2010-36

The Commonwealth of Massachusetts

Executive Office of Health & Human Services
Department of Developmental Services
500 Harrison Avenue
Boston, MA 02118-2439

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JudyAnn Bigby, M.D.
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Elin M. Howe
Commissioner

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2010

MA

Re: Appeal of - Final Decision

Dear :

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 DDS regulations. Your client's 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
Richard O'Meara, Regional Director
Marianne Meacham, General Counsel
James Bergeron, Assistant General Counsel
Elizabeth Moran Liuzzo, Regional Eligibility Manager
Frederick Johnson, Psychologist
File

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF DEVELOPMENTAL DISABILITIES

In Re: Appeal of [redacted]

This decision is issued pursuant to the regulations of the Department of Developmental Disabilities (DDS)(115 CMR 6.30 – 6.34) and M.G.L. Chapter 30A. A hearing was held on [redacted] 2010 at the Department's [redacted] in [redacted].

Those present for all or part of the proceedings were:

[redacted] Esq.	Counsel for [redacted]
[redacted]	Legal Intern
[redacted]	Appellant's mother
[redacted]	Appellant's father
[redacted]	School Psychologist
[redacted]	Transition Specialist
[redacted]	[redacted] Public Schools [redacted]
Laurie Costa	Regional Eligibility Coordinator DDS
Frederick Johnson, Psy.D.	Psychologist for DDS
James Bergeron, Esq.	Attorney for DDS

The evidence consists of documents submitted by the Appellant numbered A 1 - A 36, documents submitted by the Department of Developmental Disabilities numbered D 1 – D 16, and approximately five and a half hours of oral testimony. At the close of the Hearing, the parties requested and were given fourteen days to file Closing Arguments. Both counsel did so. The documents submitted were as follows.

APPELLANT'S EXHIBITS

Number	Description	Date
A – 1 (D – 13)	Psychological Assessment: [redacted]	[redacted]92
A – 2	Preschool Certificate	[redacted]93
A – 3	Kindergarten Report: [redacted]	1993 – 1994
A – 4	Individualized Educational Plan for [redacted]	[redacted]94 – [redacted]95
A – 5 (D – 14)	Psychological Assessment [redacted] [redacted] Schools	[redacted]96
A – 6	Neuropsychological Evaluation: [redacted]: [redacted] Hospital	[redacted]97
A – 7	Letter from DDS to Mr. and Mrs. [redacted]	[redacted]00
A – 8	Psychological Assessment: [redacted] [redacted] Schools	[redacted]00
A – 9	Individualized Educational Plan	[redacted]00 – [redacted]01
A – 10	Neuropsychological Evaluation: [redacted] [redacted] Hospital	[redacted]01
A – 11	Individualized Educational Plan	[redacted]01 – [redacted]02
A – 12	[redacted] 2002 homework sheets	
A – 13	[redacted] 2002 homework sheets	
A – 14	Adaptive Behavior Testing Report: [redacted]	[redacted]02
A – 15	Individualized Educational Plan	[redacted]02 – [redacted]03

A – 16		Child Psychiatric Assessment: Dr. [redacted]	[redacted]03
A – 17		Individualized Educational Plan	03 – [redacted]04
A – 18		Letter to Mr. and Mrs. [redacted] from [redacted] Schools	[redacted]03
A – 19	(D – 15)	Neuropsychological Evaluation: [redacted] Hospital	[redacted]03
A – 20		Psychiatric Assessment Update: Dr. [redacted]	[redacted]03
A – 21		School Observation: [redacted] Hospital	[redacted]04
A – 22		Discharge Summary [redacted]	[redacted]05
A – 23		IEP Progress Report	[redacted]05 – [redacted]06
A – 24		Individualized Educational Plan	[redacted]06 – [redacted]07
A – 25		[redacted] School Department 688 Referral Form	[redacted]06
A – 26		[redacted] Discharge Summary	[redacted]06
A – 27		MCAS Results and cover letter	[redacted]06
A – 28		[redacted] Discharge Summary	[redacted]06
A – 29		Individualized Educational Plan	[redacted]06 – [redacted]07
A – 30		Speech and Language Pathology Report (Page one is missing)	[redacted]08
A – 31	(D – 16)	Psychological Evaluation: [redacted]	[redacted]08
A – 32		IEP Notes Page	[redacted]09 – [redacted]10
A – 33		Letter from [redacted] Schools to Laurie Costa of Department of Children and Families	[redacted]09
A – 34		Individualized Educational Plan	[redacted]09 – [redacted]10
A – 35		[redacted] Medication List	

