared to have limited ability to tolerate frustration on some test activities, for example giving up or saying she "did not know" when presented with a question that was difficult to answer. Kidwell created a behavioral reward system, a sticker chart, wherein claimant would receive a sticker as a reward for each of the ten subtests completed in the assessment tool, which helped engage claimant in the testing. Claimant was also provided with multiple breaks. Dr. Kidwell opined that current testing appeared to be a valid reflection of her current functioning in a highly structured environment with minimal distractions.

92. On the WISC-V, claimant achieved a Full Scale IQ of 52, which falls in the Extremely Low Range and 0.1 percentile. Consistent with this overall estimate, her Verbal Comprehension Score was 65, 1st percentile, Visual-Spatial score was 67, 1st percentile, Fluid Reasoning score was 61, .5 percentile, Working Memory score was 67, 1st percentile, and Processing Speed was 56, 0.2 percentile; all fell in the Extremely Low Range. Dr. Kidwell opined that "Overall, results suggest that [claimant] has marked cognitive impairment across domains compared to her same-aged peers." Dr. Kidwell noted that claimant's Verbal Comprehension, Visual-Spatial, Fluid Reasoning, and Working Memory scores exhibited significant discrepancies relative to her Full Scale IQ which was much lower, which Dr. Kidwell opined suggested that these subdomains of intellectual function may be areas of personal strength for claimant, whereas Processing Speed may be a particular area of personal weakness.

93. Dr. Kidwell also noted that there was some significant discrepancy in claimant's performance on the subtests within several indices, including those within the Verbal Comprehension Index, Visual-Spatial Index, Fluid Reasoning Index, and Working Memory Index. For example, she scored a 6 on a measure of abstract verbal

reasoning (i.e., Similarities), but a 1 on a measure of her word knowledge (i.e., Vocabulary) within the Verbal Comprehension index, indicative of deficits in accessing stored word knowledge often gained through education and experience, relative to ability to reason and problem solve with verbal information presented to her. Dr. Kidwell noted that a score of 10 is average, 6 is below average, and 1 is extremely low. Dr. Kidwell opined that the test scores were valid despite these discrepancies.

94. The VABS-III was completed by Bojorquez. The tool focuses on the personal and social sufficiency of an individual across several domains, including communication, daily living, and socialization; and provides an overall score of adaptive functioning. Per Bojorquez's report, claimant's overall adaptive functioning was in the Low Range, clinically significantly lower than expected for her age. Dr. Kidwell noted that claimant's expressive communication skills appear to be significantly more developed than her receptive communication skills on the Vineland, which she opined could result in others making the assumption that she is functioning at a higher level than she is.

95. Dr. Kidwell noted that during testing, claimant's memory appeared adequate, her rate and rhythm of speech was typical, but tone flat and forceful. Her thought content was typically within normal limits, although she did make statements indicative of possible perceptual abnormalities, for example, that Pennywise was under her bed and that she owned Wal-Mart corporation. Claimant was often rude to Dr. Kidwell.

96. The Gilliam Autism Rating Scale – Third Edition (GARS-3) was completed by Bojorquez. Based on the results and her interview with Bojorquez, Kidwell opined that her responses indicate the likelihood of claimant meeting diagnostic criteria for

ASD was "very likely," with the severity of the symptoms suggesting that substantial support may be required to support her functioning. Bojorquez noted that claimant needs an excessive amount of reassurance if things are changed or go wrong, becomes frustrated when she cannot do something, exhibits temper tantrums when frustrated, repeats or echoes words or phrases, repeats words out of context, speaks with a flat tone or affect, and talks about a single subject excessively, in this case Pennywise the clown from the horror novel. Bojorquez also reported that claimant exhibits difficulties associated with Restricted/Repetitive behaviors, for example making high-pitched sounds; Social Interaction, for example showing little or no interest in other people; and Social Communication, for example, difficulty identifying when someone is teasing. In total, Dr. Kidwell opined that the "findings from this measure suggest that [claimant] exhibits a number of symptoms across domains of impairments often associated with [ASD]."

