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Executive Office of Health & Human Services
Department of Mental Retardation
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Gerald J. Morrissey, Jr.
Commissioner

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October 30, 2006

[redacted]

Re: Appeal of [redacted] - Final Decision

Dear Ms. [redacted]

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

The hearing officer's recommended decision 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 DMR regulations and therefore adopt its findings of fact, conclusions of law and reasoning as my own. Your appeal is therefore **denied**.

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

Sincerely,

Gerald J. Morrissey, Jr.
Commissioner

GJM/ecw
cc: Marcia Hudgins, Hearing Officer
Richard O'Meara, Regional Director
Marianne Meacham, General Counsel
Elizabeth Moran Liuzzo, Regional Eligibility Manager
Patrick Murphy, Assistant General Counsel
Victor Hernandez, Field Operations Senior Project Manager
File

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL RETARDATION

In Re: [redacted]

This decision is issued pursuant to the regulations of the Department of Mental Retardation (DMR) (115CMR 6.30 - 6.34) and M.G.L. Chapter 30A. A hearing was held on July 24, 2006 at DMR's Southeast Region Cape Cod/Island Area Office in Hyannis, Massachusetts.

Those present for all or part of the proceedings were:

[redacted]	Appellant
	Appellant's Mother
Tim Sindelar	Attorney for the Appellant
Frederick Johnson, Psy.D.	DMR Psychologist
Patrick Murphy	Attorney for DMR

The evidence consists of documents submitted by the Appellant numbered A1-5, documents submitted by DMR numbered D1-6 and approximately 4 hours of oral testimony. The Appellant provided no expert testimony.

ISSUE PRESENTED

Whether the Appellant meets the eligibility criteria for DMR supports by reason of mental retardation as set out in 115 CMR 6.03(1).

SUMMARY OF THE EVIDENCE PRESENTED

1. This Appeal is based on the Appellant's denial of eligibility for DMR services. (D2)
2. The Appellant is a 20-year-old female who resides in East Sandwich, MA. (D10)
3. Four evaluations of the Appellant's intellectual functioning before the age of 18 were entered into evidence. (A1, A4-A5, D-4)
4. One evaluation of the Appellant's intellectual functioning after the age of 18 was entered into evidence. (D6)
5. Four assessments of the Appellant's adaptive functioning were entered into evidence. (A4, D4-6)

6. One report of a psychiatric consultation was entered into evidence. (D5)

7. An Eligibility Report authored by Joel J. Match, Ph.D. was entered into evidence as well a chart showing the Appellant's tests and consultations. (D2-3)

8. A copy of the DMR Manual of Policies, Procedures and Practices, Eligibility Determination and Needs for Supports and Services June 17, 1996 was entered into evidence. (A2)

9. A copy of an AAMR Fact Sheet: Frequently Asked Questions about Mental Retardation was entered into evidence. (A3)

10. The parties stipulated that the Appellant has adaptive limitations across many skill areas such that there was no issue relative to her having the requisite deficits required under DMR's definition of mental retardation or the eligibility component. Despite this stipulation, evidence was provided relative to the Appellant's adaptive limitations.

11. In 1992 when the Appellant was 6 years, 9 months of age, Abigail B. Sivan, Ph.D., a licensed clinical psychologist tested her using the Wechsler Preschool and Primary Scale of Intelligence-Revised (WPPSI-R). On this test the Appellant received a Verbal IQ score of 78, a Performance IQ score of 74, and a Full Scale IQ score of 74. Dr. Sivan stated in her report that on this administration of the WPPSI-R, the Appellant exhibited intellectual functioning in borderline range. The tester noted that the Appellant exhibited a relative strength on subtests that rely heavily on rote memory, while a relative weakness was noted on subtests that require reasoning and independent problem solving. A second measure of cognitive functioning, the Columbia Mental Maturity Scale-Third Edition was administered to the Appellant and was commensurate with her performance on the WPPSI-R and was also in the borderline range. On the Wide Range Achievement Test-Revised (level 1) (WRAT-R), the Appellant continued to show a pattern of strong verbal attainments with less strong reasoning skills. On the Boehm Test of Basic Concepts-Revised, the Appellant's performance was commensurate with her overall level of measured cognitive functioning. The tester noted that the Appellant's responses on this measure placed her at the 10th percentile for middle class children ending kindergarten and at the 1st percentile for middle class children entering 1st grade. Dr. Sivan concluded that the evaluation clearly showed that the Appellant functions intellectually in the subnormal or borderline range. She noted that the Appellant was not inattentive during the evaluation. Her style of responding slowly and her difficulty processing sentences of more than a few concepts are indications of her compromised abilities and her concrete thinking. Dr. Sivan also stated that it might be beneficial to conceptualize the Appellant's difficulties as those of a slower leaner with strong skills of rote memory. She predicted that the Appellant would experience much difficulty with reading comprehension and with the

mastery of arithmetic. She did not offer a diagnosis of mental retardation. (A4)

