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Department of Mental Retardation
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March 16, 2006

Robert R. Hamel, Jr.
Hasaan & Reardon
P.O. Box 990069
Boston, MA 02199

Re: Appeal of [redacted]
Final Decision

Dear Mr. Hamel:

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 **approved**.

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,

Gerald J. Morrissey, Jr.
Commissioner

GJM/ecw

cc: Deirdre Rosenbert, Hearing Officer
Richard O'Meara, Regional Director
Marianne Meacham, General Counsel
Elizabeth Moran-Liuzzo, Regional Eligibility Manager
Allegra Munson, Assistant General Counsel
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" or "the Department"), (115CMR 6.30 - 6.34) and M.G.L. c. 30A. A fair hearing was held on October 17, 2005 at the Wrentham Developmental Center in Wrentham, Massachusetts. Those present were:

[redacted]	Mother of Appellant
Robert Hamel, Esq.	Attorney for Appellant
Dr. Kathleen Fitzgerald	Appellant's Physician
Mark S. Greenberg, Ph.D.	Appellant's Expert Witness
Allegra Munson, Esq.	Attorney for DMR
Frederick V. Johnson	Eligibility Psychologist

The evidence consists of the following documents, and approximately five and one half hours of oral testimony.

Exhibit #1	DMR Eligibility Report, May 28,
Exhibit #2	DMR Denial Letter
Exhibit #3	Bureau of Transitional Planning Referral Form
Exhibit #4	Progress Notes of Dr. Paul Dagincourt
Exhibit #5	Letter of Dr. Paul Dagincourt, June 18, 2004
Exhibit #6	Easter Seals Vocational Analysis
Exhibit #7	Notes of Healthsouth Braintree Rehabilitation Hospital
Exhibit #8	Curriculum Vitae of Kathy Fitzgerald, M.D.
Exhibit #9	Letter of Dr. Kathy Fitzgerald, dated July 22, 2004
Exhibit #10	Letter of Dr. Kathy Fitzgerald, dated August 23, 2005
Exhibit #11	Letter of Jamie Leader, dated July 25, 2005
Exhibit #12	Letter of Dr. Marvin Natowicz, dated July 31, 2000

Exhibit #13 Table 2.1 AAMR Standard for Mental Retardation (1992)

Exhibit #14 ABAS-II Exam dated April 30, 2004

Exhibit #15 ABAS-II Exam dated June 24, 2004

Exhibit #16 Neuropsychiatric Evaluation of Anne Daniels, 4/14/97

Exhibit #17 Curriculum Vitae of Dr. Fred Johnson

Exhibit #18 Psychiatric Evaluation of Abby Raelin, 2/6/03 and 2/14/03

Exhibit #19 Curriculum Vitae of Dr. Mark Greenberg

Exhibit #20 Neuropsychiatric Evaluation of Anne Daniels, 2/5/90 and 2/23/90

Exhibit #21 Neuropsychiatric Evaluation of Anne Daniels, 3/15/93 and 4/16/93

ISSUE

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

BACKGROUND

Mr. [redacted] is a 21 year old man who lives with his parents in [redacted] Massachusetts. He attends [redacted] in [redacted] Massachusetts. Prior to his current placement, [redacted] attended the [redacted] Public Schools starting in the first grade, and completed the 12th grade at [redacted] High School in 2003. He is continuing his post-graduate education at [redacted]

The Appellant applied for mental retardation services on April 30, 2004. On May 28, 2004, the DMR Regional eligibility team determined that [redacted] was not mentally retarded, and thus not eligible to receive Department of Mental Retardation services and supports. Appellant appealed the decision, and an Informal Conference was held on June 24, 2004. Eligibility was again denied on July 1, 2004. Appellant requested a fair hearing which was held on October 17, 2005, pursuant to M.G.L.c. 30A and DMR regulations at 115 CMR 6.33(2) and under the Massachusetts Code of Adjudicatory Procedure 801 CMR 1.02.

SUMMARY OF THE EVIDENCE

[redacted] was born with a host of unusual medical and mental conditions. According to Dr. Kathleen Fitzgerald, who has been [redacted] doctor for the past ten years, he "has a syndrome... which, despite years of investigation by internationally famous geneticists, neurologists and pediatricians, has eluded precise characterization. It may be unique to him." (Exhibit #10) He was born with a small, underdeveloped brain with multiple additional brain abnormalities. In addition, he suffers from a chronic and progressive disorder of the peripheral nervous system which causes progressive weakness, pain and incoordination. Currently, he uses an electric wheelchair for most of his activities. Dr. Fitzgerald testified that [redacted] also suffers from a "connective tissue disorder including a history of recurrent hernias, mitral regurgitation, bladder diverticula, and severe gastroesophageal reflux, hypogonadotropic hypogonadism and growth hormone deficiency." (Exhibit #10) Dr. Fitzgerald stated that [redacted]'s condition has deteriorated over the years, and that she expects that he will continue to deteriorate.

