

BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

INDIA J.,

Claimant,

vs.

NORTH LOS ANGELES COUNTY
REGIONAL CENTER,

Service Agency.

OAH No. 2011060645

DECISION

Ralph B. Dash, Administrative Law Judge, Office of Administrative Hearings, heard this matter on November 22, 2011, in Lancaster, California

Rhonda Campbell, Contract Administrator, represented North Los Angeles County Regional Center (Regional Center or Service Agency).

Patrina O., legal guardian, represented Claimant India J. (India).

The record was left open until December 30, 2011, to permit India's legal guardian to obtain a letter from Dr. Joshua Halbauer regarding his original referral of India to Regional Center based on an apparent diagnosis of mental retardation or autism (Exhibit 4), and to permit Regional Center's expert to comment thereon. On December 27, 2011, Regional Center submitted, by facsimile transmission, a letter dated December 7, 2011, from Dr. Halbauer, and an undated letter from Keike Ballmaier, Psy.D., Regional Center's expert, commenting on Dr. Halbauer's letter. Through clerical error, the letters were not delivered to the Administrative Law Judge until January 12, 2012. Dr. Halbauer's letter was marked as Exhibit E and admitted in evidence. Dr. Ballmaier's letter was marked as Exhibit 15 and admitted in evidence. The matter was deemed submitted on January 12, 2012.

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ISSUE

Does India have a developmental disability, as defined by the Lanterman Act,¹ entitling him to Regional Center services?

FACTUAL FINDINGS

1. India was born on March 27, 2001. She was referred to Regional Center for determination of her eligibility for services by her psychiatrist, Dr. Halbauer. This referral was in the form of a note written on Dr. Halbauer's prescription form which reads, in its entirety, "Regional Center referral (sic) for MR, Autism." (Exhibit 4.)

2. Pursuant to this referral, Regional Center conducted a Social Assessment (report dated May 4, 2010, Exhibit 6) and a Psychological Evaluation (report dated August 4, 2010 by Larry E. Gaines, Ph.D., Exhibit 8). According to Exhibit 6:²

India attends Monte Vista Elementary School in a regular 2nd grade class. India repeated both Kindergarten and 1st grade and is still lagging behind her classmates. . . . Since being on ADHD medication India has shown improvement with her behavior and focus in class but still is not making academic improvement. India enjoys going to school and reports that her teacher is nice and that she has four friends that she plays with at recess. They play on the swings, jump rope and [play] basketball at recess.

[¶] . . . [¶]

India has no toileting accidents. She washes herself in the bath with Patrina going over her as well as washing her hair. India brushes her teeth but often Patrina has to go over them. She dresses herself with help to pick out clothes that match and are appropriate for the weather. India is not sensitive to clothing materials or tags. She manages all clothing fasteners. She eats using a fork and spoon and is not yet allowed to use a butter knife. She is a sloppy eater. India has a good appetite and enjoys all types of food including some fruits and vegetables.

¹ Welfare and Institutions Code section 4500 et seq. Unless otherwise stated, all statutory references are to this code.

² The information contained in Exhibit 6 was corroborated by the legal guardian's testimony at hearing.

India is easily distracted and does not watch for cars when crossing the street. She is not stranger aware talking to everyone and approaches unfamiliar animals. She sometimes is cautious around hot things and no longer opens the front door when the doorbell rings. India does not let Patrina know when she is injured or feeling ill. She is responsible for simple household chores but never completes them due to her distractibility. She can be found wiping a clean area over and over while ignoring the dirty spot right next to it. India enjoys mixing, stirring and baking with Patrina; she is not yet allowed to use the microwave. When out shopping Patrina needs to keep an eye on India who tends to wander. She talks on the phone to familiar people and knows to dial 911 in an emergency giving valid examples. India tells time on a digital clock reading out the numbers individually. She can choose what she wants to eat when given a few choices.