DEPARTMENT OF DEVELOPMENTAL SERVICES EXHIBITS

Number		Description	Date
D – 1		Vita Dr. Frederick Johnson, Psy.D	
D – 2		115 CMR 6.00	
D – 3		115 CMR 2.00	
D – 4		Application for DMR Eligibility	[redacted]07
D – 5		Eligibility Report: Dr. Johnson	[redacted]10
D – 6		Letter – Eligibility Denial	[redacted]07
D – 7		Notice of Appeal	[redacted]07
D – 8		Informal Conference Attendance Sheet	[redacted]08
D – 9		Denial letter	[redacted]08
D – 10		Request for Fair Hearing	[redacted]08
D – 11		Notice of Receipt of Hearing Request	[redacted]08
D – 12		Notice of Fair Hearing Schedule	[redacted]09
D – 13	(A – 1)	Report of Psychological Assessment	[redacted]92
D – 14	(A – 5)	Report of Psychological Assessment	[redacted]96
D – 15	(A – 19)	Neuropsychological Evaluation	[redacted]03
D – 16	(A – 31)	Psychological Evaluation	[redacted]08
D – 17		Adaptive Behavior Assessment	[redacted]07
D – 18		Guardianship Decree	[redacted]08

ISSUE PRESENTED

Whether the applicant meets the eligibility criteria for DDS supports by reason of mental retardation as set out in 115 CMR 6.04(1). In this case the appellant's age and domicile are undisputed. The issue in dispute is whether or not [redacted] is a person with mental retardation as defined in 115 CMR 2.01.

[redacted] has had a number of evaluations of both his cognitive and emotional functioning. The earliest Psychological Assessment of [redacted] was done on [redacted] 1992. (Exhibit A – 1, D – 13) The evaluation was done by [redacted] who identifies herself as "school psychologist". In this evaluation Mr. [redacted] earned a Full Scale IQ score of 90 which is significantly different from any subsequent test result.

The report of this evaluation (Exhibit A – 1, D – 13) was not provided to the Department by the appellant. In [redacted] 2007 Mr. [redacted] was determined to be ineligible for adult supports from the Department of Developmental Disabilities due to insufficient information having been provided. (Exhibit D – 6) In [redacted] 2008 an Informal Conference was held and the need for the report of [redacted] 1992 was discussed again. The parties agreed to attempt to get the report. The Department was told that the report could not be found and a Fair Hearing was scheduled. One week before the Hearing, at the request of Dr. Johnson, an Eligibility Specialist from the Department went to [redacted] Schools to attempt to locate the report. The report was found. (Exhibit D – 5) At the Hearing, there was no testimony about exactly where or how the report was finally located.

At the Hearing, Mr. [redacted], the [redacted] for the [redacted] School Department testified that the report of the 1992 evaluation had been lost somehow and that searches by the School Department were unsuccessful. (Testimony of [redacted]) . Mr. [redacted] also raised the possibility that the evaluation of [redacted] might have been mixed up with a report of an evaluation of [redacted] ([redacted]). This Document (Exhibit A - 36) is a one page document which records a WISC – R done in [redacted] 1987 where [redacted]. In addition to [redacted] on the evaluations, the report [redacted], was done in [redacted] 1992, was a Stanford Binet and the only score was a Full Scale IQ of 90. Exhibit A – 36 was faxed and not included in the Exhibit list although it was submitted at the Hearing by the Appellant. I have numbered it "A – 36" for purpose of identification.