12. In 1996 when the Appellant was 10 years, 8 months of age, Dr. Sivan reassessed the Appellant. Dr. Sivan stated that the observations and test results obtained during this assessment were fully consistent with each other and should be considered accurate reflections of her current functioning. Among other tests, she used the Wechsler Intelligence Scale for Children-Third Edition (WISC-III) to evaluate the Appellant. On this test the Appellant received a Verbal IQ score of 76, a Performance IQ score of 75/78 and a Full Scale IQ score of 74/75. Dr. Sivan stated that as before the Appellant showed intellectual functioning in the borderline range. Dr. Sivan also administered the Wide Range Achievement Test – Revision 3 (WRAT-III) to screen the Appellant's academic achievement. Dr. Sivan noted in her report that the Appellant's performance on this measure was uneven with average word reading and spelling achievement and with borderline achievement in arithmetic. She concluded that the Appellant continues to have significant intellectual and social difficulties and continues to function in the borderline range with a relative strength on tasks that utilize rote verbal skills. She also concluded that the Appellant is a poor judge of situations in general, is inattentive to many details and has an almost naive faith in her environment as supportive. She did not offer a diagnosis of mental retardation. (A5)

11. In 1997 when the Appellant was 11 years, 9 months of age she was evaluated by Rudy Lorber, Ph.D., ABPP, a pediatric neurophysiologist. Dr. Lorber tested the Appellant over a four day period and administered a variety of tests. Dr. Lorber stated in his report that the obtained test results represent an accurate appraisal of the Appellant's present level of cognitive and academic functioning. On the WISC-III the Appellant obtained a Verbal IQ score of 74, a Performance IQ score of 78 and Full Scale IQ score of 74. Dr. Lorber stated that this places the Appellant near the middle of the borderline range of intellectual functioning. He not only tested the Appellant relative to her intellectual functioning, he assessed academic achievement and performed evaluations in the areas of social, emotional and behavioral functioning. He noted the presence of social rejection and social isolation. He found the Appellant to have impaired social judgment and social conflict resolution skills suggesting the presence of an underlying social skills deficit. He pointed out that the Appellant was a complex youngster with a significant degree of variability in her underlying cognitive functioning. He stated that the current testing indicates the presence of symptoms consistent with the Primary Characteristic of a Speech and Language Disorder. He noted the presence of a Learning Disability and Attention Deficit Hyperactivity Disorder, Predominately Inattentive Type. He also stated that his assessment of the Appellant revealed the presence of a Adjustment Disorder with Anxiety and a significant underlying social skills deficit. He not offer a diagnosis of mental retardation. (A1)

12. In 2000 when the Appellant was 15 years of age she was again evaluated by Dr. Abigail B. Sivan. Dr. Sivan tested the Appellant using the WISC-III. On this

administration the Appellant obtained a Verbal IQ score of 73, a Performance Score of 71 and a Full Scale IQ score of 70. Dr. Sivan stated that as before, the Appellant's overall performance was in the borderline range with no significant discrepancies between the verbal and performance subtest scores. According to Dr. Sivan's report, the results obtained from this test should be considered accurate representations of the Appellant's current functioning. The Appellant's academic achievement was tested using the Wechsler Individual Achievement Test (WAIT). She achieved a total composite score of 74, commensurate with her overall cognitive functioning but significantly below that of her age-mates and on average comparable to that of a 5th grader. In the section of her report labeled Diagnostic Impression, Dr. Sivan states that over an 8 year period, the Appellant's cognitive functioning has remained almost unchanged and solidly in the Low Average/Borderline range with commensurate academic achievement. In this Section of her report, Dr. Sivan also raises a concern about the Appellant's emotional status and opines out that her rigidity of thinking, her isolation and her lack of self-care may be early symptoms of the schizophrenia that her biological mother is reported to have suffered. Dr. Sivan did not offer a diagnosis of mental retardation. (D4)

