2010-39

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


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**Elin M. Howe**
Commissioner
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2010

MA

**Re: Appeal of - Final Decision**

Dear :

Enclosed please find the recommended decision of the hearing officer in the above appeal. A fair hearing was held on the appeal of your daughter'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 daughters's appeal is therefore DENIED.

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

Sincerely,

Elin M. Howe
Commissioner

EMH/ecw
cc: Elizabeth Silver, Hearing Officer
Amanda Chalmers, Regional Director
Marianne Meacham, General Counsel
Barbara Green Whitbeck, Assistant General Counsel
Paula Potvin, Regional Eligibility Manager
Patricia Shook, Psychologist
File

**COMMONWEALTH OF MASSACHUSETTS**
**DEPARTMENT OF DEVELPMENTAL SERVICES**

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

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

Those present at the hearing:

For the Appellant:

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|---|---|
| [redacted] | Appellant (present for a portion of the hearing) |
| | Mother of Appellant |
| | Psychologist |
| | Speech-Language Pathologist |
| | Grandfather of Appellant (Observer for a portion of the hearing) |
| | Grandmother of Appellant (Observer for a portion of the hearing) |
| | Aunt of Appellant (Observer for a portion of the hearing) |

For the Department:

| | |
|---|---|
| Patricia Shook. | Psychologist |
| Barbara Green Whitbeck | Attorney |

The parties submitted a total of 34 exhibits. Exhibits 1-12 were submitted by the Department; Exhibits 13-34 were submitted on behalf of the Appellant. The hearing lasted approximately four hours during which the Appellant, [redacted], Dr. [redacted], Ms. [redacted], and Dr. Shook testified.

**ISSUE PRESENTED:**

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

**SUMMARY OF THE EVIDENCE**

Initially, the Department conceded that the Appellant was domiciled in Massachusetts and that she met the adaptive functioning prong of its definition of mental retardation. Therefore, the only issue on appeal is whether the Appellant has sub-average intellectual functioning that exists concurrently and related to significant limitations in adaptive functioning.

**Exhibit 1.** Curriculum Vitae for Patricia H. Shook, Ph.D.

**Exhibit 2.** Department regulations at 115 CMR 2.01.

**Exhibit 3.** Department regulations at 115 CMR 6.00.

**Exhibit 4.** Adult Eligibility Determination prepared by Dr. Patricia Shook based on a review done on [redacted]09. Dr. Shook set forth the Appellant's diagnoses, the results of three cognitive evaluations, and the results of adaptive behavior assessments.

**Exhibit 5.** Letter dated [redacted]10 submitted by the Appellant's mother on behalf of the Appellant to appeal the Department's denial of eligibility. In addition to the notice of appeal, the letter also provides Ms. [redacted] rationale as to why she believes the Appellant is eligible for services.

**Exhibit 6.** Department letter dated [redacted]10 informing the Appellant that the Department continued to deny eligibility after the informal conference.

**Exhibit 7.** Letter dated [redacted]10 from the Appellant's mother requesting a Fair Hearing and Department's [redacted]10 Fair Hearing Scheduling Notice.

**Exhibit 8.** Psychological Evaluation done by [redacted], MEd, CAGS, NCSP, Certified School Psychologist, for [redacted]. The evaluation was administered over three days on [redacted]01, [redacted]01 and [redacted]01 when the Appellant was 9[redacted] years old. By way of background, Ms. [redacted] noted that the Appellant had an educational disability related to Autistic Spectrum Disorder, which was initially diagnosed at the age of three. She had delays in the development of speech and language skills, she received Early Intervention services, and she received special education services throughout her schooling. At the time of this evaluation the Appellant was attending [redacted] where she was in a special needs classroom with [redacted] other [redacted] children with significant communication needs.

Ms. [redacted] noted previous cognitive testing in [redacted] 1995 and in [redacted] 1998. The Appellant's overall functioning levels were in the borderline to low average range.

Ms. [redacted] administered both the Wechsler Intelligence Scale for Children-Third Edition (WISC-III) and the Leiter International Performance Scale-Revised (Leiter), which involves few verbal instructions. The Appellant was unable to respond reliably to the standard Verbal subtest questions on the WISC-III. On the Performance Scale, the Appellant achieved an IQ score of 63-79. On the Leiter the Appellant's scores were Fluid Reasoning 83-89, Brief IQ 84-90, and Full IQ 83-88.

Completion of both tests revealed a scattering of nonverbal intellectual abilities ranging from significant delay in attention to detail and visual sequencing, to solidly average abilities on motor and nonmotor involved tasks. Ms. [redacted] said that although the Appellant's areas of weakness were consistent with previous psychological and neuropsychological evaluations, the Appellant demonstrated some impressive areas of cognitive growth.

In summary, Ms. [redacted] noted that past evaluations showed significant concerns for limited communication and socialization skills development, poor sequencing abilities and difficulties attending to specific visual detail. Ms. [redacted] said these areas of concern continued to be evident in the current evaluation although the Appellant's visual reasoning and problem solving abilities appeared to have developed to a more consistently average level.

**Exhibit 9.** Psycho-Educational Reports done [redacted]07, [redacted]07, and [redacted]07 by [redacted], MA, CAGS, School Psychologist, when the Appellant was 15[redacted] years old. For cognitive testing, Ms. [redacted] administered the Universal Nonverbal Intelligence Test (UNIT) and the Wechsler Intelligence Scale for Children-Fourth Edition (WISC-IV Integrated). She also administered the Adaptive Behavior Assessment System, Second Edition (ABAS II).[1]

Ms. [redacted] discussed prior cognitive testing from 1998 in which the Appellant was functioning in the low average to average range on many of the nonverbal subtests (noted in Exh 8) and from the 2001 WISC-III (reviewed in Exh 8). Ms. [redacted] also discussed WIDC-IV testing from [redacted] 2004 on which the Appellant

[1] Because the Department conceded that the Appellant met the Department's criteria with respect to adaptive functioning, I will not be reviewing adaptive functioning assessments in detail.

obtained a Full Scale IQ (FSIQ) score of 53 and Index scores of Verbal Comprehension (VCI) 50, Perceptual Reasoning (PRI) 79, Working Memory (WMI) 52, and Processing Speed (PSI) 62.

On the WISC-IV, because the Appellant was not able to complete any of the verbal components, Ms. [redacted] implemented the Process Approach from the WISC IV Integrated, which a respondent chooses from four multiple choice options rather than thinking of the answer on her own. The Appellant's Index scores on the WISC-IV Integrated were VCI 47, PRI 75, WMI 59, and PSI 91, and her FSIQ was 60.

The UNIT measures general intelligence and cognitive abilities of children ages 5 through 17 years old who may be disadvantaged by traditional verbal and language-loaded measures. The Appellant's Quotient scores were Memory 87, Reasoning 75, Symbolic 83, and Nonsymbolic 79, and her FSIQ was 79.

On the Wechsler Individual Achievement test-Second Edition (WIAT-II), the Appellant obtained a Reading Composite score of 47 (extremely low) and a Mathematics Composite score of 40 (extremely low). Ms. [redacted] was unable to administer the Written Expression, but the Appellant scored 71 on Spelling.

The Appellant's mother and three teachers completed the ABAS II, which yielded scores ranging from extremely low to above average.

In summary, Ms. [redacted] said the Appellant had a diagnosis of Autism and her overall performance was greater when attempting nonverbal tasks. Many of the Appellant's nonverbal scores were within the low average to average range. She presented relatively strong visual scanning skills, ability to break an abstract whole down into its parts, and visual problem solving skills involving fine motor and speed. She also presented average short-term recall and recognition of both meaningful and abstract material; a measure of memory for content, location and sequence and an ability to solve problems that involve meaningful material and whose solutions lend themselves to internal verbal mediation, including labeling, organizing, and categorizing. She was greatly challenged when language was required, even when multiple choices were provided.

**Exhibit 10.** Psychological Evaluation done by [redacted], M.A., C.A.S, School Psychologist at the [redacted]. The evaluation was completed on [redacted]09 when the Appellant was 18[redacted] years old. Ms. [redacted] conducted this evaluation as part of the Appellant's three-year re-evaluation process. She noted the Appellant's special education classification of Autism.

Ms. [redacted] reported on prior testing (Exh 9) as well as another WIAT-II administered to the Appellant in [redacted] 2008 on which the Appellant's scores were Reading Composite 50, Mathematics Composite 42, and Spelling 64.

Ms. [redacted] administered the Wechsler Adult Intelligence Scale-Fourth Edition (WAIS-IV). She said overall the results were judged to be an accurate portrayal of the Appellant's current levels of functioning. The Appellant's scores were VCI 58, PRI 86, PSI 92, and WMI 71. Given the statistically significant differences between the Appellant's extremely low range VCI abilities, her borderline WMI, her low average PRI, and her average PSI, Ms. [redacted] said a full scale IQ score should not be interpreted as a valid representation of the Appellant's global skills and that cognitive functioning should be considered according to each domain.

