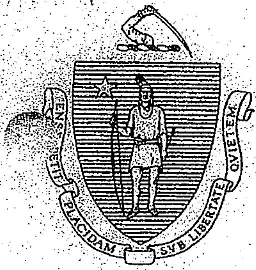

The Commonwealth of Massachusetts
Executive Office of Health & Human Services
Department of Mental Retardation
500 Harrison Avenue
Boston, MA 02118

Deval L. Patrick
Governor

Timothy P. Murray
Lieutenant Governor

JudyAnn Bigby, M.D.
Secretary

Elin M. Howe
Commissioner

Area Code (617) 727-5608
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March 4, 2008

Christine Lytle, Social Worker
DSS – Plymouth Area Office
61 Industrial Park Road
Plymouth, MA 02360

Re: Appeal of [redacted] Final Decision

Dear Ms. Lytle:

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 Massachusetts General Laws, Chapter 30A. The regulations governing the appeal process are 115 CMR 6.30-6.34 and 801 CMR 1.01-1.04.

Sincerely,

Elin M. Howe

Elin M. Howe
Commissioner

EMH/ecw

cc: Sara MacKiernan, Hearing Officer
Richard O'Meara, Regional Director
Marianne Meacham, General Counsel
Allegra Munson, Assistant General Counsel
Frederick Johnson, Psychologist
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)(115 CMR 6.30 – 6.34) and M.G.L. Chapter 30A. A hearing was held on January 16, 2008 at the Department of Mental Retardation's Wrentham Developmental Center in Wrentham, MA.

Those present for all or part of the proceedings were:

Christine Lytle	Department of Social Services Social Worker
Paula Arms	Consultant to the Department of Social Services
Allegra Munson	Assistant General Counsel Department of Mental Retardation
Frederick Johnson	Department of Mental Retardation psychologist

The evidence consists of documents submitted by the Appellant numbered A 1 – 11, (there is no exhibit A – 5), documents submitted by the Department of Mental Retardation numbered D 1 – 17, after discussion, the parties agreed to four (4) joint exhibits: A – 8 is also D – 1, A – 9 is also D – 3, A – 10 is also D – 4 and A – 11 is also D - 5. The Department presented approximately 45 minutes of oral testimony. The Department of Mental Retardation also filed a Brief following the Hearing.

PROCEDURAL HISTORY

7/18/05	Kim Baker (DSS) filed Application for DMR Services
10/24/05	DMR Eligibility Report
11/21/05	Kim Baker (DSS) requested and informal conference
5/22/06	Christine Lytle (DSS) requested Fair Hearing
11/26/07	Hearing scheduled and postponed
12/20/07	Letter from [redacted] stating that he did not wish to be present at the hearing and requesting that a decision be based on the documents presented by DSS. DMR objected to proceeding on the record and a Hearing was scheduled for 1/16/08.
1/16/08	Fair Hearing held at Wrentham Developmental Center

ISSUE PRESENTED

Whether the applicant meets the eligibility criteria for DMR supports by reason of mental retardation as set out in 115 CMR 6.04(1).

The first two and a half hours of the hearing were taken up with the exchange of exhibits. Since the Department of Social Services had not provided many of the proposed exhibits to the Department of Mental Retardation, the attorney for DMR needed to review the documents and discuss the information with her expert witness in order to respond appropriately to the information. The social worker and the consultant from the Department of Social Services had not realized that they were expected to provide the exhibits prior to the hearing.

FINDINGS AND CONCLUSIONS

1. [redacted] has been in the custody of the Department of Social Services since September 2002. In 2006, the Department of Social Services obtained guardianship of [redacted] in the Plymouth Probate Court. Prior to 2002 [redacted] had been in foster care in Massachusetts three times and had been reunited with his mother when the reason for his placement had resolved. [redacted] and his mother and brother had lived in Connecticut for periods of time while [redacted] was a child and he had been in foster care in Connecticut as well. (ex. A-3)

2. The Department of Social Services, on behalf of [redacted] presented seven evaluations that [redacted] has had over the years. The first is titled Family Developmental Report and is signed by Patti D. Ewen, school social worker at the Department of Pupil Personnel Services for the Bristol Connecticut Public Schools. This is a narrative description of [redacted] who was almost seven years old at the time. No testing was done. (ex. A-4)

3. On November 16, 1995, (age 7 years ,11 months), J. D. Wilson from the Bristol Public Schools in Connecticut conducted a "Psychological Evaluation" on [redacted] Ms. Wilson is identified only as a "school psychologist". There is no indication of her credentials. This evaluation included the Wechsler Intelligence Scale for Children – Third Edition; The Bender Visual – Motor Integration Test; and the Draw – A – Person test. Ms. Wilson noted that Patrick had been identified as having significant delays in language, cognition, motor and social development when he was three years old. On the WISC Patrick's scores were 79 verbal IQ, 74 performance IQ, and 75 full scale. His scores were in the Borderline Range of intellectual development. (ex. A – 8 / D – 1)

