2010-12

# The Commonwealth of Massachusetts
## Executive Office of Health & Human Services
## Department of Developmental Services
## 500 Harrison Avenue
## Boston, MA 02118-2439


**Deval L. Patrick**
**Governor**

**Timothy P. Murray**
**Lieutenant Governor**

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**Secretary**

**Elin M. Howe**
**Commissioner**

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2010

MA

**Re: Appeal of - Final Decision**

Dear :

Enclosed please find the recommended decision of the hearing officer in the above appeal. A fair hearing was held on the appeal of your client's eligibility determination.

The hearing officer made findings of fact, proposed conclusions of law and a recommended decision. After reviewing the hearing officer's recommended decision, I find that it is in accordance with the law and with DDS regulations. Your client's appeal is therefore DENIED.

You, or any person aggrieved by this decision may appeal to the Superior Court in accordance with Massachusetts General Laws, Chapter 30A. The regulations governing the appeal process are 115 CMR 6.30-6.34 and 801 CMR 1.01-1.04.

Sincerely,

Elin M. Howe
Commissioner

EMH/ecw
cc: Elizabeth Silver, Hearing Officer
Richard O'Meara, Regional Director
Marianne Meacham, General Counsel
James Bergeron, Assistant General Counsel
Elizabeth Moran Liuzzo, Regional Eligibility Manager
Frederick Johnson, Psychologist
File

# COMMONWEALTH OF MASSACHUSETTS
# DEPARTMENT OF DEVELOPMENTAL SERVICES

**In Re: Appeal of** [redacted]

This decision is issued pursuant to MGL Chapter 30A and the regulations promulgated thereto, 115 CMR 6.00 *et. seq.* A fair hearing was held on [redacted], 2010, at the DDS [redacted] in [redacted], MA.

Those present and participating at the hearing:

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|---|---|
| [redacted] | Father of Appellant |
| [redacted] | Attorney for Appellant |
| Frederick Johnson, Psy.D. | Psychologist for DDS |
| James Bergeron | Attorney for DDS |

At the hearing, the parties jointly submitted Exhibits 1-18. Subsequent to the hearing the Department submitted a supplemental report, which is now marked as Exhibit 19. Also submitted subsequent to the hearing, the Department submitted a written Closing Argument and Brief.[1] The hearing lasted approximately three hours. [redacted] testified on behalf of the Appellant, and Dr. Johnson testified on behalf of the Department.

**ISSUE PRESENTED**:

The issue for this hearing is whether the Appellant, [redacted], meets the Department's definition of mental retardation and is thereby eligible for DDS services.

**SUMMARY OF THE EVIDENCE**

**Exhibit 1.** Vita for Frederick V. Johnson, Psy.D.

**Exhibit 2.** DDS regulations at 115 CMR 6.00 *et. seq.*

**Exhibit 3.** DDS regulations at 115 CMR 2.00 *et. seq.*

**Exhibit 4.** Appellant's Application for DMR[2] Eligibility dated [redacted]/07.

**Exhibit 5.** Eligibility Report prepared by Frederick V. Johnson, Psy.D. on [redacted]/08. Dr. Johnson reviewed the psychological and adaptive testing in the record and concluded that the Appellant did not meet eligibility requirements for the Department's adult services.

**Exhibit 6.** Department's [redacted]/08 letter to the Appellant denying eligibility for services.

**Exhibit 7.** Letter dated [redacted]08 from Appellant's father to the Department appealing its decision denying services and attaching a Permanent Decree of Guardianship.

**Exhibit 8.** Attendance Sheet from [redacted]/08 Informal Conference.

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[1] The Appellant's attorney declined to submit a closing brief.

[2] On June 30, 2009, the Department changed its name from the Department of Mental Retardation (DMR) to the Department of Developmental Services. I will refer to the Department's new name in this decision.

**Exhibit 9.** Department's [redacted]/09 letter post-informal conference reaffirming denial of eligibility.

**Exhibit 10.** Appellant's [redacted]/09 letter requesting a Fair Hearing.

**Exhibit 11.** Department's [redacted]/09 acknowledgement of receipt of the Appellant's request for a Fair Hearing.

**Exhibit 12.** Fair Hearing Scheduling Notice dated [redacted]/10.[3]

**Exhibit 13.** Psychoeduational Assessment done over the course of three meetings on [redacted]/99, [redacted]/99, and [redacted]/99. [redacted], B.A., Educational Consultant, and [redacted], Ph.D., both of the [redacted] Institute, evaluated the Appellant to determine the nature and amount of supports she needed for school and at home. The Appellant was 10 years [redacted] old and in the 5th grade at the time of the evaluation. She was receiving special education services in an integrated class at [redacted] Elementary School.

The examiner provided background information which indicates that at the time the Appellant lived at home and had diagnoses of Mobius-like Syndrome with cranial nerve deficits in IX, X, and XII. She was status post fundoplication x2 for treatment of gastroesophageal reflux and had had swallowing difficulties since birth. Other issues of the Appellant noted in the Background section included skill delays in fine and gross motor domains, sleep disturbance, and recurrent otitis media. The examiner reported on the scores from prior testing. In [redacted] 1998, the Appellant was administered the Verbal scales of the Wechsler Intelligence Scale for Children-III (WISC-III). She obtained a score of 98, which was in the average range.

As part of this evaluation, the examiner administered the Wechsler Achievement Test (WIAT) to the Appellant. In basic reading, language, and spelling, the Appellant's standard scores were 121, 112, and 123 respectively, all of which were in the above average range as compared to others her age. Her score of 107 on reading comprehension was in the high average range, and her scores of 95 in mathematics and 86 in written expression were in the low average and below average range.

