2010-38

The Commonwealth of Massachusetts

Executive Office of Health & Human Services
Department of Developmental Services
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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 son'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 son'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: Jeanne Adamo, Hearing Officer
Richard O'Meara, Regional Director
Marianne Meacham, General Counsel
Elizabeth Duffy, Assistant General Counsel
Elizabeth Moran Liuzzo, Regional Eligibility Manager
Fred Johnson, Psychologist
File

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF DEVELOPMENTAL SERVICES

In Re: Appeal of [redacted]

This decision is issued pursuant to the regulations of the Department of Developmental Services 115 CMR 6.30 – 6.34 (formerly known as Department of Mental Retardation, hereinafter referred to as "DDS" or "Department") and M.G.L. C.30A. A fair hearing was held on [redacted] 2010 at the [redacted] Office in [redacted], Massachusetts.

Those present at the hearing were:

[redacted]	Mother of the Appellant
Elizabeth Duffy, Esq.	Counsel for DDS
Frederick V. Johnson Psy. D.	Licensed Psychologist

The Fair Hearing proceeded under the informal rules concerning evidence with approximately four and one-half hours of testimony presented. The Appellant's evidence consists of two exhibits entered into evidence and sworn oral testimony from the Appellant's mother, Ms. [redacted]. The evidence presented on behalf of the Department consists of thirty-six exhibits entered into evidence and sworn oral testimony from the Department's Licensed Psychologist, Dr. Frederick Johnson. The Hearing Officer submitted three documents for the record.

The Appellant's application for DDS services was submitted on [redacted] 2007. The Department denied that request for services on [redacted] 2007 based on insufficient information. The Appellant, with the help of his father but without the involvement of his mother, appealed the denial of services and an Informal Conference was held [redacted] 2008 at which time the Appellant and his father were given a list of what was needed to complete the application for DDS services. The Department did not receive the requested information and no further action was initiated on behalf of the Appellant at that time. However, due to the subsequent involvement and advocacy of his mother, the Appellant's application was re-opened, and a second Informal Conference was held with the Appellant and Ms. [redacted] on [redacted] 2010. The Appellant's ineligibility ruling was reviewed and upheld at the close of the second Informal Conference. The Appellant and his mother appealed that decision, requesting a Fair Hearing, which was held on [redacted] 2010; the Appellant was not present. The Appellant's mother served as her son's authorized representative at the [redacted] 2010 Fair Hearing.

ISSUE PRESENTED:

Whether the Appellant is eligible for DDS services in accordance with 115 CMR 6.04, by reason of Intellectual Disability as defined in 115 CMR 2.01.

BACKGROUND:

The Appellant, Mr. [redacted], is a twenty-three year old man who lives with [redacted]. The Appellant is not under legal guardianship; his parents are currently considering the possibility and advisability of guardianship.

The Appellant was anoxic at birth which resulted in a longer than average stay in the hospital. He showed signs of behavioral difficulties since infancy with excessive irritability and temper tantrums. As a young child, he reportedly exhibited extreme behaviors during tantrum episodes and was sometimes out of control to the point of being dangerous. The Appellant was diagnosed with Attention Deficit Disorder at approximately two years of age. He was treated pharmacologically beginning at age two and, over the course of his developmental years, with trials of multiple medications in an attempt to control his behaviors; the medications administered include: Ritalin, Norpramine, Desipramine, Lithium and Clonodine. The Appellant has a recent history of psychiatric hospitalizations and has received a psychiatric diagnosis of Bipolar disorder, mixed, severe, with psychotic behavior and Schizoaffective Disorder, bipolar type. He has been prescribed numerous psychotropic medications to treat his disorder including: Trazadone, Venlafaxine, Depakote, Respiradol, Lithium, and Benztropine.

The Appellant has required an Individual Education Plan (IEP) since first placed in a specialized early intervention program as a toddler and continued with an IEP throughout all of his education. At age nine he was sent to [redacted] with behavioral and emotional issues. He received a high school diploma at age eighteen when, after several failed attempts, he finally passed the MCAS, which was administered with accommodations. The Appellant opted to graduate from high school at age eighteen even though he was eligible to remain in a SPED school program until age twenty-two because he expected to obtain paid employment and was eager to start working and to earn money. However, he has not been able to hold down a job and now reportedly spends most of his time in his room or on the computer where he converses with people he does not know. In [redacted] 2009, without informing his family, he took a bus to [redacted].

The Appellant currently is not receiving services from any state agency. The Appellant's parents feel that they can no longer manage their son at home and worry about their son's welfare and safety. His mother is seeking services from both the Department of Mental Health and the Department of Developmental Services; she has stated that she would like to see a combination of services from both agencies so that her son could receive the structured environment that he needs for quality of life.

SUMMARY OF THE EVIDENCE PRESENTED:

EXHIBITS:
The following exhibits were accepted into evidence:

Appellant Exhibit #1

A copy of an unsigned Joint Petition For Divorce and proposed Decree Of Divorce, sent to the Appellant from [redacted], Esq., attorney for the Appellant's wife, who is petitioning for divorce.

Appellant Exhibit #2

A four page email dated [redacted] 2009, sent from [redacted], the Appellant's mother, to Gretchen Mirarchi, State House Aide to Massachusetts State Representative, Garret Bradley.

DDS Exhibit #1

DDS's Fair Hearing Scheduling Notice, dated [redacted] 2010, sent by Elisabete C. Wolfgang, Hearing Administrator, to the Appellant and the Appellant's mother.

DDS Exhibit #2

Letter to the Appellant, dated [redacted] 2010, from Beth Moran Liuzzo, Regional Eligibility Team Manager, notifying the Appellant of the results of the Informal Conference held on [redacted] 2010.

DDS Exhibit #3

Letter to the Appellant, dated [redacted] 2010, from Laurie Costa, Regional Eligibility Coordinator, confirming the date, time and location of the Appellant's scheduled Informal Conference meeting.

DDS Exhibit #4

Letter to Mr. Richard O'Meara, [redacted] Regional Director, from Attorney [redacted], dated [redacted] 2010, requesting an appeal of the Department's ineligibility determination for the Appellant.

DDS Exhibit #5

Department's Eligibility Determination Notification, denying eligibility to the Appellant, signed by Beth Moran Liuzzo, dated [redacted] 2010.

DDS Exhibit #6

Undated document regarding Appellant's [redacted] 2008 Informal Hearing titled "Information on Informal Hearing", signed by Dr. Frederick V. Johnson.

DDS Exhibit #7a through #7e

The following documents relating to the initial appeal and the first Informal Conference:

DDS Exhibit #7a

Letter, dated [redacted] 2007, notifying the Appellant that he had been determined ineligible for DDS adult services, signed by Beth Moran Liuzzo, Regional Eligibility Manager.

DDS Exhibit #7b

Letter to Mr. Richard O'Meara, [redacted] Regional Director, from the Appellant's father, Mr. [redacted], dated [redacted] 2007, requesting an appeal of the Department's ineligibility determination for the Appellant.

DDS Exhibit #7c

Letter to the Appellant's father, dated [redacted] 2008, from Jean Martin, Intake and Eligibility Coordinator, confirming the date, time and location of the Appellant's scheduled Informal Conference meeting.

DDS Exhibit #7d

Copy of the [redacted] 2008 Informal Conference Attendance Sheet, signed by the Appellant, the Appellant's father, the Regional Eligibility Manager and the DDS Psychologist in attendance.

DDS Exhibit #7e

Letter, dated [redacted] 2008, from Beth Moran Liuzzo, Regional Eligibility Team Manager, to the Appellant's father, notifying him of the results of the Informal Conference held on [redacted] 2008.

DDS Exhibit #8

Eligibility Report, dated [redacted] 2010, signed by Dr. Frederick V. Johnson, finding that the Appellant did not meet DDS eligibility requirements.

DDS Exhibit #9a- 9c

The following documents relating to the Appellant's application for DDS services:

DDS Exhibit #9a

Copy of the Adult Intake Form dated [redacted] 2007.

DDS Exhibit #9b

Request to supplement the intake application file, dated [redacted] 2007.

DDS Exhibit #9c

Application for Eligibility, dated [redacted] 2007.

DDS Exhibit #10

An unsigned, undated document titled "[redacted] Chronology".

DDS Exhibit #11a-b

The following documents relating to the Appellant's application for SSI:

DDS Exhibit #11a

A Consultative Exam report written on the letterhead of Psychologist, [redacted], Ed. D., with [redacted] noted as the "Examiner", dated [redacted] 2009, reportedly requested by the Disability Determination Services to evaluate the Appellant's eligibility for SSI benefits at the Appellant's age of twenty-two years [redacted].

DDS Exhibit #11b

WAIS-III Interpretive Report for the WAIS-III administered to the Appellant on [redacted] 2009, at the Appellant's age of twenty-two years [redacted], and electronically signed by Psychologist, [redacted] Ed. D., certifying that he personally conducted, or personally participated in conducting, the consultative examination.

DDS Exhibit #12

Discharge Summary of the Appellant's psychiatric admission to [redacted] on [redacted] 2008.

DDS Exhibit #13

A Neuropsychological Evaluation conducted in [redacted] 2007 at the Appellant's age of twenty years, with the results of a Wechsler Adult Intelligence Scale-III, administered by [redacted], Ph.D.

DDS Exhibit #14

Psychiatric Discharge Summary of the Appellant's psychiatric hospitalization at [redacted] from [redacted] 2007 through [redacted] 2007.

DDS Exhibit #15

A neurological Follow-Up Report by Pediatric Neurologist, [redacted], M.D., regarding the Appellant's status, dated [redacted] 2005.

DDS Exhibit #16

Psychological Evaluation conducted on [redacted] 2004, at the Appellant's age of seventeen years [redacted], with the results of a Wechsler Abbreviated Scale of Intelligence (WASI) and selected subtests of the Wechsler Adult Intelligence Scale-III (WAIS-III) administered by Licensed Educational Psychologist, [redacted], CAGS, NCSP.

DDS Exhibit #17

Correspondence, dated [redacted] 2003, sent to the Appellant's pediatrician, Dr. [redacted], M.D., from [redacted], M.D., titled "Neurological Evaluation".

DDS Exhibit #18

Report of the Wechsler Individual Achievement Test (WIAT) conducted at the Appellant's age of fourteen years [redacted] by [redacted].

DDS Exhibit #19

Interpretive Report of WISC-III and WAIT Testing of the Appellant at age fourteen years, [redacted] by [redacted], School Psychologist and [redacted], dated [redacted] 2001.

DDS Exhibit #20

Copy of a Crisis Response Plan for the Appellant, dated [redacted] 1998.

DDS Exhibit #21

Correspondence, dated [redacted] 2001, sent to the Appellant's pediatrician, Dr. [redacted], M.D., from [redacted], M.D.

DDS Exhibit #22

A [redacted] 1998 Comprehensive Learning Disabilities Evaluation conducted on the Appellant at [redacted].

DDS Exhibit #23a

Occupational Therapy Evaluation of the Appellant, conducted as part of the three year evaluation process, in [redacted] 1996, at the Appellant's age of nine years [redacted], by Registered Occupational Therapist [redacted] OTR/L.

DDS Exhibit #23b

A Speech and Language re-evaluation conducted by Speech-Language Specialist [redacted], M.S., C.C.C. as part of an undated Educational Assessment of the Appellant.

