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 April 30, 2004 at DMR's Walter E. Fernald Developmental Center in Waltham, Massachusetts.

Those present for the proceedings were:

[redacted]	Appellant's Mother
	Appellant's Father
Susanna Chan, Ph.D.	Metro Region Regional Eligibility Manager
Stuart Carter, Ed.D., Ph.D.	DMR Consultant
Kim LaDue	Attorney for DMR

The evidence consists of Documents submitted by DMR numbered D1-22 and approximately one hour of oral testimony. The Appellant offered no expert testimony and did not submit any additional documents. While there were several documents submitted relative to the Appellant's level of educational achievement, I did not give great weight to those test results but rather relied primarily on the results of psychological testing and expert testimony in reaching my conclusion.

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. (testimony of [redacted] and Susanna Chan)

2. The Appellant is a 20 year-old man who currently resides at the [redacted] He previously resided with his mother at [redacted] in [redacted] Massachusetts (testimony of [redacted]; Fair Hearing Notice dated November 24, 2003).

3. Six (6) evaluations of the Appellant's intellectual functioning before the age of eighteen (18) were entered into evidence (D1-2, D5, D7, D9, and D14)

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4. Two (2) evaluations of the Appellant's intellectual functioning after the age of eighteen (18) were entered into evidence (D18-19)

5. One (1) assessment of the Appellant's adaptive functioning was entered into evidence. (D20)

6. When the Appellant was 2 years, 10 months of age, he was evaluated by Dennis O'Brien, Psy.D., an employee of the [redacted] located in [redacted] Massachusetts. On this occasion, the Appellant was given the Stanford-Binet Intelligence Scale, form L-M (Stanford-Binet). Dr. O'Brien's report states that the Appellant was functioning at the 2 year, 5 month level with respect to his overall cognitive ability and at the 2.7 year level with respect to overall functioning. The results indicated consistent functioning across both social as well as cognitive arenas. The Appellant had difficulty in following simple verbal commands and in identification of objects and human body parts. He also showed weaknesses in general self-help skills, especially in the areas of dressing and eating. Dr. O'Brien suggested that the Appellant would benefit from involvement in a specialized preschool program that was able to provide adequate structure. He stated that he would do best with individualized instruction and would need specialized services in the form of speech therapy, occupational therapy and physical therapy in order to develop appropriate pre-academic skills. (D1)

Carol Craig O'Brien, an Early Childhood Special Education teacher employed by the [redacted] Public Schools evaluated the Appellant shortly after the testing referenced in the preceding paragraph. Ms. O'Brien observed the Appellant in a special ed class of 3-year old children and administered the Preschool Screening System (PSS) Ms. Crain concluded that the Appellant had a short attention span and high activity level with much distractibility. On the PSS, the Appellant scored at the average range due to his excellent ability to recall sentences and phrases above age expectancies. The report also states that he showed below average 4th and 3rd stanine respectively for body awareness and control and visual and perceptual motor abilities. Ms. O'Brien also points out that he is able to recite verbal information yet doesn't demonstrate comprehension at that level. (D2)

7. When the Appellant was 5 years, 11 months of age, he was evaluated by M. Cohen, an employee of the [redacted] Public Schools. On this occasion, the Appellant was given the Wechsler Preschool and Primary Scale of Intelligence. The Appellant obtained a Verbal IQ score of 81, a Performance IQ score of 67 and a Full Scale IQ score of 72. The report states that the overall testing conditions were good but that response times were slow and the Appellant's ability to persevere appropriately was poor. I gave somewhat less weight to this report because there was nothing in the document to indicate the tester's level of education. Additionally, there was no narrative explaining the test results, only a Test Performance Rating Scale, a Test Result Profile and the test results. (D5)

8. When the Appellant was 6 years 3 months of age, he was evaluated by Ann Woodbury, M.Ed., an employee of Children's Hospital in Boston. On this occasion, Ms. Woodbury administered a number of tests including the Stanford-Binet. She concluded that the test results suggested that the Appellant has a complex set of learning disabilities. She noted that he has many skills and achievements well within the average range, and others in the low average and borderline range. He showed much scatter within individual subtests, often missing easier items and passing more difficult ones. She opined that this may have been due to general anxiety and fluctuating attention. In the Summary and Recommendations section of her report, Ms. Woodbury states that the Appellant will continue to learn best in a carefully structured educational environment with new concepts and skills introduced in non-threatening, multi-modal formats. He may need special assistance in managing peer relations, developing successful friendships, and in managing his own anxiety and feelings around these sensitive issues. She also suggested that he would benefit from ongoing therapeutic counseling to help him manage his feelings, anxiety, and issues of self-esteem. (D7)