On the Woodcock-Johnson Tests of Achievement-Third Edition (WJ-III ACH), the Appellant's Total Achievement score was 53 (very low range, <0.1 percentile). Her Broad Reading score was 56 (very low range, <0.2 percentile), her Broad Math score was 43 (very low range, <0.1 percentile), and her Broad Written Language score was 72 (low range, <3rd percentile).

In summary, with regard to the Appellant's cognitive functioning, Ms. [redacted] said the Appellant demonstrated extremely low verbal reasoning skills. Her nonverbal reasoning skills were within the low average range. Overall, the Appellant's academic functioning fell within the very low range.

**Exhibit 11.** Occupational Therapy Screen/Assessment completed by [redacted], M.A. OTR/L, on [redacted]07 for the [redacted]. The Appellant was 15[redacted] years old. At the time of this evaluation the Appellant was in the 9th grade at [redacted] working in [redacted]. The Appellant scored below average on Manual Coordination. Within the area of Visual Perceptual/Motor Skills, the Appellant scored a 97 (average) on Berry VMI, which assesses the extent to which individuals can integrate visual and motor abilities. She had an 81 (below average) on Visual Perception and a score of 90 (average) on Motor Coordination.

**Exhibit 12.** Occupational Therapy Assessment again completed by [redacted] M.A. OTR/ for the [redacted]. This evaluation was done on [redacted]10, [redacted]10, and [redacted]10 when the Appellant was 18[redacted] years old. At the time of this evaluation the Appellant was in the 12th grade at [redacted] and still working in a [redacted]. Manual Coordination continued to be in the below average range, and on Visual Perceptual/Motor Skills the Appellant scored a 79 on Berry VMI (low), 76 on Visual Perception (low) and 76 on Motor Coordination (low). Ms. [redacted] said these scores placed the Appellant in the low range in ability to integrate her visual and motor abilities in relation to same age peers. She noted the decline in scores since the 2007 testing (Exh 11), but said the decline "does not appear to be due to a decline in functioning but due to an increase in requirement of specificity for same age peers."

**Exhibit 13.** [redacted]10 letter from State Senator Bruce Tarr and State Representative Bradford Hill on behalf of the Appellant urging DDS to consider the Appellant's appeal.

**Exhibit 14.** Letters dated [redacted]10 and [redacted]09 from [redacted], MD on behalf of the Appellant. Dr. [redacted] stated she had known the Appellant since she was three years old. She said the Appellant had been measured many times and in addition to the diagnosis of Autism she demonstrated a significant intellectual disability. Dr. [redacted] also recommended full guardianship since she believed the Appellant was not capable of giving informed consent.

**Exhibit 15.** Curriculum Vitae for [redacted], Ph.D.

**Exhibit 16.** Curriculum Vitae for [redacted], CCC-SLP along with a Speech-Language Evaluation done by Ms. [redacted] on [redacted], [redacted], and [redacted], 2009 when the Appellant was 18[redacted] years old. Ms. [redacted] noted that the Appellant had a diagnosis of Autism. She administered parts of the Clinical Evaluation of Language Fundamentals, Fourth Edition (CELF-4), a comprehensive test of Receptive and Expressive Language. The Appellant's Core Language Index score was 40, which was in the less than 0.1 percentile and in the very low/severe range. For Receptive Language Testing, Ms. [redacted] administered, among others, the Peabody Picture Vocabulary Test – 3rd Edition (PPVT-III) on which the Appellant's score of 56 (extremely low), had a percentile rank of .2 and an age equivalent of 7 years 6 months. Ms. [redacted] also tested Expressive Language and Conversation and Pragmatics. She concluded that the Appellant had severely impaired language and her use of language was at the approximate level of a 2½ to 3 year old with disordered language skills.

**Exhibit 17.** Arena Assessment done by [redacted] on [redacted]94 when the Appellant was 33 months [redacted] old. The assessment determined that the Appellant had delays in expressive and receptive communication and social interactions.

**Exhibit 18.** Umwelt Assessment dated [redacted]94 when the Appellant was 2[redacted] years old done by [redacted], Ph.D, and [redacted], M.A of the [redacted]. This assessment concluded that the Appellant presented with pervasive developmental disorder and she was functioning at the 16-18 month level. The Appellant was referred to the [redacted] Program.

**Exhibit 19.** Pediatric Evaluation done on [redacted]94 and [redacted]94 by [redacted], M.D. of the [redacted], when the Appellant was 2[redacted] years old. She was referred for evaluation to understand why she was not yet talking or playing with other children. At the time she had delayed and atypical language skills,

poorly developed social skills, and rigid, though complex play patterns. Dr. [redacted]'s opinion was that the Appellant was autistic and recommended attendance at a full-day preschool program specifically for young children with PDD/Autism.

**Exhibit 20.** Four separate documents as follows:

1. Summary of Psychiatric Consultation based on evaluation done [redacted] 94 and [redacted] 94 by [redacted], M.D., Director [redacted]. The Appellant was 2[redacted] years old at the time. She was referred for a second opinion concerning her diagnosis of Autism. Dr. [redacted] concluded that the Appellant presented with a clinical picture of developmental disorder, specifically Autistic Disorder.

2. [redacted] Pediatric Neurology Report from [redacted], M. D. dated [redacted] 94. Dr. [redacted] assessed the Appellant for purposes of determining the best educational placement to meet her needs. She recommended continued placement at her present school with some additional language services.

3. Neurology Consultation by [redacted], M.D. done [redacted] 00 when the Appellant was 8[redacted] years old.[2] The Appellant was a student at [redacted] at the time. Dr. [redacted] did a neurological examination and in summary reviewed the Appellant's diagnosis of Autism Spectrum Disorder/Pervasive Developmental Disorder and recommended evaluation by a pediatric psychopharmacologist for a review of medications.

4. Neurology Consultation, again done by [redacted], M.D. This consultation was done [redacted] 03 when the Appellant was 11[redacted] years old. She was in the 5th grade at the [redacted] in [redacted] and was making progress academically although she was performing at the 2nd grade level. Dr. [redacted] again noted the diagnosis of Autism Spectrum Disorder/Pervasive Developmental Disorder.

**Exhibit 21.** Report of Neuropsychological and Educational Assessment based on examinations done by [redacted], Ph.D, and [redacted], Ph.D on [redacted] 10, [redacted] 10, [redacted] 10, and [redacted] 10 when the Appellant was 18[redacted] years old.[3]

Dr. [redacted] reviewed the Appellant's developmental, behavioral, educational, and testing history. Her impression after this thorough and comprehensive review was confirmation of the Appellant's continued placement within the Pervasive Developmental Disorder/Autism category, although her presentation had improved notably since earlier years when she was nonverbal and exhibited aggressive behaviors. With respect to the Appellant's cognitive functioning, Dr. [redacted] noted the continuation of the Appellant's historical pattern of stronger nonverbal/visual than verbal cognitive functioning. Her scores from current testing, reviewed below, were somewhat lower than her most recent evaluation (Exh 10), but the pattern of significantly stronger nonverbal than verbal cognitive skills continued. Dr. [redacted] said this pattern was quite common in individuals with Autism due to their inherent language challenges. In terms of language, Dr. [redacted] said the Appellant's use of language remained at a mid-two year level, consistent with the results from her last evaluation (Exh 10).

Among a comprehensive battery of tests, Dr. [redacted] administered the Stanford Binet-Fifth Edition (Verbal Scale) (SB-5) and the Leiter International Performance Scale-Revised (Leiter). On the SB-5 the Appellant had a Verbal IQ standard score of 48, which was less than the 1st percentile. This was compared to the Verbal Comprehension scale score of 58 on the WAIS-IV (Exh 10). On the Leiter, the Appellant had a Brief IQ of 78, which was in the 7th percentile. This was compared to the Perceptual Reasoning scale score of 86 on the WAIS-IV (Exh 10). The Appellant's Fluid Reasoning IQ score was 84, which was in the 14th percentile.

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[2] Dr. [redacted] is also the author of the Psychiatric Consultation in Exhibit 20-2.

[3] I refer to the Exhibit as Dr. [redacted]'s report in the body of this decision.

Dr. [redacted] also administered the Wechsler Individual Achievement Tests-Third Edition (WIAT) (selected subtests). The Appellant's standard score were as follows: Word Reading 67 (grade equivalent 3-04), Reading Comprehension (GE 1-02), Numerical Operations 62 (GE 2-07), Math Problem Solving 59 (GE 2-04), and Spelling 69 (GE 4-00).[4]

In summary, Dr. [redacted] said the Appellant had several areas of strength in her profile including her stronger visual-spatial skills and her strong effort when attempting a variety of tasks. Dr. [redacted] also said the Appellant had progressed significantly since her earlier years but remained challenged in several major areas. Most significant was her high level of anxiety, associated problematic behaviors, and her language weakness.

