2010-11

The Commonwealth of Massachusetts
Executive Office of Health & Human Services
Department of Developmental Services
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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 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 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: Elizabeth Silver, Hearing Officer
Terry O'Hare, Regional Director
Marianne Meacham, General Counsel
Patricia Oney, Assistant General Counsel
Damien Arthur, Regional Eligibility Manager
Bradley Crenshaw, Psychologist
File

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF DEVELOPMENTAL SERVICES

In Re: Appeal of [redacted]

This decision is issued pursuant to MGL Chapter 30A and the regulations promulgated thereto, 115 CMR 6.00 *et. seq.* A fair hearing was held on [redacted], 2010, at the DDS [redacted] in [redacted], MA.

Those present and participating at the hearing:

[redacted]	Appellant
	Father of Appellant
	Mother of Appellant
	Clinician, [redacted] School
Yolanda Claudio	Social Worker – DCF
Bradley Crenshaw	Psychologist for DDS
Patricia Oney	Attorney for DDS

At the hearing, the Department submitted Exhibits 1-11. The hearing lasted approximately one and a half hours. [redacted], [redacted], [redacted], and Yolanda Claudio testified on behalf of the Appellant, and Dr. Crenshaw testified on behalf of the Department.

ISSUE PRESENTED:

The issue for this hearing is whether the Appellant, [redacted]. meets the Department's definition of mental retardation and is thereby eligible for DDS services.

SUMMARY OF THE EVIDENCE

Exhibit 1. Package of correspondence between the Department and the Appellant's family, including the Appellant's Application for DMR[1] Eligibility dated [redacted]/09; Department's [redacted]/09 letter denying DDS eligibility; the Appellant's [redacted]/09 appeal of the denial; [redacted]/09 notice of informal conference, informal conference report dated [redacted]/09 upholding the denial of eligibility, and [redacted]/09 letter post-informal conference confirming denial of eligibility; Appellant's request and Department's [redacted]/09 letter confirming receipt of request for a fair hearing; [redacted]/09 Notice of Fair Hearing; and [redacted]/09 reminder of fair hearing.

Exhibit 2. Eligibility Report prepared by Brad Crenshaw dated [redacted]/09. Dr. Crenshaw reviewed the Appellant's current diagnoses and cognitive testing from 2003 to 2009, as well as the adaptive assessments in the record. Dr. Crenshaw concluded that the Appellant's adaptive functioning was above the Department's cut-off and his cognitive functioning did not indicate global intellectual suppression but was commensurate with a verbal learning disability. Dr. Crenshaw attached a page with a list of cognitive test scores.

Exhibits 3 & 4. Psycho-Educational Evaluation dated [redacted]/03 when the Appellant was 11[redacted] years old and in the 4th grade. Some pages of this exhibit are missing, but the cognitive testing scores were reported in Exhibit 4.

[1] On June 30, 2009, the Department changed its name from the Department of Mental Retardation (DMR) to the Department of Developmental Services. I will refer to the Department's new name in this decision.

At the time of the evaluation in Exhibit 3, the Appellant was participating in the [redacted] classroom because of severely depressed skills in communication, daily living, and socialization. He had been held back in the 1st and 2nd grades.

The Appellant had previously been diagnosed with Pervasive Developmental Disorder, NOS (PDD), Tourette's Syndrome, Oppositional Defiant Disorder (ODD), and Attention Deficit Hyperactivity Disorder (ADHD). In addition, he had had meningitis and seizures, along with developmental delays.

Previous cognitive functioning from 2000 placed the Appellant's overall functioning in the borderline range. On the Peabody Individual Achievement Test-Revised (PIAT-R), the Appellant showed to be performing four years below age level and three years below grade level. As reported in Exhibit 4, he was administered the Wechsler Abbreviated Scale of Intelligence (WASI) and was found to have had borderline verbal abilities and average performance abilities indicating the potential presence of a language based disability.