Most of this report concentrated on some the Appellant's behaviors that interfered with functioning in school and at home. The mainstreamed teachers felt that the Appellant's behavior interfered with functioning in regular classroom settings and she needed an aide for support. The Appellant's mother, a classroom aide, and a special education teacher completed a Woodcock-Johnson Scales of Independent Behavior-Revised (SIB-R). The Appellant's scores were Broad Independence-35, Motor Skills-27, Personal Living Skills-29, and Community Living Skills-33, all of which were in the 1st percentile. Her scores on Social Interaction and Communication Skills of 80 in the home and 78 in the school were in the 9th and 7th percentiles, respectively. On the Problem Behaviors Scale, which provides information about a variety of problem behaviors, the Appellant's pattern of maladaptive behavior at home was considered very serious with unsafe behavior being the primary concern. Some of the specific problem behaviors reported by the Appellant's mother included hair pulling, tearing/scratching property, clinging, pestering, teasing, crying/laughing without reason, talking to self, making odd faces or noises, talking too loudly, standing too close, expressing unusual fears, showing little interest in activities, refusing to obey, do chores, follow rules, attend school, and defiance.

[3] The hearing had been previously scheduled for [redacted], 2009, and again on [redacted], 2010, but in both cases was continued for good cause.

The examiner reported that some of these behaviors were evident when she met with the Appellant and her mother. She said that the Appellant had to be redirected not to sit in such close proximity to her mother or the observer, and also reported on a variety of other behaviors including atypical facial expressions and eye movement, excessively loud voice volume, spinning with "bluie" (her rope), and frequent interruptions of the conversation.

**Exhibit 14.** Neuropsychological Evaluation done [redacted]/99 when the Appellant was 11 years [redacted] old and in the 6th grade. The evaluation was done by [redacted], M.A., Neuropsychology Fellow, and [redacted], Ph.D., Clinical Supervisor. The Appellant was referred for clarification of her diagnosis, to assess current behavioral and cognitive functioning, and for planning purposes.

Ms. [redacted] provided some history for the Appellant. Under Relevant History and Current Developmental Functioning, Ms. [redacted] noted a history of behavioral difficulties and that the Appellant was overly enmeshed with her mother. She had diagnoses of ADHD and anxiety and a history of behavioral difficulties. The Appellant's developmental milestones were delayed for gross and fine motor skills. Speech development was normal for vocabulary but delayed for age-appropriate content and syntax. The Appellant could not read social cues and lived in her own world. She spent most of her time playing by herself, spinning a piece of rope, and replaying scenes from the Wizard of Oz, with which she was obsessed. Because she was delayed with self-help skills, the Appellant's mother had to dress her, feed her breakfast, and help her wipe herself after toileting. Communication skills were significantly delayed, and cognitive reasoning was characterized as immature. She engaged in self-stimulating behaviors such as spinning her rope, head banging or hitting herself on the head, and rocking. At the time of the evaluation she was mainstreamed with a one-to-one aid for all classes but math.

Under Behavioral Observations, Ms. [redacted] reported that the Appellant's behavior during testing was notable for spinning a rope in circles when anxious, awkward relatedness, odd/robotic prosody, and frequent stereotypic behaviors such as shaking her hands or body, and perseverative speech patterns. It was increasingly difficult to get the Appellant to comply with testing. When challenged or confused, she withdrew from the activity. Initially she engaged easily during testing, but in subsequent sessions it was increasingly difficult to get the Appellant to comply. She was pleasant in the initial session then as that session progressed she became more labile. During the last session she had abrupt shifts in affect. She complained of being sick, then minutes later would say she was fine, then became visibly sad, then happy, then hysterically upset, and then fine again. She had frequent unpredictable outbursts during testing. She was unable to sustain effort, her attention was variable, and she was quite distractible.

Ms. [redacted] reported on an [redacted] 1996 evaluation in which the Appellant was given selected subtests from the WISC-III. She was about 7 years [redacted] at the time. The Appellant's overall performance was significantly stronger for verbally-based tasks than visually-based tasks. Her prorated Verbal IQ was 104. The Performance IQ was not calculated, but subtest scaled scores ranged from 2 to 6, suggesting deficient right hemisphere functioning.

Ms. [redacted] administered the WISC-III, which revealed discrepant intellectual functioning depending on the nature of the task. The Appellant's performance on verbally-based tasks fell in the lower end of the average range with a Verbal IQ of 90, and her performance on visually-based tasks fell in the Mentally Deficient range with a Performance IQ of 53. Given the significant split in scores, Ms. [redacted] said a Full Scale IQ would not be representative of the Appellant's skills. She said the Appellant's profile was typical of individuals with right hemisphere dysfunction (PDD spectrum disorders where logistics of language and fund of knowledge develop).

With respect to adaptive skills, Ms. [redacted] said the Appellant's self-help and socialization skills were profoundly limited. The Appellant could not independently dress herself, eat meals, or attend to toileting. Socialization was significantly limited. She had no friends. Ms. [redacted] reported that the neuropsychological protocol as a whole highlighted significant and profound deficits in all areas of functioning. She observed delayed acquisition of developmental milestones, history of significant and persistent delays in most cognitive and adaptive domains, significant problems in visual-spatial processing, gross and fine motor skills, and socialization. Numerous medical problems and neurological deficits complicated the Appellant's presentation. Ms. [redacted] did not rule out PDD. She said the Appellant's functioning was consistent with High Functioning Autism.

**Exhibit 15.** Psychological Evaluation done by [redacted], Ph.D, Licensed Psychologist, on [redacted] 2004 when the Appellant was 15 years [redacted] old. The Appellant had been referred for her 3-year evaluation. She had been attending [redacted] Rehabilitation Center in [redacted], NH, since [redacted], 2002. In the Background section, Dr. [redacted] noted the [redacted] 1999[4] IQ testing in which there was a significant discrepancy between the verbal IQ (90) and performance IQ (53) scores, and concurred that this suggested an over-reliance or dependency on the left hemisphere.

Dr. [redacted] administered the WISC-IV during which the Appellant demonstrated noteworthy behavior throughout testing including smelling crayons and rotating her head in a circular manner, and she did not seem to respond to certain verbal or body language behavior by the examiner. The examiner noted that there appeared to be a somewhat socially detached aspect to the Appellant's interpersonal relatedness. He also noted that the Appellant's sense of task orientation was not completely adequate given her tendency to be oriented to things other than the testing materials, but she saw all testing through to completion and so despite variable attention, the test results were considered to be a reasonable reflection of the Appellant's general functioning at the time.