India provides her full name, age, and birthdate. She is working on addition and subtraction at school and her math work is modified. Spelling words are also modified as she is given less than the rest of the class. She writes sentences for spelling words in ABC order but they are often incomplete and her spelling and punctuation needs improvement. India could not provide her complete address but gave the city she lives in and the correct state. She does not know her telephone number though Patrina has tried repeatedly to teach her. . . . Her attention span is 10-15 minutes on medication before she needs a break. India requires prompts every 20 minutes or so to complete her daily morning routine. She sometimes recalls new instructions and demonstrations other time (sic) it needs to be repeated several times.

India is verbal speaking in complete sentences with good clarity of speech. She reportedly received speech therapy in the school district of her former foster home and is in the process of being evaluated in her current one; she is reported to sometimes slur her words. . . . No jargon, echolalia, or scripted speech was reported or heard. India sits and tries to listen to books read to her but has poor comprehension. Reading skills are reported to be at Kindergarten level. She sits and watches movies appearing to comprehend. India does best following one-step directions.

India does not initiate peer interactions waiting to be approached first but then joins in. She recognizes emotions if they are very obvious and then shows concern. India requires adult guidance to share and turn take. She plays appropriately with toys and figures out how they work. India has never lined up or categorized toys and is not obsessive over a certain toy, theme, object, or parts of toys. She usually looks down when spoken too (sic). India only shows affection upon request. She will join the other children at social gatherings with encouragement and no disruptive

behaviors are reported. Previously her teacher reported that India would become angry with kids when socializing hitting and cursing at them but this diminished with her medication

India does not have temper tantrums, self-injurious behaviors, and does not cause property damage. No repetitive or unusual behaviors or body mannerisms were reported or observed. India makes faces and becomes moody over changes to her regular routine but enjoys going [to] new places and did fine when sent to camp but required a lot of help to organize her things, dress, etc. She fights making transitions but eventually complies.

3. In Exhibit 8, Dr. Gaines tested India to determine her current levels of cognition and adaptive functioning. He conducted a clinical interview and administered numerous tests including the Wechsler Intelligence Scale for Children - IV (WISC IV), Autistic Diagnostic Interview - Revised (ADI-R), Autism Diagnostic Observation Scale Module 3 (ADOS) and the Vineland Adaptive Behavior Scale Second Edition (Vineland). In Exhibit 8, Dr. Gaines reports the following:

India is a nine-year, four-month old girl who is suspected of presenting with mental retardation or autism. Regional Center intake reports, however, indicate that she has been diagnosed with an Attention Deficit/Hyperactivity Disorder. She is reported to be receiving special education support but not due to mental retardation.

[¶] . . . [¶]

India was administered the [WISC-IV³] on which she was functioning within the low-average to borderline range of intellectual ability. India demonstrated a weakness on verbal comprehension task falling in the borderline range of performance. India's subtest scores were fairly consistent within each cluster area.

India's performance fluctuated between low-average, borderline and mild deficiency scores in a number of developmental domains. While these scores suggest that India is likely to have some learning and life related difficulties, her performance was not consistent with individuals with mental retardation.

India's language skills fell within the mild range of deficiency on [the Vineland.⁴] India is able to talk in sentences. She can describe her

³ Dr. Gaines noted India achieved a Verbal Comprehension score of 77 and a Perceptual Reasoning score of 88. He did not report a full scale IQ.

experiences. Occasionally she will get confused or more often she goes off a topic which may suggest aspects of poor ideational control with the impulse conditions of an Attention Deficit/Hyperactivity Disorder. India is able to engage in reciprocal conversations.

No idiosyncratic aspects of language were observed or reported that might suggest autistic language patterns.

[¶] . . . [¶]

India's adaptive behavior skills fell within the mild range of deficiency on the [Vineland].

[¶] . . . [¶]

India's social skills fell within the low-average range of performance on the [Vineland].

[¶] . . . [¶]

Due to Autistic concerns, India was administered the [ADI-R] and [ADOS]. She did not elevate any clinical scales.

4. Dr. Gaines diagnosed India as having "Attention Deficit/Hyperactivity Disorder Combined Type (By History)" and "Communication Disorder NOS (Provisional)."