The summary in Exhibit 3 indicated that the Appellant's overall intellectual ability was within the low average range, but there was a clinically significant discrepancy between his verbal and non-verbal abilities indicating a language-based disability. This summary advised caution when interpreting the Appellant's full-scale IQ (which was not reported in Exhibit 4).

Exhibit 4[2] is a Psychoeducational Evaluation done by [redacted], M.Ed, CAGS, Licensed School Psychologist, on [redacted]/06 when the Appellant was 14[redacted] years old and in the 7th grade at the [redacted] School in [redacted]. The Appellant was referred to determine eligibility for special education services. Prior to this time the Appellant had been in an inclusion classroom with special education services for a variety of subjects. He exhibited both neurological and communication disabilities. It was noted that the Appellant's math skills were much more developed than his verbal skills.

Mr. [redacted] administered the Wechsler Intelligence Scale for Children-Fourth Edition (WISC-IV). The Appellant's Index scores were: Verbal Comprehension (VCI) 59, Perceptual Reasoning (PRI) 79, Working Memory (WMI) 54, Processing Speed (PSI) 53, and Full Scale IQ 54. It was again noted that the Appellant's nonverbal reasoning abilities were much better developed than his verbal reasoning abilities. His VCI, WMI, and PSI were in the Extremely Low Range, and the PRI was in the in the Borderline range.

The Appellant's overall cognitive ability could not be easily summarized because of the difference between the verbal and nonverbal reasoning abilities, which were in the Extremely Low range and the Borderline range, respectively. The examiner indicated that overall abilities were found to be within the Extremely Low Range, but this score needed to be viewed with extreme caution because of the statistically significant discrepancy between the VCI and PRI. As a result of this discrepancy, the examiner said the Appellant appeared to meet the criteria for a language-based disability.

Exhibit 5. Psychological Evaluation done on [redacted]/06 by [redacted], Ph.D, Licensed Psychologist, when the Appellant was 15[redacted] years old. The Appellant was referred for evaluation to clarify his diagnoses, assess overall personality functioning, and to obtain recommendations for treatment and case management.

This evaluation provided additional background information that indicated that the Department of Social Services became involved with the Appellant's family in 1992. It also noted that the Appellant had been resistant to attending school because of teasing and also because he was hearing voices. He was supposed

[2] There may be pages missing from this Exhibit as well. We numbered the pages at the hearing, but it has become apparent upon review that they were in the wrong order. Once I rearranged them into what appears to be the correct order, it went from 4A, Cognitive, to a different typeface, and then to the Conclusion. It is unclear if there is supposed to be a "B" section.

to have a tutor but that had not occurred. With the exception of PDD, this report lists the same diagnoses as those noted in Exhibit 3. The Appellant was taking Abilify Guanfacine, and Trileptal.

Dr. [redacted] administered several tests including the WISC-IV, the same test the Appellant had taken a little more than six months previously. The Index scores from this testing were VCI 61, PRI 82, WMI 71, PSI 68, and FSIQ 63. The Full Scale IQ placed the Appellant in the Extremely Low range. Three of the four Index scores were consistent with each other (VCI, WMI, and PSI), all of which were in the Borderline or Extremely Low range. The WMI and PSI demonstrated significant intersubtest scatter, making the overall numerical score in these domains less reliable. The Appellant performed better on visuo-spatial functioning, but there was intersubtest scatter here as well.

Because of the presence of intertest scatter, the Appellant's WISC-IV profile was idiosyncratic. He demonstrated significant verbal comprehension deficits. The examiner said it was more difficult to make generalized statements about the Appellant's nonverbal functioning. He demonstrated average functioning in two of three perceptual reasoning tasks, with the third subtest significantly lowered. PSI subtests were also variable.

Dr. [redacted]'s Diagnostic Impressions on Axis I were Tourette's Disorder (with obsessive-compulsive behaviors), ADHD, Oppositional Defiant Disorder, Depressive Disorder NOS, and R/O Psychotic Disorder NOS. His Axis II diagnosis was Mild Mental Retardation.