97. The Social Responsiveness Scale, Second Edition (SRS-2) was also completed by Bojorquez. Dr. Kidwell opined that Bojorquez's report suggests severe deficiencies associated with Restricted Interests and Repetitive Behavior as well as severe deficiencies associated with Social Communication. Dr. Kidwell opined Bojorquez's responses suggest claimant experiences impairment that regularly interferes with social interactions and are strongly associated with a clinical diagnosis of ASD.

98. Dr. Kidwell did not administer the ADOS-2 because at the time of testing masking was required by her employer when interacting clinically with any patient or client; and the ADOS-2 cannot be scored and is not considered valid when either the patient and/or evaluator are masked. Dr. Kidwell acknowledged that the ADOS-2 is considered the "gold standard" of testing tools for diagnosing ASD, that claimant is

not actively involved in the GARS nor the SRS2, and that both the GARS and the SRS-2 are screening tests. However, she opined that best practice is doing a comprehensive evaluation which includes collecting information from collateral sources that incorporates behavioral observations.

99. Dr. Kidwell conducted a clinical consultation with Paulita Peredia, the supervisor at Birch House, who has been working with claimant since she arrived in March 2020. Peredia reported that claimant's overall functioning has improved since then; when she arrived, she "had no attachment", and exhibited frequent aggressive behavior. Since then, her aggressive behavior has decreased, and she has greater capacity to form attachments, particularly to Bojorquez. However, Peredia has also observed other areas of difficulty that have remained constant over time, in particular she believes that claimant's intellectual functioning is at "about a second-grade level" with "some days that are better than others," that she struggles to comprehend instructions at a developmentally appropriate level, and that she gets agitated when she thinks things are too easy or too hard for her to do.

100. Dr. Kidwell conducted a clinical consultation with Sheryn Hildebrand, who has been claimant's court appointed special advocate since August 2019. Hildebrand has only met claimant in person on a few occasions, but she is familiar with her case and is currently her education and development rights holder. Hildebrand's biggest concern is claimant's intellectual functioning, as she believes that she functions at "a second or third grade level." At the time of Dr. Kidwell's evaluation, it was reported that claimant was only able to participate in one hour of school per day, and "has never had consistent functioning" at school. Claimant also struggles with maintaining sustained attention and focus and completing developmentally appropriate adaptive functioning tasks like having effective social interactions. Hildebrand is worried that if

supports are not put into place for claimant as an adult, she will "end up a statistic" due to the combination of her emotional and behavioral concerns with her intellectual deficits and difficulties with social engagement.

101. Dr. Kidwell conducted a clinical consultation with Buice who has been claimant's assigned social worker since approximately April 2021. Buice has met with claimant for an hour once per month to go on brief outings. Buice noted that previous evaluations have concluded claimant's issues are all trauma-based, but Buice believes there are additional factors beyond trauma that are impacting her functioning, such as intellectual or developmental delays. Buice reports that claimant does not understand the concept of summing amounts and that she does not know if she will ever be able to hold a job or go to a store by herself due to apparent intellectual delays in combination with "her temperament." Buice highlighted that the combination of delays in her adaptive and/or intellectual functioning combined with her emotional difficulties "get compounded and result in a bigger delay that really impedes her ability to have an independent life."

102. Dr. Kidwell conducted a clinical consultation with Dr. Rebecca Timme, claimant's psychiatrist with Redwood Community Services (RCS). Dr. Timme reported that when claimant entered Birch House, she was "aggressive, agitated, and easily triggered. She would yell and scream from morning to evening." Dr. Timme reported that claimant has not had a substantial change in medications since she entered Birch House. At the time of Kidwell's consultation, Dr. Timme was unsure of diagnostic impressions for claimant, given that she often refuses to openly share her symptoms. Therefore, she is "just trying to manage the behavior because we're not sure where it is coming from." Dr. Timme believes that claimant has experienced some degree of genuine psychosis symptoms but remains unsure whether there is "true psychosis." Dr.