**Exhibit 22.** Psycho-Educational Report completed [redacted]08-[redacted]08 by [redacted], M.A., CAGS, School Psychologist, for the [redacted].[5] The Appellant was 16[redacted] and in the 10th grade at the time of the report. Ms. [redacted] administered the WIAT-II on which the Appellant's Reading Composite score was 50, her Mathematics Composite score was 42, and her Spelling score was 64. Ms. [redacted] noted that the Appellant showed improvement in all areas with the exception of Spelling, and all in all she had good growth in her academic skills over the prior year. At the same time Ms. [redacted] noted an increase in behavioral problems at home and at school.

**Exhibit 23.** Speech and Language Evaluation Report completed by [redacted], M.S., CCC-SLP, on [redacted]01 when the Appellant was 9[redacted] years old. The results of this testing suggested the Appellant's receptive and expressive language abilities were in the severely delayed range when compared to age-matched, hearing peers.

**Exhibit 24.** Psychology Report done by [redacted], Ed.D, Psychologist for the [redacted], on [redacted]95 when the Appellant was 4[redacted] years old. Dr. [redacted] administered the Bayley Scales of Infant Development-Second Edition (Mental Scale) on which the Appellant achieved a developmental age level of 18 months.

**Exhibit 25.** Vineland-II completed on [redacted]09. [redacted] was the Examiner and the Appellant's mother was the Respondent. The Appellant's scores were Communication 42, Daily Living Skills 58, Socialization 46, and Adaptive Behavior Composite 48.

**Exhibit 26.** Psychological Evaluation Addendum prepared by [redacted], M.A., CAS, for [redacted]. The report is dated [redacted] 2010 when the Appellant was 18[redacted] years old. Ms. [redacted] administered the Adaptive Behavior Assessment System-Second Edition (ABAS-II) which was completed by the Appellant's mother, two of the Appellant's Special Education teachers, and her Occupational Therapist. The results showed that the Appellant had significant weaknesses in the areas of Communication, Functional Academics, Social Skills, Community Use, and Health and Safety Skills.

**Exhibit 27.** McCarron-Dial Evaluation System (MDS) completed on [redacted]08 and [redacted]08 by [redacted], Vocational Specialist, when the Appellant was 16[redacted] years old. The MDS assesses an individual's vocational potential. The results of this assessment placed the Appellant in the "Low Extended Work Training/Prevocational" range for predicted level of vocational functioning. The evaluation also provided a predicted residential level, and placed the Appellant within the "Intermediate Care/Partial Support" level.

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[4] Dr. [redacted] also administered the Vineland-II on which the Appellant's age equivalent scores were Personal 8-06, Domestic 4-07, and Community 6-06.

[5] Ms. [redacted] is the same person who administered the WIAT-II in 3/07 (Exh 9).

**Exhibit 28.** Four documents all completed by [redacted] and Dr. [redacted], both of whom are from [redacted] and [redacted]. Dr. [redacted] is Director of [redacted]

1. Independent Evaluation dated [redacted]08 when the Appellant was 16[redacted] years old. The Appellant's mother had requested an observation and assessment of the Appellant's current program at [redacted] in order to provide a fair and objective evaluation of the Appellant's current educational services. After following the Appellant all day and speaking with numerous school personnel, the assessors determined that there was an overall lack of clearly defined instructional objectives and targets, a precise system for determining the Appellant's progress over time, and clearly defined and individualized teaching procedures. Various remedial recommendations were proposed.
2. Report of a [redacted] 2008 School Consultation in which Ms. [redacted] provided training and consultation to the staff of the [redacted] Program on the Appellant's behalf.
3. Report of an [redacted] and [redacted] 2008 School Consultation in which Ms. [redacted] provided continued training and consultation to the staff of the [redacted] Program on the Appellant's behalf.
4. Report of a [redacted] 2010 School Consultation in which Ms. [redacted] provided continued training and consultation to the staff of the [redacted] Program on the Appellant's behalf.

**Exhibit 29.** Two Transition Planning Forms completed on [redacted]08 and [redacted]10 by the [redacted]. Both suggest that the Appellant was affected by a cognitive disability ([redacted]08) or Autism [redacted]10), which had an impact on the academic, vocational, and social aspects of her life. Both suggested various considerations for future planning.

**Exhibit 30.** Appellant's Individualized Educational Plan (IEP) covering [redacted]10 – [redacted]11. The IEP notes the Appellant's disability and diagnosis as Autism, and also notes she has significant delays in language, social skills, and behavior. It reviewed cognitive testing from [redacted] 2009 (Exh 10), Speech and Language Testing from [redacted] 2009 (Exh 16), and Occupational Therapy Testing from January 2010 (Exh 12). The Transition Planning Form from [redacted] 2010 (Exh 29) was attached. The IEP repeatedly discusses the impact the Appellant's Autism has on her skills and performance.

**Exhibit 31.** Letters of Guardianship documenting the Appellant's mother was appointed Permanent Guardian of the Appellant on [redacted]10.

**Exhibit 32.** Photograph labeled "Dell All in One Printer [redacted]. [redacted] 2010."

**Exhibit 33.** One-page excerpt that discusses eligibility for services in [redacted] for people with diagnoses of Autism.

**Exhibit 34.** Token chart for the Appellant.

## TESTIMONY

Exhibits 1-33 were entered into the record without objection.[6] At the outset, Department's counsel indicated that the Department conceded that the Appellant was domiciled in Massachusetts and that the scores on her adaptive assessments met the adaptive functioning prong of the Department's eligibility requirements. However, the Department believed the Appellant did not meet the cognitive functioning prong of its regulations.

Both parties made brief opening statements. [redacted] agreed to be the spokesperson on behalf of the Appellant and to coordinate testimony of the witnesses.

[6] Exhibit 34 was admitted later in the hearing.

Ms. [redacted] asked the Appellant a series of questions including her name and address, how long she has lived in [redacted] and where she goes to school. Ms. [redacted] had to direct the Appellant when said she had unresponsive answers. For example, Ms. [redacted] asked the Appellant where she went to school. The Appellant said, "[redacted]." Ms. [redacted]: [redacted]? Appellant: [redacted] Ms. [redacted]: But what's name of school? Appellant: Maybe, like [redacted].

Ms. [redacted] went on to ask the Appellant what she does, and she answered, "Maybe pay money." When asked what for, she answered, "The mall at [redacted]." When asked what she learns in school, the Appellant said, "Maybe, math." When pressed for more details, she said "Maybe, subtraction." There were further questions around who was in her class and the Appellant mischaracterized one person as being her friend when he was her teacher. The Appellant said she worked at church, she liked to stretch, she liked to do puzzle [sic]. The Appellant said, "People don't want to throw their puzzle pieces away because you makes them feel mad." When asked what she does if she wants to use the computer, the Appellant said, "Maybe look for video." When asked if she takes medicine, the Appellant said yes, and when asked how many she said "Morning and night." When asked how many she takes in the morning she first said two and then she said three, and when asked what the medicines were for she said, "PG." When asked what she takes she said "women daily." When asked again for the name of her medicine, she said, "Vitamin A?" For the record Ms. [redacted] said the Appellant took Celexa, Strattera, and Lisinopril.

Other questions elicited similar responses. The Appellant knew to look both ways when crossing a street, but Ms[redacted] said the Appellant walked right out into the busiest intersection in [redacted] and was hurt, so she doesn't walk by herself. When asked if she had any friends, the Appellant mentioned a woman who Ms. [redacted] explained was the Appellant's physical education teacher in [redacted]. When asked why she puts a stamp on a letter, the Appellant said, "Because you put post office." And then "It makes them mad." The Appellant could not provide a reasonable answer to what she would do if she got lost at the mall. When asked what she would do if a man came to the door, she said, "Maybe you got lost."

Ms. [redacted] testified next. By way of overview, she said the Appellant was her second child. Her [redacted], [redacted], is 20 and attends [redacted]. The Appellant's father is deceased. The Appellant was diagnosed with Autism at 2[redacted] years old in 1994. At that time Ms. [redacted] was told that Autism was a low incidence disability. The Appellant was only able to get three hours a week of Early Intervention services and had to go to [redacted] for it. She noted how much things have changed since then.

Ms. [redacted] said the family lived in [redacted] at the time the Appellant was diagnosed. She said no one bothered to say the Appellant had mental retardation. She said the Appellant was totally nonverbal and her cognition was half her chronological age, but no one wrote down mental retardation. Ms. [redacted] referred to testing done in 1995 when the Appellant was 4[redacted] years old (Exh 24) where test results showed the Appellant achieved a developmental age-level of 18 months on the Bayley II Mental Scale. Ms. [redacted] said no one felt they needed to write the words mental retardation at the time because if someone had Autism people assumed they also had mental retardation.

