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Executive Office of Health & Human Services
Department of Mental Retardation
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May 18, 2007

Ms. Veronica Whelan
North Shore ARC
6 Southside Road
Danvers, MA 01923

Re: Appeal of [redacted] - Final Decision

Dear Attorney Whelan:

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
Amanda Chalmers, Regional Director
Marianne Meacham, General Counsel
Veronica Wolfe, Regional Eligibility Manager
Douglas White, Assistant General Counsel
Elise Kopley, Assistant General Counsel
Victor Hernandez, Field Operations Senior Project Manager
File

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL RETARDATION

In Re: Appeal of [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 May 25, 2006 and on April 27, 2007 at DMR's Hogan Regional Center in Hathorne, Massachusetts.

Those present for all or part of the proceedings were:

[redacted]	Appellant
[redacted]	Appellant's Mother and Guardian
[redacted]	Appellant's Stepfather
Judy Bouffard	Advocate/NSARC
John J. Healey	In-Home Support Service/NSARC
Michael A. Harvey, Ph.D.	Expert Witness for Appellant
Victoria Whelan	Attorney for Appellant
Veronica Wolfe	DMR Regional Eligibility Manager
Patricia Shook, PhD.	DMR Psychologist
Douglas White	Attorney for DMR
Elise Kopley	Attorney for DMR

The evidence consists of documents submitted by the Appellant A1-12 and by DMR numbered D1-4 and approximately five hours of oral testimony. The hearing was continued from May 25, 2006 until April 27, 2007 so that the Appellant could obtain psychological tests results from the Appellant's developmental period. No such records were obtained, and therefore none were produced.

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. (A4, D4)

2. The Appellant is a 42-year-old female who resides with her family in Middleton, MA. (A8, D4)

3. Four evaluations of the Appellant's intellectual functioning after the age of 18 were entered into evidence. (A5-8)

4. An Adaptive Behavior Assessment (ABAS) was entered into evidence. I did not consider this exhibit when making my decision because the parties agreed that the Appellant's adaptive deficits were not an issue in this appeal. (A2)

5. The results of the Vineland Adaptive Behavior Scales (VABS) were entered into evidence. I did not consider these when making my decision because the parties agreed that the Appellant's adaptive deficits were not an issue in this appeal. (A7)

6. A document entitled "ICAP Computer Scoring" was entered into evidence. I did not consider this exhibit when making my decision because the parties agreed that the Appellant's adaptive deficits were not an issue in this appeal. (A3)

7. A Social Security Administration document entitled "Report of Continuing Disability" and one entitled "Physician's Medical Officer's Statement of Patient's Capability to Manage Benefits" were entered into evidence. I did not consider these documents when making my decision because there were no psychological test results included in the report or the statement and because the parties agreed that the Appellant's adaptive deficits were not an issue in this appeal. (A1)

8. A document entitled "Reviews of Four Types of Assessment Instruments Used With Deaf and Hard of Hearing Students: Cognitive Assessment" was entered into evidence. (A9)

9. A document entitled "Proceedings of the First World Conference on Mental Health and Deafness" (October 22-24, 1998, Gallaudet University, Washington, DC USA) was entered into evidence. (A10)

10. A document entitled "Introduction to the WAIS III" written by Richard Niolon, Ph.D. was entered into evidence. (A11)

11. A document entitled "Assessment Focus Spring 1999 Newsletter" was entered into evidence. (A12)

12. Two redacted documents labeled "Psychological Evaluations" written by Michael A. Harvey, Ph.D. were entered into evidence. (D1-2)

13. Michael A. Harvey's CV was entered into evidence. (A8)

14. Patricia H. Shook's CV was entered into evidence (D3)

15. In May, 1983 when the Appellant was 18 years 10 months of age, she was evaluated by Joan E. Foster, M.Ed., C.C.C., School Psychologist. On this occasion, Ms. Foster administered the Wechsler Adult Intelligence Scale – Revised (WAIS-R). Ms. Foster pointed out very early in her report that the Appellant has a marked history of severe receptive aphasia, complicated by a hearing loss. She went on to state that the Appellant does not appear to have any comprehension of the symbolic

representation for verbal language. She noted that the Appellant is better able to function with manual communication and its representation to her environment. Ms. Foster reported that she did not administer the Verbal portion of the WAIS-R due to the Appellant's severe receptive language disorder. On this test, the Appellant received a Performance Score of 89 which according to Ms. Foster is between the low average and average range. She pointed out that the Appellant was visually able to interpret the non-verbal linguistic information; yet, she was not able to auditorily interpret verbal language which also has a symbolic representation. The tester noted that the Appellant had good visual planning and spatial relations. She also noted that the Appellant had a low scaled score on Digit Symbol primarily due to her slow and deliberate method of checking and rechecking. Ms. Foster concluded that the Appellant is a classic textbook receptive aphasic, who lacks comprehension for the symbolic representation of oral language. She did not offer a diagnosis of mental retardation. (A5)