DDS Exhibit #24

A copy of Dr. [redacted]'s initial Neuropsychological Consultation at the Appellant's age of three years, [redacted] with copies of twenty-eight Follow-Up reports summarizing the Appellant's neurological status up through the Appellant's age of eight years, [redacted] and a [redacted] 1991 progress report from [redacted]. Psy.D., [redacted].

DDS Exhibit #25

Educational Assessment of the Appellant, conducted on [redacted] 1993, at the Appellant's age of six years, [redacted] by [redacted].

DDS Exhibit #26

Neuropsychological Assessment administered on [redacted] 1993, at the Appellant's age of six years, [redacted] with the results of a Stanford-Binet Intelligence Scale, Fourth Edition conducted by [redacted] Ph.D.

DDS Exhibit #27

Physical Therapy 3-Year Re-Evaluation of the Appellant, conducted at [redacted], on [redacted] 1993, at the Appellant's age of six years, [redacted], by Registered Physical Therapist [redacted].

DDS Exhibit #28

Educational Assessment of the Appellant, conducted on [redacted] 1993, at the Appellant's age of six years, [redacted], by [redacted].

DDS Exhibit #29

Psychological Evaluation of the Appellant, conducted in [redacted] 1992 and in [redacted] and [redacted] 1993, at the Appellant's age of six years, by Psychologists [redacted], Ph.D. and [redacted], Ph.D., at the [redacted]

DDS Exhibit #30a-b

The following documents relating to cognitive testing of the Appellant by the [redacted]:

DDS Exhibit #30a

Cognitive testing of the Appellant, required by Chapter 766 regulations, conducted in [redacted] 1996, at the Appellant's age of nine years, [redacted] by Certified School Psychologist [redacted] of [redacted], using a Wechsler Intelligence Scale for Children- Third Edition (WISC-III)

DDS Exhibit #30b

Cognitive testing of the Appellant, conducted in [redacted] 1992, at the Appellant's age of five years, [redacted], by Guidance Counselor, [redacted], of the [redacted], using a Wechsler Preschool and Primary Scale of Intelligence- Revised (WPPSI-R)

DDS Exhibit #31a-b

The following documents from Dr. [redacted]:

DDS Exhibit #31a

Correspondence, dated [redacted] 1991, from [redacted], Psy.D., the Appellant's psychologist at the [redacted], regarding recommendations for the Appellant.

DDS Exhibit #31b

Correspondence, dated [redacted] 1991, sent to the Appellant's parents, from [redacted], Psy.D., the Appellant's psychologist at the [redacted].

DDS Exhibit #32 [1]

Psychological & Neuro/Developmental Assessment and Behavioral Evaluation Report of the Appellant, conducted in [redacted], [redacted] and [redacted] 1990, at the Appellant's age of three years, by Licensed Psychologist, [redacted], Ph. D.

DDS Exhibit #33

Curriculum Vita of Dr. Dr. Frederick Johnson Psy. D.

DDS Exhibit #34

Copy of a chart developed by DDS Attorney Elizabeth Duffy, listing the Appellant's history of cognitive test score results over the course of time, modified during the course of the Fair Hearing.

DDS Exhibit #35

Summary page of the Appellant's Adaptive Behavior Assessment System-II (ABAS-II) conducted on [redacted] 2007 with the Appellant's mother, [redacted] as the rater.

DDS Exhibit #36

An unsigned and undated report of an unnamed academic test, noting the Appellant's academic standing in the third grade.[2]

Hearing Officer Exhibit #1

Copy of 115 CMR 2.01 Definitions

Hearing Officer Exhibit #2

115 CMR 6.04 General Eligibility .

Hearing Officer Exhibit #3

Sign in sheet for the Appellant's [redacted] 2010 Fair Hearing.

FINDING OF FACTS:

The following facts, which are the basis for conclusions made in this case, emerged from a review of the documents entered into evidence and the testimony presented by witnesses.

1. The Appellant lives with his parents [redacted]. (Testimony, Ms. [redacted])

[1] Pages #5 and #6 are missing from this report.

[2] Exhibit #36 was not identified as an exhibit at the time of the Fair Hearing. It was located with Dr. Frederick Johnson's Curriculum Vita, at Exhibit #33, where it appears to have been inadvertently placed. The assignment of this document as Exhibit #36 was made by the Hearing Officer subsequent to the Fair Hearing.

2. The Appellant is not under legal guardianship, but the advisability of obtaining legal guardianship is currently being considered by his parents. (Testimony, Ms. [redacted])

3. The Appellant's mother is his rep-payee for Social Security benefits. (Testimony, Ms. [redacted])

4. The Appellant did not attend his [redacted] 2010 Fair Hearing. His mother testified under oath that she had received verbal authorization to represent her son at his [redacted] 2010 Fair Hearing. (Testimony, Ms. [redacted])

5. The Appellant experienced [redacted] and was placed in [redacted] for four days. (Testimony Ms. [redacted] & DDS Exhibit #10)

6. The Appellant exhibited digestive problems as a child and was hospitalized three times for this problem between seven months and twenty-four months of age. (DDS Exhibit # 32)

7. Functional difficulties associated with Attention Deficit Disorder were noted beginning in the Appellant's infancy including emotionality, sleep problems, over activity, and ritualistic behavior. (DDS Exhibit # 32)

8. The Appellant was diagnosed with Attention Deficit Disorder sometime prior to age three. (DDS Exhibit # 32)

9. The Appellant's behavioral difficulties have also been noted since infancy including difficulty being comforted or consoled, extreme irritability and impulsivity, and temper tantrums. The Appellant has exhibited dangerous and extreme behaviors during some of the tantrum episodes which resulted in damage to people or property. (DDS Exhibit # 32)

10. The Appellant was followed neurologically beginning at seventeen months of age, initially due to delayed motor and speech development, but by age three, behavioral problems became more of the focus. (DDS Exhibit # 32)

11. At age nineteen months, due to developmental delays and behavioral problems, the Appellant was referred by his pediatrician to attend individual sessions at the [redacted]. (DDS Exhibit # 32)

12. At age two years, the Appellant was placed on medication due to behavioral issues including uncontrollable episodes of tantrums, fits of crying and violent outburst. (DDS Exhibit #10 & Testimony, Ms. [redacted])

13. An occupational therapy evaluation conducted by [redacted] on [redacted] 1989 at the Appellant's age of two years, [redacted], reportedly found that the Appellant showed problems with sensory input in all modalities. For example, he was easily startled by unexpected sounds or bright lights, did not tolerate light touch, conversely was unaware of pain, and had difficulty modulating his responses to input, especially touch. This report also noted that the Appellant had trouble selectively attending to tasks at hand and was unable to screen out stimuli. (DDS Exhibit # 32)

14. A psychological evaluation reportedly conducted by [redacted], Ed. D., on [redacted] 1989, at the Appellant age of two years, [redacted], placed the Appellant developmentally about six months behind his peers. Dr. [redacted] emphasized that the most salient feature of the evaluation was that the testing situation required considerable external structure to offset attention problems. (DDS Exhibit #32)

15. At the Appellant's age of approximately three years old, a neurologist, Dr. [redacted], reportedly notes the following about the Appellant: "an emerging pattern of behavior disorder, with cognitive development being close to normal." At this time the Appellant reportedly had tantrums eight to ten times a day and his sleep was disturbed by his awakening and screaming three to four times a night. (DDS Exhibit # 32)

16. At the Appellant's age of three years, [redacted], Dr. [redacted] reports in the Background section of her evaluation that the Appellant is "intelligent" but having "trouble with attention and with being impulsive", "often nearly out of control to the point of being dangerous". (DDS Exhibit # 32)

17. Psychiatric evaluations reported to have been completed by [redacted], R.N. and Dr. [redacted], M.D., at the Appellant's approximate age of three years, reportedly reiterated that the Appellant was a youngster with serious difficulties which placed him at high risk for academic failure and continued behavioral difficulties because of his high level of distractibility and impulsive behaviors. (DDS Exhibit # 32)

18. An independent evaluation was conducted by [redacted], Ph. D., at the Appellants age of three years, [redacted], using the Stanford Binet Intelligence Scales, 4th Edition among other psychological testing instruments. (DDS Exhibit #32) The overall Composite Score of the Stanford Binet IQ test was 78, in the Borderline Range of Intelligence with a Verbal Reasoning score of 97, in the Average Range of Intelligence, an Abstract/Visual Reasoning score of 64, in the Deficient Range of Intelligence, a Quantitative Reasoning score of 88, in the Average Range of Intelligence, and a Short-Term Memory score of 78, in the Borderline Range of Intelligence. Dr. [redacted] stated the following in the report's Summary and Impressions section:

> "[redacted] is a 3[redacted] years old boy who shows near normal cognitive development, but who has shown a temperamental disorder since infancy and behavioral difficulties beginning in his second year of life through the present. [redacted] shows a serious behavioral disorder associated with a constitutionally immature or overly sensitive nervous system." (DDS Exhibit # 32)
>
> " In addition to behavioral deficits, [redacted] shows difficulties with fine motor dexterity, oromotor control and gross motor coordination. This cluster of symptoms is consistent with disordered functions associated with the frontal brain systems. These systems are responsible for the organization and fine-tuned regulation of cognition and behavior, as well as fine motor programming and planning". (DDS Exhibit # 32)

> "[redacted] behaviors take him out of the normal range of the "difficult" three year old. He shows opposite extremes of behavior, from being manageable to being dangerous." (DDS Exhibit # 32)

19. The Appellant entered an all day [redacted] with an Individualized Education Plan (IEP) at age four. (DDS Exhibit #10 & Testimony, Ms. [redacted])

20. The Appellant continued to require an Individualized Education Plan (IEP) throughout all of his education. (Testimony, Ms. [redacted])

21. Cognitive testing of the Appellant at age five years, [redacted] using the Wechsler Preschool and Primary Scale of Intelligence-Revised (WPPSI-R) resulted in a Full Scale IQ of 80 with a Performance IQ of 69 and a Verbal IQ of 94. [redacted], the guidance counselor reporting the results, stated that the Appellant's "high level of distractibility interfered with and compromised his ability to stick with each task presented". The report states as follows: "The obtained Full Scale IQ may not be reflective of [redacted] true learning potential. However, the profile is indicative of the presence of learning disabilities". (DDS Exhibit # 30b)

22. A Speech and Language re-evaluation conducted by [redacted], M.S.,C.C.C. at the Appellant's approximate age of five years noted that the Appellant was quite distractible with external stimuli both significant and slight. Ms. [redacted] also reported that the Appellant's "own inner thoughts also appeared to interfere with his attention, as he sometimes made comments that were unrelated or tangential to the questions that were presented". (DDS Exhibit # 23b)

23. The Appellant was referred for Psychological Evaluation at age six due to behaviors that had recently occurred of unprovoked biting and hitting of teachers and peers. (DDS Exhibit # 29) The Psychological Evaluation was conducted at the [redacted] using multiple testing instruments including a test of cognition with the Kaufman Assessment Battery for Children (K-ABC). The Appellant reportedly had recently been placed on Lithium which his mother felt made him "overtired" and "not attending well". The report regarding the results of the ABC states as follows :

> "Results must be interpreted with caution. [redacted] impulsivity, high activity level, and inconsistent cooperation render the findings only a baseline estimate of his intellectual potential. His performance on the ABC revealed a Mental Processing Composite score of 75 (±7). Analysis of individual subtest provides the most useful index of [redacted]'s learning style."