Ms. [redacted] said that from the time Appellant was first testing through the present, she has shown an intellectual disability. Because of schooling at [redacted], the Appellant received a visual curriculum and started talking at about 6 years old. She said most recently the Appellant has been in special education programs out of the district for five years. She was in the district for the other 11 years with either one-to-one or two-to-one support. Ms. [redacted] said the Appellant has functional classes as well as help with speech, social skills, and behavior. She has a teacher and job coach and a summer program. When she was at the [redacted] before beginning the [redacted] program, the school district didn't know how to teach the Appellant and she was in danger of being excluded from the [redacted], so the district brought in the [redacted] clinic that worked on a token system.

Ms. [redacted] said the Appellant had to be put on the token chart program to learn proper behavior because she is frustrated and she can't communicate what she's thinking.[7] Most recently the Appellant hit one of her testing evaluators. In another incident she threw away the printer. This year the Appellant threw out the VCR, CD, radio, cable cord, food in the freezer and Ms. [redacted]'s prescription glasses. Ms. [redacted] said her concern was that the Appellant could presently succeed just marginally with the external set up of tokens, rules, and supervision, but it's difficult for people who don't know the Appellant to figure out what she's talking about. Ms. [redacted] said the Appellant can't be alone due to poor safety awareness. She said the Appellant usually doesn't respond to the phone or doorbell. One time she did answer the phone when it turned out a doctor's office was calling and said, "Hello Mrs. [redacted], when is it [redacted]'s sleep your house?" Ms. [redacted] said the Appellant has had seven years of travel training by professionals and she still can't cross a street or parking lot by herself. [redacted]. Once she started a fire by leaning over a candle and her hair caught on fire, another time she started a fire by putting Christmas wrap on candles and then walked away. In summary, Ms. [redacted] argued that the Appellant has mental retardation and that her narrow strengths make her appear more able on paper than she is in real life.

Dr. [redacted] testified next on behalf of the Appellant. He said he is a Neuropsychologist with a Doctorate in Clinical Psychology. He specializes in training in neuropsychology and children. He has a clinical license in psychology. His main position is the [redacted], which is a multidisciplinary center for diagnostic services and remediative services for children who have learning and developmental challenges. Additionally he is the clinical director of an agency that serves children with Autism as well as a school that serves children with Autism. He has also taught in the past.

Dr. [redacted] clients are children with all types of learning and developmental disabilities. He said he sees an average of 12-14 children per week for evaluations. Primarily he does either developmental or neuropsychological diagnostic evaluations, and he also consults with parents and schools. He said his agency treats clients with intellectual disabilities and mental retardation. He said he is trained to conduct IQ testing and is familiar with IQ testing for functional impairments. He estimated that he has administered thousands of IQ tests.

Dr. [redacted] said that he was familiar with the eligibility criteria for DDS services. He said he recently met the Appellant and participated in her evaluation (Exh 21). He said the Appellant had been seen by a number of excellent clinicians so their diagnostic determination wasn't anything new. Dr. [redacted] testified that they concurred with other professionals who determined that the Appellant's presentation was consistent with Autism. By way of an overview, Dr. [redacted] said his report described the Appellant's cognitive challenges. He said he specified the Appellant's difficulty with language, which he said is a hallmark of children with the Appellant's presentation, he addressed how her cognitive limitations translated into functional deficits, and he gave a number of recommendations for the Appellant's care and education.

Dr. [redacted] said his test results were fairly consistent with prior testing. He determined the Appellant had a diagnosis of Autism. For cognitive testing, since the WAIS had been performed a few years earlier they didn't see the relevance of using the same measure.[8] Referring to "the floor," Dr. [redacted] said the WAIS is not as sensitive particularly in the lower ranges,[9] so they opted to test using the verbal IQ portion of the Stanford-Binet. He said the Appellant's score was 48, which was 10 points lower than what she was able to obtain on the WAIS and is notably below the 1st percentile.

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[7] The token chart was taken into evidence and marked as Exhibit 34.

[8] The WAIS was given in [redacted] 2009 and the current evaluation was administered in [redacted] 2010.

[9] On cross-examination Dr. [redacted] explained his reference to "the floor" by saying that with the WAIS, the first question is naturally expected of a person with verbal capacity, and the children that don't have that capacity don't arrive at the floor, so the test is not very informative. Dr. [redacted] clarified that he was referring to the verbal portion since the Appellant wasn't testing at the floor for the nonverbal portion.

Dr. [redacted] explained that the Leiter was another battery typically used for children on the Autism spectrum because it bypasses language demands and the child doesn't have to rely on any verbal instructions. It is an instrument that assesses nonverbal capabilities. It tends to provide tasks that initially are fairly self-evident and then the complexity can be increased. Dr. [redacted] said the Appellant's scores, somewhat consistent with previous results on WAIS, ranged from the borderline to low average range, that is, from the 7th to 14th percentile.

Dr. [redacted] discussed those test portions on which he said the Appellant was fortunate to have scored well. He said those areas were fairly limited in scope but they inflate the overall scores. He said the WAIS from [redacted] 2009 shows a particularly high score on things of a spatial nature, which is not atypical for children with Autism. On Block Design and the Visual Puzzle the Appellant's scores were 9 and 9, where an average score is 10. Dr. [redacted] said those scores penalize the Appellant as much as they represent her capabilities with respect to those specific measures. He said psychologists typically use that information to see how the skills translate in a functional manner. For the majority of the population, Dr. [redacted] said there is a great deal of translatability in that scores such as a 9 on Block Design typically predict typical functioning. However, he said in the case of children with Autism it is pretty clear the higher scores don't translate into functioning. He said the most important issue was whether those higher scores achieved by children with Autism provide true indicators of the capability to use intelligence to learn and to adapt (like they are for children without Autism), or whether they represent something that is notably of a smaller scope.

Dr. [redacted] said that for children like the Appellant who have a combination of Autism and an intellectual disability, the higher scores on those two subtests do not permit them to actually use those skills in their daily functioning. He said that with the exception of those predictable spatial numbers, the Appellant doesn't have reasoning that could be used for navigating her environment, which results in her diminished ability to function.

Dr. [redacted] said the Appellant's capability in language was at the five-year old level, but the functionality of her language was even more reduced. He said the Appellant had acquired some limited academic skills, and her reading comprehension and math capabilities were in the five and six year old level, which is where the majority of her functioning was. Dr. [redacted] said there was a fairly high degree of internal consistency in the Appellant's presentation.

Dr. [redacted] said he believed that the Appellant met the Department's criteria for eligibility. To reach that opinion he said he relied on a long list of assessments that revealed very significantly diminished skills. He said the one exception happened to be a consequence of some of the Appellant's other conditions. Dr. [redacted] explained that unlike children with other disabilities who may have a flat profile, that's not the case for children with Autism. He said in some ways they are fortunate to have certain capabilities, but the reality is that those capabilities have a very narrow scope and don't have the predictability within this population that it has for the rest of the population. So in a case like the Appellant's, Dr. [redacted] said it is unfair to judge those splinter skills as a determinant of her overall capabilities, which is clearly not the case. He said there is no translatability of those splinter skills that would permit the Appellant to negotiate her environment like it would for other people without an Autism diagnosis.

With respect to Dr. Shook's statement in the DDS Eligibility Determination (Exh 4) that "given evidence of cognitive functioning extending into the low average range . . . ." Dr. [redacted] said the conclusion was accurate to the degree one adhered exclusively to the quantitative numbers, although he added that there were numbers in the record that were in the mental retardation range. Dr. [redacted] said that there was a selective use of the scores above 70 which, when used, allowed the Department to correctly say those numbers would not be considered indicative of mental retardation. However, Dr. [redacted] said he would differ in the use of those numbers because they don't necessarily have the same significance for a child with the Appellant's condition.

Dr. [redacted] pointed to the 2007 evaluation that provided a FSIQ of 60 as an indication there are scores within the Department's required range. He said it is accurate to say that the Appellant functions as a person w co-morbid mental retardation and Autism and that her mental retardation results in her functional impairments. He said Ms. [redacted]'s description of the Appellant's life history and her day-to-day performance is consistent with a diagnosis of mental retardation.

Dr. [redacted] said he agreed with Dr. [redacted]'s conclusion that the Appellant has mental retardation co-morbid with Autism (Exh 14). He said Dr. [redacted] is the developmental pediatrician that sees children for diagnostic evaluations at [redacted] and has known the Appellant since she was first diagnosed.

In summary, Dr. [redacted] said he tries to describe the strength in their children because they prefer to downplay the limitations. He said the Appellant's hobby like knitting is well fed by the good skills she's fortunate to have. But he said the more direct indications of the Appellant's overall functioning are driven by the lower aspects of the quantitative scores. He said if one did a scatter plot of where the Appellant's age equivalences are on the verbal side of intellect, they are in fact more predictive of her levels of adaptive functioning and her levels of academic capabilities. He said going forward, the Appellant will continue to be limited in both intellectual and adaptive functioning and she will require the 24/7 care to keep her safe. He said she would need support in the future and the help of trained individuals. Dr. [redacted] concluded that the Appellant would benefit from the services that would normally be provided to people with mental retardation.