16. In August, 1986 when the Appellant was 22 years 2 months of age, she was evaluated by Michael A. Harvey, Ph.D. He stated in his report that the purpose of the evaluation was to evaluate the Appellant's intellectual functioning, to be used as an aid in vocational rehabilitation planning. Dr. Harvey noted that the Appellant has a profound, bilateral, sensoi-neural hearing loss of congenital origin, as a result of maternal rubella, during the 1st trimester of pregnancy. On this occasion, Dr. Harvey administered the Performance portion of WAIS-R. In the section of his report labeled Examination Results, Dr. Harvey stated that the Appellant communicated with him using a combination of speech and Sign Language and that she was able to express herself via these two modes significantly more proficiently that she appeared to understand him when he used oral and/or signing modes. He noted that this is consistent with the previous diagnosis of receptive aphasia. He also noted that she exhibited some "ritualistic" behaviors such as what appeared to be a somewhat rigid adherence to manners, politeness, etiquette, etc. The Appellant's scaled scores on the Performance portion of the WAIS-R ranged from a score of 2 on Digit Span to a score of 11 on Object Assembly with a score of 10 considered as Average. The rest of her scores were: Picture Completion – 10, Picture Arrangement – 8, Block Design – 8 and Digit Symbol – 5. Dr. Harvey's report stated that the Appellant's Performance IQ was 86. He states that most of the Verbal subtests could not be given due to linguistic communication difficulties between himself and the Appellant, but opined that the Appellant's Full Scale IQ score would fall well below 70. In his Summary and Recommendations, Dr. Harvey stated that the Appellant's intellectual functioning is quite compromised, apparently because of neurologic dysfunction secondary to the rubella syndrome. He went on to say that this has manifested itself, in part, perhaps, by receptive aphasia which certainly compromises the Appellant's communication skills. He noted that she is quite visually oriented and certainly learns remarkably well via demonstration. At the time of this evaluation, Dr. Harvey believed that while the Appellant's Full Scale IQ score suggests overall functioning in the mentally retarded range, she appeared to exhibit severe neurologic dysfunction, rather than a completely flat profile suggestive of metal retardation per se. He went on to say

that placement in a residential program with deaf mentally retarded individuals was not deemed to be appropriate, since most of the clients at the program were functioning at a somewhat lower level than the Appellant. He did not offer a diagnosis of mental retardation. (A6)

17. In May, 2005 when the Appellant was 40 years 10 months of age, she was evaluated by Jeffrey Schumer, Psy.D. On this occasion, Dr. Schumer administered the Wechsler Adult Intelligence Scale-3rd Edition (WAIS-III). He noted in his report that the Appellant was cooperative and pleasant. She communicated via a combination of single words, nonverbal sounds, and signing. He stated that he attempted to administer the WAIS-III Verbal subtests, but that he was not able to do so because of communication difficulties between himself and the Appellant. He noted that apparently the Appellant could not comprehend the questions and instructions and could not effectively communicate her responses. He also noted that she was able to appropriately complete the different requirements for the various Performance subtests. Dr. Schumer stated that the Appellant was only able to complete the Vocabulary subtest of the Verbal subtests and earned the lowest possible scaled score on this subtest. She did not know how to define even the most basic of words. He also stated that the Appellant demonstrated better, albeit still quite limited nonverbal abilities on the Performance subtests and received a Performance IQ score of 70. He concluded that although a determination of the Appellant's overall level of functioning could not be made, she clearly shows limited intellectual resources consistent with the results of her previous evaluations. He added that the Appellant's overall Performance IQ score was much lower than her prior testing, but advised caution in comparing these scores as she was given two different versions of the test (WAIS-R, WAIS-III) Dr. Schumer concluded that the Appellant's performance on the WAIS-III suggests that she is cognitively functioning in the range of mental retardation, but suggested that caution should be used because only one Verbal subtest was able to be given. He also stated that it is very possible that her neurologic dysfunction could be integral in her limited cognitive resources. (A7)

18. In September, 2006 when the Appellant was 42 years 3 months of age, she was again evaluated by Michael A. Harvey, Ph.D. On this occasion, Dr. Harvey administered the WAIS-III. In his report Dr. Harvey stated that consistent with previous evaluations, the Appellant's receptive and expressive language appeared to be impaired. Additionally he noted that she did not seem to have any meaningful degree of proficiency in sign language. In his report, Dr. Harvey explained why he administered both the Verbal and the Performance subtests to the Appellant as part of this evaluation whereas in his 1986 evaluation, he administered only the Performance subtests. He stated that the purpose of the 1986 evaluation was to aid in placement of the Appellant in jobs that required primarily non-verbal, visual-motor skills so he chose to administer only the Performance subtests. He also explained that in twenty years ago the thinking was that many deaf individuals had been wrongly diagnosed as mentally retarded based on the administration of both the Verbal and the Performance tests from which the Full Scale score is arrived. It