On the WISC-IV, the Appellant's Index scores were Verbal Comprehension (VCI) 77, Perceptual Reasoning (PRI) 49, Working Memory (WMI) 83, and Processing Speed (PSI) 50. Her Full Scale IQ was reported as 56, placing the Appellant in the Mild range of mental retardation. There was significant intersubtest scatter, with subtest scores ranging from1 to 9.

Dr. [redacted] also administered the Vineland Adaptive Behavior Scales (VABS) in both the school and residential settings. He provided age equivalent scores (AE), not number scores. In the school setting, the Appellant's Age Equivalent scores were Communication – 6.4 years, Daily Living Skills - 5.11, Socialization - 4.1, and Adaptive Behavior Composite - 5.6. In the residential setting, her AE scores were Communication – 8.7, Daily Living Skills – 6.11, Socialization – 3.8, and Adaptive Behavior Composite – 6.5.

**Exhibit 16.** Written Summary of Evaluation Reports prepared on [redacted]/07. At the time of the report, the Appellant was a student at [redacted] School, which she had been attending since [redacted] 2002. This exhibit includes four separate reports. The first is an Educational Evaluation administered on [redacted]/07-[redacted]/07. On the Kaufman Test of Educational Achievement, there was a wide discrepancy between the Appellant's skills in reading comprehension, word-decoding, and written spelling as compared to mathematical skills. She demonstrated above-average abilities in word recognition and comprehension (standard score of 111) and a standard score of 64 in Mathematics (lower extreme range).

[4] The testing was in [redacted] 1999. (Exh 14).

Also included in this exhibit is a Psychological Testing Report from testing dated [redacted]/07 and [redacted]/07 when the Appellant was 18 years [redacted] old. [redacted], Ph.D, noted that with the consistent discipline at [redacted], the Appellant had made progress in her attention span and ability to focus. However, she continued to lack the internal discipline to control herself. Dr. [redacted] said that without firm discipline or behavioral consequences, the Appellant tended to be loud, impulsive, grabby, and rambunctious. But a simple, consistent plan used in the classroom had helped the Appellant calm down and make excellent progress both educationally and personally.

Dr. [redacted] administered the Wechsler Adult Intelligence Scale (WAIS) on which the Appellant's scores were Verbal IQ 89, Performance IQ 74, and Full Scale IQ 80. During testing the Appellant gave up quickly if the items became too hard. She was hesitant to make guesses and just said, "I don't know." She did one task for a little over a minute but then stopped saying it was boring. Dr. Cooper noted that the Appellant's scores were a huge improvement from the 2004 testing and brought her out of the mentally deficient range. Dr. [redacted] assumed this improvement had to do with the Appellant's willingness to cooperate and her ability to focus better as well as having settled down at [redacted]. The Appellant's teacher said two years earlier the Appellant had been into fantasy and spinning more, but over time she had become more engaged and increased her attention span. While the Appellant's scores overall were higher, the general pattern was consistent with the 2004 testing in which verbal scores were significantly higher than performance scores.

On the Vineland II (Teacher Rating form), the Appellant's scores were Communication 80, Daily Living Skills 94, and Socialization 85. Dr. [redacted] said that the results showed that the Appellant continued to lag behind peers in written communication but had made good gains in expressive and receptive skills. She did well with her daily living skills and leisure activities, but was more immature with peer relations and coping skills. She lacked discretion for personal issues and was likely to miss subtle social cues.

This exhibit also included an Occupational Therapy report dated [redacted]/07 and a Residential Data Base report dated [redacted]/07.

**Exhibit 17.** Letter dated [redacted]/09 from [redacted], MD, consultant Psychiatrist to the [redacted] School. Dr. [redacted] noted that the Appellant was born with deficits in cranial nerves IX, X, and XI, which was very similar but not identical to Mobius syndrome. She had a history of severe anxiety, defiant behaviors, atypical social skills, hyperactivity/impulsivity, self-stimulatory behaviors, stereotypical motor movements and unusual interests. Dr. [redacted] also noted diagnoses of Anxiety disorders, obsessive compulsive disorder, PDD, ADHD, and some other disruptive behavioral disorders. Dr. [redacted] believed that the Appellant clearly fit the profile of someone with a Pervasive Developmental Disorder, NOS, but she was a low functioning example of a person suffering with this disorder despite intelligence in the borderline range. She also had severe anxiety symptoms. The Appellant had been actively treated with psychotropic medications for her anxiety and obsessions.

**Exhibit 18.** Adaptive Behavior Assessment System II (ABAS-II) dated [redacted]/08 when the Appellant was 19 years [redacted] old. [redacted] was the rater.[5] Her scores were Conceptual 83, Social 89, Practical 77, and GAC 74.

[5] Testimony during the hearing from Mr. [redacted] established that [redacted] is the Appellant's case manager at [redacted].

**TESTIMONY**

Joint Exhibits 1-18 were entered into the record. While preparing for the hearing, the Department noticed some miscalculations on the ABAS-II (Exh 18) and so prepared a corrected score page. The Department objected to the entry of the ABAS test questions into the record. The objection was allowed after an agreement was reached between the parties that provided for a means to check the math in the raw scoring. [redacted] and Frederick Johnson were sworn in. Both parties made brief opening statements.

[redacted] testified on behalf of the Appellant. He is her father and guardian. Mr. [redacted] testified that the initial three years of the Appellant's life were spent keeping her alive. Soon after she was born she had problems due to brain stem deficits. She was not able to suck or swallow, couldn't take nourishment, and immediately lost weight. She was hospitalized the first month of her life. At the age of 5 months the Appellant had her first fundoplication and a stoma was placed in her for a feeding tube. She was under the care of a gastroenterologist at the [redacted] Hospital when she was about 3 years old. She had help in the home monitoring her apnea. So the first few years of the Appellant's life focused on getting her nourishment and protecting her airways.