On cross-examination, when Attorney Whitbeck asked Dr. [redacted] why he did not diagnose the Appellant with mental retardation in his report, he said that in part it's because his agency doesn't write reports for the Department. He also said their children fulfilled criteria for a multitude of diagnoses. When trying to convey to a parent a narrative description of what the challenges are and these are subsumed under a primary condition, there's really little purpose, except for these bureaucratic determinations, to pile up the labels. He said a child like the Appellant could probably get 15 diagnoses from the DSM-IV but there's little utility for that. He said he was happy to elaborate on the full picture of the Appellant's condition and its consequences when allowed to do so as at this fair hearing.

Attorney Whitbeck asked whether any of the other evaluations diagnosed the Appellant with mental retardation. Dr. [redacted] answered that there were a couple of evaluations where the administrators would not administer the verbal scale of the WAIS or WISC because the Appellant was not capable of participating. He said that was a benign way of acknowledging that the results would be at the bottom of the instrument. He noted that there was an evaluation that did exactly what in their field they were not supposed to do, which is average the Appellant's capabilities and provide a full scale IQ score. He said that evaluation fulfilled the Department's criteria. He said the clinical reports are not meant to try to anticipate what the regulatory limitations are going to be. The purpose of the reports is to inform the care and education of the child at that particular moment. To add up these labels for that purpose is not as useful as it might be at the regulatory level.

Attorney Whitbeck suggested that when Department personnel read those reports they couldn't assume the Appellant had a diagnosis of mental retardation. Dr. [redacted] said this was where the clinical decision needed to be made. He said if a clinician uses the nonverbal side of the scale to determine functioning of a deaf or mute child, the results would have a strong correlation with the child's functional capabilities. But with the Appellant, that does not happen and that is the difference. In most situations it is helpful to use both verbal and nonverbal information, because one will determine the other, but in this case it just doesn't happen. So higher numbers in a child with the Appellant's condition doesn't have the same meaning as it would for most people in the general population.

Dr. [redacted] acknowledged he has seen a diagnosis of Autism and mental retardation in previous testing for clients he evaluates. He said he was not disputing the numbers, but did not think the Department should consider the higher scores in visual/performance testing. The Appellant's numbers on three subtests that were considered in full scale IQ on the WAIS were a 9, 9 and 5. The two subtests on which the Appellant scored within normal

limits were purely visual tasks. For the general population, those scores would predict normal functioning both intellectually and adaptively. For children with Autism, those numbers do not translate into functional capabilities for other reasons, so the numbers are not good indices of intellect per se.

[redacted] next testified for the Appellant. She is a Speech and Language Pathologist with an undergraduate degree in Teaching the Speech and Hearing Handicapped and a Master's Degree in Speech Language Pathology. She has a Certificate of Clinical Competence from [redacted] and is licensed in Massachusetts. Ms. [redacted] said she has been in private practice since [redacted] and sees a variety of clients from the age of two years old to adults, many of whom are normal developing children with language delays and adults with strokes who need language rehabilitation. Ms. [redacted] has been at [redacted] for the last 10 years and does their speech/language evaluations for the [redacted] and for the regular population. She said she worked for 10 years for the [redacted] program in [redacted], which is a special needs program mainly for students with mental retardation, and she worked for various agencies and always had special needs students on her caseload. Presently Ms. [redacted] said she evaluates and does speech/language therapy for clients with mental retardation. She also has treated clients with Autism for the last 18 yrs. She also treats clients with both Autism and mental retardation.

Ms. [redacted] said she provided private speech and language therapy for the Appellant from age three to eight, and then met up with her again at [redacted]. She said when she evaluated the Appellant in [redacted] 2009 she had scores of all "1's" where the standard score average is 7-13 (Exh 16). Ms. [redacted] said these scores translated into a very low severe range and was indicative of a serious delay in the Appellant's language skills. On another section the Appellant had a standard score of 46 where an average score would be between 85 and 115. Ms. [redacted] said the score of 46 translated to an extremely low score and went along with the vocabulary in correlation with the Appellant's intellectual functioning. In another test having to do with understanding incoming language, Ms. [redacted] said the Appellant's score of 40 was again an extremely low score.

Ms. [redacted] explained that Pragmatics is the ability to use language for purposes of communication, thinking, and social interaction. For a student who was 18 at the time an average score was greater than or equal to 153 points. The Appellant's score of 83 points would be equivalent to less than a five year old in terms of her use of language. Ms. [redacted] said this use of language involves things of an interpersonal social nature like maintaining the topic, not repeating oneself, avoiding use of repetitive information, and adjusting language based on perspective and perception of others who are talking with you. She said the Appellant's language is totally bound to the concrete. She might use it to request or to answer a question not even too well, but for basic things like who, what, and where. She is unable to answer the kinds of questions that ask how, what, or why, which are questions requiring the use of intellectual reasoning cognitive skills.

Ms. [redacted] said the Appellant does not use language to problem solve or to govern her thinking about her day. Combined with this she has a low working memory, so she cannot hold information in mind or use it to organize herself and follow directions.

Ms. [redacted] said that the Peabody Picture test only has four pictures – the evaluator names one and the Appellant has to point to it. If she were good at nonverbal or visual things, Ms. [redacted] said she would be able to do that test, and her word knowledge would be such that she would come out at age level. Ms. [redacted] said she has autistic students whose vocabulary skills on tests like the Peabody are at age level. But she said that because of the Appellant's cognitive deficits she came out far below age level. The Appellant was 18 at the time of testing, but the results were age equivalent to 7 years 6 months.

Ms. [redacted] testified that the Appellant's language is not only delayed, it is disordered. She said the Appellant confuses the listener because her grammar structure is poor. Her problems with inflexion pattern and repetition show a disordered language related to Autism and also related to her cognitive deficit. Her scores are flat without peaks and valleys, and that is a clear indication of intellectual disability. Ms. [redacted] said children with average intelligence who also have language difficulties due to Autism or other reasons show peaks and valleys

in their testing. They have strengths and weaknesses in language, but the Appellant's scores represent a flat profile, which is a clear textbook indication of mental retardation or intellectual disability.

When asked why she didn't write this in her report, Ms. [redacted] said that it is not permissible for Speech and Language Pathologists to provide any diagnoses; these are left to medical professionals. She said the only reason she included Autism is because she was simply reporting what had already been established.

Ms. [redacted] said that while some people could use higher nonverbal skills to compensate for low verbal skills, that is not the case for the Appellant. She said the Appellant's visual skills translate into her ability to do knitting, sewing, and artwork because she has an idea of visual and perception and space. But she said the Appellant did poorly on the Matrix portion of the WAIS, which is the part that translates to being able to problem solve.

Ms. [redacted] said she thinks the Appellant meets DDS criteria for eligibility. She said the Appellant's cognitive test scores are numbers that do not translate into an intellectually and cognitively competent young woman because they don't allow her to use those skills to problem solve, to reason, and to execute her daily activities. She said the Appellant's speech and language deficiencies are permanent, and that while the Appellant may continue to achieve some learning, she will never have the kind of language that will allow her to reason and problem solve and be a functionally independent person. She will need someone to help her negotiate her day.

On cross-examination, Ms. [redacted] said the Appellant's verbal difficulties were not impacted on the Peabody. She explained that there are practice pages to see if the student understands and the Appellant, who scanned and looked and pointed successfully on the examples, clearly did.

Dr. Patricia Shook testified on behalf of the Department. She has been employed by the Department for about five years as Eligibility Psychologist in the northeast region. Her primary duties are to review materials submitted by individuals looking for services and make a determination regarding eligibility. Dr. Shook was qualified as an expert.

Dr. Shook reviewed the Department's eligibility regulations. She said she reviewed all of the information in the Appellant's case and determined that she had low adaptive functioning but that she was not eligible for adult services based on her cognitive functioning.

Dr. Shook testified that she has seen people with diagnoses of both Autism and mental retardation, and that it is usually included in documents especially when talking about adults or older adolescents. She said it is less likely to see a dual diagnosis with younger children. Dr. Shook also said her role is to follow the regulations which does not provide her any flexibility.

Dr. Shook reviewed Exhibit 8, which was a Psychological Evaluation administered by a school psychologist when the Appellant was 9[redacted] years old. The Appellant was given the WISC-III. Dr. Shook explained that the confidence interval provided on the WISC-III provides a range of scores in which the hypothetical true score is supposed to fall, so it gives a broad range of where the person's functioning is. The Appellant's range of 63-79 is extremely low to borderline. Dr. Shook said there was an enormous amount of discrepancy on the scaled scores ranging from extremely low to higher end of average, which would make a composite score more difficult to interpret on this test.