5. India's school district prepared a multi-disciplinary psycho-educational assessment on June 9, 2010 (Exhibit A), to determine if she was eligible for special education services based on a specific diagnosis of either autism or specific learning disability. In concluding that India was eligible for special education services based on a specific learning disability, the school district noted the following:

The [Cognitive Assessment System (CAS)] provides composite scores in four areas: Planning, Simultaneous, Attention, and Successive Scale. Each composite score follows the traditional psychometric characteristics of a standard score with a mean of 100 and a standard deviation of 15. . . .

India's Planning processing scale standard score falls within the Average range. This indicates that India performed well on tests that required strategies for problem solving. . . . India earned a CAS Planning scale

⁴ In Exhibit 8, Dr. Gaines reported achieving Vineland scores for India of 64 in Communication, 69 in Daily Living Skills, 80 in Socialization, and an Adaptive Behavior Composite of 70.

standard score of 97

India's Simultaneous processing scale standard score [of 73] falls within the Low range. This means that India performed relatively poorly on tests that required her to relate parts into a group or whole, understand relationships among pictures and words, and work with spatial relationships. . . .

India's Attention processing standard score of [of 85] falls within the Low Average range. India demonstrated the ability to perform well on tasks that are measure by tests that required her to focus on specific features of the material and resist reacting to distracting parts of the tests . . . [reflecting] her ability to attend and concentrate.

India's Successive scale standard score [of 86] falls within the Low Average range. [This] reflects her ability to work with information in a specific linear order.

¶ . . . ¶

India demonstrates an auditory processing deficit in the area of auditory memory. In other words, India has a difficult time storing and recalling auditory information which affects her ability to perform well in the areas of reading and math. Based on these findings, India appears to meet the eligibility criteria for Special Education services as a student with a specific learning disability. Based on a review of records, interviews, observations and current assessments, India does not meet the criteria of a student with autistic-like behaviors The results of this evaluation indicate there is a discrepancy between India's cognitive ability and academic achievement.

6. Dr. Halbauer, in Exhibit E, did nothing more than set forth his diagnoses of India, including "ADHD Combined," and "Autism, Reading D/O, Math D/O, Disorder of Written Expression, Anxiety D/O" as secondary diagnoses on Axis I. He also gave an Axis II diagnosis of "Mild MR (not regional center)." Dr. Halbauer offered no explanation as to how he reached any of his diagnoses, nor

LEGAL CONCLUSIONS

1. In order for Claimant to receive services under the Lanterman Act, not only must her condition fit into an eligibility category, it must also constitute a "substantial handicap" and must not be solely from an excluded condition.

Code section 4512 defines "developmental disability" as:

a disability which originates before an individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual, and includes mental retardation, cerebral palsy, epilepsy, autism, and disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals, but shall not include other handicapping conditions that are solely physical in nature.

2. California Code of Regulations, title 17 (CCR), section 54000 defines “developmental disability” as a disability attributable to mental retardation or other conditions similar to mental retardation that require treatment similar to that required for mentally retarded individuals. The disability must originate before age 18, be likely to continue indefinitely, and constitute a substantial handicap. Excluded are handicapping conditions that are solely psychiatric disorders, solely learning disabilities, or solely physical in nature.

3. These three exclusions from the definition of “developmental disability” under CCR section 54000 are further defined therein. Impaired intellectual or social functioning which originated as a result of a psychiatric disorder, if it was the individual’s sole disorder, would not be considered a developmental disability. “Such psychiatric disorders include psycho-social deprivation and/or psychosis, severe neurosis or personality disorders even where social and intellectual functioning have been seriously impaired as an integral manifestation of the disorder.”

4. Nor would an individual be considered developmentally disabled whose only condition was a learning disability (a significant discrepancy between estimated cognitive potential and actual level of educational performance) which is not “the result of generalized mental retardation, educational or psycho-social deprivation, [or] psychiatric disorder” Also excluded are solely physical conditions such as faulty development, not associated with a neurological impairment, which results in a need for treatment similar to that required for mental retardation.