Mr. [redacted] said it was apparent from when the Appellant was a few months old that her recognition was slow. She was also delayed in walking and balancing. Her gross and fine motor controls were slow (and still are). She had physical therapy and occupational therapy from a young age in the home. She cannot run and her balance is off.

Mr. [redacted] said the Appellant has no peristalsis so food can't be squeezed down her esophagus. Over time she has had to learn how to swallow, but it's not the usual kind of swallow since the epiglottis and esophagus do not work properly. Occasionally the Appellant had periods when she was on semi-solids food, but for the last three to four years she hasn't been able to tolerate even that, and now can only eat pureed food. The Appellant had to have a fundoplication redone, which created a lot of anxiety for her. In 2008 she also had bowel surgery because of an obstruction. The surgery was successful but afterwards the Appellant developed an infection and pneumonia and had to be airlifted to [redacted] Hospital where she was an inpatient for at least three weeks. At the time, Mr. [redacted] said the Appellant's psychiatrist said she had PTSD.

After that experience the Appellant returned to school with significantly heightened anxiety, and then got into a phase of swallowing inedible things so as to induce hospitalization again. The [redacted]s tried to get the Appellant a psychiatric placement but were unsuccessful. That was the time when a one-to-one aide was added for safety reasons.

Mr. [redacted] said the Appellant has slowly come out of that self-injury period, but she needs one-to-one support in the community. She has never been perfectly safe. At the mall, for example, she won't look for cars. She doesn't realize which people she should avoid. She continues to act inappropriately with strangers as she did when she tried to sit on the psychiatrist's lap. Mr. [redacted] said the Appellant does a lot of spinning and turning, and head rotating with her eyes closed, none of which she can control. She is incapable of focusing on anything for any length of time without going into those activities. In addition, she lives a fantasy life and takes on different personas.

On cross-examination, Mr. [redacted] testified that before starting at [redacted] the Appellant lived at home and attended school through the [redacted] school system. This schooling was not successful, which eventually led to the placement at [redacted] in 2002. He said the Appellant

had an adjustment period at [redacted], but during her stay there she improved scholastically. However, after the last hospitalization she has regressed.

Mr. Sundelin testified that [redacted], the rater on the ABAS-II (Exh 18) is the Appellant's case manager at [redacted]. His role is administrative. He is around the school but does not meet with the Appellant regularly. He organizes the Appellant's support, is responsible for writing the IEP or other reports, and he sets up testing.

Frederick Johnson testified on behalf of the Department. The Appellant's attorney stipulated to Dr. Johnson's status as an expert witness. Dr. Johnson is the Department's eligibility psychologist for the [redacted] region. After reviewing the Department's eligibility criteria, he testified that he based his decision that the Appellant was not eligible for Department services on the information he had at the time. He had not met the Appellant then, but he reviewed the WAIS-III administered in 2007 and one childhood IQ score, had a conversation with the Appellant's mother, and reviewed the ABAS scores.

Dr. Johnson testified that he first met and interviewed the Appellant at the Informal Conference. He said the Appellant is quite unusual and that he had never met anyone like her. Dr. Johnson said the Appellant was clearly impaired in many ways. She doesn't have a lot of facial expressions, which is a symptom of Moebius syndrome. He said she will deliver quotes or remarks that are devoid of affect and make you think she's trying to be funny, which Dr. Johnson thought she was.

Dr. Johnson said the Appellant came in to the interview, said she was bored, and wanted to know when she could leave. Dr. Johnson said the Appellant doesn't know how to respond to people but she can be perceptive. She couldn't tolerate being in the meeting so they had to let her leave. She was doing her rhythmical stereotypy playing with a cord the entire time. She talked about being in the Wizard of Oz as the star. They tried to get her to sing, which she did, and then she left. After the meeting ended and they went to get her, she was spinning in a chair. Dr. Johnson said the Appellant is likeable but just doesn't edit what she says. In terms of her intellectual abilities, he said the Appellant could reasonably be considered to have an IQ of 80, which seemed more consistent with her knowledge base than the IQ score of 56. Therefore, on the basis of the initial determination and also meeting her, Dr. Johnson said he had to find her not eligible for Department services. He said his decision was based on both IQ and adaptive behaviors, although the intelligence component was most compelling, and that with respect to adaptive behaviors the Appellant is a person who can't function on her own and needs a lot of supervision, patience, and energy.

Dr. Johnson said in his opinion a person cannot score better than they are intellectually able to score. He said the Appellant presented like someone who could get an IQ score of 80. There was variability in her performance, which is not typical of someone with mental retardation. Dr. Johnson said the Appellant has been diagnosed with ADD and some people have suggested she has an anxiety disorder. Therefore, he said it's not surprising that she would have some inconsistency in her scores. What was surprising, he said, is the fact that the Appellant did so much better on the more recent test than she did on the earlier one. Dr. Johnson did not have a lot of information about why this would be, but he guessed that it might have been due to medication she started taking that helped her calm down, living at [redacted] and being out of the home, and/or having consistent staff around her. Dr. Johnson couldn't say with any certainly what made the difference for her.

Dr. Johnson testified that the Appellant has tremendous variability in her cognitive intelligence. He said she can learn quickly or she could miss out on things. Her attention span is very limited so she can only focus long enough to do tasks or to express her intelligence, but it's on the fly. So it would take a lot of structuring and focusing for her to demonstrate how intelligent she is.

Dr. Johnson reviewed Exhibit 13, which he did not have during initial eligibility determination. He said the evaluation was helpful in providing background information describing how the Appellant does at school and home and some of the behaviors that were difficult to manage and the efforts to help her when she was at [redacted]. The examiners gave the Appellant a Woodcock-Johnson Scales of Independent Behavior-Revised (SIB-R) and a few other assessments although there were no intelligence tests done with this evaluation.