The Appellant was also administered the Leiter, a comprehensive non-verbal intelligence test designed for people with significant language impairments including people with Autism who can't be reliably or validly tested with traditional IQ tests. The Appellant was given this test because she has Autism and significant communication deficits.

Dr. Shook said the Leiter presents a range of scores. On the three different composite scores, the Appellant's score on Fluid Reasoning was 83-89, which is below average or could also be interpreted as low average. The

Appellant's Brief IQ score was 84-90 (low average to very low end of average), and Full IQ score was 83-88 (low average). Dr. Shook said the Appellant had some variability in the scaled scores, but nowhere near the variability on the WISC-III, which was due to the fact that subtests in the Leiter are administered to minimize verbal instructions. She said that for someone with a significant communication deficit this takes the language piece out of the equation. Dr. Shook said the extreme discrepancies on the WISC-III subtest scores make it difficult to get a valid composite score.

Dr. Shook noted that this exhibit related prior evaluations as identifying the Appellant with borderline to low average intellectual ability, and that this evaluation does not diagnose the Appellant with mental retardation. This was the earliest evaluation in the record, and generally Dr. Shook said she gives these earlier ones very little weight. Dr. Shook said generally the Department looks to later evaluations, and it also looks for consistency.

Dr. Shook next reviewed Exhibit 9. At the time of the evaluation the Appellant was 15[redacted]. Dr. Shook explained that the WISC-IV Integrated and the Universal Non-Verbal Intelligence Test (UNIT) are comprehensive non-verbal tests of intelligence used for people with significant communication deficits. Dr. Shook said she believed the Full Scale IQ of 60 on the WISC is not valid because of extreme discrepancies between the Appellant's index scores. She said many people wouldn't calculate a full scale score because it's not useful in terms of giving an overall estimate of a person's cognitive functioning. She said the 44 point difference between the VCI and the PSI means any full scale score does not provide a good estimate of cognitive functioning. Dr. Shook said the Full Scale IQ score of 79 given in the UNIT was valid because there was a lot less variation in the subtest portions. Dr. Shook believed the UNIT's full scale score was more accurate than the WISC full scale score.[10]

Next Dr. Shook reviewed Exhibit 10, another psychological evaluation done when the Appellant was 18[redacted] years old. The full scale IQ was not calculated on the WAIS-IV because of the extreme discrepancies in index scores. On the language indexes – the VCI and WMI – the Appellant scored in the extremely low to the lower end of the borderline range, but the PRI and PSI were in the low average to average range. Dr. Shook said that had a full scale IQ been calculated, it would have been a 72. She said that since this was an adult test, it would have been definitive, but the other two in the record were also taken into consideration.

Dr. Shook discussed the Appellant's scores of 9 on Block Design, 5 on Matrix Reasoning, and 9 on Visual Puzzle. She said an average score is in the range of 8 to 12. She discussed the g factor of intelligence and agreed with Dr. [redacted] that the language portions of cognitive tests ride very high on the g factor. She said Block Design is also considered to have a high loading on g. Dr. Shook said the Appellant's score of 5 on Matrix Reasoning, though lower than her scores on Block Design and Visual Puzzle, was in the 5th percentile, which is equivalent to a borderline score.

Dr. Shook said that anyone with significant communication deficits would score low on vocabulary, but that doesn't mean they have mental retardation. She noted that the summary indicates that the Appellant was receiving Special Education services under the classification of Autism, and that she was performing within the low average range with respect to nonverbal reasoning skills.

Dr. Shook next reviewed the Occupational Therapy (OT) Screen Assessments from the [redacted] when the Appellant was 15[redacted] and 18[redacted] years old (Exhs 11 and 12). She said these are not psychological or cognitive assessments; they are mostly visual motor tests administered as part of the OT. The report indicates that the Appellant's nonverbal skills are considerably higher than her verbal skills, with an average score of 97 on Visual Motor Integration, a below average score of 81 on Visual Perception, and an average score of 90 on Motor Coordination in the first OT screen (Exh 11). In the second, later OT screen (Exh 12), Dr. Shook noted that the scores were lower but still above 70, and were in the borderline range.

[10] Dr. Shook also reviewed the low adaptive behavior scores.

When asked about the significant reduction in scores from the first to the second OT screen, Dr. Shook pointed to the examiner's comment in the second screen, "Appellant's decline in scores does not appear to be due to a decline in functioning but due to an increase in requirement of specificity for same age peers." Dr. Shook explained that an 18 year old is expected to do more than a 15 year old. What the Appellant was able to do looked more like a 15 year old, so her scores were lower in comparison to 18 year olds.

Next Dr. Shook reviewed Dr [redacted]'s report (Exh 21). She said she has seen many of Dr. [redacted]'s reports and he is well-known in the field. She said his is a very good report, but it does not indicate the Appellant meets the Department's criteria for intellectual disability. Dr. Shook said Dr. [redacted] did more verbal tests than nonverbal tests on the Stanford-Binet. She said the Stanford-Binet has a lower floor than the WAIS-IV so it provides a little more information for someone functioning in the lower area. Dr. Shook said it is not surprising that the Appellant's verbal IQ scores were very low and that she scored in the extremely low range in the subtests.

Dr. Shook reviewed the Leiter-R, a nonverbal test administered to get a good measure of nonverbal abilities. She said it appeared as though Dr. [redacted] didn't do enough subtests to get a full scale IQ score. She said the score of 78 on the Brief IQ, which is in the borderline range, compared to the perceptual reasoning score of 86 on the WAIS-IV. The score of 84 on Fluid Reasoning IQ of 84 was in the average range. Dr. Shook said that there is again variability in the subtest scores but they are all above the extreme low range seen on the Stanford-Binet. She responded to Dr. [redacted] rationale for not including a diagnosis of mental retardation by saying that she has seen many evaluations by neuropsychologists that include a number of diagnoses and if they believe that a mental retardation diagnosis is relevant they usually will include it, especially for adolescents approaching the end of the developmental period.

When asked for her opinion to a reasonable degree of diagnostic certainty regarding the Appellant's cognitive level, Dr. Shook said the more valid IQ score from Leiter, UNIT, and the non-verbal portions of WAIS-IV all are above 70, and generally in the upper end of the borderline range to the low average range depending on the test. Dr. Shook concluded that the Appellant wasn't eligible for adult services from the Department.

Upon questioning, Dr. Shook clarified that the Appellant's inability to access the cognitive skills she possesses has a lot to do with her Autism diagnosis. But as an adult, the Department regulations don't look at the Autism diagnosis as a basis for eligibility.

On cross-examination, Dr. [redacted] noted that in his discipline he would never rely on the UNIT or the Leiter without special circumstances because it only considers the nonverbal component. In that sense, Dr. [redacted] asked whether the Department's emphasis on nonverbal skills discriminates against the child since it only considers and emphasizes the child's splinter skills.

Dr. Shook responded that the DSM-IV TR provides that in this situation where someone will be penalized by low scores in a particular area (as in communication), one must administer tests that will control for that. She said she agreed that the UNIT and the Leiter aren't usually administered to someone who doesn't have significant communication deficits -- there'd be no reason for that. Dr. Shook noted that the Appellant scored better on the WAIS-IV than some of the others tests. She also said the full scale IQ, were it to be calculated, would have been 72, which is above the Department's threshold score 70. Dr. [redacted] replied that the 70 would have a plus or minus 5 to consider in its score. There was a brief discussion about the confidence interval.

Dr. [redacted] said comparing the Leiter to the WAIS is unfair because it avoids consideration of an incredibly important part of the individual. Dr. Shook noted that the confidence interval in the WISC-III (Perf 63-79) is not helpful because of the huge 11 point difference in subtest scores, which range from 1 to 12. Dr. [redacted] said the Appellant scored highest on Object Assembly, which is one of the typical savant skills their children kids have, but there is little significance of that particular skill in life. He said of the numbers on the Leiter, 9-5-4-4-9, one of the 9's is a splinter savant capability with limited translatability for negotiating the environment. Dr. Shook clarified that one does not need to have average abilities to be ineligible for Department services. She said

people with IQ scores in the 71-78 range won't function like someone with an IQ in the average range, but they still won't be eligible for Department services even though they are fairly limited cognitively. She said the Appellant has a Brief IQ of 78, a Fluid Reasoning IQ of 84, none of the scaled scores were in the extremely low range, and two were in the average range. She also said Department regulations are hierarchical, so they look to cognitive functioning first, and only if someone meets that prong does the Department look at adaptive functioning.

Ms. [redacted] questioned Dr. Shook about Dr. [redacted] testimony that the Appellant has mental retardation. Dr. Shook said that Dr. [redacted] can look at things differently, but she must go by the Department regulations. She said she has seen many evaluations that provide a diagnosis of mental retardation but that don't fit Department criteria.

