

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

**In the Matter of:**

**OAH No. 2011050554**

**MARIA V.,**

**Claimant,**

**vs.**

**SOUTH CENTRAL LOS ANGELES  
REGIONAL CENTER,**

**Service Agency.**

**DECISION**

This matter was heard by Mark Harman, Administrative Law Judge with the Office of Administrative Hearings, on November 1, 2011, in Los Angeles, California.

South Central Los Angeles Regional Center (Service Agency) was represented by Johanna Arias-Bhatia, Fair Hearing/Government Affairs Manager.

Maria V. (Claimant) was represented by Sarah S. Kim, Attorney at Law.

Oral and documentary evidence was received and argument was heard. The record was closed, and the matter was submitted for decision on November 1, 2011.

**ISSUE**

Is Claimant eligible for regional center services by reason of a developmental disability within the meaning of the Lanterman Developmental Disabilities Services Act (the Lanterman Act), Welfare and Institutions Code<sup>1</sup> section 4500 et seq.?

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<sup>1</sup> All further statutory references are to the Welfare and Institutions Code, unless indicated otherwise.

## FACTUAL FINDINGS

1a. Claimant was born on July 4, 2005. She lives with her adoptive mother and attends the first grade at Lindbergh Elementary within the Lynwood Unified School District (District). Claimant receives special education services; her eligibility for those services arises under the category of “Other Health Impaired,” due to her diagnoses of Attention Deficit Hyperactivity Disorder (ADHD) and Partial Fetal Alcohol Syndrome (PFAS). Claimant also has received diagnoses of asthma and/or reactive airway disease, enuresis or incontinence, and Disruptive Behavior Disorder, NOS.<sup>2</sup> Her physician has prescribed medication<sup>3</sup> to treat impulsive and aggressive behaviors, and problematic sleeping patterns.

1b. On March 25, 2011, the Service Agency notified Claimant that its clinical team had determined she was not eligible for services under the Lanterman Act. The notification letter cited a psychological evaluation performed by clinical psychologist Thomas L. Carrillo, Ph.D. (Carrillo) on August 24, 2010; Carrillo’s re-evaluation on December 14, 2010; a July 23, 2010 psychosocial assessment by John Amador, MSW (Amador); and a psychiatric consultation by Dr. Ehab Yacoub. The team considered Claimant’s medical and school records. The team concluded Claimant did not have mental retardation, epilepsy, cerebral palsy, or autism. The team also concluded that her disabilities did not meet the criteria for eligibility under the so-called fifth category. On May 6, 2011, Claimant filed a request for a fair hearing with the Service Agency, and this matter ensued.

### *Claimant’s Background*

2. Claimant was born prematurely. Her biological mother admitted to using drugs and alcohol during her pregnancy. Claimant was exposed in utero to drugs and alcohol. Her birth weight was low, she was hypoglycemic, and her head circumference was 29 cm, which met the criteria for a diagnosis of microcephaly. Claimant has lived with her adoptive mother (hereinafter, Mother) since shortly after her birth. Mother has described Claimant as a loving and affectionate child. She learned to walk at age one, used single words with meanings by age one, and used words and phrases meaningfully by age two. She has never experienced seizures. Her hearing and vision are within normal limits. Mother has sought unceasingly, based on professional diagnoses and advice, to secure the services and supports best suited to meet her daughter’s needs at each stage of her life, but the way the system functions has, at times, impeded proper planning and coordination of these services.

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<sup>2</sup> The diagnoses referenced herein generally are derived from the Diagnostic and Statistical Manual of Mental Disorders (4th edition, Text Revision 2000) (DSM-IV-TR), published by the American Psychiatric Association. The Administrative Law Judge takes official notice of the DSM-IV-TR as a highly respected and generally accepted tool for diagnosing mental and developmental disorders.

<sup>3</sup> In April 2011, family practitioner Jatin Bhatt, M.D., prescribed Risperdal, an atypical anti-psychotic medication used in low doses to treat children with impulsive and aggressive acting out behavior, and Melatonin, to help her fall asleep and maintain sleep.

### *The Earlier Request for Service Agency Services*

3. Mother previously requested services from the Service Agency in 2008, shortly before Claimant's third birthday. Mother's primary concerns at that time were Claimant's problem behaviors and language development. Mother, Claimant, and Claimant's therapist, Araceli Covarrubias, attended the intake interview, also conducted by Amador, on July 2, 2008. In the interview, Mother reported that Claimant played with other children, but that most of her interactions ended in conflict because Claimant would hit and fight for no apparent reason. On the other hand, she played and got along well with her little sister and protected her from other children. Other reported behavioral challenges included crying, biting, screaming, and throwing her body on the ground when her wishes were denied, as often as three times per day. Mother and the therapist had been working to address Claimant's behavioral problems.