Timme suggested that her primary diagnostic "rule outs are psychosis and trauma" and she "would not be surprised" if claimant met criteria for ID or ASD.

103. Dr. Kidwell conducted a clinical consultation with Doreen Gilmore who has been a "personal connection" for claimant since she was in the fifth grade. Gilmore reported that she has invited claimant to her home once per month. Gilmore reported that claimant is "incapable of a long attention span or working toward goals," which results in claimant refusing to do schoolwork. She also reported that claimant demonstrates inflexible adherence to routines, often tensing up if they go anywhere that they do not normally go. In addition, "she will get really focused on specific things, like the It clown from Stephen King," and "it's too much sensory input for claimant to go on multiple errands during outings." Gilmore believes that claimant has "an intellectual delay of some sort," however she is currently "more concerned about her deepened mental health issues" rather than "her development" given the impact these issues appear to have on her functioning.

104. Dr. Kidwell opined that Claimant's Full Scale IQ of 52 on a measure of intellectual functioning which was in the Extremely Low Range compared to same-age peers was a primary component of her opinion that claimant qualifies for ID. Although claimant had a limited ability to tolerate frustration during Dr. Kidwell's testing, she noted that with breaks and visual reinforcement throughout testing, claimant was observed to generally provide her best effort. Thus, Dr. Kidwell opined that her lower performance did not appear to be due to distractibility or inattention; and that the current testing appeared to be a "valid reflection of her current functioning in a highly structured and well-supported one-one-one environment with minimal distractions".

105. Dr. Kidwell opined that the testing was consistent with some of the past reports that did comprehensive intellectual cognitive testing, and with claimant's academic functioning noted in testing completed in August 2019 which fell in the Extremely Low Range. In addition, Dr. Kidwell "very much" took into account the reports from claimant's collateral contacts who all expressed significant concern with claimant's cognitive functioning in combination with her emotional difficulties. The collateral contacts noted that her behavior, cognitive processing, and adaptive functioning seem much developmentally younger than her age; describing her as functioning more like an "8 to 10-year-old child." Dr. Kidwell believes these reports are consistent with observations and testing from her evaluation, claimant's adaptive functioning, as well as previous IEP testing. Dr. Kidwell opined "Given that these findings are consistent with claimant's most recent IEP assessments, her adaptive functioning, clinical observations, and reports from collateral sources, [she] has firm confidence that claimant's intellectual functioning truly falls in the Lower Extreme Range."

106. When asked about the discrepancies between her evaluation and claimant's prior testing, Dr. Kidwell noted recalling seeing a February 18, 2021, IEP raising concerns of ID. Dr. Kidwell also opined that disparity in scores can exist on any given day; but that an individual could not consistently score higher than her actual cognitive ability.

107. Dr. Kidwell pointed out that claimant could not keep up in a typical school setting. She was struggling to participate in one hour of schooling, struggling with daily living skills, and unable to communicate and engage at the level typical of her age. She opined that although claimant's IQ may have fluctuated below and above 70, her functioning is well below her chronological age and meets criteria for ID.

108. Dr. Kidwell also opined that the onset of claimant's deficits in intellectual and adaptive functioning occurred during the developmental period. Although she would have expected the onset to occur before the teen years, she opined that 11 years of age is still within the developmental period. Furthermore, she opined that it is likely claimant's intellectual deficits would have been observed earlier had she not experienced traumatic events at a younger age and transitions in caregiving.

109. Like Dr. Wright, Dr. Kidwell opined that claimant had clear impairment in multiple areas of adaptive functioning, including conceptual, social, and practical domains.

110. In the CAARE report dated March 28, 2022, Dr. Kidwell opined that based on standardized assessments, clinical observations, and collateral reports, "claimant has had persistent deficits in intellectual and adaptive functioning with onset during the developmental period" therefore a primary diagnosis of Intellectual Developmental Disorder (IDD), Moderate is warranted.