has been documented that many deaf individuals who were deaf prior to the onset of language do not achieve proficient scores on verbal measures, not because of intellectual deficits per se, but because of experiential deficits. That is, deaf individuals have limited opportunities to pick up incidental information as contrasted with hearing individuals. In the past, it was common practice not to administer the Verbal subtests so as to counter a built-in testing bias and not underestimate a deaf person's intelligence. Dr. Harvey explained that the field of deafness has now recognized that there is a significant risk of over-estimating a deaf person's actual overall cognitive abilities when reporting only a nonverbal, Performance IQ measure and references the Proceedings of the First World Conference on Mental Health and Deafness. Dr. Harvey's report indicates that this is what happened in the Appellant's case. He states that it is clear that she is functioning at a very rudimental level with respect to her verbal, language-based functioning – well below what would be accounted for by reduced opportunities for incidental learning. On this administration of the WAIS, the Appellant received a Verbal IQ score of 51, a Performance IQ score of 76 and a Full Scale IQ score of 59. Dr. Harvey stated that the Appellant's capacity for conceptualization appeared absent or minimal. Dr. Harvey points out that the Appellant's Performance IQ score of 76 is not statistically different from the 70 that she received on the test administered by Dr. Schumer in 2005. He did not offer any reason for the decline of her Performance IQ scores over a 23 year period. He did note that her verbal impairments seem to have remained constant throughout her development. He opined that if the Appellant had been given the Verbal subtests at the time of the testing that he administered in 1986, she would have likely scored a 51 and that coupled with her Performance IQ score of 86, she would have obtained a Full Scale IQ score of 65. (A6, A8)

19. The Appellant testified. When asked her to state her name and she was able to do so. When asked, "How are you?" she repeated the question. She was unable to answer many of the questions that were posed to her; she simply repeated some of the words in the questions. She was unable to say how much money she makes. According to her mother the number that she wrote down was not accurate. She was able to write down the name of the place where she works. She indicated that she folds envelopes and boxes. She was able to write down the times that the van transported her to and from work and the hours that she worked.

20. John Healey testified on behalf of the Appellant. He testified that he evaluated her adaptive functioning using the Vineland. He stated that she couldn't follow simple directions, but did better with the use of gestures. He testified that she relies heavily on visual cues. He noted that she repeats the last thing that a person says. She has very poor expressive language and is difficult to understand. He stated that she can read digital clocks and can follow a routine. He testified that the Appellant is willing to please others and has some level of social skills. He stated that she has good personal care skills. Mr. Healey testified that while she can make a snack or a sandwich, but she cannot follow a recipe. He noted the following deficits: She cannot self medicate. She has no understanding of the value of money. She cannot

make change. While she has some ability to use the phone, she does not use it and it is questionable whether she could use the phone in an emergency. She has no independent transportation skills. She can't organize activities for herself. While she can be by herself for short periods of time, she does not have the skills for self sufficiency.

21. _____ testified on behalf of the Appellant. She stated that the Appellant was diagnosed with rubella during the first trimester of her pregnancy. She testified that she was not told what deficits the Appellant had at birth because it was too early to make a diagnosis. She noted that the Appellant suffered from a hearing loss, was very slow in rolling over and didn't walk until age two. Mrs. _____ testified that she took the Appellant to Children's Hospital for an evaluation. She stated that they noted the Appellant's developmental delays in many areas. She stated when the Appellant was 5 years 6 months of age, a speech therapist suggested that the Appellant be enrolled in a school in Newton, MA. In order to be accepted that school, the Appellant had to be toilet trained. In order to achieve this, the Appellant went to the Kennedy Hospital for six weeks where she was able to be toilet trained.

22. Michael Harvey, Ph.D. testified as an expert witness for the Appellant. He stated that he been a clinical psychologist for approximately 35 years. He testified that he has worked for over 30 years with deaf individuals. He stated that has written four books and over forty articles in the field of deafness and mental heath. He further stated that has given approximately 2000 tests of the type that he administered to the Appellant. He stated that in administering psychological tests to deaf individuals, it is mostly a case of the interpretation of test results and that such interpretation depends upon one's experience in the field of deafness. He testified that there is no good test that is normed for deaf people per se. (A8)

Dr. Harvey testified that it is necessary that one have experience in working with deaf individuals to properly and therefore ethically interpret test results.

Dr. Harvey explained that 30 years ago in the field of deafness there was a correct observation made that when one administers both the Verbal and the Performance subtests, the individuals score lower because the Verbal subtests ask information about the environment that hearing people overhear without necessarily being taught. This is called incidental information. Congenitally or prelingually deaf people will score lower on the Verbal subtests not because of deficient cognitive ability but because of reduced opportunities for incidental learning. He went on to explain that there was a movement to administer only the Performance subtests to deaf people in order to avoid the real occurrence of many deaf people being falsely diagnosed as intellectually impaired. It was in this context that he first evaluated the Appellant in 1986. He further explained that another reason that he administered only the Performance subtests at that time was because he was evaluating the Plaintiff for the Massachusetts Rehabilitation Commission as part of a vocational assessment for a job involved only nonverbal skills. (A6)

Dr. Harvey stated that the field of deafness has correctly noted that for many people that is grossly misleading to only report the Performance subtests because if properly interpreted in terms of one's knowledge of deaf people, the Verbal subtests yield a lot of important information about a deaf person's functioning. He gave an example of one Verbal subtest which requires reciting a series of digits in their forward and backward order. He stated that the Appellant was only able to recite 2 digits forward and 2 digits backward. This is an example of a measure of intelligence that goes beyond the idea that deaf people naturally miss things. He concluded that now norm in the field of deafness is to interpret the both Verbal and the Performance subtests, but with one's knowledge in the field of deafness the issue is how to interpret the scores. (A8, A10)

Dr. Harvey testified that the Appellant's cognitive abilities were not accurately reflected by a Performance IQ score. It stated that it was quite apparent to him that out of the 2000 or so deaf individuals he has tested over 30 plus years, the Appellant is probably within the bottom 1% of deaf individuals relative to cognitive impairments. He stated that using solely a non verbal measure doesn't come close to capturing her degree of global impairment.