4. Mother reported that Claimant expressed her needs and ideas with gestures, words and phrases, primarily in Spanish, the language spoken in the home. Mother estimated Claimant's vocabulary to be 100 words with meaning. An unfamiliar person might have trouble understanding Claimant's speech. She had marked articulation difficulties and omissions of sounds. At that time, she was receiving speech therapy, once per month, at King/Drew Medical Center. Receptively, she responded to her name and to simple, one-step commands about activities of daily living. She could identify familiar people by name or title. In Amador's social assessment (Exhibit 6), he wrote that Claimant was engaging, responded to concrete questions, and established eye contact without difficulty.

5. On September 9, 2008, a psychological evaluation was performed by psychologist Victor C. Sanchez, Ph.D. (Sanchez). In his report, Sanchez noted Claimant's significant behavior problems and that her therapist had been working with Mother and Claimant to address these problems. (Exhibit 7.) Mother reported no self-stimulatory or ritualistic behaviors, no problems adapting to changes, and no unusual attachments to animate or inanimate objects. Claimant reportedly was "aware of the feelings of other and seems to enjoy sharing her interests/excitement with others." Sanchez noted Claimant maintained good levels of eye contact and was cooperative during the evaluation, but had trouble remaining on task for sustained periods. "As such, her approach was marked by a good deal of distractibility, impulsivity, and over activity." Sanchez administered the Wechsler Preschool and Primary Scale of Intelligence – Third Edition (WPPSI-III), which revealed Claimant's overall cognitive ability was in the average range. On the Peabody Picture Vocabulary Test, her scores fell within the low average range; however "it should be noted that the obtain [*sic*] scores overall may be mild underestimates of [Claimant's] actual abilities as her over activity, distractibility, and impulsivity probably affected her performance at least some what." An Autism Quotient of 54 was generated on the Gilliam Autism Rating Scale, which fell below the threshold for a diagnosis of Autistic Disorder, and it did not appear that Claimant had any form of pervasive developmental disorder.

6. Sanchez did not diagnose ADHD because of the limited nature of his evaluation, but he recommended an extended evaluation in order to obtain diagnostic clarity

in this area. Claimant's adaptive skills, as reported by Mother, were in the low average to average range. Sanchez offered the following diagnostic impression:

Axis I: 214.01 Attention Deficit Hyperactivity Disorder -- (Provisional)  
Axis II: v71.09 No diagnosis on Axis II

The Service Agency determined, based on this information, that Claimant did not have a developmental disability; therefore, it denied her request for services and closed her case.

### *Subsequent Diagnoses*

7. In May 2009, Claimant was evaluated by a developmental pediatrician, Lyn Laboriel, M.D. (Laboriel), director of the Violence Intervention Program, Fetal Alcohol Spectrum Disorders Center. Laboriel determined that Claimant met the medical criteria for the presence of organic brain damage and a diagnosis of PFAS. (Exhibit 14.) Laboriel found Claimant was a child with known prenatal alcohol exposure, who had all of the "dysmorphic facial features" of fetal alcohol syndrome, had static encephalopathy with microcephaly, and by report, had severe cognitive, adaptive, language, and sensory processing deficits. "She also has known prenatal exposure to other unspecified illicit drugs, and has periventricular leukomalacia, further evidence of ischemic brain injury, likely due to prenatal cocaine exposure." Laboriel referred to Claimant's many reported deficits, but wrote that, without psychological testing, she could not offer specific ways in which PFAS was affecting Claimant's functioning and, therefore, she recommended a multidisciplinary assessment.

8a. David Roman Leonelli, Ph.D. (Leonelli), a licensed clinical psychologist, performed three psychological assessments of Claimant: in December 2008, in November 2009, and on June 9, 2011. The first assessment in 2008 was performed as a part of the adoption planning process. Leonelli found that Claimant was showing "early signs of attentional deficits and hyperactivity." At that time, Leonelli administered the McCarthy Scales of Children's Abilities (MSCA), a multipart test made up of five scales that assesses the cognitive development and motor skills of young children. The combination of several scales yields the General Cognitive Scale, which measures a child's overall cognitive functioning in relation to other children her age. Claimant obtained a General Cognitive Index (GCI) score of 94, which placed her in the average range of cognitive abilities.

8b. Leonelli's 2009 and 2011 assessment reports demonstrated a dramatic change in Claimant's profile from 2008. Leonelli again administered the MSCA to Claimant on November 19, 2009. This time, Claimant obtained a GCI score of 51, meaning that her intelligence quotient had dropped 43 points, placing her in a percentile rank of less than 1, the range of someone with mental retardation. This occurred approximately 11 months after she was first tested and reportedly had average intelligence. Claimant's 2009 GCI score demonstrated a mental age of two years and three months, well below the level expected of a four-year, four-month-old child. Leonelli did not offer any reason or explanation for a variance of this magnitude. Leonelli had used the same instrument administered by the same examiner. In his testimony, Leonelli said merely that Claimant's behavior had changed. He

did not explain whether this made the 2009 testing unreliable or whether Claimant's cognitive abilities actually had decreased by more than two standard deviations over an 11-month period. In 2011, Leonelli attempted to administer the MSCA again, but the testing was discontinued because of Claimant's "refusal to engage in the testing process."

