



The Commonwealth of Massachusetts
Executive Office of Health & Human Services
Department of Mental Retardation
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February 29, 2008

[REDACTED]
[REDACTED]
[REDACTED]
Re: Appeal of [REDACTED] - Final Decision

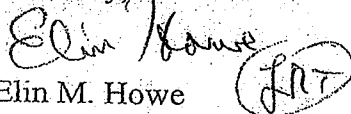
Dear Mr. & Mrs. [REDACTED]

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

The hearing officer made findings of fact, proposed conclusions of law and a recommended decision. After reviewing the hearing officer's decision, I find that it is in accordance with the law and with DMR regulations and therefore adopt the findings of fact, conclusions of law and reasoning. 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: Deirdre Rosenberg, Hearing Officer
Terry O'Hare, Regional Director
Marianne Meacham, General Counsel
Patricia Oney, Assistant General Counsel
Katrin Weir, 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) (115CMR 6.30 – 6.34) and M.G.L. c. 30A. A fair hearing was held on August 3, 2007, at the Department of Mental Retardation's Monson Developmental Center in Palmer, Massachusetts. Those present were:

[REDACTED]
[REDACTED]
[REDACTED]
Nancy Staples

Gail Epstein

Paula Morrissette

Robin Grant

Patricia Oney

Patricia Weir, Ed.D.

Appellant

Appellant's Mother

Appellant's Father

Social Worker

Psychologist

Case Manager, Massachusetts

Hospital School

DMR Counsel

DMR Psychologist

The evidence consists of the following exhibits and approximately two hours of oral testimony:

- 1) Eligibility Report, 4/16/06
- 2) Eligibility Letter, 5/3/06
- 3) Cognitive Assessment, Massachusetts Hospital School, 10/16/98
- 4) Cognitive Assessment, Massachusetts Hospital School, 12/17/01
- 5) Neurological Assessment, Children's Hospital, 5/14 and 6/26/07
- 6) Psychological Report, Franklin Public Schools, 2/18/05
- 7) Psychological Report, Franklin Public Schools, 11/4/92
- 8) Psychological Report, Franklin Public Schools, 11/26/95

ISSUE

Whether the Appellant meets the eligibility for DMR services by reason of mental retardation as defined in 115 CMR 6.03(1).

BACKGROUND

[REDACTED] is a twenty year old man who has spina bifida, lumbar myelocystocele, shunted hydrocephalus and congenital heart disease. He lives with his parents and younger sister in Franklin, Massachusetts, and has attended the Massachusetts Hospital School in Canton, Massachusetts, where he is in a full-time special education classroom that provides specialized nursing care, since the third grade. Andrew has significant difficulties ambulating independently and requires a motorized wheelchair.

SUMMARY OF THE EVIDENCE

The earliest cognitive report in the record is dated November 4, 1992, and was conducted in connection with a Chapter 766 three year reevaluation by the Franklin Public Schools (Exhibit #7). Andrew was five years old at the time of the testing and a kindergarten student in his local public school. He was administered the Kaufman Assessment Battery for Children (K-ABC), on which he performed in the "well below average" range. No numerical results were reported.

However, the clinician who evaluated Andrew was struck by the fact that Andrew's testing behaviors differed dramatically between the morning and afternoon sessions. "During the morning testing, . . . [he] had a very short attention span," was "inconsistent in his willingness to cooperate, and . . . often displayed inappropriate behaviors" (Exhibit #7, p. 5). During the afternoon sessions, he was able to stay focused for almost an hour, and was much more cooperative. She noted that [REDACTED] didn't get his first feeding (which was via a g-tube) until the end of his school day, and thought that perhaps some of the behavioral differences she observed were attributable to that. In any event, she clearly suggested that his test results on the mental processing composite would have been higher if it had been administered in the afternoon, rather than the morning, and cautioned against underestimating his intellectual abilities. His scores on achievement tests fell solidly in the average range. This psychologist also reported that Andrew had scored in the average range on a Stanford-Binet test he had taken previously.