111. Dr. Kidwell also opined that claimant's deficits specifically related to socialization and social interaction as well as restricted, repetitive patterns of behavior are of greater severity than what can be explained solely by a diagnosis of IDD, Moderate, and that based on interviews with claimant's support system as well as standardized measures completed by Bojorquez, and Dr. Kidwell's observations during the evaluation, claimant also appears to meet criteria for ASD. Although unable to administer the ADOS-2 due to the pandemic, Dr. Kidwell opined that claimant's presentation is highly consistent with ASD, and she is confident that this diagnosis is appropriate. Dr. Kidwell also provided a diagnosis of PTSD, which she believes may exacerbate claimant's deficits in adaptive and social functioning, but does not

adequately explain it. Dr. Kidwell also opined her assessment from testing and collateral information that claimant's impairments are interfering with her functioning that cannot be explained by RAD alone. Dr. Kidwell also opined that claimant's attachment to Bojorquez does not fit with a RAD diagnosis.

112. Dr. Kidwell recommended multiple services for claimant including Regional Center involvement, ASD treatment, PTSD treatment, and psychiatry services. Regarding ASD treatment, she opined that claimant would benefit from ABA therapy, an evidence-based treatment for children and adolescents who demonstrate behavioral and social difficulties related to ASD.

113. Dr. Kidwell noted that claimant currently resides at a highly structured STRTP; and that it is clear that claimant would be at a high risk of harming herself or others, whether intentionally or accidentally, if she were released to a community setting. Given the level of impairment currently displayed by claimant, and nature of her ASD and ID diagnoses, Dr. Kidwell opined it is unlikely that she can be moved to a less restrictive environment in the near future, and she may require a similar placement throughout her lifetime.

TESTIMONY OF DR. WASHINGTON

114. Anna Washington, Ph.D., reviewed the records provided to Dr. Kidwell in this matter, and testified at hearing. Dr. Washington holds a Ph.D. in clinical psychology from University of Maryland, a master's degree in experimental psychology from Saint Joseph's University in Philadelphia, Pennsylvania, and a bachelor of science degree in psychology from Drexel University in Philadelphia, Pennsylvania. Dr. Washington is employed as an associate professor and director of clinical training at Alliant International University. Dr. Washington was employed as a Behavioral Health

Psychiatric Professional at the UC Davis CAARE Center (Center) from October 2021 until September 2022, a staff psychologist from March 2018 through September 2021 at the Center, and a Postdoctoral Psychology Fellow at the Center beginning in August 2014.

115. Dr. Washington supervised Dr. Kidwell, reviewed data pertaining to claimant, consulted with Dr. Kidwell throughout claimant's evaluation, and assisted her in creating the CAARE report. Dr. Washington testified that when planning for claimant's interview and testing, she and Dr. Kidwell considered claimant's history of trauma, claimant's behavioral issues, and noted that previous testers were not confident in test results. Dr. Washington testified that best practices for performing an assessment to arrive at a diagnosis for a child, like claimant, is to take a comprehensive approach, which includes interviews with collateral sources who know the child well, in addition to testing. Specifically, evaluators consider intelligence testing and adaptive skills measures. Dr. Washington testified that the recent trend in the mental health field is to move away from very specific test scores and focus on adaptive skills; and that when scores are considered, comprehensive IQ testing is preferred over screening IQ testing.

116. Regarding discrepancies in previous test scores with the testing conducted by Dr. Kidwell, Dr. Washington proffered various explanations, including error on the part of the administrator, errors in record review, typographical errors in the records, the use of screening tests like the WASI which are not as accurate as comprehensive testing, and true changes in IQ.

117. Dr. Washington opined that because claimant exhibited multiple challenges interpreting test results could be challenging. She also opined that the

difference between comprehensive and screening tests could account for differences. As an example, she explained that the WISC-V is a comprehensive test, whereas the WASI is a screening test, which provides a "ballpark" of intelligence that only captures some components. The WASI does not include working memory and processing speed which were noted as particular weaknesses in Dr. Kidwell's assessment of claimant. Dr. Washington further testified that the KABC-II can overestimate intelligence for children on the lower range of intellectual functioning. In addition, she opined that due to the confidence interval in testing, claimant's score of 52 on current testing could be as high as a 60 or 62. She also noted that prior testing lacked claimant's cooperation and did not take into account as many collateral sources.