24. The Appellant received an Educational Assessment at age six years, [redacted] using the Detroit Tests of Learning Aptitude where he received Standard Scores ranging from 80 to 86, all in the below average range. The Reading Consultant who conducted the assessment stated that the Appellant appeared to lose attention and focus after ten minutes and needed to be redirected continuously after that time. (DDS Exhibit #28)

25. A physical therapy evaluation at the Appellant's age of six noted that the Appellant's attention span was limited, that he required frequent redirection, and that his behavior in therapy varied between cooperative to being non-compliant and exhibiting provocative behavior. (DDS Exhibit # 27)

26. A [redacted] 1993 report noted that the Appellant was followed by a pediatric neurologist who made a diagnosis of Attention Deficit Hyperactivity Disorder and possible mood disorder and treated the Appellant with medications for both disorders. (DDS Exhibit # 26)

27. Cognitive testing at the Appellant's age of six years, [redacted] using the Stanford-Binet Intelligence Scale, Fourth Edition was administered by [redacted], Ph.D. as part of a Neuropsychological Evaluation conducted at [redacted]. The Appellant's verbal intelligence was reported to fall in the solidly Average range of intelligence whereas his abstract/visual reasoning fell well below average in the Deficient range of intelligence. His overall test results revealed a severe perceptual, fine motor, and organizationally-based Learning Disability, but his overall intelligence was found to be in the Borderline range of intelligence. (DDS Exhibit #26)

28. An Educational Assessment, conducted on [redacted] 1993, at the Appellant's age of six years, [redacted] noted that the Appellant was easily distracted by visual and auditory stimuli in the environment. The results of this educational assessment demonstrated that the Appellant exhibited low average to below average academic skills in comparison to same age peers. (DDS Exhibit #25)

29. Neurological assessment reports by Dr. [redacted], Pediatric Neurologist, from the Appellant's age of three [redacted] up through age nine years [redacted] document the following medication history (DDS Exhbit#24):
    - At age seventeen months the Appellant was evaluated by a neurologist who found him to have Attention Deficit Hyperactive Disorder (ADHD), and the Appellant was given a trial of Ritalin which was discontinued in two weeks due to twitching, restless, and agitation.
    - In 1990, the Appellant was evaluated by a psychiatrist who referred him for a child psychiatric workup.
    - At age 3 [redacted] the Appellant's parents informed Dr. [redacted] that their son: hated to be cuddled, held or touched; that he cries constantly; that he did not relate to other kids normally; that he had some bizarre and destructive behaviors such as trying to break or destroy things; that his body shakes when he is over stimulated; that he has frequent outbursts of temper lasting a minute or two during which he seems to lose contract with his surroundings; that he has difficulty falling asleep; and that he wakes up frequently during the night .
    - Dr. [redacted] diagnosed the Appellant at age 3 [redacted] with Attention Deficit Hyperactive Disorder, Emotional Instability and questioned the possibility of Pervasive Developmental Disorder.

- The Appellant was started on a low dose of Ritalin at age 3 [redacted] as an anti-hyperkinetic drug to treat his severe, excessive motor hyperactivity. Ritalin was not effective. Another class of anti-hyperkinetic drug, Norpramine (Desipramine), was prescribed at a dose of 20mg per day with some improvement in overall behavior noted. The Appellant's dose of Norpramine was slowly increased to a dose of 40mg per day with good results in overall behavior.

- The Appellant's mother noted an increase in the Appellant's anxiety at age 4[redacted] years, reporting that he "twists his tongue, deviates his eyes and twists his fingers and hands when he is under stress". By age 4[redacted] years, the Appellant's behavior exacerbated with a return of hyperactivity and frequent temper tantrums. Desipramine was increased by 10mg to 50mg per day.

- At the Appellant's age of five years, Desipramine was at the level of 60mg per day without any significant change in behavior. The Appellant still had very frequent temper tantrums at inappropriate times and places. Dr. [redacted] noted that the Appellant has hyperactivity and a personality disorder, and suggested an evaluation by a Psychiatrist because the Appellant had a "definite psychiatric problem". Dr. [redacted] increased Desipramine to 70mg per day with a plan to obtain another psychiatric evaluation if the Appellant did not improve with this increased dose.

- At the Appellant's age of 5[redacted] years, Desipramine was increased to 75mg per day.

- At 5[redacted] years, the Appellant's behavior became acutely exacerbated when he did not receive his medication for four days.

- Dr. [redacted] reports at the Appellant's age of 5[redacted] years, that the Appellant had been screened by [redacted] for admission to kindergarten and that the Appellant received a full Scale IQ of 80 with a Verbal IQ of 94 and a Performance IQ of 69 on a WISC scale. Dr. [redacted] also reports that the Appellant will be seen by Dr. [redacted], a child psychiatrist at [redacted] and that the Appellant has been referred to a Behavioral Psychologist for further work. Dr. [redacted] states that it is unclear if the Appellant's current level of activity and behavior will enable him to attend and participate in the kindergarten program.

- The Appellant was taking 105mg of Desipramine at age 5[redacted] years, and despite this level of medication, the Appellant reportedly was "disrupting the family dynamics.....still extremely active, demanding and oppositional". The Appellant was receiving counseling once a week at [redacted], but his mother felt it was "going nowhere". Dr. [redacted] increased the Appellant's level of Desipramine to the maximum dose of 125mg per day stating that if the Appellant's behavior did not improve, an alternative treatment with Haldol would be considered.

- The Appellant 's behavior initially improved with the increase of Desipramine to 125mg. However, at the Appellant's age of 5[redacted] years, his mother started noting

an increase in his "bad days" reporting that he can be "very impulsive, almost uncontrollable" but in contrast can be "very quiet". He reportedly was "doing well at school", believed to be "at his grade level, though at the lower end". Dr. [redacted] noted that the Appellant had gained weight and that his dose was therefore not at the proper mg per kg level for him. Desipramine was increased to 150mg per day.

- The Appellant's behavior did not change with the increase of Desipramine to 150mg per day and a lab test taken several weeks later showed levels above the therapeutic range. Dr. [redacted] opined that the Desipramine's effect was now exhausted and that the Appellant needed to be placed on a different medication, either Lithium or Haldol: Dr. [redacted] recommended decreasing Desipramine to 125mg per day and starting Lithium 150mg per day.

- The Appellant was taking 125mg of Desipramine and 150mg of Lithium at age of 6 years without side effects but also without any benefit from the medication after one week on Lithium.

- The Appellant was removed from Lithium at age 6[redacted] years after the Lithium caused nausea, vomiting and diarrhea. As a result the Appellant could not tolerate any medication for one week; his behavior significantly escalated to the point that his mother was unable to handle him. Dr. [redacted] reports that the Appellant has a Conduct Disorder that is poorly responsive to medication. The Appellant was started again on 125mg per day of Desipramine to help control his behavior and was refered a psychiatric evaluation with Dr. [redacted].

- At the Appellant's age of 6[redacted] years, Dr. [redacted] reported a diagnosis of Attention Deficit Hyperactivity Disorder with Compulsive Disorder. The Appellant was now on Norpramine 125mg per day but still was very impulsive and still acted compulsively. Poor academic performance was now noted. The Appellant was place on a trial of Clonodine.

- At the Appellant's age of 6[redacted] years, Dr. [redacted] reports that the trial of Clonodine was not successful; Clonodine was discontinued due to an adverse reaction of extreme agitation and irritability. The Appellant was now on Norpramine 125mg per day which seemed to "control his behavior to a certain degree without side-effects".

- At the Appellant's age of 7[redacted] years, Dr. [redacted] reports that the Appellant is taking 150mg per day of Norpramine. The teacher at the Appellant's school is concerned that he is still very impulsive after lunchtime. Dr. [redacted] did not want to increase the Norpramine but recommended a trail of Ritalin 5mg a day at noon.

- At the Appellant's age of 7[redacted] years, Dr. [redacted] reports that the combination of Norpramine and Ritalin have been successful; the Appellant's teachers reported a substantial improvement in the Appellant's work after noon, but the effects reported wear off by 3:30 p.m. when he arrives home. Dr. [redacted] recommended another dose of Ritalin at 3:30.

- At the Appellant's age of 8 years, Dr. reports that the Appellant is in the third grade where he receives a modified program, with two hours of extra help in general academic subjects each day. The Appellant has been off medication for approximately one year; his behavior in school is fair but his impulsivity affects his social interactions and his family members. The Appellant's mother reports that he still has frequent temper tantrums. Dr. suggested a trial of Imipramine to treat the Appellant's impulsivity.

30. The Appellant was off all medications between the approximate ages of 8 to 10 years. During this time there was a significant escalation in impulsivity, inattention, disruptive behaviors, as well as significant impulsive outbursts.(DDS Exhibit #20)

31. Cognitive testing using the Wechsler Intelligence Scale for Children- Third Edition (WISC-III) was conducted by certified School Psychologist, , at the Appellant's age of nine years, . (DDS Exhibit # 30a) Ms. reported that the Appellant's attention and cooperation was variable and that he was highly distractible and very impulsive throughout the testing. A Full Scale IQ was not calculated by Ms. ; however, she offered her opinion as to the Appellant's cognition in the Summary and Recommendation section of the report where it states as follows:

> " It is the opinion of this examiner that it would be unfair to estimate 's learning potential by his overall performance on the WISC-III. Although at times gave an accurate representation of his abilities, other times his performance was not the result of his best efforts. Research indicates that the Vocabulary subtest of the WISC-III may be the best single indicator of one's overall learning potential. 's true ability may actually fall in the Low Average to Average range. What is evident, however, is that he is a significantly impaired boy who will continue to require substantial special education support and classroom curriculum modifications."

32. At age nine the Appellant's behaviors could no longer be managed at ; he was sent to the . The Appellant was in a self-contained classroom ; attendance at resulted in some improvement in the Appellant's behavior and learning. (DDS Exhibit #10 & Testimony, Ms.)

33. The Appellant received counseling at school and also through . Therapy occurred both as one-on-one counseling as well as social group counseling. (DDS Exhibit #10 & Testimony, Ms.)