Dr. Johnson next reviewed Exhibit 14, which he did not think he had before making his initial determination. The Appellant was age 11[redacted] years old at the time. She was given a battery of assessments. Dr. Johnson reviewed the sections on Relevant History and Behavioral Observations (see detailed description of these sections in the report on Exhibit 14, above). Dr. Johnson noted that the Appellant was reported to have demonstrated abrupt shifts in affect. Also, her attention was variable, so the Appellant had many distractions. Under these circumstances, Dr. Johnson said the Appellant wasn't able to do her best on testing. Her IQ scores were Verbal 90 and Performance 53. Dr. Johnson said that given this significant split in scores, as the examiners noted, a full scale would not be representative of the Appellant's skills and so was not reported.

Given the Appellant's state as described by the examiner, Dr. Johnson did not find it surprising that the Appellant would have difficulties in areas that required attention and focusing. He said she did very well in the Verbal areas of Information, Similarities and Vocabulary in which her scores were 14, 11, and 10, respectively. Those were her best areas. But he said the Appellant did very poorly in Mathematics, which has been an ongoing issue for her as she has significant deficits in Math.

Dr. Johnson noted that on achievement tests the Appellant did much better in verbal and reading scores while she and does very poorly in math, showing a consistent pattern with her IQ testing. Dr. Johnson said the Comprehension test, on which the Appellant only scored a 3, is very sensitive to judgment and comprehension in social areas. She did very poorly on all of the performance subtests except Picture Completion on which she got a 6. The rest of the subtest scores were 1's and 2's. Dr. Johnson thought the reason for these scores was because the Appellant was unable to attend, and that there were a lot of reasons why she could not attend. He said the Appellant did better later on a subsequent test after having gone to a residential school, which was one of the recommendations by the examiner in this exhibit. Dr. Johnson said he did not have this exhibit when he made the eligibility determination, but that it did not change his mind regarding the Appellant's eligibility. It was useful, though, in explaining some of her background and the recommendations for residential placement.

Dr. Johnson testified that he had Exhibit 15 in some form when he made the initial eligibility determination.[6] He said the WISC-IV results were Full Scale IQ 56, Verbal Comprehension 77, Perceptual Reasoning (which is sensitive to attention and focusing) 49, Working Memory 83, and Processing Speed 50, which Dr. Johnson said was not surprising given the Appellant's attentional difficulties.

Dr. Johnson reported on the Appellant's adaptive behavior composites done when the Appellant was 15 years old and living at [redacted]. She was given an older Vineland Adaptive Behavior Scale, so the scores were given in age equivalents. Dr. Johnson reported the Appellant's age equivalents as Communication 6.4, Daily Living Skills 5.11, Socialization 4.1, and Adaptive Behavior Composite 5.5. Dr. Johnson said it was helpful to note that the Appellant was hasty in her approach to tasks, and that

[6] Initially, with only three pages available, this exhibit was incomplete in the Department's file. At the hearing the Appellant's father was able to supply the entire evaluation, which was entered into the record.

examiner recommended ongoing contact with psychiatric professionals since she was taking psychotropic medication.

Dr. Johnson testified that he had Exhibit 16 when he made his initial eligibility determination. He said the evaluation included an academic assessment, occupational therapy assessment, and psychological assessment. On achievement testing Dr. Johnson said that the Appellant demonstrated age appropriate capacity in reading and spelling, but not in mathematics.

Psychological testing was administered in [redacted] 2007. Dr. Johnson said the psychologist had to set limits to get compliance from the Appellant. During testing she gave up if items were too hard and she was hesitant to make guesses, instead just saying, "I don't know."

Dr. Johnson reviewed the Appellant's test scores on the WAIS, which were Verbal IQ 89, Performance IQ 74, and Full Scale IQ 80. Dr. Johnson noted that the subtest scores showed some consistency with the Appellant's previous testing in that she did well on Vocabulary, Similarities, and Information. She also did well on Digit Span as she had in the past. Again the Appellant's arithmetic and comprehension scores were very low (3 and 4). On the Performance section, Picture Arrangement was especially high (10) and overall the scores were higher than prior testing. The Appellant had two 4s, a 6, a 10, and a pro-rated 5 on the Performance scales.

Dr. Johnson explained the pro-rated score of 5 on Coding. He said the Appellant stopped working on a Coding task after about a minute saying it was boring. Dr. Johnson said the Coding task is relatively simple. A person is more likely to lose points if she does the task slowly, but it's a task most everyone can do so it's just a matter of how many tasks a person can do in the allotted time. Since the Appellant just wouldn't comply, the test was thrown out. However, for the examiner to compute the performance and full scale IQs, she needed five subtest scores. Therefore, she pro-rated the score, which was based on the other Performance subtest scores.

Dr. Johnson recognized that the Appellant got a 1 in Coding on an earlier test. Asked by this Hearing Officer what the Appellant's performance score would have been had she been assigned a "1" instead of "5," he said he would have to do the math. The Appellant's attorney argued that if there was a large enough gap between the verbal and performance scores, it would not be possible to get a representative full scale score, and without a representative full scale score the only remaining full scale score in the record was 56. Dr. Johnson responded that the Appellant did better on the WAIS as a whole than on prior testing, irrespective of the Coding score and the full scale IQ score, which took her out of the mentally deficient range. Ultimately the parties agreed to keep the record open for Dr. Johnson to recalculate the scores substituting a score of "1" in Coding.[7]

Dr. Johnson said that in his opinion, the Appellant did not meet the cognitive prong of the Department's eligibility criteria because her intellectual abilities were not two standard deviations below the mean. He said this was evident when the Appellant was at [redacted] and able to focus better and under treatment.