9a. Claimant offered Leonelli's 2011 report. The narrative portion of the 2011 report closely parallels the 2009 report. The Service Agency offered the 2009 report. Both reports were received in evidence. (Exhibits A and 13.) Leonelli's descriptions under the heading "Behavioral Observations During Testing" in his 2011 report are nearly verbatim from Leonelli's 2009 report. The 2011 report states that:

She showed only minimal interest in the test materials and stimuli, and she appeared to lack verbal comprehension of many of the directives made by the examiner, whether they were related in English or Spanish. [She] was very active, impulsive and distractible during the testing session, and she had difficulty maintaining attention and concentration towards tasks. She was mostly uncooperative with the examiner throughout the testing process, and she rarely made eye contact and she did not socially engage with the examiner. [Claimant] exhibited a mild to moderate speech articulation problem throughout the testing process.

Leonelli's observations in his 2009 report are nearly identical, as follows (italics are used to show where the wording differs from the 2011 report):

She showed only minimal interest in the test materials and stimuli, and she appeared to lack verbal comprehension of many of the directives made by the examiner, whether they were related in English or Spanish. [She] was very active, impulsive and distractible during the testing session, and she had difficulty maintaining attention and concentration towards tasks. She was *cooperative* with the examiner throughout the testing process, *but* she rarely made eye contact and she did not socially engage with the examiner. [Claimant] exhibited a mild to moderate speech articulation problem throughout the testing process.

9b. Leonelli wrote in 2009, but not in 2011, that Claimant was observed to have several crying spells and temper tantrums when she did not get her way. Claimant's behavior during the assessment in 2011, therefore, would appear to have improved from 2009, but this was not made clear in the report. Leonelli testified that, in 2011, Claimant was speaking "gibberish," getting out of her chair, and that "we tried to get her to sit [and do tasks but] I'm guessing she did not want to do the tasks." His two reports, however, contain almost identical observations regarding the two different testing sessions, one in which Claimant cooperated and completed the tests in 2009, and another in which her behaviors prevented her from doing so in 2011.

10. Leonelli's 2009 and 2011 reports also used identical language to reference other behaviors, such as: Claimant did not get along with others, and engaged in solitary play even when in the company of others; she had self-injurious behaviors, such as picking her skin and hitting herself at times; she was not fully toilet trained, and smeared feces; and, Claimant rarely obeyed adult requests and directives. This portion of Leonelli's 2011 report, again, mimicked in most respects the 2009 report. Leonelli also testified with regard to the possibility a teacher may be isolating Claimant from other kids at school, saying that: "Claimant does not want to be with the kids, anyways, so she is happy alone."

11. On the Vineland Adaptive Behavior Scales (VABS), based on Mother's report, Claimant's standard score (SS) of 66 in the Daily Living Skills domain placed her at an age equivalence of three years, nine months, and was lower than the SS of 78 she obtained in 2009, with an age equivalence of three years, three months. In the Socialization domain, Claimant's SS of 71 placed her at an age equivalence of three years, three months, compared with a SS of 74 and age equivalence of two years, seven months in November 2009. Claimant's SS of 70 in Communication indicated she had "adequate receptive, expressive, and written language skills." The Adaptive Behavior Composite SS of 69 was within the borderline range. Her SS in the Motor Skills domain was solidly in the average range.

12. Leonelli used the Conners' Parent Rating Scales, filled out by Mother, in 2009 and 2011. These indicated that Claimant met criteria necessary for a diagnosis of ADHD, and indicated that Claimant was "excitable, impulsive, restless, and distractible, and she fails to finish tasks. [She] was also reported to be oppositional and defiant, controlling, and destructive. [She] was also prone to mood swings; she is easily frustrated, and disturbs and bullies other children at times. [Claimant] was reported to be reluctant or unwilling to take responsibility for her actions." The findings in the 2009 and 2011 reports are nearly identical. The only discrepancy is that, in 2009, Claimant was reportedly an unhappy child. This was not noted in the 2011 report.