34. The Appellant was evaluated by the at age 11 years. A neuropsychology evaluation was conducted using the Wechsler Intelligence Scale for Children-III with the scores of cognitive potential ranging from "Borderline on Verbal Testing to well below that level for non-verbal Performance items". A Full Scale Score was not calculated. The report states that these results "represent some erosion of skills from the previous school testing two years ago when the scores of Verbal testing were in the Low Average range". The report

states that the "most prominent feature of his performance is his behavior" which was described as "atypical", with his conversation having "an idiosyncratic quality that was internally driven and minimally responsive to external social cues". The report states that the Appellant's language "could be quite tangential and associative or perseverative and echolalic". The evaluation summary states that the Appellant has "a severe neurobehavioral disorder of unknown origin or kind" and that "he has a severe language disorder that affects his ability to communicate normally." (DDS Exhibit # 22)

35. The Appellant received services at [redacted] from the 5th to the 10th grade. The Appellant was transferred to [redacted] in the 11th grade at age fifteen so that he could graduate from an accredited high school program. The Appellant did graduate from the 12th grade with a diploma when, after several failed attempts, he successfully passed the MCAS, which had to be administered with accommodations. Although the Appellant was eligible for educational services at [redacted] up through age twenty-two, at the time, he and his parents thought it in his best interest to graduate at age eighteen. The plan was for the Appellant to earn a salary working in [redacted]. That did not work out, and other attempts at paid employment have failed. Ms. [redacted] now feels that it was a mistake to have taken her son out of the educational program at age eighteen, testifying that her son had little to keep him occupied and his quality of life is terrible. (DDS Exhibit #9c, #10, & Testimony, Ms. [redacted])

36. A letter dated [redacted] 2001, from Dr. [redacted], M.D., to Dr. [redacted] M.D., lists the Appellant's diagnosis as "Mild Mental Retardation and Attention Deficit Disorder". The letter does not state where or when the testing for the referenced diagnosis of Mild Mental Retardation occurred; Dr. [redacted] does not indicate how she came to a determination regarding a diagnosis of Mild Mental Retardation. (DDS Exhibit #21)

37. A cognitive test, the WISC-III, was administered to the Appellant on [redacted] 2001, at age fourteen years, [redacted] as part of a mandated three-year re-evaluation at the [redacted] (DDS Exhibit #19). The report states that issues related to impulsivity, distractibility, perserverativeness, and an inability to self-regulate impacted on test performance. The cognitive test scores from the WISC-III resulted in a Verbal IQ 81, a Performance IQ Score of 60 and a Full Scale IQ score of 69. The evaluator stated that because of the Appellant's unusually diverse abilities in Verbal and Non-verbal reasoning, the Full Scale IQ score may not be the best representation of the Appellant's general cognitive ability. The report's summary states as follows:

> "[redacted] presents with a very unique cognitive profile. He evidenced many verbal strengths. He earned an Average Scaled Score on a measure of one's ability to use language abstractly. He evidenced relative strengths in his fund of general knowledge, word knowledge, and ability to apply practical judgment while problem-solving social scenarios."
>
> "[redacted]'s weakest performance was on measures of nonverbal reasoning. His performance was further compromised when tasks involved a motor component. His hyper-vigilance to his environment resulted in an acute ability to detect missing elements in common objects, scoring in the Average Range on the Picture completion subtest. In addition, issues related to

inattention and slow processing speed adversely affected his test performance." (DDS Exhibit #19)

38. An academic achievement test, the WIAT, was administered to the Appellant at age fourteen years, [redacted] as part of a mandated three-year re-evaluation at the [redacted]. (DDS Exhibit #18). The report states as follows:

> "[redacted] reflected a relative strength in his Oral Expression and his Listening Comprehension strategies. Difficulty is seen in many of the other skill areas. His scores are in a range from Poor (two scores) to Below Average (four scores) through Average (two scores)." (DDS Exhibit #18).

39. A letter dated [redacted], 2003, from Dr. [redacted], M.D., to Dr. [redacted] M.D., titled "Neurological Evaluation", again listed the Appellant's diagnosis as "Mild Mental Retardation". This report also lists a diagnosis of "Attention Deficit Disorder, inattentive type". As is the case in Dr. [redacted]'s 2001 letter, there is no indication as to how Dr. [redacted] came to a determination regarding a diagnosis of Mild Mental Retardation. Dr. [redacted] reports that the Appellant is doing quite well, that he is very independent, and that he does extremely well in tasks of daily living. The Appellant is listed as taking Ritalin three times a day. (DDS Exhibit #17)

40. Dr. [redacted], the Licensed Psychologist who conducted a WASI-III as part of a psychological evaluation of the Appellant at the Appellant's age of 17[redacted] years, described the Appellant's overall level of cognitive functioning to be within the Borderline Range of global abilities. The Appellant obtained a Verbal IQ of 74 and a Performance IQ of 56. Dr. [redacted] stated that the 18 point difference between Performance and Verbal scales suggest that a Full Scale IQ will not be an accurate representation of overall ability. (DDS Exhibit #16)

41. A [redacted] 2005 Neurological Follow-Up report for the Appellant (DDS Exhibit #15) by Pediatric Neurologist, Dr. [redacted], again lists Mild Mental Retardation and Attention Deficit Disorder, inattentive type as Diagnosis; the report states the following about the Appellant:

> "[redacted] will be graduating in two weeks from the [redacted]. He plans to be working in [redacted] with [redacted], etc. Mother states that [redacted] is exceptionally talented in [redacted]."

> "I agree that he probably would be happier working rather than attending [redacted] until he turns 22. I had a fifteen minute conversation with [redacted]'s mother with [redacted] out of the room regarding whether or not he should drive. At this point in time I am concerned that [redacted] may lack the judgment necessary to drive and mother is in agreement. She states that this has been a difficult issue because [redacted] has read the driver's manual over and over and she believes that he would pass the written test. She relays that it is difficult because many of [redacted] peers are now driving. One of [redacted] peers was driving and had a fatal motor vehicle accident. I suggested that [redacted] mom consider just telling [redacted] that I believe he shouldn't be

driving at this time and we could revisit this in a year when I plan to see him in follow up." (DDS Exhibit #15)

42. The Appellant was admitted at age twenty under a section 12, for psychiatric care to [redacted] after becoming intoxicated and reportedly attempting suicide. The Appellant remained in [redacted] for twenty-one days, from [redacted] 2007 through [redacted] 2007. The following Diagnosis were listed (DDS Exhibit # 14):

Axis I: Clinical Disorders
Primary- Schizoaffective Disorder, Bipolar Type
Secondary-Alcohol Abuse
Secondary-Cannabis Dependence
Provisional- Attention-Deficit Hyperactivity Disorder, predominantly Inattentive Type
Rule out- Bipolar I Disorder, Most Recent Episode, Mixed, Severe w/o Psychotic Features

Axis II: Personality Disorders and Mental Retardation
Provisional -Personality Disorders NOS
Provisional – Mild Mental Retardation

The following medications were administered and prescribed at discharge:
Paxil 20mg qd
Inderal 10mg qid
Deapkote ER 2000mg qHS
Risperdal 3mg bid
Vasotec 5mg qd
Norvasc 5mg qd

43. Licensed psychologist, [redacted],Ph.D., who had begun a neuropsychological evaluation of the Appellant (DDS Exhibit #13) in her office on [redacted] 2007 completed the neuropsychological evaluation at [redacted] on [redacted] 2007. (Dr. [redacted] had requested that the Appellant be brought to her office to complete the neuropsychological evaluation but was informed that the Appellant could not safely travel out of [redacted].) A WAIS-III was administered and resulted in a Full Scale IQ of 65 with a Verbal IQ of 73 and a Performance IQ of 60. Dr. [redacted]'s neuropsychological evaluation of the Appellant which was conducted at the Appellant's age of twenty years [redacted] (DDS Exhibit #13), states in part as follows:

"During this testing session, [redacted] made concerning and worrisome comments about his intention to commit violent behavior and his interest in weapons."

"The initial purpose of this assessment was to determine whether he would be eligible for services under the Department of Mental Retardation. In summary, test results are consistent with an individual who has Borderline to Mild intellectual impairment. [redacted] obtained the following standard scores on the Wechsler Adult Intelligence Scale-III: Verbal Comprehension=78 (7th percentile), Perceptual Organization= 65 (1st percentile), Working Memory= 67 (1st percentile), and Processing Speed= 68 (2nd percentile)."

"In summary, [redacted] is a 20-year-old male with a long-standing history of developmental impairment associated with intellectual deficiency, poor

interpersonal relatedness, learning disabilities and severe impairment in adaptive behavior. The combination of these disabilities is consistent with a diagnosis of Pervasive Developmental Disorder Not Otherwise Specified."

"Further, [redacted] has profound deficits affecting insight, judgment and reasoning which potentially place [redacted] at risk for harm to himself, and there is a question as to whether he has the motivation and capacity to express his anger in a way that is potentially injurious to another individual. [redacted] has severely impaired impulse control. He has been unable to manage at home. His mother has been unsuccessful, despite her best efforts to control him. His allegations about possession and access to weapons require further investigation."

"It is apparent to this examiner that [redacted] psychiatric disabilities override whatever consideration would be pertinent regarding his developmental impairment. At times, his thinking appears delusional and /or psychotic. It is recommended that services be initiated for him through the Department of Mental Health."

"It is my strong recommendation that [redacted] not be allowed to return to [redacted] his parents' homes, and should remain in a supervised facilities for developmentally disabled and /or psychiatrically impaired young adults until a group home placement can be obtained for him".

"[redacted] requires ongoing psychiatric care and supervision to assure that he is compliant with treatment".
(DDS Exhibit #13)

44. Ms. [redacted] testified that her son [redacted] can appear intimidating if you do not know him; he does better with a strong male psychologist rather than with [redacted]. Ms. [redacted] stated the utmost respect for Dr. [redacted]s professional credentials, but opined that Dr. [redacted] was intimidated by the Appellant and indicates that Dr. [redacted] report reflects that fear. (Testimony, Ms. [redacted])

45. The Appellant was kicked out of his [redacted] home at approximately age twenty-one due to alcohol abuse and had to live with [redacted] for a while. During this time he was psychiatrically hospitalized at [redacted]. (DDS Exhibit #12)

46. Appellant was admitted to [redacted] on [redacted] 2008, at age twenty-one, for psychiatric care due to morbid depression, suicidal ideation, and alcohol abuse. The Appellant was discharged on [redacted] 2008 after his medications were adjusted; he was placed on two mood stabilizers, Lithium and Depakote as well as a low dose of Risperdal. The following Diagnosis were listed (DDS Exhibit # 12):

Axis I:
Bipolar Disorder, mixed, severe, with psychotic behavior.
Alcohol abuse, episodic

Axis II:
Mild Mental Retardation

The following medications were administered and prescribed at discharge:
Trazodone 100mg qhs
Risperdal 2mg qhs
Cogentin 1mg qhs
Depakote 250mg qam and 1000mg qhs
Effexor regular 75mg. qam
Lithium carbonate 600mg qhs (DDS Exhibit #12)

47. The Appellant suffers with sleep problem, frequently going two to three days without sleep. Ms. [redacted] has awakened in the night to find the Appellant standing over her watching her sleep. (DDS Exhibit #10 & Testimony, Ms. [redacted])

48. The Appellant has a history of unsuccessful employment. Placements by [redacted] failed to result in employment. He tried jobs [redacted], but lasted only minimal amounts of time as he needed too much supervision. Attempts at gainful employment, working for [redacted] who were trying to help out, also failed due to the need of an inordinate amount of supervision and also due to the Appellant's behaviors which caused female workers to fear him. (DDS Exhibit #9c & Testimony, Ms. [redacted])

49. The Appellant's mother has attempted to obtain work for her son, calling on local establishments and speaking to individuals she personally knew to urge them to consider employing her son and, when these efforts were successful, the Appellant's mother took it upon herself to function as a "job coach", calling the employer to find what could be done to help her son succeed. None-the-less, the Appellant could not maintain employment at any job; no job lasted longer than a few weeks or months. (Testimony, Ms. [redacted])

50. A Consultative Exam (DDS Exhibit # 11a) conducted in [redacted] 2009 for the purpose of determining SSI eligibility states the following about the Appellant, who is referred to as the "Claimant":
    - The claimant has a history of psychiatric hospitalizations: admitted to [redacted] three times in 2007 ; to [redacted] in 2008; and to [redacted] in 2009
    - The claimant is no longer taking the psychiatric medications Risperdal, Depakote and Venlafaxine which have been prescribe for him.
    - The claimant's mother wishes that a public agency could help with case management but DMH and DMR have stated that the Appellant is not eligible for their services or their residences.
    - The claimant has a history of alcohol dependence and poly substance abuse since he was twenty-one.
    - The claimant's intellectual functioning is Borderline.
    - The claimant was admitted to [redacted] eight or nine months ago.