13. In 2003 when the Appellant was 18 years of age, she was evaluated by Ellen B. Braaten, Ph.D., a licensed psychologist. Dr. Braaten notes at the outset of her report that past evaluations have documented a history of autism. Dr. Braaten tested the Appellant using the Wechsler Adult Intelligence Scale-Third Edition (WAIS-III) and the WRAT-III among several other tests. Dr. Braaten noted that the Appellant put forth her best efforts on all the tests and therefore the results of the evaluation was thought to be valid. On the WAIS-III, the Appellant obtained a Verbal IQ score of 77, a Performance IQ score of 80 and a Full Scale IQ score of 77. Dr. Braaten stated that the Appellant's Full Scale IQ score was in the borderline range. On the WRAT-III, the Appellant scored at the high school level in Reading, at the 8th grade level in Spelling and at the 3rd grade level in Arithmetic. Dr. Braaten noted that based on these results, the Appellant was found to have skills commensurate with expectations of Reading and Spelling with significantly weaker skills in Math. Dr. Braaten's diagnostic impressions were listed as Autistic Disorder and Borderline Intellectual Function. Dr. Braaten concluded that the Appellant's IQ score overestimates her ability to function independently and that when her IQ is viewed in light of her overall adaptive functioning, her capabilities are much more consistent with that of a mentally retarded young adult. She did not; however, offer a diagnosis of mental retardation. (D6)

14. In 1992 when the Appellant was 6 years, 9 months of age, her mother completed a Child Behavior Checklist and the Vineland Adaptive Behavior Scales. At that time the Appellant's mother noted that the Appellant was below average in her abilities to dress herself, clear her dishes and pick up her toys. She also noted relative weaknesses in the Appellant's receptive language and in personal and community daily level skills. Her overall adaptive level was low with an age

equivalence of 4 years, 4 months. At that time the Appellant's mother reported that the Appellant had an above average interest in activities such as books, bug collecting, and drawing. She showed relative strengths in expressive communication and socialization skills. (A4)

15. In 2000 when the Appellant was 15 years of age , Joel Bregman, M.D., Assistant Professor of Child Psychiatry and Pediatrics at the Yale Child Study Center evaluated the Appellant. His Psychiatric Consultation noted that the Appellant exhibited a profile indicative of autism and related pervasive developmental disorders. He also reported that the Appellant's mother completed the Vineland Behavior Scales (Vineland) in order to assess the Appellant's degree of responsibility and independence in the performance of day-to-day activities. The Appellant's adaptive level based on her mother's responses was Low across all categories: Communication, Daily Living Skills, and Socialization. Her Adaptive Behavior Composite was Low. Dr. Bregman pointed out in his report that the Appellant's adaptive functioning is marked by significant delays and impairments, particularly in the areas of socialization and daily living skills. (D5)

16. In 2000 when the Appellant was 15 years of age, De. Sivan administered the Vineland to the Appellant's mother. The results of that administration were essentially the same as the one administered by Dr. Bregman. The Appellant's Adaptive Behavior Composite level was listed as Severe Deficit. (D4)

17. In 2003 when the Appellant was 18 years of age, Dr. Braaten administered the BRIEF to the Appellant's mother. The BRIEF is a questionnaire that assesses executive functioning. On this scale the Appellant showed significant difficulties in planning and organization of materials and in monitoring her behavior. Dr. Braaten concluded that the Appellant is unable to care for herself. (D6)

18. [redacted] the Appellant's mother testified on behalf of the Appellant. She testified that the Appellant was adopted and had severe medical problems from birth. She had many operations on her knees which is likely causing her current circulatory problems. She also had a seizure disorder. She continues to have an auditory processing disorder, a vestibular disorder, and a bowel disorder.

