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
TTY: (617) 624-7590

May 12, 2008

Eric Rollins, Social Worker
DSS/Cambridge Area Office
810 Memorial Drive
Cambridge, MA 02139

Re: Appeal of [redacted] Final Decision

Dear Mr. Rollins:

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

The hearing officer made findings of fact, proposed conclusions of law and a recommended decision. After reviewing the hearing officer's recommended decision, I find that it is in accordance with the law and with DMR regulations. 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
Commissioner

EMH/ecw
cc: Sara MacKiernan, Hearing Officer
Gail Gillespie, Regional Director
Marianne Meacham, General Counsel
Kim LaDue, Assistant General Counsel
Ellen Kilicarslan, Regional Eligibility Manager
Randine Parry, Psychologist
File

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL RETARDATION
FAIR HEARING DIVISION

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 scheduled for March 19, 2008 but prior to the hearing date the Department of Social Services, acting on behalf of [redacted] requested that the Appeal be decided on the record. The Department of Mental Retardation agreed.

The evidence consists of documents submitted by the Department of Mental Retardation numbered D 1 – 7, and a Memorandum submitted by counsel for the Department of Mental Retardation.

PROCEDURAL HISTORY

April 5, 2007	Determination of Ineligibility made by DMR
May 30, 2007	Informal conference held
June 20, 2007	Appeal and request for hearing filed by the Department of Social Services, acting for [redacted]
March 19, 2008	Hearing scheduled

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). 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.

[1] The Department's definition of "mental retardation" was changed, effective June 2, 2006. The old definition, which incorporated he 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.

SUMMARY OF THE EVIDENCE PRESENTED

Mr. [redacted] is now nineteen years and eight months of age. He has had difficulties in school from the start. He has been receiving special education services since kindergarten. He suffers from short stature and has been treated with hormone therapy in the past. The hormone therapy was discontinued in 2004 due to his aggression and the possible effects of the hormones on his behavior. His small stature has been the cause of his being the brunt of attention from bullies in school. He has had difficulty with peer relationships in all areas of his life.

When he was seventeen months old, Mr. [redacted] was diagnosed with a seizure disorder for which he takes medication. In addition to his medical problems, Mr. [redacted] has been diagnosed with Attention Deficit Hyperactivity Disorder, Mood disorder NOS, and Oppositional Defiant Disorder at various times. He has also suffered from depression and homicidal/suicidal ideation.

Mr. [redacted] has been a residential student at Northeast Family Institute's Riverside Center since December 28, 2004. He was admitted to Riverside following a three month hospitalization at The Cambridge Hospital's Adolescent Assessment Unit. This hospitalization was precipitated by Mr. [redacted] being found in bed with his seven year old sister and hitting his father during the aftermath of his sister telling the parents what had happened. Mr. [redacted] had one other psychiatric hospitalization at Arbour Hospital in April 2004. That hospitalization lasted ten days and was the result of Mr. [redacted] homicidal ideation towards his father, assaulting his father and threatening his therapist.

Mr. [redacted] attended the Kennedy Elementary School in Somerville where he received special education services. He also attended the Next Wave Alternative School in Somerville and the Full Circle Alternative School in Somerville for unspecified periods of time.

Mr. [redacted] was evaluated on April 28, 2003 by Carlos Davila, Ed.D. He was fourteen years old at the time of this evaluation. On the WISC-III Mr. [redacted] earned a Verbal IQ score of 87; a Performance IQ of 71 and a full scale IQ of 77. The evaluator commented that there was a significant amount of scatter among the subtest scores. Dr. Davila also did projective testing on Mr. [redacted], specifically the Rorschach and the Thematic Apperception Test. These showed evidence of depression and regression. The examiner concluded that "a significant portion of [redacted] academic difficulties are emotional in nature". Dr. Davila also noted that Mr. [redacted] did have a non-verbal learning disorder. He recommended individual and group psychotherapy for Mr. [redacted] and also that Mr. [redacted] seizure disorder and maturational delays be examined closely to see if they had an effect on Mr. [redacted] ability to function in school.