A second cognitive evaluation of the Appellant was conducted by the same clinician in 1995, when [REDACTED] was eight years old (Exhibit #8). The Wechsler Intelligence Scale for Children, Third Edition (WISC-III), was administered. Again, no numerical scores were given. According to the report, his full scale IQ on the WISC-III placed him in the upper part of the borderline range of cognitive ability. His verbal IQ was at the top of the "low average" range, while his performance score was in the intellectually deficient range. There was a very significant 20 point discrepancy between his verbal and performance scores, which suggested to the psychologist who assessed

██████████ that he might have a nonverbal learning disability. She concluded that his "full scale IQ score probably underestimates his true intellectual potential" (Exhibit #8, p. 3).

The next cognitive assessment in the record is dated October 16, 1998 (Exhibit #3). ██████████ was eleven years old at the time and a student at the Massachusetts Hospital School. The evaluation was conducted by Diana King using the WISC-III to measure his intellectual abilities. Ms. King found the Appellant's overall intellectual functioning to be in the borderline range, with abilities ranging from low average to significantly below average. Yet again, there were no numerical IQ scores reported. Ms. King described ██████████ as an "animated, engaging, verbal, friendly youngster" with a well-developed sense of humor "who was cooperative throughout" her assessment (Exhibit #3, p. 1).

A fourth intellectual evaluation of the Appellant was conducted on December 14, 2001, when ██████████ was 14 and a half years old, using the WISC-III intelligence test (Exhibit #4). He achieved the following scores:

Verbal IQ	79
Performance IQ	62
Full Scale IQ	68

As can be seen, there was a statistically significant discrepancy between ██████████ verbal IQ and performance IQ scores. The clinician who conducted the assessment noted that his "verbal subtest scores varied widely, with improved scores since last assessment indicating at least three years' progress [made] within the last three years." She also stated that ██████████ attained average scores in subtests indicative of verbal reasoning skills requiring abstraction, fluid and inferential reasoning, and verbal concept formation which are higher level thinking skills (Exhibit #4, p. 2).

In 2005, the Appellant was tested by Patrick Sweeney, school psychologist for the Franklin Public Schools, as part of his three year reevaluation for special education services (Exhibit #6). The Wechsler Adult Intelligence Scale, Third Edition (WAIS-III) was administered, with the following results:

Verbal IQ	87
Performance IQ	70
Full Scale IQ	77

There was a statistically significance between ██████████ performance and verbal IQ scores, which indicates that the full scale score is not as reliable as it would be had there been more even balance between the two scales. Mr. Sweeney also stated that "those with disabilities such as spina bifida are going to struggle with tasks of the WAIS-III that are not designed for motorically challenged individuals. As such, the scores . . . should

not be used solely in assessing [redacted] true level of intelligence" (Exhibit #6, p. 2). I took this to mean that that the Appellant's "true level of intelligence" is likely higher than his scores on the WAIS-III would suggest.

Finally, the Appellant was evaluated in 2007 at Children's Hospital by Dr. Jennifer M. Turek, Neuropsychologist, using the WAIS-III, among several other evaluative instruments (Exhibit #5). On the WAIS-III, he received the following scores:

Verbal IQ	81
Performance IQ	75
Full Scale IQ	76

As can be seen, his strengths continue to be in the verbal realm. According to Dr. Turek, his scores on Verbal Comprehension Index tasks were within the average range. "His performance on Perceptual Organizational and auditory Working Memory Indices scored within the Borderline range and his graphomotor Processing Speed Index score was in the Extremely Low range" (Exhibit #5, p. 5). She concluded that "due to the heightened variability in his performance as well as the substantial discrepancy between the index scores, his full scale IQ... is not a valid representation of his overall skills" (id., p. 6). She expressly found that [redacted] was not mentally retarded, and provided a well thought out explanation of her reasoning in this regard. In addition, Dr. Turek stated that [redacted] reported elevated levels of anxiety, but she did not think that this issue was severe. I relied heavily on her thorough evaluation and lengthy report in reaching my decision regarding the Appellant's eligibility.