The witness testified that they began noticing problems with the Appellant when she began school at age 5. They ultimately found out that the Appellant had autism. Ms. [redacted] explained that the Appellant was tested by Dr. Sivan two times, once in 1992 and once in 1996, but that she did not have copies of the reports [Those reports were submitted by the Appellant at the time her brief was filed and have since become part of the record-(A4-5)]

Ms. [redacted] testified that she arranged to have the Appellant tested by Dr. Lorber in 1997 in order to help her determine what type of school would be best for the Appellant since the school she was attending only went up to 5th grade. Ms. [redacted] testified that neither Dr. Sivan nor Dr. Lorber described the

Appellant as mentally retarded, but rather used the term borderline intelligence. She testified that she was told that she would have to find a special place for the Appellant, a place where people were trained in the area of low functioning individuals. Ultimately the Riverview School on Cape Cod was chosen as a school that could meet the Appellant's needs. The witness testified that the Appellant attended Riverview for 2 years and left when she was sexually assaulted by a student. Ms. [redacted] stated that this assault which took place in 2000 interfered with everything including the Appellant's cognitive abilities. Her condition stabilized after receiving psychological counseling. (A1)

Ms. [redacted] testified that she sought help from Dr. Bregman who was doing work at Yale in the area of autism. She also testified that around the same time, October, 2000 Dr. Sivan again tested the Appellant. She agreed that at that time the Appellant's IQ score was 70, but said that she did not have any discussions with Dr. Sivan relative to the meaning of that number. (D4-5)

The Appellant went to the Lake Forest High School in Illinois until an opening became available at the UCLA Lab School which was doing work with individuals diagnosed with autism and developmental disabilities. The Appellant attended the program for 6 months, but the program wasn't working for her so the Appellant returned to Lake Forest High School. The Appellant then enrolled in a special education program at Sandwich High School; however, that program did not work for her. She now attends the high school but has a 1 to 1 aide and is engaged in activities where she can succeed. She is receiving job coaching with the help of Community Connections. She spends 2 hours per week reading to preschool children. The goal is to increase her time there.

Ms. [redacted] stated that no one has ever diagnosed the Appellant as having mental retardation. Ms. [redacted] feels that the Appellant has significant sub-average intellectual ability despite the fact that she is a very good reader and is pretty good at communication. She feels the Appellant's safety skills are nonexistent. She can be manipulated and taken advantage of. She is fearful. She needs assistance to cross the street. She has no defenses. The Appellant can not appropriately dress herself. She has no concept of time. The Appellant is on SSI.

19. Frederick Johnson, Psy.D., a psychologist employed DMR testified as an expert witness. He testified that he was familiar with the case. He stated that another DMR psychologist, Dr. Joel Match had found the Appellant ineligible for DMR services. In preparation for an informal hearing, Dr. Johnson testified that he had reviewed that decision and the information used in making that decision. (D1)

Dr. Johnson stated that approximately 75% of his time is spent doing eligibility determinations for DMR. He stated that although all information is helpful in understanding the applicant, he is primarily interested in IQ scores and adaptive behavior and whether or not there is another illness that may be causing the applicant's deficits.

Dr. Johnson testified that he met the Appellant and her mother at the Informal Conference. He stated that possible outcomes following an Informal Conference could be to uphold the decision or to reverse it. He stated that new information presented at the Informal Conference could change the decision. Meeting the Appellant in person could also change the decision. Dr. Johnson stated in this case, he did not reverse his decision. Dr. Johnson explained that during the Informal Conference he tries to determine if the picture he had of the applicant based on his review of the documents is consistent with the individual's presentation. Dr. Johnson stated that in his clinical judgment the Appellant did not meet the criteria for a diagnosis of mental retardation.

Dr. Johnson stated that his opinion after meeting with the Appellant, she seemed consistent with somebody who had a diagnosis of Pervasive Developmental Disorder (PDD) –autism spectrum. He stated that although there are diagnostic criteria for autism, there is no comprehensive understanding that all professionals come to consensus with. Dr. Johnson stated that after reviewing the documents presented by the Appellant and after meeting her, in his opinion she presents with a diagnosis consistent with that of autism. He further stated that in his opinion the Appellant's adaptive deficits are the result of autism, not mental retardation Dr. Johnson agreed that some individuals have both mental retardation and autism.

Dr. Johnson stated that it is acceptable to make a diagnosis of mental retardation on the basis of reviewing documents and meeting the individual.

Dr. Johnson stated that in making or confirming a diagnosis of mental retardation he first looks at IQ scores and uses 70 or below. He also looks at whether the person is currently functioning intellectually in the mentally retarded range and equally important that prior to the age of 18 they were functioning in the mentally retarded range. If that prong is met, then he looks at adaptive behavior and then looks to see if there is something else causing the problem such as a psychiatric illness or a physical problem.

Dr. Johnson stated that as a psychologist he follows the guidelines set out in the DSM-IV in making a diagnosis of mental retardation. He stated that the DSM-IV talks about IQ scores of 70 or below and adaptive deficits in a number of areas.