4. In October 2000 [redacted] was evaluated by Timothy Paisey, Ph. D., after a referral by the Connecticut Department of Children and Families. Patrick was in the custody of D.C. F. and had been in residential placement for two months prior to this evaluation. Dr. Paisey's evaluation consisted of the following:

Review of Lake Grove records
Interview of Patrick Gomes
Kaufman Adolescent and Adult Intelligence Test (KAIT)
Adaptive Behavior Inventory (ABI)
Emotional Problems Scales Behavior Rating Scales (BRS)
Emotional Problems Scales Self Report Inventory (SRI)
Emotional Problems Scales Sentence Completion Technique (SCT)
Attention – Deficit / Hyperactivity Disorder Test (ADHDT)

The results on the KAIT demonstrated, as had previous testing, [redacted] delayed language development. The results showed significant variation within the subtests. Some results were in the average or above average range and some in the lower extreme. Overall his scores were in the "Well Below Average" range. (Crystallized IQ – 79; Fluid IQ – 70; Composite IQ – 73).

[redacted] did not meet the criteria for Attention Deficit Hyperactivity Disorder although he had some problems focusing and was mildly inattentive. Dr. Paisey concluded that [redacted] met requirements for continued special education services due to his language delays and social – emotional factors. Dr. Paisey's diagnostic impression was:

Axis I: 299.80 Pervasive Developmental Disorder NOS
Axis II: V62.89 Borderline Intellectual Functioning

The results of this evaluation are consistent with previous findings. (A-9, D-3)

5. In November 2002 [redacted] was evaluated by the Falmouth, MA Public School Department to determine an appropriate classroom placement. He had recently been placed in a foster home in Falmouth. The evaluation was conducted by Jeffrey Twarog, Ed. D., a school psychologist. Dr. Twarog conducted the following tests:

Woodcock Johnson Tests of Cognitive Ability – III (WJIII)
Rey Complex Figure Test and Recognition Trial (RCFT)
Behavior Assessment System For Children (BASC)
Adaptive Behavior Scale (ABS)

On page 2 of the report, Dr. Twarog refers to the person he is testing as . The rest of the report is consistent with information abou rom other sources and Dr. Twarog refers to as xcept for this one instance. I find that the use of the wrong name is a scribner's error and does not invalidate the report. On the WJIII, score was in the Borderline range with a scaled score of 76. On the Adaptive Scales Patrick scored within the normal range in all four areas. He did exhibit weaknesses in the area of socialization. Dr. Twarog concluded that did not meet the classification of significant intellectual impairment. (A – 10, D – 4)

6. In 2005, had two psychiatric hospitalizations at Pembroke Hospital. The first was in January and the second in June. During the June hospitalization, had a neuropsychological evaluation conducted by Christopher White, Ed.D., DABPS, a licensed psychologist. This hospitalization was the result of hreatening his foster mother with a knife. explanation of the event was that he was angry after a discussion of his getting a job and that he wanted to go to live with his mother. He said that he knew he would get kicked out of the foster home if he threatened the foster mother with a knife. He also explained another earlier event where he had been removed from a different foster home after he exposed himself to a little girl in the home. He also said that he knew this behavior would get him kicked out of that home. At the me of this testin vas being treated with Olanzapine, Valproic Acid, Atenolol and Guanfacine. lso had a history of two suicide attempts, one in December 2004 when he jumped into a pond hoping to die. Apparently the water was very cold so he got out. In January 2005 he is reported to have attempted to jump from a highway overpass.

On the WAIS III arned a Verbal Score of 80; a Performance Score of 62; and a Full Scale Score of 69. These scores are in the upper end of the mild range of mental retardation. Dr. White noted a significant intratest scatter with scores ranging from extremely low to average range. Performance score was 18 points lower than his Verbal score. The pattern of his scores was indicative of the presence of a severe nonverbal learning disability and is consistent with the presence of an autistic spectrum disorder.

Dr. White noted that the results of the tests demonstrated that executive functions are compromised; his ability to focus his attention is impaired and his ability to organize himself is quite poor. Dr. White found rofile consistent with high functioning autism. Of the evaluations conducted on his is the first evaluation done whil vas being treated with antipsychotic medication. (A-11, D-5)

7. In December 2006, [redacted] was psychiatrically hospitalized at Heywood Hospital in Gardner after another suicide attempt. He also reported auditory hallucinations. At this time he was being treated with antidepressant medication but was not receiving antipsychotics. During this hospitalization, a Psychological Evaluation was done by Leslie Malkiewich, Ph.D. Dr. Malkiewich found that [redacted] presented with a history and current behavior consistent with a diagnosis of fetal alcohol effects, borderline intellectual functioning and post traumatic stress disorder.

This Psychological Evaluation was done in the context of an inpatient psychiatric hospitalization and did not include any of the standard tests. Dr. Malkiewich estimated [redacted] IQ to be 70 based on his history and her interactions with him.

8. [redacted] was hospitalized at Heywood Hospital again in April 2007. His discharge diagnosis on April 20, 2007 was Mood Disorder NOS.