118. Dr. Washington opined that claimant has ID. She noted that it was reported that claimant has difficulty responding to back-and-forth conversations, cannot tell time and chooses to play with children ten years younger than her; that she has not been placed in public school; and that she is functioning at a much lower level than 16 years old.

119. As it relates to the results of Dr. Wright's administration of the WISC-V to claimant in 2020, Dr. Washington noted that claimant was less cooperative with Dr. Wright, that it was only a partial administration of the test; and that some of the results to the specific tests in the subtests were similar to Dr. Kidwell's results. She opined that scores of 5 and 6, which are in the 5th and 9th percentile, are concerning. She opined that no specific test on a sub-test alone would determine whether claimant is intellectually disabled.

120. As it relates to the results of Dr. Wright's administration of the Stanford Binet in 2021, Dr. Washington opined that the test results could vary somewhat from

Dr. Kidwell's testing because the WISC-V and the Stanford Binet measure slightly different things; specifically, there is not a processing speed and working memory on the Stanford Binet in the same way there is on the WISC-V. Dr. Washington opined that if Processing Speed were to be added to the Stanford Binet, claimant's score would likely have been a lot lower.

121. Dr. Washington also opined that claimant has ASD based on the screening tools administered by Dr. Kidwell, reports from the collateral sources, and Dr. Kidwell's observations. Dr. Washington opined that symptoms of ASD would typically appear in the toddler years; however, in her experience, caregivers often do not have the ability to observe these symptoms and/or bring the child to the pediatrician for early screenings in cases with child welfare involvement. Dr. Washington opined that it is also more difficult to identify ASD when a child has behavioral problems like claimant does.

MENDOCINO COUNTY OFFICE OF EDUCATION PSYCHO-EDUCATIONAL ASSESSMENT

122. Claimant had a psychoeducational assessment completed in April 2022 when she was 16 years old by the Mendocino County Office of Education. It was noted that the Kaufman Assessment Battery for Children, Second Edition Normative Update (KABC-II NU) was administered to claimant, and that her scaled score on the measures of Nonverbal Reasoning fell within the severely below average range (61, <1 percentile). The assessor included the testing results from the CAAARE assessment and noted that "there has been some variation in [claimant's] cognitive testing results over the years with one inconsistent assessment in 2016, but with the rest of the assessments falling within the borderline to severely below average range. If one

averages the full-scale IQ from 2014, 2016, 2021 and 2022, the average standard score is 65." The assessor also noted that claimant's adaptive skills had been assessed in 2016, 2020, 2021 and 2022 with ratings consistently in the Low (severely below average) range. The assessor concluded that claimant's assessment results indicated that she was severely below average in cognitive abilities and adaptive skills and supported her qualification as a student with an Intellectual Disability. It was noted that this conclusion was consistent with the CAARE assessment.

123. The assessor also recommended that claimant qualify for special education under a secondary qualification of Autism, largely based on her ASD diagnosis from her recent CAARE evaluation, and that claimant continue to qualify for special education services under the category of Emotional Disturbance, due to her inability to access learning based on emotional regulation challenges. The assessor also noted that that claimant's history of assessment results has a consistent theme of difficulty with motivation and compliance; that claimant has periods of aggressive behavior; and that her condition under Emotional Disturbance includes an inability to learn that cannot be explained by intellectual, sensory, or health factors; and a clinically significant thought disorder that may include delusions or hallucinations that severely interfere with her learning.