In spite of his seemingly overwhelming problems, [redacted] has certain cognitive strengths.

In 1990, when [redacted] was 5 years, 9 months, he underwent a neuropsychological evaluation conducted by Anne Daniels, Ed.D. (Exhibit #20). She administered tests used to determine the subject's position on the Stanford-Binet Intelligence Scale, Fourth Edition. [redacted] achieved scores which placed him in the low average to average range. Ms. Daniel, in her report, stated that his scores "are likely an underestimate of his intellectual potential." (Exhibit #20) However, she also noted that [redacted] is "significantly hindered in his ability to demonstrate and use his strengths by marked difficulty... to sustain attention, inhibit impulsive responding, and monitor his own performance," all of which, she said, means that he has poor executive functions. (Exhibit #20)

The Appellant was again evaluated, also by Ms. Daniels, on 3/15/93 and 4/16/93, when he was 8 years, 10 months. (Exhibit #21) At this time, the test used to evaluate his cognitive abilities was the WISC-III. He achieved the following scores:

Verbal IQ	91
Performance IQ	68

A full scale IQ was not reported because of the 24 point discrepancy between his verbal and performance scores. (The extreme discrepancy between [redacted]'s verbal and performance scores has been the most notable feature of his cognitive profile in every evaluation in the record.) Ms. Daniels attributed his low performance score in large part to his extremely weak executive function skills, such as planning and

organization, and in part to his impaired fine motor skills. But it appears that Ms. Daniels believed that the principal reason [redacted] could not utilize his cognitive strengths was because of his weak executive abilities.

The next time the Appellant was evaluated was on April 14, 1997, when he was 12 years, 11 months old. (Exhibit #16) Again, the assessment was conducted by Anne Daniels. At this time, [redacted] achieved the following scores:

Verbal IQ	74
Performance IQ	52

A full scale IQ was not calculated because of the 22 point discrepancy between the two IQ components. (Apparently it is the practice to not compute a full scale IQ figure when such a discrepancy exists, because, it is believed, the result will not be valid.) She stated that "[redacted]'s severe executive function weaknesses significantly affected his performance on all tasks, with the result that his scores on the Wechsler Intelligence Scale for Children-Third Edition, were lower than before, falling into the Borderline to far below average range." (Exhibit #16) In fact, based on the scores he received in 1997, he could have been diagnosed as being mentally retarded, although that term was not used in Ms. Daniels' report. Again she mentioned [redacted]'s significant motor difficulties, but her discussion of the test results most heavily emphasizes his executive function difficulties.

A final assessment of the Appellant's cognitive abilities was made in February, 2003, when [redacted] took the Wechsler Adult Intelligence Scale-III (WASC-III). At this time he was 18 years old, and the testing was conducted by Abby P. Raelin, Ph.D., school psychologist for [redacted] Public Schools. (Exhibit #18) His scores were as follows:

Verbal IQ	82
Performance IQ	65
Full Scale IQ	72

In spite of the significant discrepancy between the verbal and performance IQ scores, this clinician did compute a full-scale IQ, and that score, 72, falls within the Department's definition of mental retardation ("the individual must have significantly sub-average intellectual functioning defined as an IQ score of approximately 70 to 75 or below. . ."), but no such diagnosis was made.

The Department's expert, Dr. Fred Johnson, testified that he agreed with DMR's determination (made by another DMR psychologist, Dr. Joel Match, Exhibit #1) that

[redacted] was not eligible for DMR services or supports because he did not fit the Department's definition of mental retardation. He stated that he believed that [redacted]'s verbal IQ score of 91, achieved when he was tested in 1993 (Exhibit #21), was inconsistent with mental retardation. On tests where [redacted] had received low verbal IQ or full scale IQ scores (Exhibits #16 and #18), Dr. Johnson testified that he gave more weight to the sub-test, or index scores, such as Verbal Comprehension, Similarities and Vocabulary, on which the Appellant had tested higher.

Dr. Johnson also said that he based his conclusion regarding [redacted]'s eligibility on the fact that [redacted] had passed the English portion of the MCAS test. (In her testimony, [redacted]'s mother stated that the MCAS had been modified for her son, and was taken "one on one with an aide"). Furthermore, Dr. Johnson stated that the fact that the Appellant was in treatment with a "talk" psychotherapist was evidence that he was not retarded. He claimed that a person who was retarded wouldn't have the necessary insights to participate in this kind of therapy. Therefore, he reasoned, since [redacted] saw a talk psychotherapist, he must not be retarded. Finally, under cross examination by the Department's attorney, Dr. Johnson was asked if he had reviewed the "Appellant's IEPs and the like," which he answered in the affirmative. Counsel for DMR then asked if [redacted] had "consistently been given the diagnosis of learning disability throughout his academic career," to which Dr. Johnson also answered in the affirmative.

