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Executive Office of Health & Human Services
Department of Mental Retardation
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December 13, 2007

Richard Lyons
688 DSS Specialist/Referring Party
DSS/Coastal Area Office
541 Main Street
South Weymouth, MA 02190

Re: Appeal of [redacted] Final Decision

Dear Mr. Lyons:

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,

Elin M. Howe
Commissioner

EMH/ecw
cc: Deirdre Rosenberg, Hearing Officer
Richard O'Meara, Regional Director
Marianne Meacham, General Counsel
Elizabeth Moran Liuzzo, Regional Eligibility Manager
Allegra Munson, Assistant General Counsel
Frederick Johnson, Psychologist
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. c. 30A. A fair hearing was held on June 18, 2007 at the Department of Mental Retardation's Wrentham Developmental Center in Wrentham, Massachusetts. Those present were:

Richard Lyons	DSS 688 Specialist
Kathleen M. Peirce	Clinical Director, Latham School
George Rodriquez, Esq.	Appellant's Education Surrogate
Diane M. Greene, Ph.D.	Psychologist (Appellant's Expert)
Frederick V. Johnson, Psy.D.	DMR Psychologist
Allegra Munson, Esq.	Attorney for the Department

The evidence consists of the following exhibits and approximately two and one-half hours of testimony:

1. Speech and Language Evaluation, 12/00/93
2. Psychological Evaluation, 12/22/93
3. Psychological Evaluation, 04/11/97
4. Psychological Evaluation, 06/03/98
5. Psychological Evaluation, 06/26/00
6. Intake Report, Concord Assabet Diagnostic Center, 07/10/00
7. Psychological Assessment, 04/25/01
8. Cognitive Evaluation, 09/25/03
9. Randolph School Department IEP, 2005
10. Application for DMR Eligibility, 01/04/06
11. Adaptive Behavior Assessment System (ABAS), 01/00/06
12. Latham Center Student Profile, 01/31/06

13. Psychological Assessment, 08/23/06

14. Education Evaluation, 10/18/06

15. DMR Eligibility Report, 12/15/06

16. DMR Eligibility Letter, 12/27/06

ISSUE

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

BACKGROUND

The Appellant, [redacted] is a 20 year old female who is a residential student at the Latham Center. Her biological mother was reportedly a drug addict, and [redacted] was born positive for cocaine. [redacted], with her older brother and sister, lived with her biological mother for three years. According to the reports in the record, the children were very poorly cared for, and may have suffered from malnutrition. She and her siblings were placed with [redacted] biological great maternal aunt, and were adopted by [redacted] in 1997 when [redacted] was ten years old. In 1998, [redacted] and her brother were placed in temporary DSS custody upon a determination that there was inadequate supervision and a high level of risk in the [redacted] household. In 1999, DSS assumed permanent custody of the Appellant.

It appears that from 1999 the Appellant has lived in a series of residential placements. Since July, 2000, she has been a student at the Latham School, which is located in Brewster, Massachusetts. A review of the many evaluations of [redacted] and the testimony at the Fair Hearing of several individuals involved with her indicate that overall, she has made some progress in this setting.

SUMMARY OF THE EVIDENCE

The first cognitive evaluation in the record was performed by Elizabeth Sanderson, Ph.D., a psychologist for the Randolph Public Schools, on December 22, 1993, January 3, 1994, and January 5, 1994 (Exhibit #2). [redacted] was seven years old at the time. She received the following scores on the Wechsler Intelligence Scale for Children-Third Edition (WISC-III):

Verbal IQ	90
Performance IQ	84
Full Scale IQ	86

Dr. Sanderson described [redacted] as "an anxious, angry girl whose early life was permeated with anxiety and depression" (Exhibit #2, p. 3). Dr. Sanderson also stated that she was explosive and easily upset, and sad and embarrassed about her lack of mastery of academic skills. Dr. Sanderson found Jamee to be functioning in the low average range of intelligence, with her verbal abilities being in the average range.

In 1997, [redacted] was again administered the WISC-III (Exhibit #3) as part of her three year Chapter 766 reevaluation. She was ten years, five months old at the time of this assessment, and a student in the Randolph Public Schools. Her results were as follows:

Verbal IQ	75
Performance IQ	67
Full Scale IQ	72

As can be seen, there was a dramatic drop in her scores between 1994 and 1997. The clinician who evaluated the Appellant did not make any reference to this change in her performance on the WISC-III. He described her as cooperative during the first session of the evaluation (apparently there were two) and "generally" cooperative during the second. He also stated that she was "at times impulsive and tended to give up on certain tasks, but did respond to encouragement" (Exhibit #3, p. 3). In short, there was nothing in her demeanor or behavior at the testing sessions that would account for the drop in her scores. The behavioral problems described by Dr. Sanderson in Exhibit #2 remained an integral part of the Appellant's profile in 1997 ("serious, long-standing emotional and behavioral problems continue to be a major impediment to [redacted] social and emotional growth," Exhibit #3, p. 4.)