Attached to this Exhibit is a [redacted]/06 Woodcock-Johnson III Tests of Achievement (W-J III) administered when the Appellant was 14[redacted] years old and in grade 7.8. Standard Scores based on age were Basic Reading Skills 52, Academic Skills 61, Academic Apps 62, and Academic Knowledge 69. Scores based on grade were Basic Reading Skills 55, Academic Skills 65, Academic Apps 69, and Academic Knowledge 77.

Exhibit 6. Psychological Evaluation again administered by [redacted], Ph.D. on [redacted]/09 when the Appellant was 18[redacted] months old. The Appellant was residing at the [redacted] School and was referred again for clarification of his diagnoses, assessment of his overall personality functioning and to provide treatment and case management recommendations.

Dr. [redacted] administered the Wechsler Adult Intelligence Scale-IV (WAIS-IV). Testing was presumed valid and reflective of the Appellant's functioning. Index scores were VCI 74, PRI 90, WMI 71, PSI 76, and Full Scale IQ 74, which placed the Appellant in the Below Average range. The pattern of the Appellant's scores was similar to the results in 2006, although the scores on the WAIS were higher in some cases. He had consistent scores in the below average range in three composite scores, and on the fourth, PRI, the Appellant scored in the average range.

As the difference between the Appellant's highest and lowest composite scores was 19 points, which was within 1.5 standard deviations, Dr. [redacted] believed the Appellant's Full Scale IQ score was a reliable estimate of overall cognitive functioning. Despite being statistically consistent, Dr. [redacted] said the Appellant's profile was anomalous. Given his limited social skills, a silly demeanor and immaturity, and a speech impediment, the Appellant's verbal presentation was of someone with significant social and adaptive challenges, despite his abilities in perceptual reasoning.

Dr. [redacted] had the [redacted] clinician complete the Devereux Scale of Mental Disorders. Item endorsements on the Depression subscale of the DSMD included social isolation, awkwardness, difficulty in keeping friends, appearing unemotional and feeling victimized. In Dr. [redacted]'s discussion of Projective Testing and Psychological Functioning, he noted that the Appellant's adaptive liabilities are longstanding in nature, and, given his history, there appeared to be little to suggest that such deficits would not exist throughout his lifetime.

Dr. [redacted]'s Diagnostic Impressions on Axis I were Tourette's Disorder, ADHD, Mood Disorder NOS, and Psychotic Disorder NOS. His Axis II diagnosis was Borderline Intellectual Functioning in most areas.

Exhibit 7. Psycho-Educational Report dated [redacted]/09 done by [redacted], School Psychologist, CAGS, when the Appellant was 18[redacted] years old and in the 12th grade at [redacted] School. The Appellant was referred for a reevaluation for planning for his future. During testing he was reasonably engaged, very cooperative, and had excellent attention and task persistency.

Mr. [redacted] administered four subtests from the Wechsler Abbreviated Scale of Intelligence (WASI). The Appellant had a full scale score of 87, which placed him in the average range, a verbal score of 74, which was in the below average range, and a performance score of 106, which was in the average range. The 32 point difference between the verbal and performance scores was highly suggestive of a language based disability.

Both the Appellant and a teacher rated the Appellant on the Behavior Assessment System for Children, Second Edition (BASC-2). On the self-report, Composite T Scores[3] were School Problems 65, Internalizing Problems 62, Inattention/Hyperactivity 63, Emotional symptom Index 57, and Personal Adjustment 53. In the Teacher Report, Composite T Scores were Externalizing Problems 63, internalizing Problems 48, School Problems 50, Behavioral Symptom Index 60, and Adaptive Skills 44.

In his conclusion, Mr. [redacted] said that it would not be appropriate to describe the Appellant as mildly mentally retarded as he demonstrated high average non-verbal reasoning with average non-verbal memory within the context of much weaker language skills including memory, reasoning, concept formation, and speech. This evaluation was consistent with but showed significant improvement from prior assessments. Mr. [redacted] confirmed that the Appellant had a language based disability that impacts the Appellant's educational, social and emotional functioning.