13. On the Childhood Autism Rating Scale (CARS), Claimant had an overall rating of 3.5 (total score of 50), placing her in the Severely Autistic range. Dr. Leonelli offered the following diagnostic impressions:

Axis I:	299.00	Autistic Disorder
	314.01	Attention Deficit Hyperactivity Disorder, Combined Type
Axis II:	317	Mild Mental Retardation
Axis II:	v71.09	No diagnosis on Axis II
Axis III:		None, by history
Axis IV:		Problems with primary support group; drug exposure at birth, removal from parent and placement in adoptive home
Axis V:		Current GAF: 45

14a. On April 20, 2010, occupational therapist Sharon Korchin, OTR/L (Korchin), performed an assessment of Claimant using the Autism Diagnostic Observation Schedule (ADOS). The ADOS is a semi-structured observation and interview measure designed to

assess children and adults suspected of having an autistic spectrum disorder (ASD). The instrument is divided into four modules intended for very young children through adults. A module is chosen based on the age and language level of the individual. Tasks range from those designed to assess preverbal social/communicative behaviors in very young, nonverbal children (pretend play, joint attention) to tasks of pragmatic language, social and emotional understanding in verbally fluent adults. The ADOS is designed to complement the Autism Diagnostic Interview – Revised. Use of the ADOS requires extensive training in administration and reliability. Users must also have a high degree of familiarity with ASD.

14b. The ADOS is generally accepted as a high quality instrument for assessing for the presence of autism. Korchin administered Module 1 of the ADOS, usually used to assess children who have not developed any language skills. In Korchin’s report, she stated that Claimant’s overall level of language showed “no use of words or word approximations during the evaluation. She never vocalized to her parent or the examiner during the entire session.” (Exhibit 12.) Korchin, therefore, was unable to assess Claimant’s intonations, use of phrase speech, or the presence of echolalia. In terms of nonverbal behaviors:

“[Claimant] had one instance of distal pointing that was coordinated with eye gaze. She did use two different spontaneous gesture types – two conventional and two instrumental with two being used more than once. [¶] She did use appropriate eye contact to initiate and regulate social interactions. She did display a responsive social smile with her parent on the second attempt during the ADOS. She did direct some facial expressions towards her parent. . . . She used only eye contact, no vocalizations to communicate social intentions during the evaluation. She showed no expression of pleasure in her interactions with the examiner. She did look toward the examiner in response to hearing her name after the first attempt. She did give several times [*sic*] to another person as part of a routine during the ADOS. . . . She responded to the examiner’s facial cue by looking toward a target. Social overtures were clearly inappropriate including kicking and throwing toys, smearing bubble liquid on the window, and smashing toys in to the examiner’s hand.”

14c. Korchin observed some limited spontaneous play with cause-and-effect toys, but it was quite brief. Claimant did not demonstrate any pretend play throughout the session. She was not observed to have any unusual sensory interests or unusual hand and finger mannerisms. There were no repetitive interests and behaviors observed. Korchin observed “[s]ignificant repeated negativism including behaviors which appeared both aggressive and impulsive and which were very disruptive including kicking and throwing toys. . . . She was very active and resisted being seated at the table to participate in most activities.” In the communication domain, Claimant exceeded the threshold for autism, in the social-interaction domain, she met the threshold for autism, and her communication-social interaction total indicated she met the threshold for autism. Korchin did not testify at the hearing and no evidence regarding her qualifications to perform the ADOS was offered. Her narrative appeared to describe more non-autistic characteristics rather than the inverse, and her scoring of the items of the ADOS was not presented. Finally, Korchin encountered the same

problem during testing as previous examiners, i.e., Claimant would not speak. It is perhaps speculative, but if Claimant had been willing to speak, as she was with Carrillo, Korchin's scoring of the ADOS may have changed significantly. Without her direct testimony and such information as the scoring results, the weight of Korchin's findings is diminished.

### *The Second Request for Services*

15a. On July 23, 2010, Claimant, Mother, and Mother's sister met with Amador to provide pertinent information about Claimant's background and current functioning. Mother submitted the reports of Leonelli and Children's Hospital. Mother reported that the District had placed Claimant in a pre-school classroom with four or five students, and Claimant was behaving well there. At that time, the results of a District speech assessment had indicated that Claimant was not in need of speech therapy. Mother reported that Claimant was toilet trained at 24 months. Mother reported that Claimant started to show signs of developmental regression around age two and one-half. Claimant stopped using the toilet, and became incontinent and aloof. "She also used to be a more talkative child."

15b. Claimant's motor skills were not a concern. In the self-help domain, she could take off her dress, underwear and shoes. She cooperated with dressing, tried to wash her hands with soap, but generally required physical assistance with bathing and all personal hygiene tasks. She wore diapers. Mother or Mother's sister had to take her to the bathroom in the home because she had a tendency to touch her feces, smear it, and put it in her mouth. She needed supervision when eating or drinking because she bit straws and ate foam cups and paper. She refused to perform simple chores in the family home. She requires handholding and supervision in the community to prevent her from running away.