The explanations suggested by the [redacted] School Department and the appellant regarding this 1992 evaluation simply do not make sense. As early as [redacted] 2007, the appellant was put on notice that this 1992 evaluation was critical to the Department's ability to make a decision relative to his eligibility. (Exhibit A – 5) It wasn't until [redacted] 2010 that the evaluation report was located by a Department employee at the request of Dr. Johnson. The report was found on the first attempt. While there is no evidence that this evaluation report was deliberately withheld from the Department, the circumstances of its discovery undermine the credibility of the appellant and his representatives.

EVIDENCE PRESENTED: PSYCHOLOGICAL AND PSYCHIATRIC EVALUATIONS

Exhibit A – 1, D – 13 is a two page report of the evaluation done on [redacted] 1992 when [redacted] was four years old. It is titled "[redacted], Guidance Services Department, Report of Psychological Assessment" Ms. [redacted] states that [redacted] was referred for a Team Evaluation by his parents due to concerns about his speech and motor development. She noted a history of two [redacted]. [redacted] was cooperative, enthusiastic, attended well and responded well to positive reinforcement during the evaluation. [redacted] demonstrated delays in motor skill development and significant speech difficulties. He made many articulation errors and Ms. [redacted] commented that at times he was very difficult to understand. She states further that "scores may reflect a low estimate of his ability as some items were scored as failures when he couldn't be understood." [redacted] earned a full scale IQ score of 90 and a mental age of four years [redacted] (his actual age was just four years). Ms. [redacted] states that [redacted] might benefit from special needs services for his speech and motor needs.

Dr. Johnson testified that the Stanford Binet test is a "ratio I.Q. test". The score given on the Stanford Binet is the ratio of the chronologic age of the person tested compared to the mental age. This evaluation report did not include any subtest scores.

Mr. [redacted] who identified himself as a "school psychologist" testified on behalf of the appellant. Mr. [redacted] said that he believed tests on a four year old child were "useless". (testimony Mr. [redacted]) He referred to a study done by the World Health Organization which supported the idea that such tests were useless. Unfortunately, he could not give any specific information about this study or remember where he read about it. ([redacted] was four years old when the 1992 evaluation was done.)

[redacted]'s next evaluation on [redacted] 1996 when he was seven years [redacted] of age, was done by [redacted], a licensed Educational Psychologist. (Exhibit A – 5, D – 14) During this evaluation, [redacted] was pleasant and friendly, highly distractible and impulsive and talked constantly during the evaluation. He could only maintain concentration for brief periods of time. His speech was still difficult to understand at times and he made many articulation errors. On the Weschler Intelligence Scale for Children – III [redacted] earned a Verbal IQ score of 66; a Performance IQ score of 60 and a Full Scale IQ score of 60. The evaluator stated that "...these scores should be interpreted with great caution. There were many significant factors that interfered with his performance, i.e., attentional problems, high activity, distractibility and impulsivity, as well as, receptive and expressive language difficulties." (Exhibit A – 5, D - 14) The evaluator recommended that medical or neurological consultation be sought to evaluate the possible effects of [redacted] [redacted] on his functioning and to evaluate his attention problems.

When [redacted] was eight years [redacted] of age he was evaluated at the [redacted] by [redacted], Ph.D. and [redacted], Ph,D. (Exhibit A – 6) [redacted] was referred for this evaluation primarily due to concerns about his functioning in school and to determine what services would be most appropriate for him. In addition to neuropsychological testing, the evaluation included interviews with [redacted] and his parents, psychosocial adjustment questionnaires filled out by [redacted] parents and teacher and observation of [redacted].