Dr. Harvey stated that he tested the Appellant using the WAIS-III in September, 2006. He stated that the Appellant's social interaction with him was very superficial. Her communication skills were very impaired. She had very limited sign language. She did not know what day it was. She did not know her home address. She did not know who the president was. He stated that this is very consistent with other reports of her adaptive skill deficits. He stated that her Verbal IQ score was 51. He stated her Performance IQ score was 76. Her Full Scale IQ score was 59. He stated that her conceptual skills were quite minimal. He testified that he has tested many individuals like the Appellant and has been able to explain the concept of how two things are similar. He testified that he was unable to do so with the Appellant despite using a variety of techniques. He stated that this was quite significant. He testified that other test reports have indicated that the Appellant has severe receptive aphasia which he stated was part of the Appellant's clinical picture. He went on to say that it was his strong clinical opinion that the Appellant's primary diagnosis is one of mental retardation. He stated that only looking at the Appellant's receptive aphasia as a learning disability does not take into consideration her global deficits. He stated that it was his judgment that she is mentally retarded and functions at the level of mental retardation. (A8)

On cross examination, counsel for DMR reviewed the Dr. Harvey's 1986 test report. Dr. Harvey agreed that the stated purpose of his evaluation at that time was to evaluate the Appellant's current intellectual functioning. He agreed that at the time the WAIS-R was the current test used in psychometric testing. Upon reviewing his report, Dr. Harvey stated that he attempted to administer the Verbal subtests, but the Appellant was unable to perform most of the tasks. (A6)

Dr. Harvey testified that deafness is separate and distinct from receptive aphasia. He stated that receptive aphasia is the inability to understand language. He agreed that he was aware from other test reports that the Appellant had been found to have classic receptive aphasia. Dr. Harvey stated that in the Appellant's case, her receptive aphasia would affect her ability to understand other people's signing. Dr. Harvey agreed that his examination findings were consistent with the previous diagnoses of receptive aphasia. Dr. Harvey testified that at the time of the 1986 testing the Appellant was 22 years of age. He agreed that the onset of mental retardation must be prior to the age of 18. Dr. Harvey stated that the Appellant's Performance IQ score was 86 which he explained is inadequate to describe the cognitive functioning of deaf persons, but just taking the Performance IQ score into account, the Appellant's score would be in the low average range. He stated that receptive aphasia would decrease an individual's Verbal subtest scores, but it would not affect an individual's global adaptive functioning as mental retardation would. One must take the totality of the person into account when rendering a diagnosis based on any one given test. Dr. Harvey agreed that in 1986, the Appellant's mother had reported that the Appellant's daily living skills were excellent. He went on to say that when talking to a professional, it is not unusual for the mother of a mentally retarded young adult to say that her child is doing very well. (A6)

Dr. Harvey stated that the current practice when administering the WAIS-III to deaf individuals is to give both the Verbal and the Performance subtests. It was not common practice to do that 20 some years ago.

In reviewing prior testing, Dr. Harvey agreed that the Appellant's Performance score in 2006 was lower than what she had obtained when he previously tested in 1986 as well as what she had obtained on a test administered in 1983. (A5, A6, A8)

Dr. Harvey stated that approximately 25% of his experience with assessment has been with mentally retarded individuals. He stated that it was misleading to say that most mentally retarded individuals have flat subtest scores. He stated that just looking at subtest scores, just looking at psychometric testing without looking at the adaptive behavior skills and deficits is misleading. He stated that there are some mentally retarded persons, the Appellant being one of them who show disparity between Verbal and Performance tests – not a flat profile. He stated that while a flat profile across subtests is suggestive of mental retardation that is not to say that one must have a flat profile to be assessed as mentally retarded. He stated that there are persons functioning as mentally retarded who have higher level non verbal functioning than verbal functioning. He agreed that there are conditions other than impaired intelligence that could account for someone having difficulty functioning in the world. Dr. Harvey testified that in his 1986 report, he opined that because the Appellant was unable to perform most of the tasks on the Verbal subtest, her Full Scale IQ score would fall well below 70.

When asked the reason for the Appellant's inability to perform on many of the Verbal subtests on the WAIS-III in 2006, Dr. Harvey stated that it was not a result

of her deafness per se, but could not say that it was solely the result of receptive aphasia. Dr. Harvey testified that in his view it was a combination of receptive aphasia and mental retardation. He stated that he has tested a number of individuals who have receptive aphasia and is well able to get them to understand the directions, but that he was unable to do so with the Appellant. He stated that he did not see the problem as solely the influence of aphasic issues. (A8)

Dr. Harvey agreed that there was a 24 point[1] difference between the Appellant's Verbal IQ score of 51 and the performance IQ score of 76. He stated that this was a significant difference. He agreed that one must use caution when reporting the Full Scale IQ score when there is such a large discrepancy between the Verbal and the Performance IQ, but stated that this speaks to the expertise in interpreting overall test results with deaf people in the context of other factors. He stated that 30 years ago it would have been the practice to only report the Performance score of deaf people because of a fear of misdiagnosis. He stated that as in the case of the Appellant to only report the higher Performance IQ score would be to grossly overestimate her cognitive abilities and her ability to function in the world. (A8)