15c. Amador reported that Claimant presented as a reserved and quiet child. Mother also reported that Claimant was not social or gregarious. She was still very protective of her little sister and liked to stay home. When Mother told this to Amador during the meeting, Claimant nodded affirmatively and smiled. Mother operated a child care program in the home, but Claimant did not play with the children in the program. She enjoyed watching cartoons and Sponge-Bob, playing or, usually, making a mess with toys, and eating chocolate. She enjoyed going to the beach, the swimming pool, McDonalds and the park. She was afraid of large crowds and loud parties. During the meeting, she climbed onto Mother's lap and arms, like an infant. She was having sleeping problems.

15d. Claimant did not say one word during this entire interview with Amador. She only smiled responsively when spoken to. "She tightened her lips as if trying to prevent herself from laughing or talking. She engaged in eye contact without difficulty. She avoided most interactions. Mother said that she talks well at times and then is silent for days." Following this interview, the Service Agency referred Claimant for a psychological evaluation by Carrillo.

16a. In his report of his August 2010 examination (Exhibit 5), Carrillo wrote that Claimant presented as a very unusual child; she was very timid, but she demonstrated

significantly good, meaningful, eye contact that demonstrated adequate social reciprocity. She was generally unresponsive to the stimulus items presented by Carrillo. Despite Mother's and Carrillo's attempts to engage Claimant, she refused to engage with the stimulus items, wandering about the testing room and, at one point, hiding under the desk. Carrillo believed Claimant was intentional in her opposition. The formal testing of her cognitive abilities could not be completed. Carrillo found that Claimant presented as a child with cognitive delays, but he suggested further evaluation was needed to better estimate her level of cognition. Based solely on Mother's report and his clinical observations, Carrillo said Claimant's overall cognitive abilities appeared to lie within the borderline range of delay.

16b. Carrillo reported his assessment of Claimant's adaptive/social skills using the VABS-II. In the areas of Daily Living Skills and Socialization, Claimant received SS's of 66 and 61, both within the mild range of delay. In Communication, she received a SS of 69, within the borderline range of delay. Claimant's overall adaptive abilities, based on an Adaptive Behavior Composite SS of 61, lay within the mild range of delay. Claimant was not seen as hyperactive on the testing day, which Carrillo speculated was because Claimant was taking medication. Due to her tentative style, she was screened for ASD. On the Gilliam Autism Rating Scale – Second Edition, Claimant received an Autism Index Score of 64, which was within the unlikely probability of autism. To further assess her for an autistic spectrum disorder, Carrillo administered the CARS. Claimant received a total score of 29.5, which was just below the cut-off, but still within the non-autistic range.

16c. The results of Carrillo's first evaluation of Claimant in August 2010 suggested diagnoses of Pervasive Developmental Disorder – Not Otherwise Specified (PDD-NOS), because of her unusual behaviors; Mixed Receptive-Expressive Language Disorder, because she demonstrated a significant communication delay; and ADHD, by history, because she did not display ADHD symptoms during the evaluation. Carrillo wrote that Claimant displayed some behaviors that are seen in children with autism, but "these behaviors were not demonstrated at a level of intensity or frequency to support a diagnosis within the Autistic Spectrum Disorder range," but would support a diagnosis of PDD-NOS. Carrillo also offered a provisional diagnosis of Borderline Intellectual Functioning, "provisional" due to the lack of psychometric data from formal testing.

17a. Carrillo performed a re-evaluation on December 14, 2010. Claimant was stubborn at first, attempting to avoid interaction with formal testing, but eventually, she provided enough responses to the stimulus items that, in Carrillo's opinion, the overall results were seen as valid. "With notable encouragement from this examiner, as well as allowing a period of acclimation to the testing environment, [Claimant] eventually responded to the items associated" with the Leiter International Performance Scale – Revised (Leiter), on which Claimant received a Fluid Reasoning IQ Composite Score of 87, a Brief IQ Composite Score of 76, a Fundamental Visualization IQ Composite Score of 87, and a Full-

Scale IQ Composite Score of 78.<sup>4</sup> Carrillo said: “She is seen as a child who possesses cognitive abilities within the low normal range.”

17b. In Carrillo’s description of his interaction with Claimant, Claimant “quickly failed at attempts on primitive questions that a one- or two-year-old child could answer.” Claimant “initially ‘faked bad’ by responding incorrectly to the stimulus items presented.” Carrillo began to “fake bad” with her, thereby indicating to her that those were correct responses when they obviously were incorrect ones. This elicited “a very typical response,” in that, Claimant smiled and began to understand that both of them were playing a game of “faking bad,” and it was through this kind of social interaction that it became apparent to Carrillo that Claimant’s behaviors were not all that much odd as they were intentional. For example, there was a stimulus page with a huge ball and a giant cat; Carrillo asked Claimant to point out the ball, and she pointed to the cat; Carrillo responded: “Good job. That is correct. That is the ball.” It was a form of playful manipulation, where she was pretending not to know, but in a way that was enjoyable. Claimant came to understand that Carrillo understood what was happening, and after they both had acknowledged that fact with their facial expressions, Claimant was able to make a reasonable effort in the testing. She completed enough of the responses that Carrillo was able to validate the results.