After reviewing the DSM-IV- TR (text revision), Dr. Johnson stated that general intellectual functioning is defined by an IQ obtained by assessment. Significantly sub-average intellectual functioning is defined as an IQ of about 70, approximately 2 standard deviations below the mean, the mean being 100. He stated that generally a standard deviation is 15 points although it varies depending on the test and the age of the individual. He stated that the Wechsler type tests are generally accepted by professionals in his field.

Dr. Johnson stated that if someone scores below 70 on a Wechsler type test, he or she will be 2 standard deviations below the mean and therefore meet the 1st prong of the definition for mental retardation.

Dr. Johnson stated that there is always some chance of error in measuring an individual's intelligence. He stated that generally this error is plus or minus 4.5 to 5 points. He stated that assuming a reasonable time passes before retesting, the more times a person has been tested, the closer their score is to a "true score". He stated that the notion of a "true score" is a concept which is as close as you can get to a good description of a person. There is more variability in children's IQ scores than in adult scores due to children's development which is one of the reasons that DMR looks at childhood scores to see if the individual meets the criteria for mental retardation. Functioning after the age of 18 is also looked at. An increase in scores can be attributed to the maturational process. Children with ADD either due to medication or the maturational process can focus better as they grow older.

Dr. Johnson testified that there are a number of things that could compromise a test score such as poor test conditions, a poor relationship with the tester, hunger, anxiety, capacity to attend, psychiatric issues and trauma.

Dr. Johnson stated that in his opinion, the standard error of measurement is more of a concern if only one test is given as opposed to several testings. He stated with repeated testing over time, one is less concerned that something is compromising the test. The more times you sample the behavior the closer it is to the person's usual behavior.

Dr. Johnson sated that as a licensed psychologist he does not rely simply on numbers when making a diagnosis of mental retardation, but does use numbers when comparing individuals within a certain age group. He stated that he relies on his clinical judgment when making a determination of mental retardation.

Dr. Johnson explained that IQ scores between 70 and 79 are considered borderline intellectual functioning. He stated that 80-89 would be low average intellectual functioning. He stated that 69 and below would be considered to be in the extremely low range of intellectual functioning. This used to be labeled as mental retardation. Dr. Johnson stated that the DSM IV-TR states that in order to responsibly diagnose someone with mental retardation, you must find that the individual has sub-average intelligence which corresponds to an IQ score of about 70 or below.

Dr. Johnson stated that he does not believe that the Appellant has significantly sub-average intelligence as demonstrated on IQ tests using the definition that clinicians use. In some areas she has significant strengths and in some areas, she has significant weaknesses, but taken as a whole she does not meet the criteria for significantly sub-average intellectual functioning.

In reviewing DMR's Eligibility Report and the Chart outlining testing that had been given, Dr. Johnson stated the Appellant's intellectual functioning had never fallen into the mentally retarded range. Dr. Johnson questioned a diagnosis of high-functioning autism. He stated that he believed that autism was a good description of the Appellant but that she was not high functioning. Dr. Johnson explained the term learning disability and stated that it refers to assumed difficulty or lack of capacity in a certain area of intellectual functioning as opposed to a global deficiency. (D2-3)

Dr. Johnson reviewed Dr. Lorber's report and noted the lack of a diagnosis of mental retardation. He pointed out that the Appellant obtained a score of 1 on the Comprehension subtest and noted that this is consistent with what is known about her in that she does very poorly on things that require judgment. She also did very poorly in the Arithmetic subtest. He pointed out that the scores on these two subtests caused the Appellant to have a lower Verbal score than she would have had otherwise. He stated that he thought the report was very comprehensive and very useful. (A1)

Dr. Johnson reviewed Dr. Sivan's report dated November15, 2000. He stated that Dr. Sivan did not diagnose the Appellant as a person with mental retardation. Dr. Johnson explained that although Dr. Seven raises the possibility that the Appellant may be exhibiting early symptoms of schizophrenia, upon his meeting with the Appellant and his review of the records, he believes that she most likely falls within the autism spectrum. (D4)

Dr. Johnson reviewed Dr. Bregman's report. The report characterized the Appellant has having high functioning autism and a learning disability in mathematics. Dr. Johnson disagreed that with the notion that the Appellant is high functioning. It was pointed out by the Appellant's counsel that this clinician did no psychological testing. (D5)

Dr. Johnson reviewed Dr. Braaten's report. Dr. Johnson stated that the clinician described the Appellant as having a Full Scale IQ score in the borderline range. (D6)

Dr. Johnson stated that he exercises his clinical judgment in making determinations of eligibility. He exercises that clinical judgment to determine an individual's level of cognitive functioning. He is looking at other people's evaluations in an effort to confirm a diagnosis of mental retardation.