Exhibit 8. Two Vineland Adaptive Behavior Scales. The first is dated [redacted]/06 when the Appellant was 14[redacted] years old. The Appellant's scores were Communication 41, Daily Living Skills 69, Socialization 62, and Adaptive Behavior Composite 53. All of these scores showed a low level of adaptive functioning.

On the second Vineland-II, dated 7/24/09, the Appellant's mother was the rater. The Appellant was 18 years old and in the 10th grade. His scores were Communication 81, Daily Living Skills 79, Socialization 74, Motor Skills (Est) 78, and Adaptive Behavior Composite 75. All of the scores were Moderately Low, however, the examiner, [redacted] attached a hand-written note that stated: " . . . the results may indicate a higher level of functioning due to the fact that [redacted] School is so structured that [the Appellant] functions well in this environment but he may not do quite as well when at home in a less structured environment."

Exhibit 9. Academic Evaluation in which the Peabody Individual Achievement Test-Revised (PIAT-R) was administered to the Appellant on [redacted]/03 when he was 11[redacted] years old. The total Test Score age equivalent was 7 years [redacted] and grade equivalent was 1.7.

Exhibit 10. This exhibit includes two separate Woodcock Johnson III Tests of Achievement, administered on [redacted]/08 when the Appellant was 17.4 years old, and on [redacted]/09 when the Appellant was 18[redacted] years old. In both cases the Appellant's academic skills were within the very low range of others at his age level.

[3] According to Mr. [redacted], scale scores in the Clinically Significant range (70 and above) suggest a high level of maladjustment, and scores in the At-Risk range (65 to 69) may identify a significant problem that may not be severe enough to require formal treatment or may identify the potential of developing a problem that needs careful monitoring.

Compared to others his own age, in the 2008 testing the Appellant's performance was low average in math and math calculation skills, and very low in broad reading and basic reading skills. In the 2009 testing, the Appellant's performance was average in math and math calculation skills, and very low in broad reading and basic reading skills. Standard scores in 2008 were: Broad Reading 66, Broad Math 87, Basic Reading Skills 62, Math Calculation Skills 83, and Academic Skills 60.

In 2009, the Appellant's standard scores were Broad Reading 61, Broad Math 94, Basic Reading Skills 63, Math Calculation Skills 95, and Academic Skills 63.

Exhibit 11. IEP covering [redacted]/08 – [redacted]/09.

TESTIMONY

Exhibits 1-11 were entered into the record. Yolanda Claudio and [redacted] agreed to be the spokespeople for the Appellant. [redacted] and [redacted], [redacted], Yolanda Claudio, and Bradley Crenshaw were sworn in. Opening statements were waived.

The Appellant was present throughout the hearing. He displayed some of the behaviors discussed by some of the examiners including giggling, immaturity/silliness (intentionally raising the wrong hand to be sworn in, then refusing to raise the correct hand) and moved around the room going up close to then away from various individuals. He walked around the room for the duration of the hearing and interjected comments and noises that sometimes related and sometimes did not relate to the hearing. As noted by his witnesses, this behavior is typical when the Appellant is nervous or anxious about a situation, in this case the hearing.

Before the Appellant's witnesses began their testimony, Dr. Crenshaw reviewed the Department's regulatory criteria.

Mrs. [redacted] testified first for the Appellant. The Appellant's birthday is [redacted], 1991. He grew up in [redacted]. She said the Appellant had meningitis when he was three weeks old. He had seizures as a toddler that he has since outgrown. His milestones were delayed. For pre-school he attended the toddler group of the [redacted] Developmental Services. He attended regular public schools in [redacted] and received special classes. When he 11 he was in the [redacted], which was a separate classroom. He attended the [redacted] School for nine years. At age 14 the Appellant went to [redacted], but that school didn't work out because he had been placed inappropriately in a problem behavior class. The Appellant constantly skipped school. That was when the [redacted]'s asked DCF for assistance. A tutor was supposed to come to the home for a couple of hours each day until they could find an appropriate placement for the Appellant. After assaulting a police officer, the Appellant was voluntarily signed in to the [redacted] School to avoid juvenile hall.