Although no numerical scores were given, [redacted] scored in the intellectually deficient range in the tests. The evaluator noted that [redacted] early developmental milestones were met within normal limits, although he had ongoing difficulty with speech and fine and gross motor skills. His parents noted that he was afraid of the dark, lightening and thunder and was anxious about riding his bike. It was also noted that [redacted] had attended [redacted] schools since starting kindergarten.

The report of this evaluation includes a discussion of [redacted] trial of Ritalin in 1996. [redacted] had side effects from the Ritalin which included agitation and decreased appetite. [redacted] was taking Ritalin only on the days he attended school and was not on the medication on the day of this evaluation. When the evaluator went to school to observe [redacted], she re-administered several of the WISC – III subtests to see if he performed better when he was on Ritalin. He did perform slightly better. The evaluator stated "...it appears that his being on the Ritalin may be benefiting him in terms of his attentional capacities at school, but his being on this medication does not significantly change his intellectual capacities."

The evaluator observed that [redacted] had significant attention difficulties; he made eye contact but his affect was flat; his speech was difficult to understand; he was easily distracted and unable to focus on a task on his own. Despite these difficulties, [redacted] did appear to put forth his best effort during the testing and the results were felt to be an accurate measure of his cognitive and psychosocial function at that time. Throughout the report, [redacted] difficulties with attention are noted as affecting his performance.

[redacted] scores on the Academic / Achievement test were all in the Kindergarten and First grade range. This was in [redacted] of [redacted] second grade year. It was noted that [redacted] did not like school and was becoming increasingly frustrated. His behavior was deteriorating in school and at home.

[redacted]'s parents and teacher indicate that he is at risk for hyperactivity, anxiety, attention problems, atypicality, withdrawal and depression. [redacted] indicated that he was struggling with issues of self-esteem. On the Vineland, [redacted] scored well below age level in the domains of communication, daily living skills, socialization and motor skills. The evaluator concluded that [redacted] test results indicated mild mental retardation and Attention Deficit Disorder.

[redacted]t was evaluated on [redacted] 2000 by [redacted], M.Ed., a school psychologist. (Exhibit A – 8) Unfortunately, page two of this three page report is missing. Ms. [redacted] found [redacted] to be soft-spoke but verbal and cooperative. She opined that his cognitive functioning was similar to that in the 1996 testing but there is no information in the report that supports that opinion. She also noted [redacted].

Over a three day period in [redacted] 2001, [redacted] was again evaluated by [redacted], Ph.D. and [redacted], Ph,D. from [redacted]. (Exhibit A – 10) At the time of this evaluation, [redacted] was in a substantially separate sixth grade classroom. He had been having increasing behavioral difficulties at school and had become violent on several occasions. He had been suspended from school three times and was reported to make violent, threatening remarks to others. He pretended to [redacted] other students. He pretended to [redacted] and then said he was only kidding. He had no meaningful interaction with other students and was quite impulsive. His teacher noted a rapid deterioration in his behavior at school and that he had become very anxious, nervous, worried, impulsive, restless and overactive. [redacted] had one strange episode in school [redacted]. He also asked for help because [redacted]. [redacted] the following day and his teacher thought that he may have been reacting to over heard conversations about [redacted]. Nothing like this has happened again.

[redacted] academic testing scores were quite similar to the results of testing done in 1996. He continued to exhibit articulation difficulties, attention and concentration was consistent with a diagnosis of Attention Deficit Hyperactivity Disorder. Although he was cooperative during the

testing he had significant difficulty in behaving in a socially appropriate manner. [redacted] parents reported that he wanted to be sociable but was unable to establish peer relationships. He was often the victim of bullying. He also was described as lacking common sense and has trouble finishing activities because of his repetitious and rigid thoughts and actions. The evaluator thought that [redacted] presentation was consistent with an autistic spectrum disorder. Further evaluation by a neurologist and an occupational therapist was recommended. [redacted] was described as having [redacted] which required further exploration.