5. CCR section 54001 provides:

(a) ‘Substantial handicap’ [as required to find a “developmental disability” under CCR §54000] means a condition which results in major impairment of cognitive and/or social functioning. Moreover, a substantial handicap represents a condition of sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential.⁵

⁵ For some reason, the phrase used in Welfare and Institutions Code §4512 is “substantial disability,” not “substantial handicap,” as used in the Regulations. There are no significant differences in the phrases.

(b) Since an individual's cognitive and/or social functioning are many-faceted, the existence of a major impairment shall be determined through an assessment which shall address aspects of functioning including, but not limited to:

- (1) Communication skills;
- (2) Learning;
- (3) Self-care;
- (4) Mobility;
- (5) Self-direction;
- (6) Capacity for independent living;
- (7) Economic self-sufficiency

6. In CCR 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."

7. The Diagnostic and Statistical Manual of Mental Disorders (4th edition, Text Revision, 2000, American Psychiatric Association, also known as DSM-IV-TR) is a well respected and generally accepted manual listing the diagnostic criteria and discussing the identifying factors of most known mental disorders. The manual uses a number system for the different disorders which is accepted by most medical and psychotherapeutic professionals (and insurance companies) as a shorthand method to designate the disorders that are more specifically described in the manual.

8. The DSM-IV-TR contains information on the diagnosis of mental retardation which can assist in answering the eligibility issue in this case. The three essential criteria of mental retardation are: (1) significantly sub-average general intellectual functioning; (2) 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; and (3) the onset must occur before age 18.

9. The first criterion, general intellectual functioning, is defined by the intelligence quotient (IQ or equivalent), assessed by use of one or more standardized tests. The level of "significantly subaverage," as required by this criterion, is defined as an IQ of 70 or below, and it must be noted that the scoring is such that there is a measurement error of about 5 points in assessing IQ. For example, a Full Scale IQ of 70 on one of the standardized tests is considered to represent a range of 65-75. Although Dr. Gaines did not offer a full scale IQ for India, the two scores he achieved, 77 for verbal comprehension and 88 for perceptual reasoning, are both above the threshold for a finding of mental retardation.

10. Beginning at page 75 of the DSM-IV-TR, the diagnostic criteria for

Autistic Disorder are described as follows:

“A. A total of six (or more) items from (1), (2), and (3), with at least two from (1), and one each from (2) and (3):

“(1) qualitative impairment in social interaction, as manifested by at least two of the following:

“(a) marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction

“(b) failure to develop peer relationships appropriate to developmental level

“(c) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)

“(d) lack of social or emotional reciprocity

“(2) qualitative impairments in communication as manifested by at least one of the following:

“(a) delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)

“(b) in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others

“(c) stereotyped and repetitive use of language or idiosyncratic language

“(d) lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level

“(3) restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

“(a) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus

“(b) apparently inflexible adherence to specific, nonfunctional routines or rituals

“(c) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)

“(d) persistent preoccupation with parts of objects

“B. Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years: (1) social interaction, (2) language as used in social communication, or (3) symbolic or imaginative play.

“C. The disturbance is not better accounted for by Rett’s Disorder or Childhood Disintegrative Disorder.”

11. As referenced above, the diagnosis is made by a finding of six or more symptoms in three separate groups, with findings of two or more symptoms in the first group and findings of one or more symptoms in second and third groups. Once those criteria are met, the diagnostician must find delays or abnormal functioning in at least one of three additional areas, with onset prior to age three. The disorder must then be distinguished from Rett’s Disorder or Childhood Disintegrative Disorder. With the diagnostic criteria being as broad as they are, an individual’s symptoms are subject to the diagnostician’s discretion and interpretation to determine whether those symptoms satisfy the criteria. Further, because of the wide range of symptoms that can satisfy each of the criteria, individuals with Autistic Disorder can present with immensely disparate symptomatology.