[redacted] is a small residential school that has seven dorms. The Appellant is in a dorm for regular students (as opposed to vocational, pre-vocational, and independent student dorms.) [redacted], a clinician at [redacted], testified that the Appellant is in the Pervasive Developmental group. She said he is probably one of the best behaved students they have. He has been in [redacted] for a little more than three years.

Mrs. [redacted] testified regarding the Appellant's adaptive behavior. She said he gets silly in social settings when he gets nervous. His hands shake and he gets giggly. He had a few friends from school. He has to be reminded to take care of his hygiene including brushing his teeth, taking showers, and changing his clothes.

Mr. [redacted] testified that when the Appellant was home he would be off somewhere in the house playing video games, but then without provocation he would explode when people in another room were talking. He said there were times the Appellant would fly off the handle and attack family members. As he

was getting bigger and stronger, the [redacted]'s called in DCF for help and filed a CHINS petition on the Appellant because of school truancy. More recently, Mr. [redacted] said the Appellant can get frustrated but has learned to control his temper somewhat. Mr. [redacted] also said his concern was for his family's safety as well as the Appellant's safety if the Appellant comes back home to live after he graduates. There are two other children in the home, aged 20 and 17.

Yolanda Claudio from DCF testified for the Appellant. She has been the social worker working with the family based upon the Appellant's issues. DCF does monthly home visits, assesses services the family needs, and provides referrals. She said the [redacted]'s initially reached out to DCF for help with the Appellant's truancy issues, and also because his aggression towards his mother and brother had escalated at home. After many meetings, it was decided that the Appellant needed a residential educational setting, and he was referred to the [redacted] School. Ms. Claudio said the Appellant has worked really hard to improve.

Ms. Claudio and Ms. [redacted] both raised the argument that the Appellant had undergone testing numerous times, and therefore exposure to and familiarity with testing would have accounted for the improvement in his scores.[4]

[redacted] also testified regarding the Appellant's adaptive functioning. She said that he cannot manage money, cooking, housekeeping or any independent living activities. She said the Appellant struggles with communication and has barely passing social skills. He has difficulty grasping proper social etiquette and learning what behaviors he needs to get along. She said it is hard for the Appellant to develop friendships. He's been at [redacted] for three years and can only name one person he says is a friend. He is gruff with people, which is consistent with the PDD diagnosis. The Appellant is good with hygiene only because he takes redirection well. He will always be in a situation where he will need assistance not only for adult daily living skills, but also for help in taking medications. He takes anti-psychotic medications that he will likely need for the rest of his life, and Ms. [redacted] cannot see him managing this on his own.

While [redacted] does not have a full vocational program, Ms. [redacted] said it does have a pre-vocational program called [redacted]. It teaches students how to manage a checkbook, cook meals, shop, and how to manage hygiene. They are considering transferring the Appellant to this pre-vocational program.

Ms. [redacted] discussed the typical day at [redacted] for the Appellant, which involves a highly structured mix of daily activities and academics. She described classroom settings and a regimented organization in programming that provides a stimulating environment with 24/7 staffing. There is an eight person clinical team with each person in the team responsible for 10 students. She also described the school's efforts to bring families to the school to participate in activities.

Dr. Bradley Crenshaw testified on behalf of the Department. He was qualified as an expert witness.

Dr. Crenshaw first reviewed Exhibit 3. He noted that the test results from the missing page in this exhibit were reported in Exhibit 4. Taken together, exhibits 3 and 4 report the first testing on record, which was done in 2003. The Wechsler Abbreviated Scale of Intelligence (WASI) was administered to the Appellant. Dr. Crenshaw reported that the results of the WASI showed that the Appellant was average in his visual spatial processing and in the borderline range of verbal processing, indicating the potential presence of a language based disability. He said the psychologist observed a split that was to become characteristic for the Appellant throughout his testing history in which he has higher development in visual spatial processing as compared to verbal linguistic processing. Dr. Crenshaw said that split is characteristic of a verbal learning disability.