9. When the Appellant was 11 years of age, he was evaluated by Sherrie Schnee, School Psychologist employed by the [redacted] Public Schools. On this occasion, Ms Schnee administered the Wechsler Intelligence Scale for Children -Third Edition (WISC-III). The Appellant obtained a Verbal IQ score of 73, a Performance IQ score of 58 and a Full Scale IQ score of 63. She noted that the Appellant has significantly below average ability. His Verbal IQ was in the borderline range, his Performance IQ was significantly below average and his Full Scale IQ score was also significantly below average. She went on to say that there was much more variability in the Verbal Scale than there was in the Performance Scale. He showed good rote memory and attention. Another strength was in his ability to define words, which fell in the low average range. Arithmetic was difficult for the Appellant and he had enormous difficulty with any tasks that required spatial reasoning or visual perception. In the Impressions and Recommendations section of her report, Ms. Schnee stated that the Appellant is developmentally delayed. She opined that because his language skills are much closer to the low average range, he has been able with support to function in the school setting. I gave somewhat less weight to this report than to others because I was unable to discern the tester's level of education. (D9)

10. When the Appellant was 14 years, 8 months of age, he was evaluated by J. Miner, Ph.D. On this occasion, Dr. Miner administered the WISC-III. The Appellant obtained a Verbal IQ score of 80, a Performance IQ score of 72 and a Full scale IQ Score of 74. The tester noted a superiority of verbal functioning over nonverbal and stated that this was a consistent pattern over all previous testing. It also stated that it was important to note that for instructional purposes, although the Appellant's non verbal performance was in the deficient range on intelligence testing, his visuospatial deficits appeared to be more a matter of impaired motor functioning under time constraint, rather that perceptual impairment. I gave great weight to this report because of its level of detail and the

tester's advanced degree. (D14)

11. When the Appellant was 18 years of age, he was evaluated by Kenneth F. Durant, School Psychologist employed by the [redacted] Public Schools. On this occasion, Mr. Durant administered the Wechsler Adult Intelligence Scale-III (WAIS-III). The Appellant obtained a Verbal IQ score of 77, a Performance IQ score of 68 and a Full Scale IQ score of 71. I did not give a great deal of weight to this exhibit due to the absence of a detailed report of the test results and my inability to discern the tester's level of education. (D18)

12. When the Appellant was 19 years of age, he was evaluated by Stuart Carter, Ed.D, Ph. D., a consultant to DMR. Dr. Carter is a licensed psychologist. On this occasion, Dr. Carter administered the WAIS-III. The Appellant obtained a Verbal IQ score of 86, a Performance IQ score of 78 and a Full Scale IQ score of 80. Dr Carter's report states that the Appellant is functioning in the low average category of intelligence. This is the lowest possible score in the low average category, as 79 begins the borderline category. His Verbal IQ score of is low average and his Performance IQ is high borderline. Dr. Carter opined that this is the profile of a subject with an involved visuo-spatial Learning Disability. He concluded that he is not mentally retarded. In reviewing his past testing, Dr. Carter noted that there is a clear pattern of consistently low average verbal scores and consistently borderline or high mild mental retardation performance scores. He states that this is not a mental retardation profile according to the AAMD (American Association of Mental Deficiency) as objective IQ scores must be uniformly low. He agrees that the Appellant may have limitations in self-care or social skills, but he believes that he likely has mild to moderate Asperger's Syndrome and that this is the cause of his limitations. I gave great weight to this report because of its level of detail, Dr. Carter's advanced degrees and his status as a licensed psychologist. (D19)