As a result of his review of all of the information he had available to him and his informal meeting with the Appellant, Dr. Johnson stated that he had reached an opinion to a reasonable degree of medical certainty that the Appellant's cognitive level is within the borderline range and as such does not meet the criteria for a diagnosis of mental retardation.

On cross-examination, Dr. Johnson disagreed that the concept of mental retardation is a fluid concept and stated that is very specific and very concrete. He stated that he was not aware that the definition of mental retardation was ever one standard deviation below the mean.

Dr. Johnson stated that although he was somewhat familiar with the AAMR definition of mental retardation, it was not the one that he used. He stated that as a licensed psychologist in order to defend any diagnosis he uses the DSM- IV. The DSM is not required by law, but it is considered the standard for use in the United States.

Dr. Johnson stated that he was somewhat familiar with the DMR regulations for eligibility. He stated that the AAMR definition differs from the DSM-IV TR definition in terms of the adaptive behaviors.

Dr. Johnson agreed that with the exception of meeting the Appellant at the informal conference and at this hearing, he had not had an opportunity to evaluate her. He agreed that his knowledge of the Appellant is based on his review of the records and on his brief meetings with her. He agreed that he would not normally form a diagnostic impression on the basis of the record review and the meetings alone.

In reading a portion of the DSM-IV TR relative to the diagnosis of mental retardation, Dr. Johnson stated that it is possible to diagnose mental retardation in individuals with IQs of 70 to 75 who exhibit significant deficits in adaptive behavior. He agreed that the Appellant does exhibit significant deficits in adaptive behavior.

Dr. Johnson agreed that the 1992 AAMR definition also uses that range (70-75) in talking about significantly sub-average. He agreed that the AAMR definition recognizes that the standard error of measurement in most IQ tests is 5 so that the ceiling may go to 75.

Dr. Johnston stated that he had seen DMR's Manual of Policies and Procedures. He agreed that the manual states that individuals with IQs as high as 75 may meet the eligibility criteria. He stated that he does review this manual and is reading it over for revisions. He agreed that the current manual is still in effect. He agreed that the manual states that the 1992 definition of mental retardation defines significant sub-average intellectual functioning through scores of 70-75 on an individualized IQ test. Dr. Johnson stated that although the manual was used in making a determination in this case that it does not dictate his practice. He stated that he is aware of the language and what it means. (A-2)

Dr. Johnson agreed that individuals with a diagnosis on the autism spectrum may have mental retardation. He agreed that it is not uncommon. He agreed that in

general, a high percentage of individuals with autism also have mental retardation.

Dr. Johnson agreed that the WISC-III and the WAIS-R do not use the classification of mental retardation when looking at IQ scores. Dr. Johnson explained that the use of borderline intellectual functioning in the Appellant's psychological reports suggests that the clinicians reached a conclusion that the Appellant's cognitive functioning does not meet the criteria for a diagnosis of mental retardation. Dr. Johnson stated that perhaps educational psychologist may avoid using the term mental retardation, but he didn't know that for a fact. He agreed that Wechsler avoids using the term.

The issue as to whether or not the Appellant had a specific learning disability in the area of Mathematics was questioned by Appellant's counsel. Although such a learning disability was noted in the Psychiatric Consultation performed by Joel Bregman, Dr. Johnson agreed that Dr. Bregman had not administered any tests in order to reach this conclusion, but had in all likelihood relied upon tests reports that he reviewed. Dr. Johnson review Dr. Sivan's report dated November 15, 2000 and stated that her conclusion was that the Appellant did not have a specific learning disability in the area of mathematics. He declined to agree that her characterization of the Appellant's weakness as being related to a more general deficit in reasoning and applied problem solving was more consistent with a significantly sub-average cognitive deficit. (D4-5)

Dr. Johnson agreed that while some neuropsychological tests do not yield an IQ score, they do tell a tale of cognitive functioning. He agreed that such tests do tell a lot about the ability to plan, to initiate, to make judgments.