17c. Carrillo’s opportunity to observe and test Claimant a second time resulted in Carrillo’s making some changes in his diagnoses. He now felt that Claimant’s manipulative and passive-aggressive behaviors, which were initially seen as symptoms of PDD-NOS, could no longer validly support this diagnosis. He wrote that Claimant “seems to have the social acuteness to understand demands that are made upon her and she voluntarily chooses to be uncooperative depending on her mood or motivations.” Carrillo said that Claimant wanted to control her environment to her behavior, and that her ability to be intentionally unresponsive would not usually be seen in people with PDD-NOS, because these people would not be looking at you, or even be aware of the presence of anyone else, and therefore, they would not have the ability to read social cues or to know that their uncooperative acts were having their intended impact. Carrillo recalled that, in the CARS test during the first evaluation, Claimant had related very well. Carrillo opined that, if he had re-administered the CARS during the second evaluation, the scores “would probably be in the low 20’s.” Carrillo opined that he no longer saw Claimant as a child with ADHD, but a child who certainly has difficulty with attention and concentration. He offered that Claimant “is most effectively described as a child with a Mixed-Receptive-Expressive Language Disorder and undersocialized behavior.” (Exhibit 5.) Finally, Carrillo recommended that Claimant receive special education programming for speech and language delays and that Mother and Claimant engage in psychotherapeutic intervention in an effort to improve parenting skills and to help Claimant to develop socialized behavior “so that she is able to more effectively respond and interact with peers, as well as individuals of authority.”

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<sup>4</sup> Carrillo also attempted to administer the WPPSI-III, but the testing was aborted due to Claimant’s unresponsiveness to the stimulus items presented.

18. On September 7, 2010, Claimant was assessed at the Los Angeles Child Guidance Clinic (LACGC), and received diagnoses of Disruptive Behavior Disorder, Not Otherwise Specified (NOS); Autistic Disorder; and Fetal Alcohol Syndrome/Toxic effects of alcohol. Claimant did not offer a psychological evaluation report by Melanie Morones, MFT I, ATR (Morones), who offered the diagnoses, or any other documentation of the findings upon which Morones' had relied in making these diagnoses. These diagnoses were submitted to the District, apparently in an effort to secure services for Claimant. Beginning on September 16, 2010, Mother and Claimant received mental health services at LACGC. They attended the Triple P program comprised of 10 weekly therapy sessions provided by Grace Garcia, Family Advocate. These services focused on helping Mother to utilize positive parenting techniques in managing Claimant's problem behaviors. Mother and Claimant responded well to these sessions, and Mother was able to implement the Triple P techniques in the home. Claimant's tantrums decreased from two times per day to zero. At the final discharge session of the Triple P program, Mother was informed that LACGC did not offer services specifically to address the deficits and behaviors related to autism.

19a. On September 9, 2011, the Service Agency's Education Specialist, Monique E. Craig-Douglas, M.S., observed Claimant in her school classroom. (Exhibit 16.) Claimant was first observed seated at a small corner table with a male peer. She had been separated from other students by her teacher because had been talking with and bothering other students, and allegedly had dumped pencil shavings on a male peer's head. She was working on math exercises. Claimant was observed rocking her chair back and forth, crawling and looking under the table, and purposely falling out of her chair while lifting her legs wide open. She covered her ears and began to speak in a forced whisper to herself, "Be quiet," "be quiet." Claimant initiated social communication with the observer in a brief verbal exchange. The observer then politely asked Claimant to quiet herself and listen to her teacher's instruction, and Claimant politely obliged.

19b. After snack time, the teacher directed the students to prepare for "story time." Students hurried over to the rug area with minimal instruction. Claimant, however, required more verbal prompting, and once seated in the front row, she yelled, "I can't see." As story time began, Claimant began taking her shoes off, adjusting her socks, pulling a dangling string from her skirt, rolling and flipping about on the floor, and scratching her vaginal area. The teacher later told the observer that Claimant was easily distracted, often bothered other students, and required constant verbal prompting to complete tasks. The teacher on occasion observed Claimant, when seated in the rug area, open her legs and dig into her vaginal area.

## **LEGAL CONCLUSIONS**

1. Claimant has the burden of proof as to each fact necessary to establish her eligibility for services provided by the Service Agency. (Evid. Code, § 500.)
2. Section 4512, subdivision (a), states:

(a) "Developmental disability" means a disability that originates before an individual attains age 18 years, 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 mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation, but shall not include other handicapping conditions that are solely physical in nature.