12. There is little in India’s behavior, as described in the above Findings, to suggest she has autism. Portions of the discussion of Autistic Disorder in DSM-IV-TR shed light on autism’s multifarious nature. Albeit lengthy, those portions warrant review to place the instant case in its proper perspective:

“**Diagnostic Features**

“The essential features of Autistic Disorder are the presence of markedly abnormal or impaired development in social interaction and communication and a markedly restricted repertoire of activity and interests. Manifestations of the disorder vary greatly depending on the developmental level and chronological age of the individual. Autistic Disorder is sometimes referred to as *early infantile autism*, *childhood autism*, or *Kenner’s autism*.

“The impairment in reciprocal social interaction is gross and sustained. There may be marked impairment in the use of multiple nonverbal behaviors (e.g., eye-to-eye gaze, facial expression, body postures and gestures) to regulate social interaction and appropriate to developmental level (Criterion A1b) that may take different forms at different ages. Younger individuals may have little or no interest in establishing friendships. Older individuals may have an interest in friendship but lack understanding of the conventions of social interaction. There may be a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., not showing, bringing, or pointing out objects they find interesting) (Criterion A1c). Lack of social or emotional reciprocity may be present (e.g., not actively participating in simple social play or games, preferring solitary activities, or involving others in activities only as tools or ‘mechanical’ aids) (Criterion A1d). Often an individual’s awareness of others is markedly impaired. Individuals with this disorder may be oblivious to other children (including siblings), may have no concept of the needs of others, or may not notice another person’s distress.

“The impairment in communication is also marked and sustained and affects both verbal and nonverbal skills. There may be delay in, or total lack of, the development of spoken language (Criterion A2a). In individuals who do speak, there may be marked impairment in the ability to initiate or sustain a conversation with others (Criterion A2b), or a stereotyped and repetitive use of language or idiosyncratic language (Criterion A2c). There may also be a lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level (Criterion A2d). When speech does develop, the pitch, intonation, rate, rhythm, or stress may be abnormal (e.g., tone of voice may be monotonous or inappropriate to context or may contain questionlike rises at ends of statements). Grammatical structures are often immature and include stereotyped and repetitive use of language (e.g., repetition of words or phrases regardless of meaning; repeating jingles or commercials) or idiosyncratic language (e.g., language that has meaning only to those familiar with the individual’s communication style). Language comprehension is often very delayed, and the individual may be unable to understand simple questions or directions. A disturbance in the pragmatic (social use) of language is often evidenced by an inability to integrate words with gestures or understand humor or nonliteral aspects of speech such as irony or implied meaning. Imaginative play is often absent or markedly impaired. These individuals also tend not to engage in the simple imitation games or routines of infancy or early childhood or do so only out of context or in a mechanical way.

“Individuals with Autistic Disorder have restricted, repetitive, and stereotyped patterns of behavior, interests, and activities. There may be an encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus (Criterion A3a); an apparently inflexible adherence to specific, nonfunctional routines or rituals (Criterion A3b); stereotyped and repetitive motor mannerisms (Criterion A3c); or a persistent preoccupation with parts of objects (Criterion A3d). Individuals with Autistic Disorder display a markedly restricted range of interests and are often preoccupied with one narrow interest (e.g., dates, phone numbers, radio station call letters). They may line up an exact number of play things in the same manner over and over again or repetitively mimic the actions of a television actor. They may insist on sameness and show resistance to or distress over trivial changes (e.g., a younger child may have a catastrophic reaction to a minor change in the environment such as rearrangement of the furniture or use of a new set of utensils at the dinner table). There is often an interest in nonfunctional routines or rituals or an unreasonable insistence on following routines (e.g., taking exactly the same route to school every day). Stereotyped body movements include the hands (clapping, finger flicking) or whole body (rocking, dipping, and swaying). Abnormalities of posture (e.g., walking on tiptoe, odd hand movements and body postures) may be present. These individuals show a persistent preoccupation with parts of objects (buttons, parts of the body). There may also be a fascination with movement (e.g., the spinning wheels of toys, the opening and closing of doors, an electric fan or other rapidly revolving object). The person may be highly attached to some inanimate object (e.g., a piece of string or a rubber band).