The Appellant's expert witness, Paula Morrissette, testified regarding several of the cognitive evaluations in the record. In regard to Exhibit #3, Ms. Morrissette said that [redacted] scores on the vocabulary and information subtests were highly correlated with academic background. I believe that she was suggesting that these two subtests did not necessarily speak to Mr. McLaughlin's innate cognitive abilities, but her point was not clear. In any event, "vocabulary" and "information" were not his best subtest scores—those were "digit span" and "similarities." She also pointed out that his comprehension score was very low. Regarding Exhibit #4, she emphasized that his full scale IQ score was 68, well below the Department's "70 to 75" range in effect at the time Andrew applied for eligibility. Ms. Morrissette also testified that because of the wide scatter among the verbal subtests seen in Exhibit #5, his full scale IQ score of 76 was not reliable.

Robin Grant, who is [redacted] case manager at the Massachusetts Hospital School, testified that patients with spina bifida typically have high verbal IQ scores, but that this does not translate into skills such as coordinating and goal setting. However, DMR is not challenging the Appellant's contention that his adaptive skills are significantly compromised.

Katrin Rouse-Weir, who is an eligibility psychologist for Region I, testified that the clinician who evaluated [REDACTED] when he was five years old and eight years old (Exhibits #7 and #8), considered his performance on the cognitive tests administered to be underestimates of his intelligence. Regarding Exhibit #3, Ms. Weir stated that she agreed with its author's opinion that [REDACTED] difficulty on sub tests which required specific factual information was due in part to the fact that his schooling had been somewhat fragmented due to medical problems. In her Eligibility Report of April 16, 2006 (Exhibit #1), Ms. Weir concluded that the Appellant was ineligible for DMR supports because "his intellectual functioning is above the regulatory range." She based her decision on the IQ scores he received in Exhibit #6. There he obtained a verbal IQ of 87, a performance IQ of 70, and a full scale IQ of 77.

FINDINGS AND CONCLUSIONS

After a careful review of all of the evidence, 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 criterion and I specifically find that he meets that criterion. However, I find that he is not mentally retarded as that term was defined at 115 CMR 2.01 when he applied for Department of Mental Retardation services.¹

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 had adopted the American Association on Mental Retardation (AAMR) standards as the clinical authority to which it referred in determining whether an individual has "inadequately developed or impaired

¹ Effective June 2, 2006, DMR changed its definition of "mental retardation" to "significantly sub-average intellectual function" as defined by "intelligence indicated by a score of 70 or below..." See 115 CMR 2.00.

intelligence," and the AAMR standard was in effect when [redacted] applied for DMR services. 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 include 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 criteria (a) and (b) before the age of 18.

I concur with the Department of Mental Retardation that the Appellant does not have "inadequately developed or impaired intelligence." [redacted] was five and eight years old respectively at the time of the first two cognitive reports in the record (Exhibits #7 and #8). It is generally accepted in the psychometric testing profession that test results of children at these early ages are considerably less reliable than tests given at a later developmental stage. Also, neither of these reports contained numerical IQ scores, making it somewhat difficult to know where, exactly, the Appellant's IQ fell on the various scales used to evaluate his intelligence. Nevertheless, both reports stated that the results were probably underestimations of his true intellectual potential.

The next cognitive assessment (Exhibit #3) also did not contain numerical IQ scores. [redacted] overall intellectual functioning was described as being in the borderline range, a range which does include IQs above "approximately 70 to 75 or below," which is the DMR standard that must be used to determine this Appellant's eligibility.

When he was evaluated in 2001 (Exhibit #1), [redacted] received a verbal IQ of 79, a performance IQ of 62, and a full scale IQ of 68. While it is true that his full scale IQ of 68 would put him in the eligibility range, I also note that the clinician who conducted this assessment said that [redacted] received scores in the average range of intelligence on subtests that required higher level thinking skills, again implying that his numbers understated his intellectual abilities.

Finally, on the WAIS-III administered to the Appellant in 2005 (Exhibit #6), [redacted] received a verbal IQ of 87, a performance IQ of 70, and a full scale IQ of 77. Not only does his full scale IQ score put him beyond the mental retardation range, the report also suggested that [redacted] scores were likely lowered by the difficulties he encountered on tests which involved motor skills. That the various IQ tests given to this Appellant over a course of fourteen years understated his actual intellectual abilities was a continuing theme of all the reports in the record before me. For that reason, and because most of his scores did in fact put him outside DMR's eligibility range, I concur with the Department's decision that [redacted] not eligible for its services.

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:

4/30/08

Deirdre Rosenberg
Deirdre Rosenberg
Hearing Officer