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Executive Office of Health & Human Services
Department of Mental Retardation
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July 16, 2007

Ms. [redacted]
33 East Street
Fitchburg, MA 01420

Re: Appeal of [redacted] - Final Decision

Dear Ms. [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 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

Elin M. Howe
Commissioner

GJM/ecw
cc: Deirdre Rosenberg, Hearing Officer
Terry O'Hare, Regional Director
Marianne Meacham, General Counsel
Damien Arthur, Regional Eligibility Manager
John Geenty, Assistant General Counsel
Katrin Weir, Psychologist
Tim Sindelar, Appellant's 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) (115CMR 6.30-6.34) and M.G.L. c. 30A. A fair hearing was held on December 12, 2006 at the Department of Mental Retardation's Worcester Area Office. Those present were:

[redacted]	Appellant
	Appellant's mother
[redacted]	Appellant's PCA
Tim Sindelar, Esq.	Appellant's counsel
John C. Geenty, Jr.	DMR Attorney
Katrin Weir	DMR Eligibility Psychologist

The evidence consists of the following exhibits and one and one-half hours of oral testimony.

1. List of All Communication Between DMR and Appellant
2. Curriculum Vitae of Katrin Rouse-Weir, Ed.D.
3. Neuropsychological Evaluation, 12/22/05
4. Psychological Evaluation, 12/11/91 & 1/8,15/92
5. DMR Eligibility Report, 5/22/2006
6. Psychological Evaluation, 11/04/02
7. Psychological Evaluation, 5/8/95
8. Psychological Assessment, January 15, 1998

ISSUE

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

BACKGROUND

The Appellant, [redacted] is an 18 year old young man who lives with his mother and older sister in Fitchburg, Massachusetts. He has received special education services pursuant to Chapter 766 from the time he was three years old until he completed the twelfth grade at Fitchburg High School in 2006. Mr. [redacted] has been provided with a one-to-one aide throughout his schooling. In addition, in the past, and for at least eleven years, he received services from DMR as part of an initiative between the Department of Retardation and the Department of Education. The object of this collaborative was to provide in-home services to handicapped children who would otherwise require a residential placement. Mr. [redacted] was recently referred to the Massachusetts Rehabilitation Commission. Although he was determined to be eligible for services, Mass Rehab also concluded that he was not capable of "competitive employment."

He has been diagnosed with Pervasive Developmental Disorder (PDD) and Attention Deficit Hyperactivity Disorder (ADHD). When the Appellant was eight years old, he was diagnosed with Duchenne's Muscular Dystrophy. Duchenne's is a progressive neurological disease which can cause both physical and mental symptoms. Mr. [redacted] currently relies on a motorized wheelchair for ambulation. He presently has a personal care attendant for 17 and one-half hours per week. This service is paid for by Massachusetts Health.

There were many references in the record to the Appellant's behavior problems, which have been ongoing. These include impulsivity, inflexibility, disruptiveness, and unwillingness to cooperate.

Summary of the Evidence

The first cognitive assessment of the Appellant in the record was administered on December 11, 1991, January 8 and 15, 1992, when [redacted] was three years and eight months old (Exhibit #4). The test used was the Wechsler Preschool and Primary Scale of Intelligence—Revised (WPPSI-R). He received the following scores:

Prorated Verbal IQ	69
Prorated Performance IQ	78
Prorated Full Scale IQ	71

According to the clinician who conducted the evaluation, Andrea Barnes, Ph.D., the Appellant had difficulty responding to the WPPSI. She therefore tested him using selected items from the Bayley Scales of Infant Development. Dr. Barnes stated that "[t]his test was designed for children up to age 2 years and 6 months, and therefore

cannot be used to derive a Standard Score for [redacted]" (Exhibit #4). I gave little weight to the results of this assessment of Mr. [redacted]

The Appellant's next cognitive evaluation is dated May 8, 1995 (Exhibit #7). He was seven years old and his IQ was measured on the Wechsler Intelligence Scale for Children-III (WISC-III). His scores were as follows:

Verbal IQ	69
Performance IQ	66
Full Scale IQ	65

Donald O. Goranson, Licensed Education Psychologist, who administered the test, stated that [redacted] "attention to task was very brief, requiring constant directives to keep working or reassuring complimentary remarks" (Exhibit #7). Mr. Goranson concluded that the Appellant was functioning within the intellectually deficient range of intelligence. Neither this report, nor that of 1992, contain any statements regarding the validity of the test results.

On January 15, 1998, the Appellant was evaluated by Stephen Stolfers, M.A., NCSP, a school psychologist in the North Middlesex Regional School District, as part of his three year special education re-evaluation process (Exhibit #8). Mr. [redacted] was nine years, nine months old at the time. He achieved the following results on the WISC-III:

Verbal IQ	71
Performance IQ	57
Full Scale IQ	61

Although a full scale IQ was computed, it should not have been because of the 21 point difference between the verbal and performance scales. According to Mr. Stolfers, [redacted] had difficulty maintaining attention, and was "easily frustrated or overwhelmed" by certain tasks (Exhibit #8). Nevertheless, this clinician concluded that "this assessment serves as an estimate of his current intellectual functioning."