“The disturbance must be manifest by delays or abnormal functioning in at least one (and often several) of the following areas prior to age 3 years: social interaction, language as used in social communication, or symbolic or imaginative play (Criterion B). In most cases, there is no period of unequivocally normal development, although in perhaps 20% of cases parents report relatively normal development for 1 or 2 years. In such cases, parents may report that the child acquired a few words and lost these or seemed to stagnate developmentally.

“By definition, if there is a period of normal development, it cannot extend past age 3 years. The disturbance must not be better accounted for by Rett’s Disorder or Childhood Disintegrative Disorder (Criterion C).

“Associated Features and Disorders

“Associated descriptive features and mental disorders. In most cases, there is an associated diagnosis of Mental Retardation, which can range from mild to profound. There may be abnormalities in the development of cognitive skills. The profile of cognitive skills is usually uneven, regardless of the general level of intelligence, with verbal skills typically weaker than nonverbal skills. Sometimes special skills are present (e.g., a 4½-year-old girl with Autistic Disorder may be able to ‘decode’ written materials with minimal understanding of the meaning of what is read [hyperlexia] or a 10-year-old boy may have prodigious abilities to calculate dates [calendar calculation]). Estimates of single-word (receptive or expressive) vocabulary are not always good estimates of language level (i.e., actual language skills may be at much lower levels).

“Individuals with Autistic Disorder may have a range of behavioral symptoms, including hyperactivity, short attention span, impulsivity, aggressiveness, self-injurious behaviors, and, particularly in young children, temper tantrums. There may be odd responses to sensory stimuli (e.g., a high threshold for pain, oversensitivity to sounds or being touched, exaggerated reactions to light or odors, fascination with certain stimuli). There may be abnormalities in eating (e.g., limiting diet to a few foods, Pica) or sleeping (e.g., recurrent awakening at night with rocking). Abnormalities of mood or affect (e.g., giggling or weeping for no apparent reason, an apparent absence of emotional reaction) may be present. There may be a lack of fear in response to real dangers, and excessive fearfulness in response to harmless objects. A variety of self-injurious behaviors may be present (e.g., head banging or finger, hand, or wrist biting). In adolescence or early adult life, individuals with Autistic Disorder who have the intellectual capacity for insight may become depressed in response to the realization of their serious impairment.

“Associated laboratory findings. When Autistic Disorder is associated with a general medical condition, laboratory findings consistent with the general medical condition will be observed. There are group differences in some measures of serotonergic activity, but these are not diagnostic for Autistic Disorder. Imaging studies may be abnormal in some cases, but no specific pattern has been clearly identified. EEG abnormalities are common even in the absence of seizure disorders.

“Associated physical examination findings and general medical conditions. Various nonspecific neurological symptoms or signs may be noted (e.g., primitive reflexes, delayed development of hand dominance) in Autistic Disorder. The condition is sometimes observed in association with a neurological or other general medical condition (e.g., fragile X syndrome and tuberous sclerosis).

“Seizures may develop (particularly in adolescence) in as many as 25% of cases. Both microcephaly and macrocephaly are observed. When other general medical conditions are present, they should be noted on Axis III.

“Specific Age and Gender Features

“The nature of the impairment in social interaction may change over time in Autistic Disorder and may vary depending on the developmental level of the individual. In infants, there may be a failure to cuddle; an indifference or aversion to affection or physical contact; a lack of eye contact, facial responsiveness, or socially directed smiles; and a failure to respond to their parents’ voices. As a result, parents may be concerned initially that the child is deaf. Young children with this disorder may treat adults as interchangeable, may cling mechanically to a specific person, or may use the parent’s hand to obtain desired objects without ever making eye contact (as if it were the hand rather than the person that is relevant). Over the course of development, the child may become more willing to be passively engaged in social interaction and may even become more interested in social interaction. However, even in such instances, the child tends to treat other people in unusual ways (e.g., expecting other people to answer ritualized questions in specific ways, having little sense of other people’s boundaries, and being inappropriately intrusive in social interaction). In older individuals, tasks involving long-term memory (e.g., train timetables, historical dates, chemical formulas, or recall of the exact words of songs heard years before) may be excellent, but the information tends to be repeated over and over again, regardless of the appropriateness of the information to the social context. Rates of the disorder are four to five times higher in males than in females. Females with the disorder are more likely, however, to exhibit more severe Mental Retardation.”