For several reasons I do not give much weight to Dr. Johnson's expert opinion. First, when he stated that he had reviewed Appellant's IEPs and the like, and that [redacted] had consistently been given the diagnosis of learning disability, he apparently mispoke. On redirect, Appellant's attorney asked Johnson where he could find the diagnosis of learning disability in [redacted]'s IEPs. Both he and counsel for the Department perused their materials for many minutes and could not find any diagnosis of learning disability applied to [redacted]'s condition in the referenced materials. He had never been given the diagnosis of learning disability in his IEPs.

Similarly, he mischaracterized [redacted]'s participation in psychotherapy, which was one of the factors upon which his conclusion that [redacted] was not retarded was based. A review of the extensive notes of Dr. Paul Dagincourt, [redacted]'s treating therapist (Exhibit #4), makes it clear that little or no cognitive behavioral, or insight therapy, occurred during his sessions with the Appellant. Approximately half of Dr. Dagincourt's progress notes relate to discussions about [redacted]'s medication regimen, including side effects of the drugs he was taking, and to his physical problems generally. In addition, apparently at least one of his parents was present at all of [redacted]'s therapy sessions, and in his notes much attention is given to parental observations of their son. In any case, Dr. Dagincourt explicitly stated in a letter dated June 18, 2004 (Exhibit #5) that "[redacted]'s cognitive limitation largely precludes effective use of cognitive behavioral therapy."

Finally, Dr. Johnson's position regarding the standard DMR uses to determine retardation (an IQ score of approximately 70 to 75 or below) was deeply troubling.

During questioning by counsel for Appellant, Dr. Johnson was asked if [redacted]'s full scale IQ of 72, which he received in 2003, wasn't some evidence that [redacted] was retarded. He said it was not. After further questioning, Dr. Johnson acknowledged that DMR's standard for mental retardation was 70 to 75 or below, but, he testified, *"that is not what I use"* (emphasis added). In 1997, when [redacted] was 12, his verbal IQ was 74 and his performance IQ was 52. (Exhibit #16). Because Dr. Johnson does not use the 70 to 75 or below IQ range for determining retardation, which is the DMR standard currently in effect, he similarly did not consider these scores as evidence of mental retardation. As for the Appellant's performance IQ scores, which have been consistently extremely low, Dr. Johnson attributed them to factors other than mental retardation, such as impulsivity and poor fine motor control. Overall, I find that Dr. Johnson's assessment of Appellant's eligibility for DMR's supports and services was not balanced and unfairly prejudiced [redacted]. Therefore, I give his testimony little weight.

Dr. Kathleen Fitzgerald is a board certified pediatrician who has been the Appellant's physician for the past ten years. She testified that although she had never used the term mentally retarded in describing [redacted] she had always believed that he in fact was. She attributes his mental condition to his having been born with a small, abnormal brain, and pointed to his "obvious lack of abstract thinking" as evidence of his retardation.

Dr. Mark Greenberg, who is a clinical psychologist, was the Appellant's expert witness. In assessing [redacted]'s condition, he reviewed his medical records from the time of his birth to the present, including records of all of his cognitive tests; independently researched [redacted]'s medical conditions; and met with [redacted] and his mother. He did not administer any tests anew. He testified that [redacted]'s nervous system did not develop normally in utero. As a result, his head size is small, his brain is malformed and lacks volume; [redacted] also suffers from numerous other brain anomalies. In addition, Dr. Greenberg testified that [redacted] has distinct dysmorphic features, which are associated with mental retardation. In reviewing the Appellant's test scores, he stated the "he should have and could have been classified as mentally retarded when he was tested at age 12," when his verbal IQ was 74 and this performance IQ was 52. He agreed with Dr. Johnson that the 91verbal IQ that [redacted] achieved in 1993, when he was 8 years old, is not typically associated with mental retardation. But, he testified, that one score by itself does not exclude a diagnosis of mental retardation.

It should be noted that counsel for DMR repeatedly made the point that the Appellant had never been formally diagnosed as being mentally retarded. Since it has been the practice in the disabilities field for approximately three decades to avoid using that label because of its pejorative connotations, I do not find the absence of this diagnosis in connection with Mr. [redacted]'s cognitive abilities to have any evidentiary weight.

To qualify for DMR supports and services, an applicant must, in addition to having an IQ in the retarded range, demonstrate that he is 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. 115 CMR 2.01. The evidence before me clearly establishes that the Appellant requires specialized supports in at least work, and health and safety.