9. The Department of Social Services requested an eligibility determination from the Department of Mental Health on [redacted] behalf. On November 23, 2007, Linda Lundin, Plymouth Site Director, Department of Mental Health sent a letter to [redacted] stating that he had been found eligible for adult continuing care services. Since he is now in the custody of the Department of Social Services and is being provided services by them and the Special Education Department of the Plymouth schools, the eligibility date would be in December 2009. (A – 2)

10. The Department of Social Services requested a determination [redacted] eligibility for services from the Department of Mental Retardation in July 2005. (D – 6) The Department of Mental Retardation reviewed [redacted] history and testing and after careful evaluation, concluded that [redacted] was not eligible for supports from the Department of Mental Retardation. The final Eligibility Report was authored by Dr. Frederick Johnson, Psy. D. (D – 12) Dr. Johnson also testified at the hearing. Dr. Johnson's is a licensed psychologist. His education, training and experience are impressive and he is more than qualified to make eligibility determinations. (D – 16)

11. Dr. Johnson based his opinion th[redacted] was not mentally retarded on the following facts. [redacted] has been tested multiple times and only one IQ score was below 70. That evaluation resulted in a verbal IQ score of 80 and a performance IQ score of 62. Dr. Johnson testified that given the difference in the two scores, many evaluators would not give a full scale score. In the testing that has been done, [redacted] has shown wide variations in the subtest scores. This is usually an indication that something is interfering with the person ability to think and perform. It is not usual

to find this wide discrepancy in sub scores in a person with mental retardation. All [redacted] behavior problems are consistent with mental illness, not mental retardation. [redacted] has had multiple psychiatric hospitalizations and been diagnosed with several mental illnesses. He has and is presently being treated with antipsychotic medication.

[redacted] verbal skills far outweigh his performance skills and this is another characteristic not found in persons with mental retardation. Dr. Johnson concluded that [redacted] was suffering from mental illness, not mental retardation. (D – 12, testimony of Dr. Johnson)

12. On December 20, 2007 [redacted] sent a letter to the Department of Mental Retardation requesting that his presence at the hearing be waived and that his social worker be permitted to present his case using documents in his file. (D – 18)

13. [redacted] has been evaluated by the Department of Mental Health and found to be eligible for their continuing care services. The logical conclusion to this is that the Department of Mental Health believes that [redacted] has a mental illness.

SUMMARY OF THE EVIDENCE PRESENTED

[redacted] is a twenty year old young man who has a lengthy history of out of home placements, residential treatment, psychiatric hospitalization and when younger, returns to his mother's care for varying periods of time. He has been diagnosed as suffering from mild mental retardation, pervasive developmental delay, Rhett's Disorder, fetal alcohol effects, autism, attention deficit disorder, bipolar disorder, depression with suicidal ideation, psychosis NOS and others. He has been treated with antipsychotic medication, stimulants, antidepressants and medications for his high blood pressure and thyroid disease. [redacted] has been in special education throughout his school career. [redacted] has had multiple batteries of tests throughout his childhood and adolescence. In June 2005, [redacted] was tested and earned a full scale IQ score of 69.

This June 2005 testing is the only full scale IQ score which is below 70. The wide discrepancy in his verbal and performance scores on this test make the result very questionable and given that all of his other testing reached different conclusions, I find that this score is not credible. (A – 11, D – 5, testimony of Dr. Johnson)

CONCLUSION

In order to be eligible for DMR supports, an individual who is eighteen (18) years of age or older must meet the three criteria set forth at 115 CMR 6.04. The person must be (a) domiciled in the Commonwealth, (b) a person with mental retardation as defined in 115 CMR 2.01[1], and (c) 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.

After a careful review of all the evidence presented, I find that [redacted] s over the age of eighteen, is domiciled in Massachusetts and is in need of supports in areas that involve his his safety. His impulsivity, anger, depression and self injurious behaviors are such that he cannot live safely without supervision. [redacted] able to care for himself, communicate his needs, and with proper support he can function in school. He has never had a job. His functioning is dependant on his being free from the symptoms of his mental illness such as the hallucinations and delusions he has reported in the past. All of the evidence points to Patrick suffering from a mental illness. The Department of Mental Health has agreed that [redacted] will be eligible for adult services from them when he reaches the age of twenty – two. (A – 2)

I find that [redacted] although he has many needs, is not a person with mental retardation and therefore is not eligible for supports from the Department of Mental Retardation.

APPEAL

Any person aggrieved by a final decision of the Department may appeal to the Superior Court in accordance with M.G.L. c30A (115 CMR 6.34[5]).

Date: 2/25/08

Sara Mackiernan
Sara Mackiernan
Hearing Officer

[1] The Department's definition of "mental retardation" was changed, effective June 2, 2006. The old definition, which incorporated e AAMR's 1992 standard, defined mental retardation as "between seventy (70) and seventy-five (75)" on the applicable intelligence test score range. The new definition of "mental retardation" is "significantly sub-average intellectual functioning". All appeals filed after June 2, 2006 will be considered under the new standard while any appeals filed prior to June 2, 2006 will be decided using the old definition.