Dr. Harvey stated that he had reviewed the "Proceedings of the First World Conference on Mental Health and Deafness" which the Appellant had entered into evidence. Dr. Harvey stated that the lower end of the borderline range in nonverbal intelligence would be a Performance IQ score of 68-73. He agreed that the Appellant received scores in the low average range on nonverbal tests performed in 1983 and 1986. Dr. Harvey stated that he did not have an explanation for why the Appellant's Performance IQ score on the testing conducted in 2006 was lower than her Performance IQ score in 1983 and 1986. He stated that the huge concern in only reporting the Performance IQ scores for deaf individuals is the under diagnosis of mental retardation, not the over diagnosis. The doctor explained that if someone who spoke Spanish was given a Verbal test in English and received a low score, it would indicate that the person didn't understand the language, but the person could also be mentally retarded. In response to a question posed by the Hearing Officer, the witness agreed that the clinician must try to differentiate between the issues and try to determine what is causing the low score. (A5, A6, A8, A10)

Dr. Harvey reviewed a heavily redacted document entitled "Psychological Evaluation" dated July 1, 2004. Dr. Harvey agreed that his signature was on the last page of the document. He stated that the evaluation was performed in 2004. He agreed that his report stated, "The Performance subtests are considered a more valid measure of intellectual potential for congenitally or prelingually hearing – impaired persons, as they minimize the effects of so called incidental learning. Incidental learning refers to information that hearing persons naturally pick up in the environment, frequently through the auditory channel". Dr. Harvey also reviewed a heavy redacted document entitled "Psychological Evaluation" dated March 3, 2006. He agreed that his signature was on the last page of the document. Dr. Harvey agreed that in the report he stated, "The verbal subtests were

[1] There was actually a 25 point difference.

administered to assess .....'s verbal skills, relative to hearing persons. These tests include knowledge of "incidental information – that is, information which hearing persons typically pick up from the environment, often through the auditory channel. Accordingly, they are not considered a valid measure of intellectual potential for congenitally or prelingually deaf or hard or hearing persons". (D1, D2)

On redirect, Dr. Harvey stated that he could not tell if there was a large disparity between the individuals' Verbal and Performance IQ test scores on the redacted reports that DMR introduced. He also stated that he was unable to determine if those individuals were similar to the Appellant. He agreed that he would make different comments depending on the person that he was evaluating. He stated that from his experience testing many people it was his opinion that the case at hand does not present a difficult clinical differential diagnosis. He stated that the Appellant is mentally retarded. He stated that he was able to get a retrospective analysis of the Appellant's IQ relative to the testing done in 1986. He stated that at that time the Full Scale IQ would have been 65. (A6, A8)

On re-cross, Dr. Harvey agreed that the statements that he made in the redacted reports are general statements about deaf persons and are not specific to the individuals that he tested. He stated that had he administered the Verbal IQ tests to the Appellant in 1986, her Full Scale IQ score would have been below 70. He agreed that taking a Verbal IQ score from one test and combining it with a Performance IQ from another test was not consistent with the WAIS-III manual. He stated that this was an aggregate average that he calculated. He agreed that receptive aphasia would affect one's Verbal score and that it would cause the score to be lower. He also agreed that receptive aphasia is separate and distinct although can be present with mental retardation. (A6, D1, D2)

23. Patricia H. Shook, Ph.D. testified as an expert witness for DMR. Dr. Shook testified that she is the Regional Eligibility Psychologist for the Northeast Region of DMR. She stated that has held that position for a year and a half and that in that capacity is responsible to make determinations as to the eligibility of individuals for DMR services. She stated that she has worked in many different capacities in the field of Mental Retardation for 25 years. She testified that she has done therapy and counseling with mentally retarded individuals, their families and their caregivers. Dr. Shook stated that she has done cognitive and adaptive behavior assessments. She testified that she has done behavioral consultations and has worked for DMR in state schools including Wrentham, Dever and Fernald. She stated that she has done approximately 500 eligibility evaluations for DMR. She stated that she has participated in approximately 6 fair hearings. (D3)

She agreed that as part of her responsibility she has reviewed the eligibility determinations of other individuals employed by DMR. She stated that she had reviewed the eligibility report authored by Elina Wayrynen. She agreed that she was familiar with the DMR eligibility regulations that were in effect on October 12, 2004, the date that Elina Wayrynen made her eligibility determination in the instant

case. She stated that the regulations in effect at that time required that the individual have significantly sub-average intellectual functioning that occurring concurrently with related limitations in 2 or more applicable areas of specific adaptive skills. She explained that the 10 areas include communication, self-care, functional academics, work, home living, community use, health and safety and so forth. She also stated that mental retardation must manifest before the age of 18. (A4)

Dr. Shook described the process of applying for DMR services. She noted that if there were no valid cognitive tests available, arrangements can be made to have testing done. Once all the materials including adaptive evaluations have been submitted, the information is passed on to the Eligibility Psychologist. She agreed that in the case of the Appellant, documents over and above those reviewed by Elina Wayrynen were submitted as part of the application for eligibility. Those documents included Dr. Schumer's 2005 report and Dr. Harvey's second report from 2006 as well as some articles. Dr. Shook testified that based on the documents reviewed by Dr. Wayrynen, she agreed with the doctor's determination that the Appellant was not eligible for DMR services. She agreed that after reviewing the two more recent reports her opinion was unchanged. (A4-8)

Dr. Shook reviewed the psychological tests that had been submitted. She stated that the WAIS-R was given in 1983 and in 1986 and that these were the appropriate tests to be given. The Appellant was given the WAIS-III in 2005 and 2006 and these were the appropriate tests to be administered. She stated that she had reviewed all four tests. She stated that validity as it relates to psychometric testing means that the test measures what it purports to measure. Validity is important because you want the test to measure what you are attempting to assess i.e. intelligence and not something else.