In [redacted] 2003 [redacted] was evaluated by [redacted] Psy.D. (Exhibit A – 19, D – 15) This independent evaluation was requested by Mr. and Mrs. [redacted] The evaluation included observation of [redacted] school [redacted]. The evaluator reviewed all of the past evaluations done on [redacted], his Individualized Educational Plans for 2003 and 2004 and the psychiatric evaluation done by Dr. [redacted]. After reviewing the records on [redacted], Dr. [redacted] opined "...I felt an impairment in frontally mediated pathways was certainly suggested by stimulus bound behavior, exceedingly concrete reasoning, etc. that seemed greater than that which would be expected based on his cognitive function, alone."

On the Disruptive Behavior Disorder Rating Scale the primary concern on the parental report was [redacted] episodes of loss of behavioral control and symptoms associated with Oppositional Defiant Disorder. Mrs. [redacted] reported significant behavioral difficulties in the previous year. He had been [redacted]. [redacted] tended to escalate easily. In general, his behavior was escalating. The [redacted] also reported [redacted].

[redacted] reported some awareness of having an "anger problem". He had difficulty making eye contact and throughout the assessment he demonstrated difficulty with both attention and visual tracking.

On the Weschler Intelligence Scale for Children – III [redacted] earned a Full Scale IQ score of 54. His Verbal IQ score was 64 and his Performance IQ score was 64. His highest score on a subtest (similarities) was 7. His other scores were between 1 and 4. On a test for Attention and Self-Regulation [redacted] best performance was at the six year old level. On a computerized test of attention, his performance was consistent with a diagnosis of Attention Deficit Hyperactivity Disorder. Under the highly structured test conditions, impulsivity was adequately curbed and vigilance was maintained.

[redacted] scores on tests of academic achievement fell between first and second grade. His grade equivalent scores were consistent. On the WISC – III subtests his verbal skills were consistently better than his visual-perceptual skills.

Throughout this evaluation, [redacted] exhibited anxiety. He also had features associated with a diagnosis of Pervasive Developmental Disorder but that diagnosis was not felt to best describe his presentation. Some of these features which had been reported were; [redacted] also avoided eye contact and rigidly adhered to non-functional routines.

[redacted] was also exhibiting [redacted] which were seen as being reactive to frustration rather than spontaneous. [redacted] disruptive behavior met the

criteria for Oppositional Defiant Disorder. Overall, [redacted] scores placed him the mentally retarded range.

Dr[redacted] made a number of recommendations for educational and behavioral interventions to be incorporated into [redacted] educational plan. [redacted] was scheduled to start at [redacted] in [redacted] 2004. [redacted] is designed for students with [redacted]. [redacted] was placed there in the hope of getting his behavior under better control.

In [redacted] 2004, Dr. [redacted] observed [redacted] in his educational program at [redacted]. He continued to exhibit difficulty sustaining attention, even with one to one interaction and explicit cues for attention. The primary goal of [redacted] placement was to develop an effective behavior management program. The staff had noted that [redacted] responded to humor and that he appeared to experience significant anxiety. He also continued to experience severe difficulty with sustained attention and experienced significant distraction from internal stimuli. [redacted] attendance was also a concern. He had been absent [redacted] school days. [redacted] of these absences were due to [redacted]. A secondary goal for [redacted] was medication management of his attention problems and his anxiety which was thought to contribute to refusal to participate in educational activities at times. Incorporating [redacted] educational program was another goal.

[redacted] first evaluation done by a psychiatrist includes the information that [redacted] did not have hallucinations or delusions. (Exhibit A – 16, A – 20) [redacted] was fourteen years old at the time of this evaluation. At this time, [redacted] parents identified school as the major stressor in [redacted] life. The psychiatrist also states that [redacted]s rage and angry outbursts appear to be secondary to frustration and not without antecedent.