(DSM-IV-TR, pp. 70-73.) (Bold and italic print in text.)

13. There is nothing contained in Dr. Halbauer’s letter of December 2, 2011 (Exhibit E), that sheds any light on the nature of India’s demonstrated disabilities. He sets forth his diagnoses but offers no support therefore. “[A]n expert’s conclusory opinion that something did occur, when unaccompanied by a reasoned explanation

illuminating how the expert employed his or her superior knowledge and training to connect the facts with the ultimate conclusion, does not assist the [factfinder].” (*Jennings v. Palomar Pomerado Health Systems, Inc.* (2003) 114 Cal.App.4th 1108, 1117; see also Evid. Code, § 801.)

14. Learning disabilities are often identified by school psychologists, clinical psychologists, and neuropsychologists through a combination of intelligence testing, academic achievement testing, classroom performance, and social interaction and aptitude. Other areas of assessment may include perception, cognition, memory, attention, and language abilities. The resulting information is used to determine whether a child's academic performance is commensurate with his or her cognitive ability. If a child's cognitive ability is much higher than his or her academic performance, the student is often diagnosed with a learning disability. The DSM-IV TR and many school systems and government programs diagnose learning disabilities in this way (DSM-IV TR uses the term “disorder” rather than “disability”).

15. Learning disabilities are associated with brain dysfunctions that affect a number of basic skills. Perhaps the most fundamental is sensory-perceptual ability—the capacity to take in and process information through the senses. Difficulties involving vision, hearing, and touch will have an adverse effect on learning. Although learning is usually considered a mental rather than a physical pursuit, it involves motor skills, and it can also be impaired by problems with motor development. Other basic skills fundamental to learning include memory, attention, and language abilities.

16. The three most common academic skill areas affected by learning disabilities are reading, writing, and arithmetic. Some sources estimate that between 60 percent and 80 percent of children diagnosed with learning disabilities have reading as their only or main problem area. Learning disabilities involving reading have traditionally been known as dyslexia; currently, the preferred term is reading disorder. A wide array of problems is associated with reading disorder, including difficulty identifying groups of letters, problems relating letters to sounds, reversals and other errors involving letter position, chaotic spelling, trouble with syllabication (breaking words into syllables), failure to recognize words, hesitant oral reading, and word-by-word rather than contextual reading.

17. Writing disabilities, known as dysgraphia or disorder of written expression, include problems with letter formation and writing layout on the page, repetitions and omissions, punctuation and capitalization errors, “mirror writing” (writing right to left), and a variety of spelling problems. Children with dysgraphia typically labor at written work much longer than their classmates, only to produce large, uneven writing that would be appropriate for a much younger child.

18. Learning abilities involving math skills, generally referred to as dyscalcula (or dyscalculia) or mathematics disorder, usually become apparent later than reading and writing problems—often at about the age of eight. Children with

dyscalcula may have trouble counting, reading and writing numbers, understanding basic math concepts, mastering calculations, and measuring. This type of disability may also involve problems with nonverbal learning, including spatial organization.

19. As noted in the school district's assessment (Exhibit A) and Dr. Gaines' report (Exhibit 8), and based on Conclusions 14 through 18, India's disabilities are best explained by the diagnosis of Learning Disability, a diagnosis that does not entitle India to Regional Center services. The evidence of Dr. Halbauer's conclusions was insufficient to establish eligibility.

ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

India J.'s appeal of Regional Center's determination that she is not entitled to services under the Lanterman Act is denied.

DATED: _____

RALPH B. DASH
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.