Ms. [redacted] asked whether the regulations' reference to an IQ of 70 or below refers to the full scale IQ. Dr. Shook said no, the regulations refer to a valid IQ score. She said the full scale score in a case like the Appellant's was not particularly useful. She said there are problems with the full scale score of 60 on the WISC-IV (Exh 9) where there is a 44 point difference on the index scores, and there are problems with what would have been a full scale IQ score of 72 on the WAIS-IV (Exh 10) where there was a 34 point difference on index scores. Dr. [redacted] suggested the approach that considers the UNIT and Leiter's full scale IQ scores is discriminatory and not correct in the discipline because the Department is separating out the tests on which a full scale score cannot be calculated because of the spread, but then it is using the tests that reflect the Appellant's particular skill and using that to weigh heavily on the decision. He said equating the UNIT and the Leiter to a full scale IQ is not accurate. Dr. Shook responded that when someone has a significant communication deficit, such as someone with aphasia, one has to rely on the nonverbal IQ scores. Dr. [redacted] said that someone with aphasia can go out and cross the street. Dr. Shook said that those activities are adaptive behaviors. She said the whole point of doing a nonverbal test for someone with significant language deficits is to see where their functioning lies when you control for that factor. Dr. [redacted] said that that is not what a full scale score means in their discipline. He said the full scale score on the UNIT is a composite score of nonverbal capacities, it is not given for purposes of an overall IQ.

When asked how she can separate out the Autism from consideration, Dr. Shook said that in terms of the regulations, the diagnosis of Autism does not come into the consideration. She said that people with Asperger's, for example, score very high on verbal tests and much lower on nonverbal ones. They can't get a full scale IQ score but are seldom eligible for Department services because by definition people with Asperger's are much higher functioning. Dr. [redacted] responded that the Appellant's case is different form Asperger's. Her numbers are not in the 120 range and then in the 70 range.

He said the difficulty he had was that the Appellant is highly challenged verbally, but the Department is setting that aside saying that is due to a communication disorder. The Department is looking at her splinter skills and considering them to be similar to capabilities that determine adaptive functioning in the general population, but he said that is not the case for the Appellant.

Of the three scores in the WAIS-IV Perceptual Reasoning Index (Exh 10) – 9, 5, 9 – Dr. [redacted] said both Block Design and Visual Puzzles are splinter skills. If they are removed from the equation, Matrix Reasoning is in the borderline range. Scores of "5's" will get an overall score in the mentally retarded range. He said the issue for him is that the Department is using the Appellant's splinter skills to determine the totality of her full scale IQ. Dr. [redacted] said he understood that an individual with scores of 8's or 9's across the board would present a fairly balanced profile on the nonverbal side and would not be eligible. He said that is that was typical for a person with a significant communication disorder, and by definition that nonverbal IQ should translate into appropriate adaptive functioning. But the reality for the Appellant is that she is an individual who could step out of the building and not care for herself.

Dr. Shook agreed that if someone had all "5's" they would end up with a composite score below 70, but noted that the Appellant did not get all "5's" but got some "9's" which are average. She said the Department generally sees individuals in the borderline range, not people who are average or even close to average. She said the term "intellectual disability" is dishonest because you can have an intellectual disability and not have mental retardation.

Ms. [redacted] raised the g factor and suggested that Dr. Shook previously said vocabulary tests are seen as having a high correlation to general intelligence, and pointed out the Appellant's extremely low vocabulary scores. Dr. Shook agreed except in the case of someone with a significant language problem, in which case she said it is necessary to look beyond the test. Dr. [redacted] concurred with Dr. Shook that vocabulary has the highest loading and the next highest loading is Block Design. However, Block Design is best understood in the popular culture such as in the movie with Dustin Hoffman. He had the ability to count matches on the floor, or count cards, which is basically what Block Design is for the Appellant. Dr. [redacted] said to use that number to predict intelligence and to preclude the Appellant from getting services on the basis of that is unfair. He said it is not accurate to compare Block Design in the general population and the loading it has on the g factor with their autistic children – it's not the same thing.

Ms. [redacted] said the Appellant doesn't have just a communication problem. When she went to [redacted] she started off in the classroom with the regular kids but then got moved into the multiple handicap room with kids with mental retardation and deafness. She didn't have deafness but she couldn't learn in the regular classroom because she didn't have the cognitive skills.

At the conclusion of testimony, the Department concurred that the Appellant could not live independently. Both parties made brief closing statements.

**FINDINGS AND CONCLUSIONS**

**The Law**

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

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

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

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

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

115 CMR 2.01 provides the following definitions:

Mental Retardation

Mental Retardation means significantly sub-average intellectual functioning existing concurrently and related to significant limitations in adaptive functioning. Mental retardation manifests before age 18. A person with

mental retardation may be considered to be mentally ill as defined in 104 CMR (Department of Mental Health), provided that no person with mental retardation shall be considered to be mentally ill solely by reason of his or her mental retardation.

Significantly Sub-average Intellectual Functioning

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

Significant Limitations in Adaptive Functioning

An overall composite adaptive functioning limitation that is two standard deviations below the mean or adaptive functioning limitations in two out of three domains at 1.5 standard deviations below the mean of the appropriate norming sample determined from the findings of assessment using a comprehensive, standardized measure of adaptive behavior, interpreted by a qualified practitioner. The domains of adaptive functioning that are assessed shall be:

(a) areas of independent living/practical skills;
(b) cognitive, communication and academic/conceptual skills; and
(c) social competence/social skills.

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

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

**Findings of Fact and Conclusions of Law**

The issue in this case is whether the Appellant meets the Department's definition of mental retardation. Born [redacted] 1991, she is 19 years old. She lives with her mother in [redacted] MA, and presently attends the [redacted]. She meets the domicile requirement of the Department and, as the Department conceded, she also meets the adaptive functioning prong of the Department's regulations. Thus, the issue for this hearing is whether the Appellant meets the Department's criteria for cognitive functioning.

The record in this case reflects that the Appellant was diagnosed with Autism when she was about three years old. She had significant delays in the development of speech and language and did not begin speaking until she was about six years old. She received Early Intervention services and has received special education throughout her schooling. Testing over the years has consistently resulted in extremely low verbal scores and consistent diagnoses of Autism.

**Adaptive Functioning**

As noted, the Department indicated that it conceded that the Appellant meets the Department criteria with respect to adaptive functioning. Accordingly, I will not review this aspect of eligibility criteria other than to reiterate that all witnesses, including Dr. Shook, testified that the Appellant will not be able to function independently and that her various behavioral assessments support that testimony.

**Cognitive Functioning**

[redacted], [redacted], and Dr. [redacted], testified that the Appellant has mental retardation. Dr. Shook disagreed and argued that while the Appellant's cognitive functioning is limited, it is not in the range of

meeting the Department's definition of sub-average intellectual functioning. Thus, the initial inquiry into cognitive functioning is a review of the Appellant's IQ test results in the record.

| Year/age | Test | Exh# | FSIQ | Verbal | Perf | VCI | PRI | WMI | PSI |
|---|---|---|---|---|---|---|---|---|---|
| 1995 (4[redacted]) | | 8 | Overall functioning was in the borderline to low average range | | | | | | |
| 1998 (7[redacted]) | | 8 | Overall functioning was in the borderline to low average range | | | | | | |
| 2001 (9[redacted]) | WISC-III | 8 | | | 63-79 | | | | |
| " | Leiter | 8 | FIQ 83-88 | | | | BIQ 84-90 | | FR 83-89[11] |
| 2004 (12[redacted]) | WISC-IV | 9 | 53 | | | 50 | 79 | 52 | 62 |
| 2007 (15[redacted]) | WISC-IV Int | 9 | 60 | | | 47 | 75 | 59 | 91 |
| " | UNIT | 9 | 79 | | | S 83 | N 79 | R 75 | M 87[12] |
| 2009 (18[redacted]) | WAIS-IV | 10 | | | | 58 | 86 | 71 | 92 |
| 2010 (18[redacted]) | S-B 5 | 21 | | 48 | | | | | |
| " | Leiter | 21 | | | | | BIQ 78 | | FR 84 |

The Appellant also was given academic tests. In [redacted] 2007, the Appellant's scores on the WIAT-II (Exh 9) were: Reading Composite 47 (extremely low), Mathematics Composite 40 (extremely low), and Spelling 71. In October 2009 the Appellant's scores on the WJ-III ACH (Exh 10) were: Total Achievement 53 (very low range, <0.1 %), Broad Reading 56 (very low range, <0.2%), Broad Math 43 (very low range, <0.1 %), and Broad Written Language 72 (low range, <3rd %). In [redacted] 2010 the Appellant's scores on the WIAT-III (Exh 21) were Word Reading 67 (GE 3-04), Reading Comprehension (GE 1-02), Numerical Operations 62 (GE 2-07), Math Problem Solving 59 (GE 2-04), and Spelling 69 (GE 4-00).