[4] Dr. Crenshaw responded to this argument during his testimony. See, *infra*, pp 7-8.

In Exhibit 4, dated [redacted] 2006, the Appellant was 14[redacted] years old. He was given the WISC-IV. Dr. Crenshaw reported the Appellant's Index scores of 59 on Verbal Comprehension (VCI), 79 on Perceptual Reasoning (PRI), 54 on Working Memory (WMI), and 53 on Processing Speed (PSI). His Full Scale IQ was 54.

Dr. Crenshaw said the results of the WISC-IV show the same split as seen on the WASI, but with the WISC-IV it was possible to determine if the split was meaningful or not, that is, whether the split in scores is attributable to every day variance or whether there is a true disparity in skills. In the Appellant's case, he said there is a true disparity between skills. Thus, the full scale score is not representative of overall ability and one must look to the factor scores instead. For the Appellant, there are some areas in which he has pronounced abilities (spatial) and in other areas very pronounced disabilities (verbal).

Dr. Crenshaw next reviewed Exhibit 5. This evaluation included another WISC-IV, this one administered on [redacted] 2006, just over six months after the last one. According to Dr. Crenshaw, the timing was too soon, since normally there should be a minimum of a year between repeating the same test so as to avoid practice effects. Dr. Crenshaw said it was possible the results of the second WISC-IV showed a practice effect, but the place where it was actually seen was in attention and processing speed, not on the cognitive side. Dr. Crenshaw explained that some of the challenge of a test is its novelty, designed to require a person to do something with which he has not had any educational practice. When the test is no longer novel, it is possible to see improvement the second time around. In fact, the Appellant's scores relating to the speed with which he took the test did improve, perhaps because he had some memory of the test from six months earlier. Thus, Dr. Crenshaw believed the changes seen in the WMI (54 in [redacted], 71 in [redacted]) and the PSI (53 in [redacted], 68 in [redacted]) showed the vulnerability of those areas to the practice effect.

However, Dr. Crenshaw noted that the close proximity between the two tests did not affect the Appellant's intellectual test results in that the same 21-point difference between visual and verbal processing existed in both tests (PRI: 79 in [redacted], 82 in [redacted], VCI: 59 in [redacted], 61 in [redacted]). Thus, Dr. Crenshaw said he was confident the Appellant's mental processing was not uniform but instead was a mixed bag of particular deficits and particular intellectual skills. But because the intellectual scores between the two tests were similar, Dr. Crenshaw considered the results of the second WISC-IV valid.

In Exhibit 6, Dr. Crenshaw reviewed the results of the WAIS-IV given to the Appellant on [redacted] 2009 when he was 18[redacted] years old. Dr. Crenshaw said the same characteristic split that was seen before is apparent in this testing as well. The Appellant had a PRI score of 90 while the VCI score was 74. The full scale score was 74.

Dr. Crenshaw noted that the full scale score, which was above the Department's criteria anyway, would not represent the Appellant's intellectual functioning as a whole. Dr. Crenshaw noted that the Appellant was within average limits in his visual spatial processing and borderline in his verbal processing. There was some narrowing between the disparities but the 16 point split was still extremely significant. Dr. Crenshaw interpreted the split as providing increased confidence that the Appellant did not match Department eligibility criteria because he has intellectual skills within the average range. Dr. Crenshaw noted that testing of the Appellant started at about the age of 12, and his scores have improved over time. He said the improvement was not attributable to the practice effect but to the Appellant's continued neurological growth.