Ultimate Findings

124. The opinions of Dr. Wright and Dr. Kissinger were more persuasive than the opinions of Dr. Kidwell and Dr. Washington. Dr. Wright is the most experienced and most qualified of the experts who testified in this proceeding. He reviewed extensive records and prior testing, and evaluated claimant twice. Dr. Wright persuasively testified that records from claimant's developmental period, as well as his

own testing, showed that claimant does not have an intellectual disability nor ASD, but instead suffers from PTSD and RAD. Dr. Kissinger persuasively opined that claimant's IQ scores show a range of different levels on the subtests that are part of intelligence testing; and that the range demonstrated is more typically found in individuals with a learning disability than in a person with ID. While claimant's inability to maintain focus coupled with her general resistance and refusal to cooperate with subjects that she finds challenging have a significant impact on her ability to learn and function in society, those traits are not due to ID.

125. The evaluation done by CAARE Center provided much lower IQ scores than previous testing and includes a tentative diagnosis of ASD. Prior to completing the CAARE report, Dr. Kidwell did not review Dr. Wright's first evaluation prepared in 2020, nor any of claimant's educational records with the exception of an IEP prepared by Mendocino County Office of Education in 2021. Dr. Kidwell reviewed social service and court records, as well as Dr. Wright's second evaluation in November 2021 and NBRC's evaluation from 2016. Dr. Kidwell and Dr. Washington failed to adequately explain why the CAARE Center results would differ significantly from previous testing and failed to present sufficient evidence that claimant met the required criteria for a diagnosis of ASD. Most of the assessments with the exception of the CAARE report state that test results are probably not an accurate reflection of her abilities due to her lack of cooperation, and Dr. Wright credibly testified that her scores are in likelihood higher. Furthermore, the diagnosis of ASD in the CAARE report was not substantiated by a documented history or the use of the ADOS-2, which the experts agree is the "gold standard" in diagnosing ASD.

126. Furthermore, the opinion in the Mendocino Psycho-educational Assessment is not persuasive. The assessor did not testify at hearing, the assessor

relied heavily on the CAARE report, no evidence was presented that the method of averaging the IQ scores to determine ID was valid, the assessor determined that claimant continued to qualify for special education under Emotional Disturbance, and it was not shown that the criteria for receiving special education services due to ASD or ID under special education law are the same as those under the Lanterman Act.

127. Claimant's cognitive testing results do not reflect intellectual deficits similar to those seen in people with intellectual disability. In addition, her cognitive skills fluctuate, sometimes dramatically, which is not consistent with a condition similar to ID.

128. Claimant has shown that she has substantial limitations in her adaptive functioning, but she has not shown that these are due to a developmental disability as defined by the Lanterman Act. Claimant has not demonstrated by a preponderance of the evidence that she has ASD, ID nor a condition falling within the fifth category of regional center eligibility.

129. Nor has claimant demonstrated that she requires treatment similar to that required for intellectual disability—instead, the evidence shows that claimant has significant mental health disorders that require mental health treatment.

130. Any additional arguments presented by the claimant have been considered and are rejected.

LEGAL CONCLUSIONS

1. In a proceeding to determine whether an individual is eligible for regional center services, the burden of proof is on the claimant to establish that he or

she has a qualifying developmental disability. The standard of proof required is a preponderance of the evidence. (Evid. Code, §§ 115, 500.)

2. 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.)

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).) Solely psychiatric disorders and learning disabilities are excluded. (Id., § 54000, subd. (c)(1).).

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).)

5. Claimant has not met her burden of establishing that she has a developmental disability as that term is defined in the Lanterman Act. (Factual Findings 124 through 130.) It is undisputed that at present, claimant is substantially disabled. However, Regional Center Services are limited to individuals who meet the statutory eligibility requirements. Claimant's severely impaired adaptive functioning appears to be caused by her serious mental health conditions. Individuals with handicapping conditions that are solely physical or psychiatric, or a learning disability, are not eligible for regional center services under the Lanterman Act. There is insufficient evidence that claimant has ASD, ID, or a condition similar to intellectual disability or that she has treatment needs that are similar to the intellectually disabled. Claimant's appeal must be denied.

ORDER

Claimant's appeal of the service agency's denial of regional center eligibility is denied.

DATE:

MICHELLE DYLAN
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.