- The claimant's has a learner's permit to drive, but his mother won't let him drive because his behavior is so erratic.

- The claimant's mother has been a strong advocate for employment, contacting many businesses after the claimant was hired and meeting with employers to find out what problems he was having with the job. Problems reported include: getting distracted easily and needing constant supervision; forgetting his job and instead talking with people he knows; and, walking off the job.

- The claimant has poor social skills that are difficult for other people and especially professional people to tolerate. He makes personal comments that are inappropriate.

- The claimant spends most of the day in the house or [redacted].

- The claimant's mother is recovering from [redacted]. She has been on leave from work and therefore able to supervise him closely. She now needs to return to work and has no one to monitor her son. When he stays at home he does foolish things like buying expensive presents for her that she doesn't need.

- The claimant can care for his own personal hygiene. He will help with the household chores with supervision.

- The claimant came to the interview with his mother. He appeared kempt and groomed. He sat restlessly and spoke loud and often. His thought process was disorganized. He would spontaneously laugh and make comments that were playful but unrelated to the context of the interview. His speech is tangential. He was friendly and cooperative, with lapses of attention or to make inappropriate comments. His eye contact was variable. His affect and mood were hypo-manic. He has impulsive traits. His judgment appears to be partial.

- His memory and intellectual functioning are estimated as Borderline.

- DSM IV Summary (tentative diagnosis) on Axis I of Schizoaffective Disorder, Tourette's Disorder, Poly Substance Dependence, and Nicotine use Disorder Dependence was determined.

- DSM IV Summary (tentative diagnosis) on Axis II of Borderline Intellectual Functioning was determined.

51. A WAIS-III conducted at the Appellant's age of twenty-two by Psychologist, [redacted] Ed.D., for the purpose of determining SSI eligibility resulted in a Full Scale IQ of 71. Dr. [redacted] stated that the Appellant's overall cognitive ability, as estimated by the Full Scale IQ, is in the Borderline Range of intelligence. (DDS Exhibit #11b)

52. In [redacted] 2007, after disappearing for three days, the Appellant was found in [redacted] by the police, brought to the emergency room, and subsequently transferred to [redacted] where he was psychiatrically evaluated and admitted. He remained at the [redacted] for approximately one month and was placed on the following psychiatric medications: Trazadone, Venlafaxine, Depakote, Respiradol, Lithium, and

Benztropine. (DDS Exhibit #10 & Testimony, Ms. [redacted])

53. The Appellant has a history of making poor choices. The Appellant destroyed his credit by opening up a line of credit and purchasing [redacted] that he could not pay for. He gave the [redacted] who is unknown to his family; as a result it is not possible for the family to attempt to retrieve and return [redacted]. (DDS Exhibit #10 & Testimony, Ms. [redacted])

54. The Appellant has a history fleeing his home in the middle of the night for days at a time, and also for traveling out of state without notifying his family that he is leaving. On at least two occasions he took a bus to [redacted] to meet up with people he had never met but had befriended online. His mother opined that he was able to pay for the bus tickets without her knowledge by saving money he earned doing odd jobs, [redacted]. Several family members had to [redacted] to bring him back home. On one of these occasions he met up with [redacted]. This woman has now filed for divorce. The Appellant does not have the funds to obtain legal counsel to process an out of state divorce; as a result, he remains legally married. (DDS Exhibit #10 & Testimony, Ms. [redacted])

55. The Appellant reportedly spends most of his time on the computer where he finds and responds to multiple "get the first one free" mail offers without regard to the fact that he will need to pay for subsequent mailings. The items he obtains reportedly are, for the most part, items that he will not have use for and will not use. He reportedly perceives them as free, does not intend to pay for future mailings, and will not stop this activity even though his mother has explained that this practice is wrong and is ruining his credit. (Testimony, Ms. [redacted])

56. The Appellant's mother feared leaving her son home while she worked [redacted] in order to keep him safe, [redacted]. She is currently not working but must return to work at some point and is very apprehensive about leaving her son unsupervised. (Testimony, Ms. [redacted])

57. The Appellant was admitted to [redacted] for approximately one week. Little is known about the circumstances of this admission because the Appellant's mother has not been successful in obtaining documents from [redacted]. However, based on what the Appellant has told his mother and based on the Appellant's cell phone records, Ms. [redacted] believes that her son walked all the way to [redacted], got severe blisters on both feet, was seen by a doctor at a hospital and then referred for psychiatric treatment. (DDS Exhibit #10 & Testimony, Ms. [redacted])

58. The Appellant applied for DDS adult services on [redacted] 2007 and was found not eligible on [redacted] 2007due to insufficient information.(DDS Exhibit #6 & DDS Exhibit #9c)

59. The Appellant with the help of his father appealed the denial of DDS adult services and an Informal Conference was held on [redacted], 2008 at which time the Appellant and his father were given a list of four items needed in order for the application to be considered complete; the items listed were as follows:

    1. A current Stanford-Binet V or a Wechsler Adult Intelligence Scale.

2. The inpatient discharge summary from [redacted]
3. The inpatient discharge summary from [redacted]
4. A list of the Appellant's current medications from his current prescriber.

The four items requested were not forthcoming and no further action was taken to continue the appeal process at that time. (DDS Exhibit #6)

60. In [redacted] 2008, the Appellant was arrested after [redacted]. (DDS Exhibit #10)

61. Due to the Appellant's mental instability in [redacted] 2009, the Massachusetts Rehab Commission (MRC) refused to reopen the Appellant case. (DDS Exhibit #10 & Testimony, Ms. [redacted])

62. The Department of Mental Health denied the Appellant's request for services.(Testimony, Ms. [redacted])

63. The Appellant gets into trouble, in his mother's opinion, because he has nothing to do during the day. He will walk to a bar or package store to obtain alcohol. In [redacted] 2009, he [redacted] she had to go to [redacted] so that her son would not be criminally charged. Ms. [redacted] is very concerned that her son will end up in the criminal system, not because he belongs in the criminal justice system, but because he has poor judgment. She would like her son to be involved in a day program that will keep him busy and safe. (Testimony, Ms. [redacted])

64. The Appellant had obtained a learner's permit to drive. In [redacted] 2009, a judge ordered that the Appellant could not ever be allowed to obtain a drivers license after having been found guilty of [redacted]; the Appellant had [redacted]. (Testimony, Ms. [redacted]

65. The Appellant's mother became re-involved with her son's request for state agency services. Because of her advocacy, the Appellant eligibility for DMH and DDS services are again being evaluated. (Testimony, Ms. [redacted])

66. The Appellant's application for Department of Mental Health (DMH) services is currently in process; the Appellant has met with a DMH psychologist and is scheduled to return for a second session. An evaluation by a psychiatrist will also be required prior to a final determination regarding DMH service eligibility. (Testimony, Ms. [redacted])

67. The Appellant's application for DDS eligibility was reopened and an Informal Conference with the Appellant and the Appellant's mother was held on [redacted] 2010 at which time the finding of ineligibility was reviewed and upheld. (DDS Exhibit #2 & Testimony of Dr. Frederick Johnson)

68. Ms. [redacted] appealed the denial of DDS eligibility and a Fair Hearing was held on [redacted] 2010. (Hearing Officer Document #3)

69. The Department's regulations have recently been revised to state that an individual must have an "Intellectual Disability" to be eligible for DDS services. However, the change in terminology has not changed the eligibility criteria. The regulations define "Intellectual Disability" as "the preferred term to describe the condition of Mental Retardation, and, for purposes of 115 CMR 2.00, is synonymous with the term Mental Retardation." (Hearing Officer Exhibit #1)

70. IQ testing must be administered by qualified professionals following criteria set out by licensure and by professional standards. In the state of Massachusetts, licensed psychologist are qualified to administer and interpret cognitive testing. (Testimony, Dr. Frederick Johnson)

71. Dr. Frederick Johnson, DDS's Licensed Psychologist, is properly credentialed and qualified by licensure and experience in the field of Developmental Disabilities to assess and evaluate cognitive testing and adaptive testing results; Dr. Frederick Johnson testified as an expert witness at the Appellant's Fair Hearing. (DDS Exhibit # 33)

72. A diagnosis of Pervasive Developmental Disorder (PDD) is not a diagnosis of Mental Retardation. However, a diagnosis of PDD does not exclude a possible diagnosis of Mental Retardation. (Testimony, Dr. Frederick Johnson)

73. A diagnosis of a mental illness disorder does not exclude the possibility of a diagnosis of Mental Retardation. A person with mental illness could be eligible for DDS services if the individual meets the criteria for a diagnosis of Mental Retardation as defined in DDS regulation. (Testimony, Dr. Frederick Johnson)

74. The presence of Mental Retardation in a person with mental illness must be demonstrated by a valid measurement of the person's level of cognitive ability, a measurement that has not been compromised by other factors such as the inability to focus or by symptoms of active psychosis on the day of testing. (Testimony, Dr. Frederick Johnson)

75. Professionals who are not licensed psychologists and therefore not licensed to administer and interpret cognitive testing have more flexibility when using the term Mental Retardation, and in some instances, do use the term Mental Retardation when the person is functioning at the level of Mental Retardation. There is a distinction between the level of functioning (also called adaptive functioning) and the level of *intellectual* functioning or *intellectual ability*. A person who does not have Mental Retardation can be functioning at the level of Mental Retardation due to other factors; for example, active psychosis can impede upon functioning. As DDS's eligibility psychologist, Dr. Johnson must adhere to the regulations and the manner in which Mental Retardation is defined in 115 CMR 2.01 when making a determination that a person is mentally retarded. (Testimony, Dr. Frederick Johnson)

76. The Appellant's adaptive functioning was tested on [redacted] 2007 using an Adaptive Behavior Assessment System, second edition (ABAS-II) and found to be at a deficient level with a GAC Score of 44, a score within the regulatory criteria for DDS eligibility. (Testimony, Dr. Frederick Johnson)

77. Dr. Johnson testified that the Appellant's very low ABAS-II score of 44 was not consistent with the activities that the Appellant was able to perform, such as planning to

travel on his own and successfully getting to an out of state destination. Dr. Johnson opined that the Appellant's very low adaptive functioning score is a reflection of the Appellant's significant psychosis. (Testimony Dr. Frederick Johnson)

78. In order to be eligible for DDS adult services, Department regulations require the person to have significantly sub-average intellectual functioning manifesting before age 18 and existing concurrently and related to significant limitations in adaptive functioning. (Testimony, Dr. Frederick Johnson)

79. The Department has defined "significantly sub-average intellectual functioning" as 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. The regulations have both a cognitive and an adaptive functioning component; to meet the adaptive functioning component of the regulations a person must have "significant limitations in adaptive functioning" existing concurrently and related to the sub-average intellectual functioning. The regulations require that both components must be present to be eligible for Department services. (Testimony, Dr. Frederick Johnson)

80. Ms. [redacted] argued that her son was an unusual case and that the Full Scale IQ score in the cognitive testing results are not an accurate depiction of the Appellant's cognition and that her son is, in fact, Mentally Retarded as shown by some of the subtest IQ results that fall in the extremely deficient range. Ms. [redacted] opined that her son tested better in the Verbal IQ because he has not been able to play with children and, as a result, has spent all of his time with adults, getting the benefit of listening to adult language. (Testimony, Ms. [redacted])