3a. To prove the existence of a developmental disability within the meaning of section 4512, a Claimant must show that she has a "substantial disability." California Code of Regulations, title 17, section 54001, states, in pertinent part, as follows:

(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.

3c. In California Code of Regulations, title 17, section 54002, the term "cognitive" is defined as the ability of an individual to solve problems with insight, to adapt to new situations, to think abstractly, and to profit from experience.

4a In addition to proving a "substantial disability," a Claimant must show that her disability fits into one of the five categories of eligibility set forth in section 4512. The first four categories are specified as: mental retardation, epilepsy, autism and cerebral palsy. The fifth and last category of eligibility is listed as a "[d]isabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation." (§ 4512.) This category is not further defined by statute or regulation.

4b. Whereas the first four categories of eligibility are very specific, the disabling conditions under this residual, fifth category are intentionally broad to encompass unspecified conditions and disorders. However, this broad language is not intended to be a catchall, requiring unlimited access to all persons with some form of learning or behavioral disability. There are many persons with sub-average functioning and impaired adaptive behavior; the Service Agency does not have a duty to serve all of them.

4c. While the Legislature did not define the fifth category, it did require that the qualifying condition be “closely related” (§ 4512) or “similar” (Cal. Code. Regs., tit. 17, § 54000) to mental retardation or “require treatment similar to that required for mentally retarded individuals.” (§ 4512.) The definitive characteristics of mental retardation include a significant degree of cognitive and adaptive deficits. Thus, to be “closely related” or “similar” to mental retardation, there must be a manifestation of cognitive and/or adaptive deficits which render that individual’s disability like that of a person with mental retardation. However, this does not require strict replication of all of the cognitive and adaptive criteria typically utilized when establishing eligibility due to mental retardation (e.g., reliance on I.Q. scores). If this were so, the fifth category would be redundant. Eligibility under this category requires analysis of the quality of Claimant’s cognitive and adaptive functioning and a determination of whether the effect on Claimant’s performance renders him or her like a person with mental retardation. Furthermore, determining whether a Claimant’s condition “requires treatment similar to that required for mentally retarded individuals” is not a simple exercise of enumerating the services provided and finding that Claimant would benefit from them. Many people could benefit from the types of services offered by regional centers (e.g., counseling, vocational training or living skills training). The criterion is not whether someone would benefit. Rather, it is whether someone’s condition requires such treatment.

5. In order to maintain eligibility, Claimant’s substantial disability must not be solely caused by an excluded condition. The statutory and regulatory definitions of “developmental disability” (§ 4512 and Cal. Code. Regs., tit. 17, § 54000) exclude conditions that are solely physical in nature. California Code of Regulations, title 17, section 54000, also excludes conditions that are solely psychiatric disorders or solely learning disabilities. Therefore, a person with a “dual diagnosis,” that is, a developmental disability coupled with a psychiatric disorder, a physical disorder, or a learning disability, could still be eligible for services. However, someone whose conditions originate from just the excluded categories (psychiatric disorder, physical disorder, or learning disability, alone or in some combination) and who does not have a developmental disability would not be eligible.

6a. The DSM-IV-TR describes mental retardation as follows:

The essential feature of Mental Retardation is significantly subaverage general intellectual functioning (Criterion A) that is accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work,

leisure, health, and safety (Criterion B). The onset must occur before age 18 years (Criterion C). Mental Retardation has many different etiologies and may be seen as a final common pathway of various pathological processes that affect the functioning of the central nervous system.

*General intellectual functioning* is defined by the intelligence quotient (IQ or IQ-equivalent) obtained by assessment with one or more of the standardized, individually administered intelligence tests (e.g., Wechsler Intelligence Scales for Children—Revised, Stanford-Binet, Kaufman Assessment Battery for Children). Significantly subaverage intellectual functioning is defined as an IQ of about 70 or below (approximately 2 standard deviations below the mean). It should be noted that there is a measurement error of approximately 5 points in assessing IQ, although this may vary from instrument to instrument (e.g., a Wechsler IQ of 70 is considered to represent a range of 65-75). Thus, it is possible to diagnose Mental Retardation in individuals with IQs between 70 and 75 who exhibit significant deficits in adaptive behavior. Conversely, Mental Retardation would not be diagnosed in an individual with an IQ lower than 70 if there are no significant deficits or impairments in adaptive functioning. . . . When there is significant scatter in the subtest scores, the profile of strengths and weaknesses, rather than the mathematically derived full-scale IQ, will more accurately reflect the person's learning abilities. When there is a marked discrepancy across verbal and performance scores, averaging to obtain a full-scale IQ score can be misleading.