Dr. Crenshaw reviewed the last testing in Exhibit 7, done within days of the testing in Exhibit 6. The Appellant was given a WASI, which uses the same Wechsler scales as are in the WAIS-IV and so was given too close in time to the prior testing. Since the WASI uses the same tests as WAIS-IV, just not all of them, Dr. Crenshaw acknowledged that there would be a practice effect in giving the tests so close in time. However, Dr. Crenshaw also said that the practice effect would be most noticeable for someone with normal

intellectual abilities rather than someone with lower than average intellectual abilities. Even with a practice effect the Appellant did not max out the tests. He had been within average limits in his performance scores on the WAIS (90) and he stayed within average limits in his performance score on the WASI (106). On the verbal tests, the Appellant had the same score of 74 on both the WAIS and the WASI, both in the borderline range. Dr. Crenshaw said there was probably some practice effect on the performance, which is where the Appellant has the most skills.

Dr. Crenshaw again noted the same pattern in which the Appellant's performance side was notably superior to the verbal side. From the beginning, the Appellant has shown a pattern of suppressed verbal skills relative to other talents, which Dr. Crenshaw noted were within average limits. In conclusion, Dr. Crenshaw said he did not think the Appellant met DDS eligibility criteria because he has pronounced intellectual skills. This is not to say he does not have significant difficulties intellectually as well, but they are not global.

Dr. Crenshaw also testified that he believed the Appellant did not meet the Department's adaptive functioning requirements. He only reviewed the 2009 Vineland[5], which scores were Communication 81, Daily living skills 79, Socialization 74, Motor 78, and Adaptive Behavior Composite 75. Dr. Crenshaw noted that these scores were above the DDS threshold.

FINDINGS AND CONCLUSIONS

The Law

M.G.L c. 123B §1 defines a mentally retarded person as follows:

[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.

A mentally retarded person may be considered mentally ill provided that no mentally retarded person shall be considered mentally ill solely by virtue of his mental retardation.

115 CMR 6.04 sets forth the general eligibility requirements for DDS services. In relevant part these provide:

> (1) Persons who are 18 years of age or older are eligible for supports provided, purchased, or arranged by the Department if the person:
> (a) is domiciled in the Commonwealth; and
> (b) is a person with mental retardation as defined in 115 CMR 2.01. . . .

115 CMR 2.01 provides the following definitions:

Mental Retardation

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

[5] Dr. Crenshaw said the 2006 Vineland only gave age equivalents, although as noted above, there are standard scores reported. See, Exhibit 8.

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

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.

Significant Limitations in Adaptive Functioning

An overall composite adaptive functioning limitation that is two standard deviations below the mean or adaptive functioning limitations in two out of three domains at 1.5 standard deviations below the mean of the appropriate norming sample determined from the findings of assessment using a comprehensive, standardized measure of adaptive behavior, interpreted by a qualified practitioner. The domains of adaptive functioning that are assessed shall be:

(a) areas of independent living/practical skills;
(b) cognitive, communication and academic/conceptual skills; and
(c) social competence/social skills.

115 CMR 6.34 sets the standard and burden of proof. In relevant part these provide:

(1) - Standard of Proof. The standard of proof on all issues shall be a preponderance of the evidence.
(2) - Burden of Proof. The burden of proof shall be on the appellant . . . .

Findings of Fact and Conclusions of Law

The issue in this case is whether the Appellant meets the Department's definition of mental retardation. He applied for DDS services on [redacted], 2009. Born [redacted] 1991, the Appellant is 18 years old. He meets the domicile requirement of the Department. For the reasons set forth below, I find that the Appellant does not meet the Department's definition of mental retardation.

When he was just a few weeks old the Appellant had meningitis and as a toddler he had seizures, which he has since outgrown. He had developmental delays and as a pre-schooler attended the [redacted] Developmental Services. He was held back in the 1st and 2nd grades. He received special education services throughout his schooling. At the age of 11 he was participating in the [redacted] program because of severely depressed skills in communication, daily living, and socialization. He attended the [redacted] School for nine years and then went to the [redacted] School. Because of teasing and also because he was hearing voices, the Appellant began skipping school. The Appellant also was getting bigger and more aggressive towards family members. These events led to the family's involvement with DSS and eventually the Appellant's residential placement at the [redacted] School where he continues to reside and attend school.