81. Dr. Johnson testified that a person who meets the definition of Mental Retardation would not test higher in Verbal IQ because of spending time around adults while growing up, rather than spending time with children; children whose cognition is in the Mental Retardation range are not capable of attaining a high level of verbal ability and therefore would not learn as a result of exposure to adult conversation. However, a person who does have the cognitive capacity to learn may benefit from that situation. (Testimony, Dr. Frederick Johnson)

82. Ms. [redacted] questioned why the cognitive tests that resulted in an IQ above 70 were considered more valid than the tests that show her son's IQ to be below 70. Dr Johnson testified that a person cannot score out of the range of Mental Retardation if he or she does not have the capacity to do so. The tests used for cognitive testing are designed so that a person could not score better just by chance. A person must give the proper information or perform the requested task in order to obtain the IQ score, and a person cannot give information that he or she does not know. In contrast, a person can score lower for a variety of reasons, for example: psychiatric difficulties, attention difficulties, fatigue, environmental distractions, poor motivation, poor rapport with the examiners, problems with medications, and any other situation that would impact on the person's ability to perform on the day of testing. (Testimony, Dr. Frederick Johnson)

83. Dr. Johnson testified that the Appellant's Verbal IQ has always tested higher than his Performance IQ but that the Appellant's IQ scores are variable. Thus the Appellant's cognitive test results show that he is not able to consistently test at his is true cognitive

ability. Dr. Johnson explained that a "ceiling" of a cognitive test is a measurement that indicates you have gone as far as you can go; that you cannot get any more of the questions right. The ceiling can be considered the person's correct level of cognitive ability. In the Appellant's case, his capacity to test is compromised by his ADHD which would impact his performance on measures of processing speed and on timed sections of the test. In testing where the Appellant's inability to focus has caused him to run out of time, it is not possible to know if he reached his "ceiling"; he very well may have known the answers to more questions but ran out of time before he could get to them which will impact his overall scores. When the Appellant is tested on days where he is impacted by his ADHD, or the medications he is taking, or impacted by active psychosis, he will not test at his true cognitive ability. (Testimony, Dr. Frederick Johnson)

84. In answer to a question asked by Ms. [redacted] Dr. Johnson testified that he has spent approximately a total of two hours in the presence of the Appellant. Ms. [redacted] questioned how Dr. Johnson could form an opinion about her son's eligibility as a person with Mental Retardation after only spending a total of approximately two hours in his presence. Dr. Johnson testified that, in assessing the Appellant's application for DDS adult services, he (Dr. Johnson) follows the Department's regulatory requirements and assessed eligibility using the cognitive test results in evidence. Dr. Johnson summarized the component parts of the process he follows to determine eligibility. He looks primarily at comprehensive test of intellectual functioning and in the Appellant's case there were many. He looks at adaptive behavior assessment results to determine how the person functions. He also looks at documents related to psychiatric information that could mitigate his opinion about score results. In addition, Dr. Johnson looks at achievement scores to see if they are consistent with the person's intellectual functioning on IQ tests. After reviewing all the documents submitted by the Appellant in support of eligibility, Dr Johnson makes a determination regarding eligibility. (Testimony, Ms. [redacted] & Dr. Johnson)

85. Dr. Johnson discussed the graph of the Appellant's Intelligence Test results (DDS Exhibit #34) that demonstrate a decline in the Appellant's test results over time with a FSIQ of 78 at age three years, [redacted]; a FSIQ of 80 at age five years, [redacted]; FSIQ of 75 at age six years; a FSIQ range of 80 to 109 at age nine years, [redacted]; a FSIQ of 69 at age fourteen years, [redacted], a FSIQ of 65 at age twenty years, [redacted] and FSIQ of 71 at age twenty-two. It is Dr. Johnson's clinical opinion that the Appellant's cognitive capacity lies in the IQ range that was demonstrated during his early years, and as his mental illness progressed during his adolescent years, he was not able to test at his true cognitive capacity. (Testimony, Dr. Frederick Johnson & DDS Exhibit # 34)

86. Dr. Johnson discussed the first Full Scale IQ that fell below 70, the WISC-III administered at the Appellant's age of fourteen years [redacted], which resulted in a Verbal IQ of 81, a Performance IQ of 60 and a Full Scale IQ of 69. [redacted] and [redacted], the examiners conducting the WISC-III, reported that issues related to impulsivity, distractibility, perserverativeness, and an inability to self-regulate impacted on the test performance. Dr. Johnson agrees with the examiners who also reported that the Full Scale IQ score may not be the best representation of the Appellant's general cognitive ability. (Testimony, Dr. Frederick Johnson, & DDS Exhibit #19)

87. Dr. Johnson discussed the other Full Scale IQ that fell below 70, the WAIS-III administered at the Appellant's age of twenty years, [redacted] which resulted in a Verbal IQ of 73, a Performance IQ of 60 and a Full Scale IQ of 65. Dr. [redacted], the psychologist conducting the WAIS-III, reports the Appellant's condition stating in her report that: "at times, his thinking appears delusional and or/psychotic". This testing was administered during a period of time when it was necessary to hospitalize the Appellant for his own safety. (Testimony, Dr. Frederick Johnson, & DDS Exhibit #13)

88. Ms. [redacted] questioned why her son would have scored better on one test as compared to another test. Dr. Johnson testified that it is difficult to say specifically why the Appellant did better on one test as compared to another; there are a number of explanations why he could have done better; he could have been better focused, could have been getting treatment that was helpful to him at the time. Dr. Johnson testified that it is not an unusual phenomenon to see variability in scoring for a person with psychiatric illness, because from day to day the person's mental status is different, and just as the Appellant has been described as some days being very docile and sweet and other days as being potentially violet, his behavior in a testing situation and his capacity to answer questions is also going to change as a result of the differences in his mental status. (Testimony, Ms. [redacted] & Dr. Johnson)

89. Ms. [redacted] questioned what Dr. Johnson meant when he uses the term "in his clinical opinion". Dr. Johnson testified that his clinical opinion is different than a personal opinion or a scientific opinion. A personal opinion is just that, a personal feeling or belief and has no part in a professional clinical opinion. A scientific opinion is based on results that have been proven using tests conducted in compliance with the scientific principals of testing, using a control group and a test group, which is also not applicable to this situation. A clinical opinion is one that is based on professional experience and training, in this case, a licensed psychologist's experience, using the training that he has received and the requirements set out in licensure that must be followed in making a clinical opinion. (Testimony, Dr. Frederick Johnson)

90. Dr. Frederick Johnson made his final determination that the Appellant was not eligible for DDS services after reviewing all information that had been submitted which included all the cognitive test results (DDS Exhibits #32, #30, #29,#26, #22, #19, #16, #13, & #11). Dr. Johnson found that the Appellant's level of cognition was higher than the regulatory requirement for eligibility , and therefore, the Appellant was ineligible for DDS services due to a failure to meet the Department's definition of Mental Retardation. (Testimony, Dr. Frederick Johnson)

91. Dr. Johnson testified that, in his clinical opinion, the Appellant is a person who has persistent psychiatric illness with significant psychotic symptoms. It is Dr. Johnson's clinical opinion that the Appellant does not present consistent with the lower IQ scores obtained on some of his IQ tests. He does present as someone with significant psychiatric illness that has a significant impact on his functioning, every day and in every way. (Testimony, Dr. Frederick Johnson)

92. Dr. Frederick Johnson testified that after meeting the Appellant at the Informal Conference and after hearing all the evidence presented at the Fair Hearing, he had not changed his opinion; it is Dr. Johnson's clinical opinion that the Appellant is a person with significant mental illness which impacts on his ability to consistently perform and

score at his true cognitive level on IQ tests, and that the Appellant is not a person with Mental Retardation. Dr. Frederick Johnson stated that the Appellant's cognitive deficits are above the level required for a diagnosis of Mental Retardation; therefore the Appellant does not meet the criteria for service eligibility from the Department. (Testimony, Dr. Frederick Johnson)

RECOMMENDED DECISION:

After a thorough review of all of the evidence, I find that the Appellant has not shown by a preponderance of the evidence that he meets the DDS eligibility criteria as required by 115 CMR 6.04. I find that the weight of the evidence shows that the Appellant does not meet the Department's definition of Intellectual Disability as that term is used in statute and regulation for the determination of DDS supports, and as defined in 115 CMR 2.01. My reasons are as follows:

REGULATORY REQUIREMENTS:

In accordance with statutory and regulatory authority and in accordance with Massachusetts General Law c. 123B, section 1, the Department has promulgated regulations setting standards by which an individual may be determined eligible for DDS services. In order to be eligible for DDS supports, an individual who is 18 year of age or older must meet the following criteria for general eligibility:

The General Eligibility requirements for services from the Department of Developmental Services (DDS) are found in 115 CMR 6.04 where it states the following:

> "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 Intellectual Disability as defined in 115 CMR 2.01"

The Department's definition of "Intellectual Disability" found in 115 CMR 2.01 is as follows:

> "Intellectual Disability is the preferred term to describe the condition of Mental Retardation, and, for purposes of 115 CMR 2.00, is synonymous with the term Mental Retardation."

The Department's definition of "Mental Retardation" found in 115 CMR 2.01 with its incorporated definition of "significantly sub-average intellectual functioning" and "significant limitations in adaptive functioning" is stated as follows:

> "Mental retardation means significantly sub-average intellectual functioning existing concurrently and related to significant limitations in adaptive functioning. Mental retardation manifests before age 18."

The Department's definition of "significantly sub-average intellectual functioning" found in 115 CMR 2.01 is stated as follows:

> "...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."

And, the Department's definition of "significant limitation in adaptive functioning" found in 115 CMR 2.01 requires a test score of 70 to meet the requirement of two standard deviations below the mean or a test score of 77 to meet the requirement 1.5 standard deviations below the mean, and is stated as follows:

> "...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."

The standard and burden of proof is found at 115 CMR 6.34 and states as follows:

> (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....

CONCLUSIONS:

- The Appellant's domicile in the state of Massachusetts is not an issue in this appeal. The evidence shows that the Appellant is domiciled in the state of Massachusetts, [redacted]. I therefore find that the Appellant meets the domicile requirement for eligibility.

- The issue before us is whether the Appellant has met his burden of proving by a preponderance of the evidence that he is a person with an Intellectual Disability as that term is used and defined by the Department of Developmental Services; Intellectual Disability for purposes of DDS eligibility is synonymous with the term Mental Retardation.

- To be diagnosed with Mental Retardation, one must have both a significant deficit in adaptive functioning and a significant deficit in cognitive functioning. There is a diagnostic distinction between adaptive functioning and cognitive functioning. Adaptive functioning relates to a person's success, or lack thereof, in performing day to day activities, whereas cognitive functioning is a measurement of a person's cognitive ability and cognitive capacity. Both are determined by the results of approved tests that must be administered by qualified professions properly trained to conduct such tests, and both test results can be compromised by the symptoms of ADHD and mental illness.