The Appellant was next tested on November 4, 2002 when he was fourteen and one-half years old (Exhibit #6). Arelindo S. Alves, M.Ed., C.A.G.S., administered the WISC-III. At this time, Mr. [redacted] attained the following scores:

Verbal IQ	90
Performance IQ	60

Full Scale IQ 73

Ms. Alves stated that the full scale score cannot be considered valid because of the significant difference between the verbal and performance IQs. She further reported that although [redacted] was cooperative during the session, "he did have a tendency to give up quickly when he encountered difficulty, [and] at times he became visibly upset and ...was easily distracted" (Exhibit #6). Clearly, though, his verbal IQ, where he had demonstrated strength in the past, was at this time in the low end of the average range of intelligence.

The final evaluation in the record was conducted by Cynthia Levinson, Ph.D., on December 22, 2005, when [redacted] was seventeen years and eight months old. (Exhibit #3). His cognitive abilities were measured on the Wechsler Adult Intelligence Scale—Third Edition (WAIS-III), among several others. Only the results of the WAIS-III are reported here:

Prorated Verbal IQ	99
Prorated Performance IQ	74
Full Scale IQ	87

Dr. Levinson noted, correctly, that the full scale IQ score was of limited interpretive value because of the great discrepancy between his verbal and performance scores (the former realm being his strength, as in the past). [redacted] was described as "a cheerful young man in a wheelchair who related well to the examiner and worked persistently and cooperatively in the highly structured...testing situation" (Exhibit #3, p. 3). The report also states that tasks assessing manual motor speed were not administered because of his physical limitations. According to Dr. Levinson, Mr. [redacted]'s current intellectual functioning was within the low average range. She did not discuss the difference between his performance on the WAIS and earlier test results.

Katrin Rouse-Weir, Ed.D., who is the Eligibility Psychologist for the Department's Region I, determined that the Appellant was not eligible for DMR services in a report dated May 22, 2006 (Exhibit #5). The only cognitive assessment mentioned in the report is that of 2005, discussed above, where he scored a verbal IQ of 99, a performance IQ of 74, and a full-scale IQ of 87. These scores, she testified, convinced her that Mr. [redacted]'s IQ is outside the eligibility parameters. However, at the hearing, Ms. Weir stated that she had also reviewed the results of the 1991 and 1992 cognitive evaluation (Exhibit #4), certain recent achievement tests, his most recent Individual Education Plan (IEP), and a 2005 Adaptive Behavior Assessment System—Second Edition) (ABAS-II) before making her decision. She had no persuasive explanation for the significantly improved cognitive scores seen in 2002 and 2006, beyond surmising that other factors, such as depression, attentional problems, and family issues, had negatively affected his scores in the past. Although I was not convinced by Dr. Weir's testimony, it

does appear that at least at the 2006 testing (Exhibit #3), his demeanor, behavior and effort at the evaluation were described more positively than they had been in the past.

Several of the Appellant's witnesses expressed concerns about his ability to function without the structure of the Kolburne School, a concern which I find to be well-founded. Nevertheless, because I also find that he does not meet the Department's definition of impaired intelligence, it is unnecessary for me to consider these concerns.

FINDINGS AND CONCLUSIONS

After a careful review of all of the evidence, and despite Mr. [redacted]'s obvious need for a highly structured residential setting, I find that he 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 (see footnote 1 below).

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 intelligence," and that standard was in effect when Mr. [redacted] applied for DMR services.[1] The AAMR standards establish a three-prong test: (a) the individual must have significantly sub average intellectual functioning defined as an IQ score of

[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 or below..." *See* 115 CMR 2.00. The Appellant filed his appeal before the new definition was adopted.

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.

In reaching my decision that the Appellant does not have "inadequately developed or impaired intelligence," as defined above, I gave most weight to his last three cognitive evaluations, that is, Exhibits #8 (1998), #6 (2002), and #3 (2005). I gave no weight to the first IQ test in the record (Exhibit #4), because Mr. [redacted] was barely four years old at the time of this evaluation, and IQ scores of children at this early stage of their development are highly unreliable. For similar reasons, I did not give great weight to Exhibit #7, which was conducted when [redacted] was seven years old.

On two of the remaining evaluations, Exhibits #6 and #3, the Appellant received verbal IQ scores in the low average to average range, 90 and 99, respectively, and it is very difficult for me to ignore these. Furthermore, on the 2005 test (Exhibit #3), he achieved his highest score ever on the performance scale, presumably because, according to the clinician who administered the test, she did not ask Mr. [redacted] perform those tasks which assessed manual motor speed, because of his physical limitations. I am persuaded that his Duchenne's Muscular Dystrophy plays some part in depressing his scores on performance tests. It is true that the Appellant's IQ results on the third cognitive report that I considered in reaching my decision, that of 1998 (Exhibit #8) meet the Department's standard for mental retardation. However, his behavior during this evaluation was far from ideal (difficulty maintaining attention and concentration, difficulty in remaining in his seat, low tolerance for frustration, not motivated to complete the various tasks of the assessment). I believe that his performance was adversely affected by these behaviors, and that it was not an accurate reflection of his abilities. Thus, I concur with DMR that the Appellant does not have "inadequately developed or impaired intelligence," as evidenced by his IQ scores, and is ineligible 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: 6/23/07

Deirdre Rosenberg
Hearing Officer