Dr. Shook reviewed the Appellant's 1983 psychological evaluation conducted by Joan E. Foster, M.Ed., C.C. C. Dr. Shook stated that the Appellant was 18 years old at the time of this evaluation. She agreed that part of the testing is to observe behavior and testified that the examiner noted that while the Appellant appeared to make meaningful eye contact, she did not appear to have any comprehension of the symbolic representation for verbal language. The examiner also noted that the Appellant had good visual analysis and planning. Dr. Shook stated that the report describes the Appellant as having severe receptive aphasia complicated by a hearing loss. She went on to define receptive aphasia as a condition that usually occurs as a result of a lesion to a specific area of the brain, the left temporal lobe and results in difficulty understanding language. Individuals with receptive aphasia may also have difficulty communicating in part because they may not understand what they're not understanding. She stated that mental retardation is a much more global deficit in comparison to receptive aphasia. She stated that with mental retardation, all areas are affected. She stated that receptive aphasia is a separate issue from hearing loss. She stated that a receptive aphasia coupled with a hearing loss would lead to increased difficulty in understanding. This means that one with both

conditions would have difficulty communicating whether using lip reading or sign language. She noted that the Appellant was able to perform fairly well on the Performance tests which are visually based. Dr. Shook explained that the Appellant's scores on four of the five Performance subtests were in the average range. She went on to say that on one subtest, Digit Symbol the Appellant received a scaled score of 5 which is in the borderline range. Dr. Shook stated that the examiner reported a Performance IQ score of 89 which is at the upper end of the low average range. Dr. Shook testified that according to the examiner's report the Verbal subtests were not administered due to the Appellant's severe receptive language disorder which appears to refer to her receptive aphasia, not to her hearing loss. Dr. Shook said that you do not see mentally retarded individuals scoring in the average range on four out of five subtests. She stated that people with mental retardation tend to have scores much lower than that across the board. Their scores tend to be relatively flat, but when there is variation you don't have a number of scores in the average range. The witness explained that the reason the Appellant received a low score on the Digit Symbol subtest was not because she made errors but because she was slow. She stated that the examiner noted that if this test were not included the Appellant would have scored in the average range. Dr. Shook testified that it would be unusual to have someone with mental retardation possess very strong visual analytical skills which is how the examiner described the Appellant in the Summary and Recommendations section of her report. She stated that she had never encountered an individual with a Performance IQ score of 89 who would be eligible services under the DMR regulations. Dr. Shook stated that someone with mental retardation could have receptive aphasia but that doesn't mean that someone with receptive aphasia is mentally retarded. (A5)

Dr. Shook reviewed the 1986 evaluation conducted by Michael A. Harvey, Ph.D. Dr. Shook stated that the Appellant was 22 at the time of that evaluation. She agreed that this evaluation and the one done in 1986 were both conducted after the Appellant was 18. She stated that DMR was not given any evaluations prior to age 18 and that these two were the closest to the developmental period which she explained is critical in making a diagnosis of mental retardation. She testified that the examiner noted the presence of receptive aphasia and that he tested her using the WAIS-R. She said the results were similar to those in 1983. The Appellant again scored in the average range on out of five Performance subtests and again received a borderline score on the Digit Symbol subtest. She noted that Dr. Harvey administered one Verbal subtest, Digit Span. She went on to explain that according to the report, the examiner was unable to administer the other Verbal subtests due to communication difficulties between the himself and the Appellant and that this appeared to be the result of the Appellant's receptive aphasia. She stated that Dr. Harvey was guessing when he made the statement that based on his testing, the Appellant would fall well below 70. She opined that because Dr. Harvey couldn't administer most of the Verbal subtests to the Appellant because of communication difficulties, he determined that she wouldn't have done well on them. She again stated that you don't see individuals with mental retardation scoring in the average range on four subtests, particularly on Block Design and Picture Arrangement

which are fairly complicated and require visual analysis. She noted that the Appellant scored in the average range on both of these subtests, albeit in the low average range. Dr. Shook testified that Dr. Harvey did not attribute the Appellant's low Verbal scores to deafness but seems to talking about the aphasia. She stated that while mental retardation and receptive aphasia can be intertwined they are separated diagnoses. She noted that in Dr. Harvey's 2006 report he talks about his results not in terms of receptive aphasia but in terms of deafness unlike he does in the instant report. Dr. Shook testified that receptive aphasia is something that is going to disrupt communication but by itself is not a global deficit as would be the case with mental retardation. (A6, A8)