Dr. Johnson stated that in reaching a determination relative to mental retardation, he reviewed all of the testing including the Appellant's most recent testing. Dr. Johnson explained that if he only had the test results from the testing done in 2000 by Dr. Sivan (Full Scale IQ score – 70), he would want to look at current testing because that test was only a sample of behavior and it would only tell how the individual was doing at that time, not how she was performing after the developmental period. He stated that he would not make a decision pending further testing. He said testing would be relevant at age 18. (D4)

Dr. Johnson reviewed the statement made in Dr. Braaten's 2003 report. In the report Dr. Braaten stated, "I feel that the [redacted] IQ score *overestimates* (Dr. Braaton's emphasis) her ability to function independently and that when her IQ is viewed in light of her overall adaptive functioning, her capabilities are much more consistent with that of a mildly mentally retarded young adult". Dr. Johnson testified that Dr. Braaten statement does not mean that she feels the Appellant meets the diagnosis for mental retardation. (D6)

Dr. Johnson said that he was familiar with the Flynn Effect from an article that he read. His understanding is that you can use this effect to argue that someone is functioning higher than they scored or that they are functioning lower than they scored. He stated that the Flynn Effect is based on someone's interpretation of studies that have been done, and it is not used for the diagnosis for mental retardation. He stated that when used it would be taken into consideration in the same way as the standard error of measurement would be considered. Dr. Johnson stated that he was not familiar with Dr. Flynn's testimony in death penalty cases. He stated that the Flynn Effect is one of the pieces of information that a clinician can use to mediate their decision relative to mental retardation. He agreed that when looking at a test that was normed some time ago one has to look at whether the test is meeting the same definition of significantly sub-average intelligence as in comparison to a test that is normed now. He was not able to say when the WAIS was last normed. He agreed that a work is underway to produce a new edition of the WAIS. He stated that in according to the opinion of the author of the Flynn Effect, scores are slowly increasing over time.

Dr. Johnson stated that intensive special education could help to raise someone's IQ. He conceded that there is therefore probably no fixed IQ score for an individual.

Dr. Johnson stated that in some areas the Appellant has significant sub-average cognitive functioning. He explained that overall he does not believe that the Appellant has an IQ that is consistent with a diagnosis of mental retardation.

On redirect, counsel for DMR reviewed the 1992 AAMR definition of mental retardation. He stated that the DMR regulation, the AAMR definition and the DSM-IV are somewhat consistent. He stated that the DSM-IV is helpful to him because it is used consistently by clinicians. He stated that the DSM-IV defines significantly sub-average intellectual functioning as 70 or below or below 70 as well as 2 standard deviations below the mean. He agreed that in other definitions there is no mention of a number or of standard deviations.

Dr. Johnson explained that in observing the Appellant at the informal conference, he noted that while she spent most of her time coloring, when she heard something being said that she didn't like she responded. He opined that this might be why in one evaluation she was characterized as having high functioning autism. Dr. Johnson again made the point that he believes that the Appellant's functional limitations arise out of her autism. Dr. Johnson stated that he had no reason to question the findings of the clinicians who had tested the Appellant and he found no diagnosis of mental retardation in any of their reports. He also stated that there was no question that the Appellant was impaired.

Dr. Johnson testified that while the Flynn Effect is talked about, he does not feel that it has had a tremendous impact in practice.

He stated that the IQ tests are accepted and that designed in such a way that they are tested for reliability and validity. The theory is that over time, an individual's score will cluster around the true score. Although Dr. Johnson stated that he could not say that there was no doubt that the Appellant's true score was in the mid 70s, he could say that she did not meet the cut-off for mental retardation.

On re-cross, Dr. Johnson agreed that when the WAIS-III first came out there was a drop in scores from the WAIS-R. He was also aware that there was a similar drop in score from the WISC-III to the WISC-IV. He agreed that more recently normed tests may result in lower scores than a test that was normed several years ago, but stated that there were other reasons for this. He stated; however that he could not responsibly answer why.

Appellant's counsel did not provide the witness with the 1992 AAMR definition, and Dr. Johnson did not answer the question of whether or not the Appellant met the 1992 AAMR definition with regard to significantly sub-average intelligence saying he would have to look at the definition to answer responsibly.