Other than the earliest evaluations,[13] every cognitive evaluation in the record (as well as some other reports) either reached, related, or confirmed a diagnosis of Autism. (Exhs 8, 9, 10, 14, 16, 19, 20, 21, 22, 23, 24, 26, 28, 29,[14] 30). With one exception,[15] none of the evaluations provides a diagnosis of mental retardation. While this alone is not conclusive on the outcome of the Appellant's case, it does raise significant questions as to why such a critical factor, were it to exist, would not be noted in any of these evaluation or the above noted exhibits. Dr. [redacted] argued forcefully that the failure to include mental retardation as a diagnosis is attributable to the fact that 1) clinicians are not eager to label individuals, especially young children; 2) it is a matter of succinctness – the Appellant could easily trigger at least 15 DSM-IV diagnoses so it would be overkill to include them all; and 3) there is little purpose, except for bureaucratic determinations, to pile up the labels.

While this explanation has some logic, it is telling that Dr. [redacted] evaluation especially, done with the Department's denial in mind, did not include mental retardation as a diagnosis. His evaluation (Exh 21) was administered in [redacted] and [redacted] 2010, well after the Appellant's requests for an Informal Conference on [redacted]10 and a Fair Hearing on [redacted]10 (Exhs 5, 7). Indeed, Dr. [redacted] testified that the Appellant's mother approached him about assisting with the Appellant's hearing. He said he was happy to do so and thereafter evaluated the Appellant. Accordingly, he knew the issue was before the Department and yet still failed to include a diagnosis

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[11] FIQ = Full IQ, BIQ = Brief IQ, and FR = Fluid Reasoning

[12] The Quotients with the UNIT are S = Symbolic, N = Nonsymbolic, R = Reasoning, and M = Memory.

[13] The Arena Assessment (Exh 17) concluded that the Appellant presented with delays in the areas of communication (expressive and receptive – cognition). The Appellant was only 33 months old at the time. The Umwelt Assessment concluded that the Appellant presented with pervasive developmental disorder (Exh 18). She was only 3 years old at the time.

[14] Exhibit 29 includes two Transition Planning Forms. The one from [redacted]08 says the Appellant continues to be effected (sic) by "a cognitive disability" while the one from [redacted]10 says the Appellant is "affected by autism." The remainder of the sentences in which those words appear, which indicate how the conditions affect the Appellant's life, are virtually identical.

[15] Dr. [redacted] letter (Exh 14) said, "In addition to her diagnosis of autism, she demonstrates a significant intellectual disability that impacts all areas of her life. . . ." Dr. [redacted] did not herself administer any cognitive tests. In her previous letter of [redacted]09, written to recommend full guardianship for the Appellant, Dr. [redacted] did not mention any diagnosis.

of mental retardation. What he does say, after reviewing the Appellant's history, is that it was his impression that the "these and other examples confirm [the Appellant's] continued placement within the Pervasive Developmental Disorder/Autism category...." He also reviewed the Appellant's cognitive functioning and said, "This pattern of significantly stronger nonverbal/visual skills than verbal/language skill is quite common in individuals with Autism...."

Dr. [redacted] failure to include mental retardation anywhere in the report stands in stark contract to his frequent reference to the Appellant's high level of anxiety. While he did not offer anxiety as a diagnosis per se, it is notable that Dr. [redacted] found anxiety integral enough to the Appellant's functioning to warrant several references to it. Given the thoroughness of his report, and the core issue at stake, it would seem only logical for Dr. [redacted] to have included reference to mental retardation had he thought it applicable to the Appellant.

Again, it is not the failure, per se, to include the words "mental retardation" that is determinative in this case. Instead, it is the fact that the record includes cognitive evaluations and reports of cognitive evaluations that consistently place the Appellant above the Department's threshold for eligibility. I do not dispute Dr. [redacted] testimony, or the compelling testimony of the Appellant's mother or Ms. [redacted], that the Appellant is unable to apply the cognitive skills she has to help her navigate her daily functioning. But Department regulations require a first step analysis of intellectual functioning without regard to adaptive functioning and without regard to the ability to apply cognitive functioning to adaptive functioning.

Earliest test results from when the Appellant was four and seven years old showed overall functioning in the borderline to low average range (Exh 8). The results on the Performance Scale of the WISC-III and the Leiter-R (Exh 8), when the Appellant was nine years old, showed a scattering of nonverbal intellectual abilities ranging from significant delay in attention to detail and visual sequencing, to solidly average abilities on motor and nonmotor involved tasks. On the WISC-IV Integrated, the Appellant had a PRI in the low average range and a full scale IQ on the UNIT in the Delayed range ($8^{th}$ %). All of the scores on the UNIT (Exh 9) were in the delayed to low average range, and according to the examiner of that evaluation, and many of the Appellant's nonverbal scores were in the low average to average range. On the more recent Leiter done by Dr. [redacted] (Exh 21), the Appellant placed in the $7^{th}$ and $14^{th}$ percentiles in Brief IQ and Fluid Reasoning, both above the Department's threshold and, according to Dr. [redacted] somewhat consistent with the previous WAIS where results ranged from the borderline to low average range.

During his testimony, Dr. [redacted] discussed the aspects of the Appellant's test results on which she did well. He suggested those areas, or splinter skills, were typical of individuals with Autism but had no real application to adaptive functioning, and that the Department's consideration of those higher scores penalized the Appellant by raising her overall IQ scores. He said psychologists typically use test information to see how the skills translate in a functional manner. At another point in his testimony, Dr. [redacted] said there is no translatability of the Appellant's splinter skills that would permit her to navigate her environment. Dr. Shook responded saying that Dr. [redacted] referred to adaptive functioning, but Department rules consider cognitive functioning in and of itself before reaching an analysis of adaptive functioning.

Dr. Shook has correctly interpreted the Department regulations in this regard. The definition of mental retardation is "significantly sub-average intellectual functioning existing concurrently and related to significant limitations in adaptive functioning." 115 CMR 2.01. Significantly sub-average intellectual functioning is defined 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." 115 CMR 2.01. Thus, before one reaches an

analysis of adaptive functioning, it must first be determined that the individual has significantly sub-average intellectual functioning.[16]

The Appellant's scores on the nonverbal tests and test portions are above Department eligibility levels. Clearly, though, the Appellant has significantly limited language abilities and her scores on the verbal portion of tests are significantly below the Department's threshold. I am struck by Ms. [redacted] testimony that the Appellant's scores on her speech and language testing presented a flat profile, which she said was a textbook indication of mental retardation or intellectual disability. Given these two disparate sets of scores, the question raised by Ms. [redacted] and Dr. [redacted]'s testimony is whether it is reasonable to look at the scores of the UNIT and the Leiter, and other nonverbal portions of evaluations, as true indications of the Appellant's level of cognitive functioning.

Both Dr. [redacted] and Dr. Shook agree that the UNIT and the Leiter are both nonverbal tests designed for individuals who have significant challenges in language, and are also designed to be culturally neutral. In that regard, these tests do not require a person to rely on verbal instructions, but they are comprehensive in their assessment of cognitive functioning. Accordingly, of all the testing in the record, I find that the results of the UNIT and the Leiter are not only legitimate to include, but they also provide the most accurate assessment of the Appellant's actual cognitive functioning.

I note the agreement between Drs. [redacted] and Shook that an individual can have diagnoses of both Autism and mental retardation. However, in order to have both diagnoses, an individual must meet the criteria for both diagnoses. Mental retardation requires sub-average intellectual functioning, which generally presents a flat profile across the board with respect to cognitive testing. The Appellant, with her vast discrepancies in scores, many of which are above the Department's threshold, does not present that flat profile. As Dr. Shook noted, applicants for Department services frequently have cognitive functioning in the borderline range, but even though the scores are below the average, these individuals in the borderline range of cognitive functioning are not eligible for Department adult services.[17]

I am persuaded by Dr. Shook's explanation of the Appellant's condition and her conclusions that the Appellant is not mentally retarded within the meaning of the Department regulations. Dr. Shook is a qualified practitioner who is an expert in her field. I find that her interpretation of the Appellant's test results is reasonable and credible.

The Appellant has the burden of proving beyond a preponderance of the evidence that she meets the Department's eligibility criteria. In this case, because she has been unable to show that she has sub-average intellectual functioning, the Appellant has not met her burden.

## CONCLUSION

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

## APPEAL RIGHTS

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[16] Even if it were determined that an individual had significantly sub-average intellectual functioning, it would still need to be determined whether the person's adaptive functioning was significantly limited. If so, the last step of the analysis is whether those significant limitations were related to the significantly sub-average intellectual functioning.

[17] Dr. Shook also clarified that even though the Department changed its name, its regulations have not changed substantively, so the issue continues to be whether the Appellant meets the Department's definition of mental retardation.

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

Date: [redacted], 2010

Elizabeth A. Silver
Hearing Officer