Dr. Johnson reviewed the Vineland-II in this exhibit in which the Appellant's scores were Communication 80, Daily Living Skills 94, and Socialization 85. He said these scores were not in the

[7] Dr. Johnson did this recalculation and submitted it. See, Exhibit 19. He indicated that the prorating method used by Dr. [redacted] is not a standardized procedure and differed from the instructions given in the WAIS-III Manual. Dr. Johnson recalculated the scores two separate ways, first as indicated by the WAIS-III manual, which yielded IQ scores of Verbal 89, Performance 75, and Full Scale 86. He also recalculated scores based on using a "1" on Coding, which yielded IQ scores of Verbal 89, Performance 69, and Full Scale 78.

average range, but they exceeded the Department's eligibility range for adaptive behaviors. Dr. Johnson noted that the Appellant's teacher said over the prior two years that the Appellant had become more engaged and increased her attention span.

Dr. Johnson next reviewed the ABAS-II (Exh 18). He said the Appellant did not meet the Department's criteria based on her scores, which he said appeared to be consistent with the Vineland assessment (Exh 16). Dr. Johnson said the Appellant's score of 77 on Practical would be 1.5 standard deviations below the mean, but the Appellant would need at least two out of the three skill areas to be in that range to meet the adaptive functioning requirements and in this case only had the one.

On cross-examination the Appellant's attorney argued that the ABAS is subjective, and in this case the person who did the rating did not know the Appellant well. Dr. Johnson first clarified how the ABAS is scored. Then he reiterated that he, too, believed that the Appellant was unable to function on her own. He said the test questions on the ABAS refer to specific areas that were not particular to the Appellant's idiosyncrasies. This Hearing Officer asked Dr. Johnson whether the results under health and safety were representative of the Appellant. He said no, but also said that question was different than the question of whether the ABAS questions were answered appropriately. He said the ABAS is a sample of behavior. The Appellant has idiosyncratic things that make her unsafe. Dr. Johnson said if he is asked whether he thinks the ABAS reflects best how the Appellant functions, the answer would be no. But that doesn't mean the test is wrong, it means the test is not capable of assessing the idiosyncratic areas where the Appellant is not safe.

This Hearing Officer also asked Dr. Johnson whether he thinks the Appellant has significant adaptive limitations apart from the ABAS and he answered in the affirmative. When asked whether she has significant adaptive limitations within the meaning of the Department regulations, Dr. Johnson said that answer was a little more difficult because adaptive behavior is supposed to be tied to intellectual capacity, not to emotional components. But without regard to the relationship between cognitive and adaptive functioning, Dr. Johnson said the Appellant did have significant limitations in adaptive functioning.

The parties made closing statements and, as noted above, the Department's attorney submitted a Closing Argument and Brief.

## FINDINGS AND CONCLUSIONS

### The Law

M.G.L c. 123B §1 defines a mentally retarded person as follows:

[A] person who, as a result of inadequately developed or impaired intelligence, as determined by clinical authorities as described in the regulations of the department is substantially limited in his ability to learn or adapt, as judged by established standards available for the evaluation of a person's ability to function in the community.

A mentally retarded person may be considered mentally ill provided that no mentally retarded person shall be considered mentally ill solely by virtue of his mental retardation.

115 CMR 6.04 sets forth the general eligibility requirements for DDS services. In relevant part these provide:

(1) Persons who are 18 years of age or older are eligible for supports provided, purchased, or arranged by the Department if the person:
(a) is domiciled in the Commonwealth; and
(b) is a person with mental retardation as defined in 115 CMR 2.01. . . .

115 CMR 2.01 provides the following definitions:

Mental Retardation

Mental Retardation means significantly sub-average intellectual functioning existing concurrently and related to significant limitations in adaptive functioning. Mental retardation manifests before age 18. A person with mental retardation may be considered to be mentally ill as defined in 104 CMR (Department of Mental Health), provided that no person with mental retardation shall be considered to be mentally ill solely by reason of his or her mental retardation.

Significantly Sub-average Intellectual Functioning

Significantly Sub-average Intellectual Functioning means an intelligence test score that is indicated by a score of 70 or below as determined from the findings of assessment using valid and comprehensive, individual measures of intelligence that are administered in standardized formats and interpreted by qualified practitioners.

Significant Limitations in Adaptive Functioning

An overall composite adaptive functioning limitation that is two standard deviations below the mean or adaptive functioning limitations in two out of three domains at 1.5 standard deviations below the mean of the appropriate norming sample determined from the findings of assessment using a comprehensive, standardized measure of adaptive behavior, interpreted by a qualified practitioner. The domains of adaptive functioning that are assessed shall be:
(a) areas of independent living/practical skills;
(b) cognitive, communication and academic/conceptual skills; and
(c) social competence/social skills.

115 CMR 6.34 sets the standard and burden of proof. In relevant part these provide:

(1) - Standard of Proof. The standard of proof on all issues shall be a preponderance of the evidence.
(2) - Burden of Proof. The burden of proof shall be on the appellant . . . .

**Findings of Fact and Conclusions of Law**

The issue in this case is whether the Appellant meets the Department's definition of mental retardation. She applied for DDS services on [redacted]/07. Born [redacted]/88, the Appellant is 21 years old. She meets the domicile requirement of the Department. For the reasons set forth below, I find that the Appellant does not meet the Department's definition of mental retardation.

The Appellant has had significant medical problems from the time she was born. Brain stem deficits became evident shortly after birth, and she was unable to suck or swallow. She spent the first month of her life in the neonatal intensive care unit at [redacted] Hospital and was in and out of hospitals for the first three years of her life. In that time efforts were devoted to keeping her nourished and protecting her airways. She was diagnosed with Moebius-like Syndrome with deficits in cranial nerves IX, X, and XI. Throughout her life the Appellant has endured several significant surgeries, the most recent of which caused her severe anxiety and, as a result, some regression in the progress she had made at [redacted].

From birth, delays were evident. As she aged, the Appellant also had delays in walking and balancing, and was slow with gross and fine motor controls. She endured physical therapy and occupational therapy from a young age. To this day the Appellant's gross and fine motor controls are slow, she cannot run, and her balance is off.

The Appellant's history is notable for severe anxiety, defiant behaviors, atypical social skills, hyperactivity/impulsivity, self-stimulatory behaviors, stereotypical motor movements and unusual interests. She has been diagnosed with Anxiety disorders, Obsessive compulsive disorder, Pervasive developmental disorder, NOS, ADHD, and other disruptive behavioral disorders. It is an understatement to say the Appellant has had a complex medical and behavioral history.