FINDINGS AND CONCLUSIONS

After a careful review of all of the evidence and despite her need for continuing supports, I find that the Appellant has failed to show by a preponderance of the evidence that she meets the DMR eligibility criteria. My specific reasons are as follows:

In order to be eligible for DMR supports, an individual who is 18 years of age or older must meet the three criteria set forth at 115 CMR 6.03: (a) she must be domiciled in the Commonwealth, (b) she must be a person with Mental Retardation as defined in 115 CMR 2.01, and (c) she must be in need of specialized supports in three or more of the following seven adaptive skill areas: communication, self-care, home living, community use, health and safety, functional academics and work. There is no dispute that the Appellant meets the first criteria and I specifically find that she meets that criterion. However, I find that she is not mentally retarded as that term is defined in 115 CMR 2.01.

By statute, M.G.L. c. 123B, section 1, a mentally retarded person "is 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." Consistent with its statutory mandate, DMR has adopted the American Association on Mental Retardation (AAMR) 1992 standards as the clinical authority to which it refers in determining whether an individual has "inadequately developed or impaired intelligence". The AAMR standards establish a three-prong test: (a) the individual must have significantly sub average intellectual functioning defined as an IQ score of approximately 70 to 75 or below, based on assessments that includes one or more individually administered general intelligence

tests, (b) related limitations in two or more of the following adaptive skill areas: communication, self care, home living, social skills, community use, self direction, health and safety, functional academics, leisure and work must exist concurrently with sub average intellectual functioning, and the individual must have manifested the criteria (a) and (b) before the age of 18.

I find that the Appellant is a complex individual with a variety of strengths and weaknesses. She faces many challenges, both medically and cognitively. Her mother has gone to great lengths to have her diagnosed and to find educational programs that best fit her needs. However, I find that the Appellant is not "mentally retarded" as that term is used in statute and regulation for the determination of DMR supports.

The Appellant's most recent Full Scale IQ score of 77 places her solidly in the borderline range of intellectual functioning. The clinician administering that test, the WAIS-III made no mention of the Flynn Effect in her report and I was not persuaded that the Flynn Effect had a significant bearing on the Appellant's IQ score. The achievement test scores received by the Appellant at that time are commensurate with her IQ scores. She showed strengths in Reading and Spelling with significantly weaker skills in Math. Three out of four IQ tests administered prior to the Appellant's 18th birthday, yielded Full Scale scores of 74-75 which are also in the borderline range.

In making my decision, only one score, a 70 raised significant questions relative to a diagnosis of mental retardation. According to expert testimony, a score of 70 is 2 standard deviations below the mean and would be considered to be evidence of significantly sub-average intellectual functioning. However, I find that shortly before the time of that testing the Appellant was the victim of a traumatic event. According to her mother's testimony, that event interfered with everything including the Appellant's cognitive abilities. DMR's expert testified that one of the things that could compromise a test score is trauma.

I find that even if the traumatic event had no effect on her score on that test, the Appellant has failed to meet her burden of showing by a preponderance of the evidence that she has significant sub-average intellectual functioning as required by the 1992 AAMR definition of mental retardation.

I find that clinical judgment must be exercised in making a determination of mental retardation, since many factors must be considered when interpreting IQ scores. The AAMR definition refers to substantial limitations in present functioning. Such limitations must be predicated on significantly sub-average intellectual functioning which has been further defined as an IQ score of approximately 70-75 or below. The term approximately does not mean that the individual must score a specific number; rather it leaves room for a margin of error of plus or minus 5 points as well as for the exercise of clinical judgment. In making a judgment as to whether an individual's scores meet the definition of significantly sub-average, clinicians take into account the margin of error as well as consistency in scores over time. Although the majority of the Appellant's IQ scores fit within the range of 70-75, it was the judgment of all the clinicians who tested

the Appellant, the DMR psychologist who made the initial determination of ineligibility and DMR's expert witness that she falls within the borderline range of intellectual functioning. The Appellant offered no expert testimony to refute that judgment.

While the parties stipulated that the Appellant has multiple functional limitations, and evidence was presented relative to those functional limitations and her need for continuing supports, I did not consider such limitations in reaching my decision because I found that the weight of the evidence presented relative to the Appellant's intellectual functioning showed that the Appellant does not manifest significant sub-average intellectual functioning. Functional limitations can be caused by a variety of conditions and are not necessarily related to intellectual functioning.

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 [115 CMR 6.34(5)].

Date: October 19, 2006

Marcia A. Hudgins
Hearing Officer