A third evaluation was conducted on June 3, 1998, by Matthe Croteau, Ph.D. (Exhibit #4). This assessment was requested by her adoptive mother, Geneva Trent, because of [redacted] increasing behavioral problems. Specifically, [redacted] reported that [redacted] had thrown heavy objects at her, frequently fought with her brother, and had been arrested for trespassing and stealing. At school, she had assaulted other students and teachers. Consequently, she had to be physically restrained (Exhibit #4, p. 1). Both her teachers and her adoptive mother related that she often refused to bathe. As a result, her classmates would not sit near her. Other oppositional behavior included refusing to wear eyeglasses or braces (both of which she needed), perhaps because she felt other students would tease her. On the WISC-III, which Dr. Croteau administered, among other tests, she received the following results:

Verbal IQ	81
Performance IQ	68
Full Scale IQ	72

In her report, Dr. Croteau stated that "...[redacted] came willingly into the testing situation but was defiant throughout the entire session. At times she refused to answer questions or [do] specific assigned tasks" (Exhibit 4, p. 3). There were no indications of inattentiveness or hyperactivity. This clinician further observed that the Appellant perceived herself as being undesirable (Exhibit #4, p. 4). Again, there is reference to her rage. This report contained the first formal diagnoses in the record: Learning Disorder-NOS; Disruptive Behavior Disorder; Psychotic Disorder NOS; and moderate retardation.

On June 19 and 22, 2000 the Appellant was evaluated by Concord-Assabet Family and Adolescent Services, Inc. (Exhibit #5). [redacted] was 13 years old at the time. Her scores on the WISC-III were as follows:

Verbal IQ	69
Performance IQ	71
Full Scale IQ	70

Kathryn Yamartino, who conducted the assessment, characterized the results as being "fully" consistent with the prior testing (Exhibit #5, p. 2), which is not entirely accurate, since her Verbal IQ score was twelve points lower in this testing than it was in 1998 (Exhibit #4). According to Ms. Yamartino, the Appellant's verbal subtest scores showed wide variability, ranging from a score of 1 on the vocabulary subtest to an 8 on comprehension. Consistent with earlier evaluators, this clinician reported that [redacted] "experiences the world in an anxious, pessimistic way that engenders considerable anger and oppositionality," and that she was aware of and ashamed of her cognitive limitations (Exhibit #5, p. 3). She also stated that emotional factors clearly interfered with her functioning. Nevertheless, Ms. Yamartino stated that [redacted] "worked to the best of her abilities and was pleasant throughout." Therefore, she considered the results to be a valid measure of her current functioning (Exhibit #5, p. 2). At the time of this evaluation, the Appellant was on the following medications: Ritalin, Wellbutrin, Risperdal, Benedryl, Lithobid, and Clonodine.

A fifth evaluation was conducted on April 25, 2001, by Diane M. Greene, Ph.D., when [redacted] was fourteen and one-half years old (Exhibit #7). Her cognitive abilities were measured on the WISC-III, with the following results:

Verbal IQ	73
Performance IQ	70
Full Scale IQ	70

Dr. Greene described her as a "rather suspicious...girl manifesting clear signs of cognitive slippage, of thought-disorder" (Exhibit #7, p. 3), with an IQ consistently in the

borderline range. Both Dr. Greene and Dr. Croteau, who evaluated the Appellant in 1998, observed that [redacted] had serious problems with her thinking patterns. In addition, according to Dr. Greene there was considerable variability in subtests. It was her opinion that this variability suggested that emotional factors played some role in her cognitive functioning (Exhibit #7, p. 2).

The record contains two more evaluations of the Appellant by Dr. Greene, one in 2003, when she was almost seventeen years old (Exhibit #8), and another in 2006 (Exhibit #13), when she was almost twenty years old. These two reports may be summarized as follows. Generally, Dr. Green described [redacted] a multiply impaired adolescent with severe mental health problems as well as organic impairment which had resulted in mild mental retardation. Her IQ scores remained generally the same over this period, with some slippage over the years noted (which is perhaps the basis for Dr. Greene's ultimate conclusion that [redacted] is mildly mentally retarded). Her emotional problems and sense of shame regarding her cognitive deficits continued to be problems for the Appellant.