Until 2002, the Appellant lived at home with her mother and attended school through the [redacted] school system. Because this schooling did not meet the Appellant's needs, she moved into a residential placement at [redacted] in July 2002. The school provides consistent structure and supervision, and after an initial adjustment the Appellant improved both academically and to some extent behaviorally, although she continued to display significant behavioral problems. Exhibit 17, a letter from [redacted], MD, consultant Psychiatrist to [redacted], amply describes the continued behavioral issues faced by the Appellant. The Appellant will be turning 22 in [redacted] 2010.

**Adaptive Functioning**

With respect to adaptive functioning, there can be no dispute that the Appellant has significant issues. As early as 10 years old, records document the Appellant's pattern of maladaptive behavior at home with unsafe behavior as the primary concern (Exh 13). On the Problems Behavior Scale of the Woodcock-Johnson Scales of Independent Behavior-Revised (SIB-R), problem behaviors reported by the Appellant's mother at that time included hair pulling, tearing/scratching property, clinging, pestering, teasing, crying/laughing without reason, talking to self, making odd faces or noises, talking too loudly, standing too close, expressing unusual fears, showing little interest in activities, refusing to obey, do chores, follow rules, attend school, and defiance.

About six months later, when the Appellant was 11 years [redacted] old, the Appellant's adaptive skills and socialization skills were determined to be profoundly limited (Exh 14). The Appellant could not independently dress herself, eat meals, or attend to toileting. Socialization was significantly limited. She had no friends. She spent most of her time playing by herself, spinning a piece of rope, and replaying scenes from the Wizard of Oz, with which she was obsessed. In a psychological evaluation done when the Appellant was 15 years [redacted], the examiner indicated that the Appellant was a girl with a significant degree of behavioral disinhibition and had a unique interactive pattern. She appeared to be absorbed within her own fantasy interests (Exh15). Finally, [redacted], M.D., described continued behavioral issues when the Appellant was 21 years old (Exh 17). The Appellant could still live in an imaginary world for hours to days at a time, and did this at the expense of essential

activities in her life. She continued to have several prominent stereotypical movements of her face and neck. She continued to spin – at one point for more than a half hour. At the time she was experiencing heightened anxiety after a recent hospitalization and began swallowing large inedible items. From that point on the Appellant has been maintained on a one-to-one supervision.

The Appellant's father credibly testified to the Appellant's many behavioral and adaptive limitations. He described her lack of awareness regarding safety, her inappropriate behavior with strangers, and the fact that she lives in a fantasy world and has no peer relationships. Finally, the Department's psychologist also testified that apart from the ABAS, the Appellant had significant adaptive limitations. He also conceded that if adaptive behaviors were separated out from cognitive behaviors, the Appellant did have significant limitations in adaptive functioning.

Results of the adaptive functioning assessments (Exhs 15 and 16) and the ABAS (Exh 18) were as follows:

| Test/Age/Exh# Composite | Communication | Daily Living | Socialization | Adaptive Beh |
|---|---|---|---|---|
| 1. VABS (15[redacted]) #15 - School | 6.4 (AE) | 5.11 | 4.1 | 5.5 |
| - Residential | 8.7 | 6.11 | 3.8 | 6.5 |
| 2. Vineland II (18[redacted]) #16 | 80 | 94 | 85 | |
| | Conceptual | Practical | Social | GAC |
| 3. ABAS II (19[redacted]) #18 | 83 | 77 | 89 | 74 |

On the one hand, looking at the Department's definition of significant limitations of adaptive functioning, one cannot dispute that the Appellant's scores exceed the Department's standards. The only domain score at or less than 1.5 standard deviations below the mean of the appropriate norming samples is the Practical score on the ABAS. Thus, where Department regulations require two of three domains to meet that standard, the Appellant only meets it in one domain.

On the other hand, one also cannot dispute that the Appellant absolutely has significant limitations of adaptive functioning. The Department's psychologist, in his candid assessment, noted that he had never met anyone like the Appellant, and that apart from other considerations such as cognitive functioning, the Appellant clearly had significant limitations in adaptive functioning.

Based on the numerous exhibits documenting the unusual and extreme behavior exhibited by the Appellant, along with the many assessments that she lives in her own world, fantasizes, has extensive disruptive, stereotypical, and defiant behaviors, and has no friends and deficient socialization skills, coupled most notably with the honest and credible testimony of the Department's psychologist, there is no doubt in this Hearing Officer's mind that the Appellant has significant limitations in adaptive functioning and is functionally unable to manage on her own. The Appellant's situation is the very rare one where standardized tests cannot appropriately measure what is an extremely unusual set of behaviors, and consequently the constraints of the Department's standards are unable to capture the true limitations of this individual. Given the severity of the Appellant's maladaptive behaviors, I cannot find that she is not seriously limited, and accordingly I find that she has significant limitations in adaptive functioning.

Given these limitations, the next question is whether they are related to and exist concurrently with significant sub-average intellectual functioning. This question has two components, the first of which

is whether the Appellant has significant sub-average intellectual functioning. If so, the examination then turns to whether her intellectual and adaptive functioning are related.

**Cognitive Functioning**

The records in this case consistently show a significant split between the Appellant's verbal and performance abilities. Over time the Appellant's scores improved, yet a split between these scores continued to be present. There are three complete cognitive tests in the record.[8] The first was given to the Appellant when she was 11 years [redacted] old. During testing the Appellant displayed many distracting and impulsive behaviors (see description of these behaviors under Exhibit 14). Thus the Appellant's performance was variable due to fatigue, a high degree of distractibility, inconsistent motivation and labile affect.

The second test was administered when the Appellant was 15[redacted] and had already been living at [redacted] for nearly two years. Despite the Appellant's distraction to the task at hand, overall the examiner believed the test results were a reasonable reflection of the Appellant's general functioning at the time because she saw testing through to completion.