- The evidence is quite clear regarding the Appellant's diagnosis of ADHD and mental illness. Both disorders are well documented throughout the evidence presented in this matter. The indications of a psychiatric problem began as early as age three when the Appellant was evaluated by a psychiatrist who referred him for a child psychiatric work-up, and the diagnosis and pharmaceutical treatment of ADHD also occurred during

these very early years. (DDS Exhibit #32) The Appellant was diagnosed with an Axis I primary diagnosis of Schizoaffective Disorder Bipolar Type in 2007 (DDS Exhibit #14), and a psychiatric hospitalization in 2008 resulted in an Axis I primary diagnosis of Bipolar Disorder, mixed, severe, with psychotic behavior. (DDS Exhibit # 12) Thus, the evidence shows that the Appellant clearly suffers not only from ADHD, but also from mental illness, a mental illness currently determined to be Bipolar Type, mixed, severe, with psychotic behavior. (DDS #12)

- A mentally ill person could also be diagnosed as a person with Mental Retardation. However, a diagnosis of Mental Retardation must be based on the results of an intelligence test 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. The term Mental Retardation is sometimes used to indicate an individual's level of adaptive functioning without consideration of the individuals cognitive functioning. When this occurs, the determination that a person has Mental Retardation cannot be considered a valid diagnosis in accordance with accepted diagnostic standards; the statement that a person has a diagnosis of Mental Retardation must be based on valid IQ test results. In evaluating the evidence, the following documents were found to have reported that the Appellant is a person with Mental Retardation without reference as to how the diagnosis was determined (which IQ tests were administered and who administered and interpreted the results):

EXHIBIT	SOURCE	IQ TEST	OVERALL FS IQ VALUE	STATEMENT in REPORT
DDS#21	[redacted], M.D.	None referenced	None referenced	Diagnosis of Mild Mental Retardation
DDS#17	[redacted], M.D.	None referenced	None referenced	Diagnosis of Mild Mental Retardation
DDS#15	[redacted], M.D.	None referenced	None referenced	Diagnosis of Mild Mental Retardation
DDS#14	[redacted] Discharge	None referenced	None referenced	Provisional Mild Mental Retardation
DDS#12	[redacted] Discharge	None referenced	None referenced	Diagnosis of Mild Mental Retardation

- DDS exhibits #21, #17 and #15 noted above are Neurological Evaluation reports of the Appellant generated over the course of a four year period from 2001 to 2005, by Pediatric Neurologist, Dr. [redacted] M.D., in which Dr. [redacted] starts each report with a section identifying diagnosis and medications. In each report, Dr. [redacted] lists Mild Mental Retardation under the heading of diagnosis. There is no reference as to how Dr. [redacted] came to a determination regarding a diagnosis of Mild Mental Retardation for the Appellant; Dr. [redacted] is a medical doctor, not a licensed psychologist, and therefore would not have conducted cognitive testing on the Appellant. Dr. [redacted] gives no indication as to how her diagnosis of Mental Retardation has been made; there is no reference to cognitive testing in any of her reports. This leads one to conclude that Dr. [redacted]'s determination regarding Mental Retardation is, more likely than not, based on her opinion of the Appellant's level of adaptive functioning. Given that it is not possible to review the criteria used to determine a diagnosis of Mental Retardation, no weight has been given to the statements that the Appellant is diagnosed with Mental Retardation.

- DDS Exhibit # 14 is a discharge report from [redacted] where the Appellant was psychiatrically hospitalized in [redacted] 2007, and DDS Exhibit #12, is a discharge report from [redacted] where the Appellant was psychiatrically hospitalized in [redacted] 2008. Both discharge summary reports list a diagnosis of Mental Retardation, with the [redacted] report qualifying the diagnosis as "provisional". As is the case with Dr. [redacted]'s reports, these discharge reports give no indication as to the IQ testing

dates or IQ results by which a finding of Mental Retardation is based. Therefore, no weight has been given to the statements found in DDS Exhibits #12 & #14 regarding a diagnosis of Mental Retardation for the Appellant.

- In accordance with professional standards and in accordance with the regulatory requirements for DDS eligibility, the presence of Mental Retardation can only be determined through the findings of approved IQ assessment tests, IQ assessment tests that have been determined to use valid and comprehensive, individual measures of intelligence. In addition, in accordance with regulatory requirements and professional standards, these IQ tests must be administered in standardized formats by qualified professionals and must be interpreted by qualified professionals who possess the proper training and licensure to do so.

- The Appellant's level of cognitive ability has been evaluated many times using approved IQ testing instruments. In evaluating the evidence in this matter, the following documents were found to have information about IQ tests administered to the Appellant:

EXHIBIT	AGE	IQ TEST	OVERALL IQ VALUE	STATEMENT in REPORT
#32	3[redacted]	Stanford Binet-IV	Composite Score 78	Near normal cognitive development
#30b	5[redacted]	WPPSI-R	Full Scale 80	Low Average level of intelligence
#29	6[redacted]	K-ABC	Full Scale 75	Only a baseline estimate of intellectual potential
#26	6[redacted]	Stanford Binet-IV	No numerical values noted	Overall in the Borderline range of intelligence
#30a	9[redacted]	WISC-III	No Full Scale value noted	True ability may fall in Low Average to Average
#22	11[redacted]	WISC-III .	No Full Scale value noted	Significant neurobehavioral disorder
#19	14[redacted]	WISC-III	VIQ 81; PIQ 60; Full Scale IQ 69	FS IQ may not be best representation of general cognitive ability- a very unique cognitive profile
#16	17[redacted]	WASI-III	VIQ 74; PIQ 56; No Full Scale noted.	Overall cognitive functioning in Borderline Range
#13	20[redacted]	WAIS-III	VIQ 73; PIQ 60: Full Scale IQ 65	His combination of disabilities is consistent with a diagnosis of PDD,NOS
#11	22[redacted]	WAIS-III	FSIQ 71	Borderline intellectual functioning

- The first cognitive test listed above is the Stanford Binet-IV (DDS Exhibit #32) that was conducted in 1990 by Dr. [redacted] Ph.D., licensed psychologist, at the Appellant's age of three years, [redacted]. This cognitive test resulted in an overall IQ score of 78, a score that falls in the Borderline range of intelligence. However, Dr. [redacted] did not determine Borderline range of intelligence for the Appellant; as the qualified professional who conducted the IQ test, she made a professional judgment that the Appellant's cognition fell above the Borderline range of intelligence and states that the Appellant is a boy who "shows near normal cognitive development, but who has shown a temperamental disorder since infancy and behavioral difficulties beginning in his second year of life.." Dr. [redacted] documents the Appellant's problems with maintaining attention and focus; she notes that he shows a number of behaviors characteristic of Attention Deficit Disorder. As a result, Dr. [redacted] assessed the Appellant's cognitive capacity to be higher than his scores would indicate. Thus in this evaluation, the actual scores place the Appellant's cognition above the range of Mental Retardation, in the Borderline range of intelligence, and the qualified professional conducting and interpreting the IQ test places

the Appellant's level even higher. As this cognitive evaluation meets all the regulatory requirements of a qualified professional properly administering and interpreting the results of an approved IQ testing instrument, full weight was given to the results of this cognitive assessment in making a determination as to the Appellant's level of cognition at the age of three years, [redacted] a level that is shown to be above DDS's requirement for eligibility.

- The second cognitive test listed is the WPPSI-R (DDS Exhibit #33b) that was conducted in 1992 by [redacted], guidance counselor, at the Appellant's age of five years, [redacted]. This cognitive test resulted in an overall IQ score of 80, a score that falls in the Low Average range of intelligence. Ms. [redacted] reports a Verbal IQ of 94 and a Performance IQ of 69, which represents a twenty-five point discrepancy between the two, a discrepancy that is statistically significant and an indication of the Appellant's significantly better developed verbal comprehension abilities over his perceptual organization skills. Ms. [redacted] cautions as follows in her summary: "it is important that those working with [redacted] recognized that a low IQ simply summarizes below average test performance and not necessarily intellectual impairment per se" and that "other variables such as emotional factors and distractibility contribute to the obtained scores." Ms. [redacted] goes on to state: "For this examiner it was difficult determining how much of [redacted]'s difficulties stemmed from behavioral or affective factors, or how much was due to lack of skill developments". Ms. [redacted] has signed the report as "guidance counselor" and therefore does not appear to have the regulatory qualifications to be considered a "qualified professional" for the purpose of conducting and interpreting the IQ test administered to the Appellant. Therefore, although the findings of this cognitive evaluation were considered, minimal weight was given to the results of this cognitive assessment in making a determination as to the Appellant's level of cognition at the age of five years, [redacted].

- The third cognitive test listed is the K-ABC (DDS Exhibit #29) that was conducted in 1993 by [redacted] Ph.D., and [redacted], Ph.D., at the Appellant's age of six years. This cognitive test resulted in an overall IQ score of 75, a score that would fall in the Borderline range of intelligence. The evidence shows that the Appellant who had been recently been placed on Lithium, was affected by this medication which caused him to be "overtired" and "not attending well". The professionals administering and interpreting the test advise that the results must be interpreted with caution as the Appellant's impulsivity, high activity level, and inconsistent cooperation were deemed to render the findings as only a baseline estimate of his intellectual potential. As a result, Dr. [redacted] and Dr. [redacted] assessed the Appellant's cognitive capacity to possibility be higher than his scores would indicate. As this cognitive evaluation meets all the regulatory requirements of a qualified professional properly administering and interpreting the results of an approved IQ testing instrument, full weight was given to the results of this cognitive assessment in making a determination as to the Appellant's level of cognition at age six years, a level that is shown to be above DDS's requirement for eligibility.

- The fourth cognitive test listed is the Stanford Binet-IV (DDS Exhibit #26) that was conducted in 1993 as part of a neuropsychological evaluation by Dr. [redacted], Ph.D., licensed psychologist. This Stanford Binet-IV was administered to the Appellant at age six years [redacted]. The report does not calculate a Full Scale IQ score for the Stanford Binet cognitive test but does offer a comprehensive written report of the

subtest results and does make an assessment of the Appellant's level of cognition. Dr. [redacted] reports that the Appellant's performance fell in the " below average (borderline) range" and notes a large significant difference between the Appellant's scores on Verbal tasks versus Visual tasks; his verbal intelligence was found to fall in the solidly average range whereas his abstract/visual reasoning was found to fall well below average in the deficient range. The Appellant's considerable difficulty sustaining attention along with problems with motivation and concentration were documented. After evaluating all the test score results, Dr. [redacted] made a determined that the Appellant's overall level of cognition fell in the Borderline range of intelligence. As this cognitive evaluation meets all the regulatory requirements of a qualified professional properly administering and interpreting the results of an approved IQ testing instrument, full weight was given to the results of this cognitive assessment in making a determination as to the Appellant's level of cognition at the age of six years [redacted], a level that is shown to be above DDS's requirement for eligibility.

- The fifth cognitive test listed is a WISC-III (DDS Exhibit #30a) that was conducted in 1996 as part of a Chapter 766 three-year re-evaluation, by [redacted] who is now identified as Certified School Psychologist. This WISC-III was administered to the Appellant at age nine years, [redacted]. The report does not calculate a Full Scale IQ score for the WISC-III test but does offer scores for Verbal subtests and Performance subtests along with a comprehensive written report of the subtest results. As was the case in past testing of the Appellant, attention and cooperation proved to be problematic in that he was highly distractible and very impulsive. [redacted] states that "some of the subtests were discontinued before a true ceiling could be established" and states that the Appellant's performance on the various subtests "ranged from well below average to average". Although a Full Scale score was not calculated for this cognitive assessment, Ms. [redacted] reports that the Appellant's "true ability may actually fall in the Low Average to Average range" of intelligence. As this cognitive evaluation meets all the regulatory requirements of a qualified professional properly administering and interpreting the results of an approved IQ testing instrument, full weight was given to the results of this cognitive assessment in making a determination as to the Appellant's level of cognition at the age of nine years [redacted], a level that is shown to be above DDS's requirement for eligibility.