Dr. Shook reviewed the 2005 evaluation conducted by Jeffrey Schumer, Psy.D. This evaluation was done after the eligibility determination was complete. The evaluation was done when the Appellant was 40 years of age. This evaluation was suggested for purposes of the Appeal. Dr. Shook refuted Dr. Schumer's charterization of the reasons for the Appellant being denied eligibility for DMR services. She stated that it was not due to the indication of receptive aphasia but due to the fact that she does not have mental retardation. Dr. Shook testified that on this occasion the examiner administered the WAIS-III, the current form of the test. Dr. Shook stated that she was familiar with the test, had given the test and had interpreted the test results. She stated that she had interpreted it many times, especially reading other interpretations of it and had administered it a 6 times. Dr. Shook stated that the examiner could not administer the Verbal portion of the test due to communication difficulties yet the Appellant was able to complete the Performance subtests. Dr. Shook testified that on this administration of the test, the Appellant received an overall Performance IQ score of 70 which would be at the very bottom of the borderline range. She had subtest scores ranging from the very low range to the low average range. Dr. Shook could not account for the large discrepancy between the Appellant's Performance IQ scores in 1983 (89) and 1986 (86) and her score on this test (70). Some of the discrepancy may be due to the new version of the test which for a while produces somewhat lower scores, but Dr. Shook suggested that something else is going on. She testified that there may be many reasons for a decline in cognitive functioning but once past the developmental period, it cannot be attributed to mental retardation. When asked by the Hearing Officer what the average point difference would be between the WAIS-R and the WAIS-III, Dr. Shook was unable to say, but she said that it would be problematic to see a 20 point difference between the two tests. She thought there would be a difference of a few points, perhaps 3-5. (A5-A7)

Dr. Shook stated that the current WAIS manual states that the Performance Scales of the Wechsler Intelligence Scales are the most preferred instrument for assessing the intellectual functioning of individuals with hearing impairments. She stated that the diagnosis of receptive aphasia makes it difficult to use the Verbal tests to measure intellectual impairment. She said that when testing someone with receptive aphasia and/or deafness it is cleaner to use just the Performance Scales. Dr. Shook pointed out that the DMR regulations do not say that you must use a Full

Scale IQ score, but rather say that you must use an acceptable individual standardized IQ test. She stated that when one estimates a Full Scale IQ score, it must be noted in the tester's report and such a score does not have as much value as one obtained in a standardized way.

Dr. Shook reviewed a portion of the document entitled "Proceedings of the First World Conference on Mental Health and Deafness" and took exception with Dr. Harvey's characterization that giving both the Verbal and the Performance subtests to deaf individuals is now the preferred method of testing for mental retardation. She stated that this may be so for those individuals who test at the lower end of the borderline range in nonverbal intelligence, but that this in not the case with the earlier testing of the Appellant. The two tests that were administered closest to the developmental period show her to be in the low average range on the Performance Scales. She stated that her more recent Performance IQ scores should not be considered as they are far beyond the developmental period. (A10)

Dr. Shook stated that she had the opportunity to review Dr. Harvey's 2006 report. She testified that the Appellant's attorney had requested that the Appellant's verbal and nonverbal functioning be tested. She stated that Dr. Harvey acknowledged that the Appellant has severe receptive aphasia but does not refer to that condition in his results. Dr. Shook agreed that you would expect the Appellant's Verbal scores to be low given the problems that she has. She agreed that the results of this examination were a Performance IQ score of 76, a Verbal IQ score of 51 and a Full Scale IQ score of 59. Dr. Shook stated that a 25 point difference is statistically significant and would occur in less than 2.2% of the population. She stated that a significant reason for the discrepancy would be the Appellant's deafness and receptive aphasia. She said many psychologists will not calculate a Full Scale IQ with a difference of 25 points. She said this is because this would not accurately reflect an individual's overall cognitive functioning. She stated that sometimes the score is reported with the caveat that caution must be used when interpreting such a score. Dr. Shook was not able to explain how Dr. Harvey was able to administer the Verbal subtests to the Appellant in 2006, but was unable to do so in 1986. Dr. Shook testified that the Appellant scored in the low average range on the Performance subtests administered in 1983 and 1986. She noted that Dr. Harvey's report stated that the decline from the earlier test scores was not clear. She stated that there was no reason to question the validity of the tests given in 1983 and 1986 and neither examiner questioned the validity at the time they wrote their reports. (A5-8)

Dr. Shook testified that the DMR regulations do not address the decline in cognitive functioning after the age of 18 because mental retardation has to occur before the age of 18 and whatever happens after age 18 cannot be attributed to mental retardation. Dr. Shook said that it was not standard practice to take a Performance IQ score obtained on one test and combine it with a Verbal IQ score obtained on a test done at a later time and calculate a Full Scale IQ score as Dr. Harvey did in his 2006 report. She also said taking the Performance IQ score obtained in 1986 of 86

and the Verbal IQ score obtained in 2006 of 51 gives you an even greater discrepancy (35 points) than if you used both Performance (76) and Verbal IQ (51) scores obtained in 2006. She stated that the Full Scale IQ score is supposed to represent an individual's overall cognitive functioning. Dr. Shook also stated that the score of 51 does not solely represent the Appellant's cognitive abilities but is impacted by her receptive aphasia and her deafness. (A6, A8)

Dr. Shook testified that after reviewing all of the documents presented relative to the Appellant's eligibility for DMR services, the testimony given at this hearing and the DMR regulations as they existed in 2004 which require that mental retardation manifest before the age of 18, it was her opinion that the Appellant does not meet requirements for eligibility.