In [redacted] 2003, [redacted] was evaluated by Dr. [redacted], a psychiatrist with the [redacted] which provides the [redacted] at [redacted]. (Exhibit A – 16) The initial evaluation was done prior to [redacted] attending [redacted] and a re-evaluation was done in [redacted] 2003 after [redacted] was attending [redacted]. Dr. [redacted] interviewed [redacted], his parents, and his adjustment counselor and his classroom teacher. Mr. and Mrs. [redacted] reported that [redacted] was very stressed by school. He was also envious of the things his siblings could do that he could not. Parents also reported that [redacted] was a "late bloomer" and was significantly late in learning to walk and talk.

Dr. [redacted] noted that [redacted] was taking Nortriptyline at the time of the evaluation. He noted that [redacted] had had a trial of Ritalin but had unacceptable weight loss on that medication. His attention span and behavior may have improved on Ritalin. When treated with [redacted] experienced severe deterioration of behavior and explosive outbursts that resolved when the medication was discontinued.

Dr. [redacted] assessed [redacted] as not being at risk for harming himself or others. He noted that [redacted] had mental retardation and sensory integration problems. He found that [redacted] was not motivated to perform in school because he saw little chance of esteem enhancing experiences there. Dr. [redacted] also noted that [redacted] had a sense of humor, a creative streak and the capacity for remorse. While Dr. [redacted] noted that [redacted] had mood instability, disruptive behavior and outbursts of rage, he felt that [redacted] outbursts of rage were generally reactive to frustration. [redacted]s prevailing mood was not significantly depressed, manic or irritable. His rage appeared to be reactive rather than spontaneous. He noted that [redacted] did have significant anxiety and was relatively compulsive and easily overwhelmed.

Dr. [redacted] diagnoses were Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Mood Disorder NOS, Anxiety Disorder NOS and Mild Mental Retardation. In both evaluations, Dr. [redacted] noted that [redacted] did not experience hallucinations or delusions. In the [redacted] evaluation, Dr. [redacted] noted that [redacted] was exhibiting an escalating pattern of disruptive and dangerous behavior. At that time, [redacted] was diagnosed as having a Mood Disorder NOS (excessive mood instability and reactivity without clear signs of mania), Anxiety Disorder NOS, Attention Deficit Hyperactivity Disorder and Mild to Moderate Mental Retardation.

Three Discharge Summaries from psychiatric hospitalizations were submitted into evidence. The first is a one page document from [redacted]. (Exhibit A – 22) The admission date is [redacted] 2005 and the Discharge date is blank although the Discharge Summary is dated [redacted] 2005. The Discharge Diagnosis is Psychotic Disorder NOS, R/O Schizophrenaform, Moderate Mental Retardation, and GERD. The summary describes [redacted] as being floridly psychotic for most of the [redacted] weeks of his hospitalization. His medications were adjusted and he stabilized and was discharged. This is the first time that [redacted] was described as being psychotic. Unfortunately, the one page document does not elaborate on [redacted] symptoms.

The next, is a Discharge Summary from [redacted]. (Exhibit A – 26) The dates of admission are from [redacted]06 to [redacted]06. The "Reason for Admission" states 17 y.o. adolescent Caucasian male, 1st/2nd grade level, on SPED, with MR, autism, multiple psych hospitalizations, on psych meds, with long history of depression, psychosis, moodiness/irritability/agitation, suicidal behavior, now admitted for dangerousness/suicidality." [redacted] diagnosis is listed as Mood Disorder, ADHD r/o Bipolar Disorder, Pervasive Developmental Disorder, mental retardation. There is no indication that [redacted] suffered from any psychosis during this hospitalization.

The third is a Discharge Summary from [redacted]. (Exhibit A – 28) The admission date is [redacted]06 and the discharge date [redacted]06. The document is unreadable. The discharge diagnosis is schizophrenia disorganized type. The rest of the diagnosis is unreadable. A diagnosis of schizophrenia infers a psychotic process but there is no other information.