- The sixth cognitive test listed is a WISC-III (DDS Exhibit #22) that was conducted in 1998, at the Appellant's age of eleven years [redacted], as part of a Learning Disabilities Evaluation at [redacted]. The report indicates that selected subtests of the WISC-III were administered; a Full Scale IQ score was not calculated. Although the report indicates that the Appellant shows some erosion of skills when compared to the previous year, his scores continue to show the same cognitive potential from Borderline range on Verbal testing to well below that level for non-verbal Performance items. As in past evaluations, the Appellant's attention and concentration were problematic, but in this evaluation, his constellation of behaviors is noted to be of concern; he is described as having language that is perseverative, echoialic and quite disordered, and as having [redacted]. The overall summary states that the Appellant presents with behaviors that are most consistent with a "significant neurobehavioral disorder, whose origin is not clear, which affects his adaptation in all aspects of his social and academic development." Noteworthy is the fact that, although the Appellant tested from Borderline on Verbal items to well below that level on non-verbal Performance items, the professionals who conducted and interpreted the results of this IQ test did not make a finding of Mental

Retardation. I find this report to be confirmation that the Appellant is not seen to be a person with an overall cognitive level in the Mental Retardation range of intelligence. As this cognitive evaluation meets all the regulatory requirements of a qualified professional properly administering and interpreting the results of an approved IQ testing instrument, full weight was given to the results of this cognitive assessment in making a determination as to the Appellant's cognition at the age of eleven years, [redacted] cognition that has not been diagnosed as Mental Retardation.

- The seventh cognitive test listed is a WISC-III (DDS Exhibit #19) that was conducted in 2001 as part of a mandated three-year re-evaluation, by [redacted], Certified School Psychologist and [redacted]. This WISC-III was administered to the Appellant at age fourteen years, [redacted], and resulted in a Verbal IQ of 81 and a Performance IQ of 60, scores that represent a twenty-one point discrepancy; a twenty-one point discrepancy is statistically significant and therefore does not allow a valid calculation of a Full Scale IQ score. The narrative portion of this evaluation clearly notes that "issues related to impulsivity, distractibility, perserverativeness, and an inability to self-regulate impacted on test performance." Ms. [redacted] cautions that the Appellant presents with a "very unique cognitive profile" with "unusually diverse abilities indicated by a Verbal IQ of 81, in the Low Average range, and a non-verbal reasoning Performance IQ of 60, in the Intellectually Deficient range" and correctly cautions that a "Full Scale IQ score may not be the best representation of his general cognitive ability". A Full Scale IQ was nonetheless calculated in the numerical summary section of the report and was listed as a Full Scale IQ score of 69, a score that falls in the Intellectually Deficient range of intelligence. However, the qualified professionals who administered and interpreted the test did not make a diagnosis of Mental Retardation. As noted above, the Full Scale IQ was calculated using index scores with a twenty-one point discrepancy and therefore not considered to be the best representation of general cognitive ability. As this cognitive evaluation meets all the regulatory requirements of qualified professionals properly administering and interpreting the results of an approved IQ testing instrument, full weight was given to the results of this cognitive assessment in making a determination as to the Appellant's cognition at the age of fourteen years, [redacted] a level of cognition that has not been diagnosed as falling in the range of Mental Retardation.

- The eighth cognitive test listed is the WAIS-III (DDS Exhibit #16) that was conducted in 2004 as part of a psychological evaluation by Certified School Psychologist, [redacted] CAGS, NCSP. This WAIS-III was administered to the Appellant at age seventeen years, [redacted]. The report does not calculate a Full Scale IQ score for the WAIS-III but does offer a professional assessment as to overall level of cognitive functioning, placing the Appellant's level of overall cognition in the Borderline Range of intelligence. As has been shown in past cognitive evaluations, the Appellant scored a significant difference between his Performance (non-verbal) scale score and his Verbal scale score, with a Verbal IQ of 74 and a Performance IQ of 56. This evaluation reports that the Appellant "did present with a high degree of accuracy in his analysis of information, but acquired the low scores because he completed a minimal amount in the time frame allowed." The 2004 assessment also included an evaluation of the Appellant's academic skills and found that the Appellant's academic skills fell "within the very low range of others at his age level". Noteworthy is the fact that although the Appellant's Verbal and Performance index scores in this evaluation have declined slightly when compared to the previous 2001index scores, the Appellant's overall level of intelligence was still determined to fall in the Borderline range of intelligence. As this

cognitive evaluation meets all the regulatory requirements of a qualified professional properly administering and interpreting the results of an approved IQ testing instrument, full weight was given to the results of this cognitive assessment in making a determination as to the Appellant's level of cognition at the age of seventeen years, [redacted] a level that is above DDS's requirement for eligibility.

- The ninth cognitive test listed is the WAIS-III (DDS Exhibit #13) that was administered to the Appellant by psychologist, [redacted], Ph.D., as part of a neuropsychological evaluation which began in [redacted] 2007 at Dr. [redacted] office but was completed in [redacted] 2007 at [redacted] where the Appellant was psychiatrically hospitalized at that time. This WAIS-III was conducted at the Appellant's age of twenty years, [redacted] and resulted in a Full Scale IQ of 65 with a Verbal IQ of 73 and a Performance IQ of 60. The purpose of the cognitive testing is identified as an assessment to determine whether the Appellant would be eligible for services under the Department of Mental Retardation. Dr. [redacted] reports that the Appellant's thinking appeared delusional and, or psychotic at times, and in making a professional judgment regarding the Appellant's overall level of intelligence, Dr. [redacted] determines the Appellant's level of cognition to fall in the Borderline range of intelligence, a range that is above the level required for a diagnosis of Mental Retardation. As seen in the past, although the Appellant's Full Scale IQ score does fall in the Mentally Retarded range of intelligence, the qualified professional conducting the assessment, after evaluating all aspects of the Appellant's performance on the day of testing, has determined that his true overall level of cognition falls in the Borderline range of intelligence. Dr. [redacted] summarizes by stating that the Appellant is "a 20-year-old male with a long-standing history of developmental impairment associated with intellectual deficiency, poor interpersonal relatedness, learning disabilities and severe impairment in adaptive behavior. The combination of these disabilities is consistent with a diagnosis of Pervasive Developmental Disorder Not Otherwise Specified." As this cognitive evaluation meets all the regulatory requirements of a qualified professional properly administering and interpreting the results of an approved IQ testing instrument, full weight was given to the results of this cognitive assessment in making a determination as to the Appellant's level of cognition at the age of twenty years, [redacted] a level that is above DDS's requirement for eligibility.

- The last listed and most recent cognitive testing of the Appellant is the WAIS-III (DDS Exhibit #11) that was administered by [redacted], Ed. D., Consulting Psychologist, in [redacted] 2009, at the Appellant's age of twenty-two. Dr. [redacted] notes the following about the Appellant: his thought process was disorganized; he would spontaneously laugh and make comments that were playful but unrelated to the context of the conversation; his speech was tangential; he was friendly and cooperative with lapses of attention or to make inappropriate comments; he has impulsive traits; his judgment appeared to be partial; and he was no longer taking psychiatric medications. The WAIS-III resulted in a Verbal IQ of 80, a Performance IQ of 65 and a Full Scale IQ of 71. Dr. [redacted] found the Appellant's overall cognitive ability to fall in the Borderline range of intelligence. As this cognitive evaluation meets all the regulatory requirements of a qualified professional properly administering and interpreting the results of an approved IQ testing instrument, full weight was given to the results of this cognitive assessment in making a determination as to the Appellant's level of cognition at the age of twenty-two, a level that is above DDS's requirement for eligibility.

- Significant weight was also given to Dr. Frederick Johnson's assessment of the Appellant's overall level of cognition. Dr. Johnson who is a professional qualified in the administration of cognitive tests, testified that a person cannot score above his or her cognitive capacity by chance. In order to obtain credit on cognitive tests, an individual must give the proper information or perform the requested task. The Appellant could not score out of the range of Mental Retardation if he did not have the cognitive capacity to do so. On the other hand, the Appellant may perform poorer on a test due to multiple reasons, such as an inability to attend to task and other difficulties associated with the Appellant's ADHD and mental illness. The Appellant has scored in the Borderline range of cognition, above the level required for a diagnosis of Mental Retardation. Also significant is the fact that the Appellant was not determined to be a person with Mental Retardation even when his IQ test scores fell at the level that meet the requirement for a diagnosis of Mental Retardation; in every case the professional conducting the test found the Appellant's level of intelligence to fall in the Borderline range of intelligence, above the level required for a diagnosis of Mental Retardation. The evidence in this matter makes clear that all the professionals conducting cognitive testing on the Appellant were aware that factors associated with the Appellant's ADHD and mental illness impacted upon his performance.

- In addition, the Appellant's academic testing and accomplishments support a finding that that Appellant is not a person with Mental Retardation. The Appellant has graduated from high school with a diploma, has passed the test required to obtain a drivers permit, and has exhibited the ability to successfully use the internet, albeit to his detriment.

- There is no question that the Appellant has significant limitations in adaptive functioning and that he consistently shows very poor judgment. However, the fact that a person shows very poor judgment and exhibits significant adaptive deficits does not cause the person to be diagnosed with Mental Retardation. While the Appellant's adaptive function test results did not rule out a possible diagnosis of Mental Retardation, DDS regulations do not allow eligibility to be determined based on adaptive functioning alone; adaptive functioning deficits can be result of conditions other than Mental Retardation. Significant limitations in adaptive functioning can be caused by mental illness and other medical problems that impede upon an individuals ability to function. A person very well could be functioning in the range of Mental Retardation but unless it is demonstrated through valid IQ test results that the cause of the significant adaptive deficits is due to Mental Retardation, eligibility for DDS services is not allowed. In the Appellant's case, there is ample evidence of a significant mental disability that could impede upon his ability to function. Therefore the results of the Appellant's adaptive functioning tests are not dispositive in this matter.

In summary, upon a comprehensive review of the oral testimony and documentary evidence submitted in this matter, I find that the preponderance of the evidence supports the Department's finding that the Appellant's overall cognitive ability falls in the Borderline range of intelligence, above the range required for DDS eligibility. The Appellant's difficulties with mental illness and adaptive functioning, while indicating that the Appellant is functioning at a low level, are not verification of the presence of Mental Retardation as that term is used and defined by DDS regulations. The Department's eligibility regulations require that a finding of DDS eligibility cannot be made without an overall cognitive ability in a range established to be at or below the level of Mild Mental Retardation, a cognitive range which is shown by a valid FSIQ score of 70 or below. The Appellant's variation in

subtest scores with some subtest scores in the Average range of intelligence and others in the Extremely Low range of intelligence, has not been determined by any of the psychologists who have conducted IQ testing on the Appellant to establish a finding of Mental Retardation. Similarly, the scoring of a Full Scale IQ of below 70 on some IQ tests has not been determined to be a valid scoring by the psychologists conducting the IQ tests, and therefore, was not determined to be a finding of Mental Retardation for the Appellant. As the Appellant has not met the burden of proof in this matter, I do not find for the Appellant. I further find that the evidence presented by DDS supports a finding that DDS followed established standards and procedures in considering the Appellant's eligibility. Therefore, DDS's determination of ineligibly is upheld.

APPEAL:

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

Date:_____

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Jeanne Adamo