One year and six months later, Mr. [redacted] was tested again. This evaluation was done by Grace Kim, a masters level Psychology Intern who was supervised by Eric Nass, Ph.D., Director of Psychology Training on the Adolescent Assessment Unit at Cambridge Hospital. This evaluation was done one month into Mr. [redacted] inpatient stay on the Adolescent Assessment Unit. This evaluation was conducted on two different days. On the second day, the WISC-IV was given. Mr. [redacted] made little effort on any of the tests which he thought were "stupid". He complained of being tired and wanting to go back to bed. The results of the WISC-IV were thought to be invalid due to Mr. [redacted]'s lack of effort and general attitude. He earned a Full Scale IQ of 53. Interestingly, there was significant intratest scatter in this test as was noted earlier. The Personality Testing done revealed a great deal of anger, frustration, sadness, low self-esteem and interpersonal conflicts. The examiner concluded that Mr. [redacted] psychological and social difficulties negatively affected his information processing and cognitive functioning.

Mr. [redacted] was evaluated again on January 27, 2005. He was then seventeen years and five months of age and had been a residential student at Riverside for approximately one and a half years. This evaluation was done by G. William Freeman, Ed.D. On the WAIS-III Mr. [redacted] earned the following scores: Verbal IQ 83, Performance IQ 65 and Full Scale IQ 73. He again had significant scatter in his subtest scores. The examiner noted that Mr. [redacted] was only moderately persistent in problem solving, became emotionally immobilized when tasks were difficult for him, and he appeared to be disorganized and disoriented during the verbally oriented tests.

Dr. Freeman also conducted projective testing on Mr. [redacted] Mr. [redacted] was, in the examiners opinion, quite depressed and a possible suicide risk. Dr. Freeman found Mr. [redacted] to have serious learning disabilities and to be an impulse-ridden and emotionally depressed individual. Dr. Freeman recommended ongoing residential services to address both learning disabilities and emotional problems.

The most recent testing done on Mr. [redacted] was done on February 5, 2007 by Jeff Schumer, Psy.D. At the time of this evaluation Mr. [redacted] was prescribed Abilify, Concerta, Depakote, Lithium and Iburoprion. He was eighteen years and five months of age. During the testing, Mr. [redacted] was sleepy and yawned frequently. He did appear to be motivated to take the tests and said that he wanted to continue.

On the WAIS-III Mr. [redacted] earned a full scale IQ of 75; Verbal IQ of 82 and Performance IQ of 72. The tests suggested a nonverbal learning disability. His scores were similar to past testing. Dr. Schumer's interpretation of the projective tests done on Mr. [redacted] was that this was an angry and depressed individual who could be resistant and oppositional. The results

also suggested aggression and guardedness. Dr. Schumer did not find indication of a clear disturbance of reality testing.

The results of this testing were consistent with other evaluations done in the past.

FINDINGS AND CONCLUSIONS

Mr. [redacted] is over the age of eight-teen, DOB August 27, 1988. He has lived in Massachusetts all of his life.

Mr. [redacted] has been in a residential school since October 2004. (D-4,5)

Mr. [redacted] has been diagnosed with a seizure disorder, mood disorder, oppositional defiant disorder and ADHD. He is being treated with medication including Abilify, an antipsychotic medication. (D-4)

Mr. [redacted] has had two psychiatric hospitalizations, one lasting three months which immediately preceded his admission to the residential school where he now lives. (D-4,5)

Mr. [redacted] has had at least four evaluations of his intelligence and emotional state. The results of these evaluations are consistant. Mr. [redacted] has borderline to average intelligence, a nonverbal learning disability and significant mental health issues. (D-1,2,3,4)

CONCLUSION

After a careful review of all the evidence presented, I find that [redacted] is over the age of eighteen and is domiciled in Massachusetts. I find that although Mr. [redacted] does have a nonverbal learning disability, all of the evidence points to Mr. [redacted] suffering from a mental illness. Mr. [redacted] will need many supports as he enters adulthood. His history of depression, suicidal and homicidal ideation, aggression, violence and sexual assault of his younger sister place him at high risk of harming himself or others if he is not in a supervised setting. There is no clear evidence before me of how he functions in every day life except that he is not passing any of his subjects in a residential school and that he has great difficulty relating to peers and adults.

I find that Jonathan [redacted], although he has many needs, has not shown by a preponderance of the evidence that he is a person with mental retardation and therefore I find that he 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: 4/29/08

Sara Mackiernan
Hearing Officer