Impairments in adaptive functioning, rather than a low IQ are usually the presenting symptoms in individuals with Mental Retardation. *Adaptive functioning* refers to how effectively individuals cope with common life demands and how well they meet the standards of personal independence expected of someone in their particular age group, sociocultural background, and community setting. Adaptive functioning may be influenced by various factors, including education, motivation, personality characteristics, social and vocational opportunities, and the mental disorders and general medical conditions that may coexist with Mental Retardation. Problems in adaptation are more likely to improve with remedial efforts than is the cognitive IQ, which tends to remain a more stable attribute.

(DSM-IV-TR, pages 39 - 42.)

6b. The DSM-IV-TR describes persons with Mild Mental Retardation (I.Q. level of 50-55 to approximately 70) as follows:

[T]ypically develop social and communication skills during the preschool years (ages 0-5 years), have minimal impairment in sensorimotor areas, and often are not distinguishable from

children without Mental Retardation until a later age. By their late teens, they can acquire academic skills up to approximately the sixth-grade level. During their adult years, they usually achieve social and vocational skills adequate for minimum self-support, but may need supervision, guidance, and assistance, especially when under unusual social or economic stress. With appropriate supports, individuals with Mild Mental Retardation can usually live successfully in the community, either independently or in supervised settings.

(DSM-IV-TR, pages 42 - 43.)

7. Claimant has failed to establish that she has mental retardation. The earliest standardized testing of her cognitive ability by Sanchez in 2008, and three months later by Leonelli, indicated that she had average intelligence. The 2010 testing by Carrillo, in which Claimant's scores were spread from the borderline to the average range, indicated that Claimant's abilities may lie in the borderline range, still above the threshold for a diagnosis of mental retardation. Her scores in 2009 are the exception, and these scores were significantly lower than the results of the other three tests in which Claimant was able to provide enough responses to validate the findings. Only Leonelli has made a determination that Claimant has mild mental retardation based on the psychometric testing data that was presented in this proceeding. Leonelli's 2009 report does not explain the variances between his earlier findings and the results in 2009. The narratives Leonelli wrote in the 2009 and 2011 are nearly identical. They lack reliable descriptions that might have solidified Leonelli's estimates of Claimant's intelligence by direct observation or by history.

8. Carrillo's evaluation of Claimant's behaviors and his opinion that these behaviors are better seen as passive-resistive and manipulative behaviors rather than autistic-like behaviors is given more weight than the evidence offered by Claimant, including the ADOS evaluation performed by Korchin, which appeared to be incomplete. Carrillo appears to have been the only examiner who was able, over an extended period of time, to help Claimant acclimate to the testing environment, to engage her in her own game, and to gain insight into her resistive behaviors, which allowed him to see that her behaviors were not necessarily odd or unusual. For these reasons, Korchin's and Leonelli's findings are given less weight than Carrillo's. Claimant has not established a diagnosis of autism at this time.

9. Claimant also has failed to establish that her condition is closely related to mental retardation or requires treatment similar to that required for individuals with mental retardation. Claimant's impairments are the result of a variety of factors, and her delays in cognitive abilities are not typically identified with the criteria for mental retardation. Eligibility under the "fifth category" cannot be found unless it can be shown that Claimant, in fact, is functioning at an adaptive and cognitive level similar to a mentally retarded person. Evidence of Claimant's limitations, as identified by clinicians, starts with her scores on the Leiter test, which indicates borderline intellectual abilities. Her inability to engage successfully in her social and learning environment, which impairs her learning, appears

more closely related to her inability to focus on tasks and her high level of distractibility. Her deficits in socialization skills also appear related to her impulsivity, aggressive acting out behaviors, and motivations. These factors do not establish the need for interdisciplinary planning and coordination of services to address a very broad range of developmental needs, which could be a separate basis for finding eligibility under the fifth category.

10. The evidence established that Claimant does not suffer from mental retardation or autism. Carrillo's second evaluation convincingly demonstrated that Claimant is aware of and capable of responding to others, and that her absence of speech is intentional. These characteristics would not normally be seen in a person with autism. Based on Carrillo's psychometric data, Claimant has borderline to low average intellectual ability. Claimant's problems with a short attention span and inability to concentrate are real and serious. Her sensitivity to certain stimuli, extreme and inappropriate emotional responses, and aggressive acting out and other behaviors cause significant concern, and she may need mental health services or other therapies to address these behaviors. These facts, however, fail to establish that Claimant has a disabling condition that makes her eligible for services under the Lanterman Act. Likewise, Claimant has failed to establish that her disabling condition is closely related to mental retardation or that it requires treatment similar to that required for individuals with mental retardation. In sum, the weight of the evidence supports a finding that Claimant is not eligible to receive regional center services.

### **ORDER**

Claimant's appeal is denied. Claimant has failed to establish that she is eligible for regional center services.

DATED: March \_\_\_\_, 2012

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MARK HARMAN  
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.**