[redacted] most recent evaluation was done on [redacted] 2008. (Exhibit A – 31, D – 16) This evaluation was done by [redacted], a certified school psychologist. On the WAIS – III [redacted] earned a Full Scale IQ score of 58, a Verbal IQ score of 63 and a Performance IQ score of 58. [redacted] was described as being cooperative during the testing. The evaluator also noted that [redacted] was impulsive, sometimes frustrated and guessed randomly at questions. He was not able to sustain attention to tasks without prompting and extensive support.

SUMMARY OF THE EVIDENCE PRESENTED

[redacted] is a now twenty-one year old man who is currently a [redacted]. He has been provided with special educational services since kindergarten. [redacted] has been in substantially separate programs through the [redacted] through the [redacted] in [redacted] and the [redacted] in [redacted]. Until his recent admission to [redacted], he had lived at home with his parents and siblings. In [redacted] 2008, [redacted] parents obtained guardianship over him. The Guardianship was granted on the basis of Mental Illness and a monitor was appointed to review and supervise the use of antipsychotic medications.

Dr. Frederick Johnson was qualified as an expert witness and testified as such at the Hearing. Dr. Johnson's interpretation of [redacted] I.Q. score of 90 at the age of four and subsequent lower scores begining at age seven [redacted] were the result of [redacted] mental illness and behavioral problems interfering with his demonstrating his true cognitive abilities. Dr. Johnson testified that [redacted] appeared to suffer from a mental illness similar to early onset childhood schizophrenia. Dr. Johnson is an expert in interpreting historical information, such as evaluations, of applicants for Department of Developmental Services' supports. Between ages four and seven [redacted] I.Q. scores dropped thirty points. When [redacted] was tested at age seven years [redacted], the evaluator noted "There were many significant factors that interfered with his performance, i.e., attentional problems, high activity, distractibility and impulsivity....." (Exhibit A – 5) [redacted] had also suffered [redacted] between age four and age seven years [redacted].

Dr. Johnson's opinion is consistent with the evidence presented and I find his testimony creditable and compelling. The evidence shows that [redacted] intellectual functioning was adversely affected by an emotional illness that began between four and seven years of age.

FINDINGS AND CONCLUSIONS

In order to be eligible for DDS 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, 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.

The applicable definitions are set out in 115 CMR 2.01.

> Mental Retardation means significantly sub-average intellectual functioning existing concurrently and related to significant limitations in adaptive functioning. Mental retardation manifests before age 18. A person with mental retardation may be considered to be mentally ill as defined in 104 CMR (Department of Mental Health), provided that no person with mental retardation shall be considered to be mentally ill solely by reason of his or her mental retardation.
>
> Significantly Sub-average Intellectual Functioning means an intelligence test score that is indicated by a score of 70 or below as determined from the findings of assessment using valid and comprehensive, individual measures of intelligence that are administered in standardized formats and interpreted by qualified practitioners.

After a careful review of all the evidence presented, I find that:

1[redacted] is not a person with mental retardation as defined above. He has had IQ scores in the mentally retarded range but his intellectual functioning is and has been since at least seven years of age, adversely affected by his emotional and mental health issues.

2. When tested at the age of four, [redacted] was described as cooperative, enthusiastic, attended well and responded well to positive reinforcement. By the age of seven years [redacted] he was highly distractible, impulsive, could only attend for brief periods of time and talked constantly throughout the evaluation.

3. As [redacted] mental health and behavioral issues worsened, his intellectual abilities declined as well. He became violent, injured other people and was repeatedly suspended from school. By the age of fourteen, he required psychiatric hospitalization.

CONCLUSION

I find that [redacted] has not shown by the preponderance of the evidence that he is a person with mental retardation as set out in 115 CMR 2.01. He is therefore, not eligible for supports from the Department of Developmental Services. 115 CMR 6.04.

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:_____

_____
Sara Mackiernan
Hearing Officer