Dr. Frederick Johnson, an eligibility psychologist for the Department, testified that it was his opinion that the Appellant's cognitive deficits were more a result of mental illness than mental retardation. In fact, he stated that she was not mentally retarded. Dr. Johnson attributed her cognitive slippage to the onset of her psychological problems. He also noted that a thought disorder, which the Appellant's expert, Dr. Greene, had stated that [redacted] suffered from, can negatively affect an individual's cognitive performance. In addition, it was his opinion that the sub-test scores reported in Exhibits #4 and #5 were not consistent with someone with a global cognitive impairment (such as mental retardation), but were more likely indicative of a psychiatric disorder or Attention Deficit Disorder. It is important to note that Dr. Johnson used the DSM definition of mental retardation—an IQ score of 70 or below—rather than the AAMR standard of an IQ score of "approximately 70 to 75 or below," which was the definition used by DMR at the time [redacted] applied for DMR supports.[1] Furthermore, Dr. Johnson testified that there was no basis to support Dr. Greene's speculation that [redacted] mother's cocaine abuse while she was pregnant with the Appellant resulted in her daughter's cognitive deficits. In any event, the Appellant has never been assessed for neurological damage to test this theory.

I do not believe that we can know with any certainty what has caused this Appellant's diminished cognitive abilities. It is my opinion that even if [redacted] had an ideal childhood and emotional and/or psychological issues were not part of her profile, her IQ would be below the norm. I also believe that the test results from 1993/1994, when she was seven years old (Exhibit #2) are not a reliable basis for determining her IQ, since IQ tests from early childhood are often unreliable (which Dr. Johnson acknowledged in his testimony). Also, [redacted] in fact does have severe emotional problems, and there can be no doubt that these have had a negative impact on her

[1]Effective June 2, 2006, DMR changed its definition of mental retardation to "significant sub-average intellectual function" as defined by "intelligence indicated by a score of 70 of below…" *See* 115 CMR 2.00. Prior to that date, the Department had defined mental retardation as "inadequately developed or impaired intelligence" as evidenced (in part) by an "IQ score of approximately 70 or 75 or below."

cognitive performance. That being said, if Dr. Johnson had used the AAMR standard for determining retardation, which was the standard that should have been used, he may well have found her to be mentally retarded as that term was defined at the time she applied for supports.

However, an individual's eligibility for DMR services is not determined by "significantly sub average intellectual functioning" alone. In addition to having an IQ score of "approximately 70 to 75 or below," an applicant must also be in need of specialized supports 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. I find that the Appellant does not have impairments significant enough to meet the department's requirements in this regard. My decision is based largely on the Student Profile of the Latham School dated January 31, 2006. According to this report, [redacted] showed much competency in her vocational placement, and was scheduled to start working at a local supermarket in a paid position (Exhibit #12, p. 3). Also, according to the Student Profile, the Appellant rarely needed reminders to complete her daily chores, and in fact liked to do her chores ahead of time (Exhibit #12, p. 5). In addition, it was stated that she could cook, went on trips to the grocery store, library and movie theatre without any problems, had excellent table manners and good self-care skills.

It is true that on the Adaptive Behavior Assessment System II (ABAS II), (Exhibit #11), she fell more than two standard deviations below the mean in two skill areas, community use and functional academics, which would indicate that she met the second prong of DMR 'S eligibility criteria. However, the individual who completed the ABAS questionnaire did not provide responses to several of the statements in the "community use" category of the ABAS. Thus, I did not give any weight to her score in this section. I find that the only adaptive skill area in which the Appellant's score was two standard deviations below the mean was "functional academics." Thus, she is ineligible for services from the Department.

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) she must be domiciled in the Commonwealth,

b) she must be a person with Mental Retardation as defined in 115 CMR 2.01, and

c) she must be in need of specialized supports in two or more of the following seven

adaptive skill areas: communication, self-care, home living, community use, health and safety, functional academics, and work.

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."[2] 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 take no position as to whether [redacted] meets the Department of Mental Retardation's definition of mental retardation based on her IQ for the reasons discussed above. However, consistent with the Department's regulations, an applicant for its services must have related limitations in two or more of the above enumerated adaptive skill areas. I find that the Appellant does not have adaptive impairments severe enough to meet the Department's standards. Thus, she is ineligible for DMR supports.

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: Dec. 6, 2007

Deirdre Rosenberg
Hearing Officer

[2] Please see Footnote 1.