On cross examination, Dr. Shook stated that although she had met the Appellant she had not evaluated her. Dr. Shook testified that she had done one evaluation of a deaf individual. Dr. Shook agreed that one could have both metal retardation and receptive aphasia. Dr. Shook stated that Dr. Schumer's report indicated that the Appellant could not define the most basic of words. Dr. Shook testified that the the WAIS-III states that Performance test is the preferred test when testing deaf adults. She stated that although there are other possibilities that is the preferred test to use. She agreed that when there is a large disparity between verbal and nonverbal scores there is something more to be interpreted. She stated that individuals who have experience working with deaf individuals would have experience that would help them to interpret those types of scores.

On redirect examination, Dr. Shook agreed that the tests that were given to the Appellant were standardized tests and the tests are approved to be used with deaf individuals. She testified that she can interpret the scores in the sense that people who are deaf and have receptive aphasia are going to have lower Verbal IQ scores and that has to be taken into consideration when interpreting a test. She further testified that her training says that whenever there is a large discrepancy, one does not use a Full Scale IQ score or one is very careful about using it. She stated that is just basic practice. She stated that the Full Scale IQ score is supposed to be a representation of global cognitive functioning and when a lot of variation exists it is difficult to get a good measure of global cognitive functioning.

On recross, counsel for the Appellant asked if one's Performance IQ score could overestimate one's IQ. Dr. Shook testified in some cases it could. She went on to explain that when an individual has a Performance IQ score in the average range, it does not tend to imply that the individual is mentally retarded. She stated that if the Appellant had a Performance IQ of 72 at age 18; it would be difficult to deny her eligibility. It would be too close to call. Someone with a score of 89 is not too close to call. She again stated that mental retardation is a global impairment so someone must have impaired nonverbal as well as impaired verbal scores. She stated that everything has to be impaired; with such a big discrepancy something else is going on.

On follow-up questioning by counsel for DMR, Dr. Shook stated that there was nothing in the test reports of 1983 or1986 that indicate that the Appellant has global impairments.

FINDINGS AND CONCLUSIONS

After a careful review of all of the evidence and despite her obvious 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[2], 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.

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 not "mentally retarded" as that term is used in statute and regulation for the determination of DMR supports.

I find that the Appellant does not have significantly sub-average intellectual functioning. This appeal presents a particularly difficult case in that the Appellant suffers from a hearing loss as well as receptive aphasia. I find that both conditions impact her ability to communicate and have an affect on her ability to perform on the Verbal portion

[2] DMR changed its definition of "mental retardation" and the incorporated the definition of "significantly sub-average intellectual functioning" effective June 2, 2006. Because the Appellant's application for DMR supports was filed before June 2, 2006, the earlier standard applies.

of an IQ test. I find that the Appellant presented no evidence of IQ testing done prior to the age of 18. I find that the only IQ score submitted by the Appellant close to the age of 18 was a Performance IQ score of 89 which is in the low average range of intelligence. Despite a written report and expert testimony that purported to calculate the Appellant's Full Scale IQ at the age of 22 using test results from a test administered in 2006, I find that her Performance IQ score of 86 at age 22 to be in the low average range of intelligence. I find that the Appellant's expert witness' attempt to retrospectively calculate a Full Scale IQ score based on a Verbal subtest score from a test given in 2006 is not a valid measure of her Full Scale IQ score at age 22. Although it is apparent from her mother's testimony that the Appellant experienced delays during her developmental period, the Appellant did not present credible evidence to show that she was globally impaired at that time, nor did most of the evidence of testing done subsequent to the developmental period show such global impairment. I find that the Appellant's expert witness' testimony that it is now common practice to give hearing impaired individuals both the Verbal and the Performance portions of the IQ test in conflict with what he stated in reports authored by him in 2004 and 2006. In those reports he stated that the Performance subtests are a more valid measure of intellectual potential for congenitally or prelingually hearing impaired persons. Despite his expertise in the field of deafness, I find that this contradiction calls into question his credibility relative to the testing that he administered in 2006. I find that the large discrepancy between the Verbal IQ score of 51 and the Performance IQ score of 76 obtained by the Appellant in 2006 raises questions about the validity of the Full Scale IQ score. Even if the Appellant's Full Scale IQ score of 59 were to be considered, this score was obtained by the Appellant at age 42, well beyond the developmental period.

While DMR agreed that the Appellant has multiple functional limitations and evidence was presented relative to the those functional limitations and the need for continuing supports, I did not give consideration to such evidence in reaching my determination because I found that the weight of the evidence presented relative to the Appellant's intellectual functioning showed that the Appellant does not have significantly sub-average intellectual functioning. Because the Appellant failed to show by a preponderance of the evidence that she met the criteria of the first prong of the three pronged AAMR definition of mental retardation, I did not find it necessary to consider the Appellant's functional limitations in reaching my decision. Functional limitations can result from a variety of conditions. Unless the weight of the evidence shows that an individual has significantly sub-average intellectual functioning, it is not necessary to give consideration to such functional limitations.

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: May 10, 2007

Marcia A. Hudgins
Hearing Officer