The last test, administered when the Appellant was 18[redacted] years old, was given slightly beyond the end of the developmental era. By that time the Appellant had been living at [redacted] for nearly five years and had benefitted from the structured routine and consistent discipline, as well as treatment she received, at the school. Her test scores were much higher than in prior testing, which the examiner attributed to the benefits of residing at [redacted].

| Year/age | Test | Exh# | V | P | FSIQ | VCI | PRI | WMI | PSI |
|---|---|---|---|---|---|---|---|---|---|
| 1. 1999 (11.4) | WISC-III | 14 | 90 | 53 | N/A (given split between V/P scores, FS not given) | | | | |
| 2. 2004 (15.8) | WISC-IV | 15 | | | 56 | 77 | 49 | 83 | 50 |
| 3. 2007 (18.8) | WAIS-III | 16 | 89 | 74 | 80 | | | | |
| 3. Same test but recalculated | | | | | | | | | |
| a. with "1" in Coding | | | 89 | 69 | 78 | | | | |
| b. by WAIS manual | | | 89 | 75 | 86[9] | | | | |

Throughout these tests, the Appellant did significantly better on verbal than performance scores. The disparity was so great that in the first testing from 1999 no full scale score was given inasmuch as it would not have been representative of the Appellant's abilities. The pattern of a split between verbal and performance scores continued throughout all of the Appellant's testing (which includes achievement testing). Even as the Appellant scored higher on the 2007 testing, the split between these scores remained.

Dr. Johnson's expert opinion was that the Appellant did not meet the cognitive prong of the Department's eligibility criteria because her 2007 test scores were not two standard deviations below

[8] I also note that in 1996 the Appellant had a prorated verbal IQ score of 104 on selected subtests of the WISC-III, and an overall performance significantly stronger for verbal tasks than visual tasks (Exh 14). In 1998, on the Verbal scales of the WISC-III, the Appellant obtained a score of 98, which was in the average range (Exh 13).

[9] I reject this Full Scale score without more explanation from the Department psychologist as to how it would be possible for the Performance score to increase by just one point (from 74 to 75) but the Full Scale score to increase from 80 to 86, 80 being the full scale score reached when Coding was pro-rated as a 5.

the mean. He attributed the better performance to the fact that the Appellant had calmed down and was being treated, and thus was able to focus better on testing.

The Appellant's attorney, however, argued that the full scale score from the 2007 WAIS-III is not usable because 1) pro-rating on Coding was improper and having done so skewed the full scale score; or 2) if the Coding was scored as a "1", the split between the verbal and performance scores would be so great that providing a full scale IQ is improvident and not representative of the Appellant's abilities. As a result, the only remaining usable full scale IQ score was the score of 56 from the 2004 testing, and that score meets the Department's regulations. For the reasons stated below, I do not give this argument credit.

As Dr. Johnson correctly noted, the Appellant's scores on the WISC-IV, as well as those on the WISC-III, were affected by the Appellant's significant behavioral issues present during testing. When the Appellant was at [redacted], her behavior was somewhat more under control, she was calmer, she was better able to focus, and she had improved attention. With these improvements her behavioral issues during testing did not disappear, but they were not as prevalent, and her test scores were much higher. Thus, as Dr. Johnson opined, test scores from earlier testing were lower because of the Appellant's behavioral problems apparent during testing. But as Dr. Johnson also noted, even the earliest testing yielded subtest scores of 14, 11, and 10 in Information, Similarities, and Vocabulary, which were in the average to above average range. Dr. Johnson said Vocabulary is considered by many clinicians to be best predictor of general intelligence, and someone who scores in the average range on Vocabulary would not be considered mentally retarded. These scores provide indications from an early age that the Appellant was not mentally retarded.

With respect to the most recent testing, I cannot agree with the Appellant's attorney that the full scale score must be discarded. The recalculation of the full scale score after adjusting for the change in Coding does not result in an unusable score. Whichever method of scoring Coding is used, they all result in a full scale score that exceeds 70. I agree that there is a reasonable dispute over which of the three possible full scores are correct, but what becomes clear is that whichever score is correct, it exceeds the Department's eligibility standard.

Based on Dr. Johnson's expert testimony, I find the Appellant does not have sub-average intellectual functioning. As noted by Ms. [redacted], the Appellant's profile was consistent with right hemisphere dysfunction or, as Dr. [redacted] put it, over-reliance or dependency on the left hemisphere (Exhs 14, 15). Dr. Johnson discussed this phenomenon as a learning disability and brain damage. But as Dr. Johnson noted, one cannot perform better than her capabilities allow. The fact that the Appellant was able to obtain a full scale score above 70 on the WAIS-III and a score of significantly above 70 on verbal tests indicates that she is not mentally retarded. While it is abundantly clear that the Appellant has significant deficits and as Dr. Johnson said there is no question that she could benefit from Department services, the Appellant does not meet the Department's specific eligibility requirements given her test results.

Because of the Appellant's significant adaptive limitations, she will likely need supports throughout her life to keep her safe and out of danger. The question that I must focus on for purposes of this decision, though, is whether these adaptive limitations are related to and exist concurrently with significant sub-average intellectual functioning. Since I have determined that the Appellant's 2007 full scale score is both viable and above the Department's eligibility level, and I have also determined that her verbal test scores also significantly exceed the Department's threshold score of 70, I cannot find that the Appellant has shown that she has sub-average intellectual functioning or that her adaptive limitations are related to and exist concurrently with sub-average intellectual functioning.

## CONCLUSION

Based on my determination that the Appellant has not shown that he has sub-average intellectual functioning, she has not been able to show by a preponderance of the evidence that she meets the Department's definition of mental retardation. Therefore, I conclude she is not eligible for DDS services.

## APPEAL RIGHTS

Any person aggrieved by a final decision of the Department may appeal to the Superior Court in accordance with M.G.L c. 30A and 115 CMR 6.34(5).

Date: _____

_____
Elizabeth A. Silver
Hearing Officer