13. [redacted] testified on behalf of the Appellant. She stated that her son needs services from DMR. He has made great strides but is not able to live independently. She said that he was born with Pervasive Developmental Disorder, Autism and Asperger's Syndrome. His IQ scores range from 67-80. He hasn't made the gains that a neurologically intact child would have made. He has been under an Individual Education Program (IEP) with the [redacted] School Department since he was 18 months old. He currently resides in a residential program at the [redacted]. The program he is in is called [redacted]. He is trying to learn how to take care of his daily needs. His greatest disadvantage is his social interaction. He doesn't have an understanding of finances. When asked by the Hearing Officer if the Appellant has been diagnosed as mentally retarded, the witness replied that that term is not used in the field of education. He has been described as having deficits, lacking skills. In his IEP's he has been described as having PDD (Pervasive Developmental Disorder), Asperger's or Autism. (testimony of [redacted])

14. Susanna Chan, Ph.D. testified on Behalf of DMR. She stated that she is the Regional Eligibility Manager. She was trained as a psychologist and has worked for many years in the field of mental health and mental retardation. She has worked for DMR for three years. She explained that a psychologist on the Regional Eligibility Team reviews each case to render a clinical opinion as to eligibility. In reviewing the Appellant's application, it was recommended to Dr. Chan that additional testing be done. Usually the Regional Eligibility Psychologist does not perform the testing so as to avoid any conflict of interest. DMR retained Dr. Stuart Carter to perform the additional testing. Dr Chan stated that currently the Region does not have a full-time Eligibility Psychologist, only one serving in an interim, part-time capacity. Therefore, Dr. Chan decided to have Dr. Carter defend DMR's decision to deny the Appellant eligibility.

Dr. Chan testified that DMR decided to deny eligibility based on Dr. Carter's recommendation. Dr. Carter performed testing because previous IQ tests that had been provided to DMR were close to the DMR eligibility criteria. She went on the explain that the scores which range from the 60s to the 80s raised serious questions regarding mental retardation. DMR wanted to see the results of additional testing before making a decision on eligibility.

Dr. Chan further testified that it was her understanding that DMR can only serve adults with demonstrated mental retardation prior to the age of 18. To make the determination, they rely heavily on IQ scores and also look at functional deficits. She went on to say that the prerequisite is that there must be evidence of mental retardation in cognitive functioning. The IQ scores are the prerequisite for such a finding.

In the Appellant's case, Dr. Chan stated that DMR does not feel that there is mental retardation. They recognize that he has deficits. It is their understanding, however, that the Appellant has learning disabilities more related to his diagnosis of Autism and Asperger's Syndrome than to mental retardation.

Dr. Chan explained that the Appellant has difficulty in the social functioning area, which presents him with a lot of challenges. She further testified that someone with Asperger's Syndrome doesn't understand how information relates to social situations; they don't have the ability to decode behaviorally based cues or to do problem solving. (testimony of Susanna Chan)

15. Stuart Carter, Ed.D, Ph.D. testified for DMR as an expert witness. He is currently the Director of Inpatient Psychology Services for the Arbour Health Care System. He explained that there are a number of different types of tests as well as surveys or scales that measure intellectual functioning. He explained that IQ tests measure innate intelligence while achievement tests like the Woodcock Johnson measure the extent of learned material. He went on to say that achievement tests are much more academically oriented. They measure how much of a content area has been learned. Composite scores

on achievement tests are not the same as IQ scores.

Dr. Carter stated that in theory a person's IQ score shouldn't change more than 15 points under normal circumstances. People who have impairments such as CP may have higher IQs than they appear to have because they do not have the ability to convey information. If that inability is remedied by some type of device, they may be able to score higher on an IQ test. This is also true for individuals who have Autism or Asperger's Syndrome. Dr. Carter stated that the interventions that the Appellant has experienced have helped him to convey the ability that he has had all along.

Dr. Carter explained that children with CP, Autism and Asperger's Syndrome may perform poorly on IQ tests when they are young due to communication problems, not because of mental retardation. He stated that IQ tests will tell where a person is at a particular point in time.

He also explained that Asperger's describes someone who is not literally Autistic because they have too many skills and strengths. The Autism Spectrum goes from severe to not too severe. In the Autism Spectrum on a scale from 1 (most severe) to 10 (least severe), Dr. Carter stated that the Appellant is a 6 or a 7. He testified that in his opinion the Appellant is not technically mentally retarded by DMR's definition or by the definition of the AAMD (American Association of Mental Disorders). Dr. carter went on to say that the Appellant is limited; he needs services, but he is not mentally retarded. He has never been called mentally retarded by any professional. If he were mentally retarded, he would not have experienced the kind of growth that he has.