When he was 19 years old, [redacted] participated in a three day vocational assessment conducted by Easter Seals, Job Training and Employment. (Exhibit #6) In her report, the evaluator stated that "[redacted] presents in an aggressive, dominating manner." He demonstrated a poor ability to focus when given a task to complete. The evaluator also found that [redacted] needed continuous verbal cueing to draw him from perseverating. She concluded that "[redacted] could with very clear directions, expectations & structure work in a video store" but "would require a job coach to be successful at this job." (Exhibit #6, emphasis in the original) I understand this to mean that [redacted] would require a job coach at his work site on an ongoing basis, rather than temporarily.

The assessment of Jamie Leader, Senior Vocational Rehabilitation Counselor at the Massachusetts Rehabilitation Commission, was similar. In a letter dated July 25, 2005, she wrote:

> "I have observed Mr. [redacted] in several simulated work environments at [redacted] High School, Easter Seals, and currently in an unpaid internship at a sporting goods store in which he received 1:1 job coaching for a two and half hour work day. In all of these placements, Mr. [redacted] has required ongoing one on one job coaching to understand directions, follow directions and remain on task." Exhibit #11.

Regarding the sporting goods store internship referenced in the passage above, [redacted] mother testified that his job at that site had been cut back to one hour, one day a week, because he was having so much difficulty staying on task and doing the job. It should be noted that [redacted]'s poor vocational performance--and potential--was not attributed to his physical condition.

"Health and safety" is another adaptive skill area in which the record makes clear that [redacted] needs specialized supports. The Department of Mental Retardation uses the Adaptive Behavior Assessment System, second edition (ABAS-II), to measure adaptive functioning. Two such tests assessing the Appellant's adaptive skills were entered into evidence at the hearing (Exhibits #14 and #15). On the first test, dated 4/30/04, [redacted] received a 60 on the General Adaptive Composite, which puts the Appellant in the .4 percentile. Dr. Johnson, DMR's psychologist, acknowledged that this was an extremely low score. In the nine skill areas measured (communication, community use, functional

academics, home living, health and safety, leisure, self-care, self-direction and social), [redacted] scored especially low in self-direction, community use, and health and safety.

A second ABAS was conducted on 6/24/04 (Exhibit #15). The Appellant's General Adaptive Composite score this time was 57, even lower than the prior test, putting [redacted] in the .2 percentile. Again, his score in health and safety was notably low.

FINDINGS AND CONCLUSIONS

After a careful review of all of the evidence, I find that the Appellant has shown 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

d) he 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.

There is no dispute that the Appellant meets the first criterion and I specifically find that he meets that criterion. I also find that he is mentally retarded as that term is defined at 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 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.

Applying those standards, I find that the Appellant has significantly sub-average intellectual function. At the outset, it should be said that [redacted]'s case is highly unusual. As his pediatrician, Dr. Kathy Fitzgerald wrote, his condition may be unique to him. (Exhibit #10) But it is beyond dispute that [redacted] was born with a small, underdeveloped brain with additional serious brain abnormalities. Although I agree that it is unlikely that a person with mental retardation would have a verbal IQ of 91, which was what [redacted] scored in 1993, when he was 8 years old (Exhibit #21), there was no testimony that a person with mental retardation could not receive such a score. I find that this score was anomalous. Also, his performance score of 68 which he received at that time, while probably negatively affected by his physical problems, cannot be disregarded as insignificant.

In addition, the verbal IQ score of 74 and the performance IQ score of 52 which [redacted] received in 1997 (Exhibit #16), are clearly within the mental retardation range that the Department uses when determining the eligibility of applicants for its services. While I agree that his performance IQ would probably have been higher if he did not have the physical problems that he does have, there was nothing in the record to suggest that if he did not have those physical problems, his performance IQ score would have been 24 points higher, which it would have needed to be to take him out of the retarded category.

Finally, Dr. Mark Greenberg, the Appellant's expert, was an impressive witness, and I gave his testimony great weight. His experience and expertise regarding cognitive disabilities was evident in both his curriculum vitae (Exhibit #19) and his discussions of [redacted]'s condition. He had clearly done a thorough review of his medical history, and the reasoning upon which he based his conclusion that [redacted] is mentally retarded was persuasive.

Therefore, I conclude that the Appellant has "significantly sub average intellectual functioning defined as an IQ of approximately 70 to 75 or below."

I also find that the Appellant has "related limitations in two or more…adaptive skill areas"—work and health and safety--, and that these "exist concurrently with sub average intellectual functioning." My reasons for so concluding are discussed in detail on pages 7 and 8 of this decision.

Lastly, I find that [redacted] manifested the above two criteria before the age of 18.

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: 2/12/06

Deirdre Rosenberg
Hearing Officer