Dr Carter testified that he reviewed all of the documents entered into evidence. He stated that the Appellant has progressed significantly. He has more ability than is shown under the "P" (Performance) IQ because of his inability to complete things within a specific time which causes him to have a lower score. He has good verbal skills but most verbal skills are used in communication with others, and the Appellant has limitations in his ability to read social cues. This is a problem probably directly related to Asperger's Syndrome. This is why he has low scores in the Comprehension and Picture Completion subtests. Digit Symbol and Coding subtest scores are low because the Appellant has visual, spatial and fine motor coordination problems.

Dr. Carter testified that prior to age 18 the Appellant had some IQ scores that were in the area of mental retardation. He explained that one must ask not only what the number is, but why. Dr. Carter believes that the Appellant's low scores are related to Asperger's Syndrome and the specific impairments related to that syndrome, for example, his visual spatial problems. These lower scores do not lead to a diagnosis of mental retardation per se.

Additionally, Dr. Carter stated that the in the testing that he administered, the Appellant's clock drawing, complex figure and Rorscharch responses were not consistent with a diagnosis of mental retardation. His spelling and penmanship which were tested

on the Wide Range Achievement Test -3 (WRAT-3) were not the product of a person with mental retardation.

Dr. Carter stated that the Appellant's low scores on the Adaptive Behavior Assessment System (ABAS) could just as easily be attributed to Asperger's Syndrome as to mental retardation. (testimony of Stuart Carter, D19, D22)

FINDINGS AND CONCLUSIONS

After a careful review of all of the evidence and despite his need for continuing supports, I find that the Appellant has failed to show by a preponderance of the evidence that he 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) he must be domiciled in the Commonwealth, (b) he must be a person with Mental Retardation as defined in 115 CMR 2.01, and (c) he 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 he meets that criterion. However, I find that he 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) 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 eligibility for DMR supports.

The Appellant presents a complex picture. He has IQ scores prior to the age of 18 that on their face appear to meet the AAMR definition of sub-intellectual functioning. Despite

these scores, I do not find that the Appellant has sub average intellectual functioning.

Turning to the testing done when the Appellant was 5 years, 11 months, I note that although his Full Scale IQ score was 72; there was a 14 point difference between the Verbal (81) and the Performance (67) scores. The tester noted that response times were slow and that the Appellant's ability to persevere was poor. A few months later when he was tested, the tester noted that he had many skills and achievements well within the average range and others in the low average and borderline range.

Looking at the testing that was done when the Appellant was 11 years of age, I note that although his Full Scale IQ score was 63; there was a 15 point difference between the Verbal (73) and Performance (58) scores. The tester believed that because the Appellant's language skills were much closer to the low average range, he had been able to function in a school setting with support.

On the IQ test administered when he was 14 years, 8 months of age, the Appellant's Full Scale IQ score was 74. There was an (8-point) difference between his Verbal (80) and his Performance (72) scores. The tester noted that although the Appellant's non-verbal performance was in the deficient range, his visuospatial deficits appeared to be more a matter of impaired motor functioning than of a perceptual impairment.

The testing done by Dr. Stuart Carter when the Appellant was 19 years of age resulted in a Full-Scale score of 80. Like previous test, there was (8-point) discrepancy between the Verbal (86) and the Performance (78) scores. Dr. Carter stated in his report that the Appellant is functioning in the low average range of intelligence. He noted the consistent pattern of higher scores in the Verbal IQ compared to the Performance IQ and went on to state that this is not a mental retardation profile. He referred to the AAMD definition of mental retardation, which requires that objective IQ scores must be uniformly low.

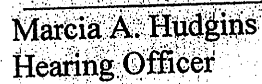
Dr. Carter's testimony added additional information, which led to my determination that the Appellant is not mentally retarded. He recognized the Appellant's lower IQ scores prior to age 18, and stated that in his opinion the low scores were related to Asperger's Syndrome and the specific impairments related to that syndrome. He testified that if the Appellant were mentally retarded, he would not have experienced the kind of growth that has occurred over the years. He also stated that the Appellant's performance on other tests that he administered did not lead to a diagnosis of mental retardation.

While there was evidence presented relative to the Appellant's functional limitations and his 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 he 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 15, 2004

Marcia A. Hudgins
Hearing Officer