Previous to age 11 the Appellant was diagnosed with Pervasive Developmental Disorder, NOS (PDD), Tourette's Syndrome, Oppositional Defiant Disorder (ODD), and Attention Deficit Hyperactivity Disorder (ADHD). Those diagnoses remain current, although PDD has not shown up in a more recent list of diagnoses.

Adaptive Functioning

With respect to adaptive functioning, several of the witnesses testified to the Appellant's limitations in adaptive functioning in different domains. [redacted], the clinician from [redacted], credibly testified that the Appellant was not able to manage any activities of daily living independently. She testified that he cannot manage money, cook, or do housekeeping. The Appellant's mother credibly testified that he must be reminded to take care of his hygiene, including brushing his teeth, taking showers, and changing his clothes. [redacted] said the only reason the Appellant did well with hygiene at [redacted] was because he takes redirection well and they have a highly structured routine in which these activities are required and monitored. In Exhibit 3, the earliest exhibit in the record, it was noted that at the age of 11 the Appellant had severely depressed skills in communication, daily living, and socialization. All of the Appellant's witnesses and many of the exhibits described the Appellant's behavior as having the nature of being silly, immature, and giggly. These behaviors were evident during the hearing. As a consequence, the Appellant has great difficulty socially, and by all accounts has few, if any, friends.

There are two Vinelands in the record, one from 2006 and the other from 2009. The Appellant's scores were as follows:

Year/Age	Exhibit	ABC	Communication	Daily Living	Socialization	Motor
2. 2006 (14[redacted])	8	53	41	69	62	
3. 2009 (18[redacted])	8	75	81	79	74	78

The scores from 2006 meet the Department's eligibility threshold but the 2009 scores exceed that threshold. In reaching a finding as to the Appellant's adaptive behavior, I note Dr. Crenshaw's explanation that behaviors, unlike intellect, can change from week to week. Thus, I consider these scores in light of that possibility of transience. Mr. [redacted], the examiner for the 2009 Vineland, included a hand-written note admonishing that " . . . the results may indicate a higher level of functioning due to the fact that [redacted] School is so structured that [the Appellant] functions well in this environment but he may not do quite as well when at home in a less structured environment."

The Appellant's parents and witnesses all testified credibly in some manner to the fact that the Appellant was incapable of living independently and caring for himself, and that his adaptive behaviors were significantly limited. Just a few months ago Dr. [redacted] noted that the Appellant's adaptive liabilities were longstanding in nature, and given his history, there appeared to be little to suggest that these deficits will not exist throughout the Appellant's lifetime (Exh 6). Indeed, from the limited observation of the Appellant during the hearing, I find the testimony of [redacted] particularly compelling, as over the last few years she has probably had the most contact with the Appellant on a day-to-day basis of any of the witnesses. Her testimony confirmed Mr. [redacted]'s assessment that the 2009 scores are likely inflated.

Based on my observation of the Appellant, the testimony of the witnesses, the results of the 2006 and 2009 Vineland with [redacted]'s caveat, and the statement from Dr. [redacted], I am persuaded that the Appellant has significant limitations in adaptive functioning within the meaning of the Department's definition.

Given these limitations, the next question is whether they are related to and exist concurrently with significant sub-average intellectual functioning. This question has two components, the first of which is whether the Appellant has significant sub-average intellectual functioning. If so, the examination then turns to whether his intellectual and adaptive functioning are related.

Cognitive Functioning

From the earliest record, testing has shown a disparity between the Appellant's verbal and non-verbal abilities. The summary in Exhibit 3 indicated that the Appellant's overall intellectual ability was within the low average range, but there was a clinically significant discrepancy between his verbal and non-verbal

abilities indicating a language-based disability. The summary from this evaluation advised caution when interpreting the Appellant's full-scale IQ. This pattern persisted throughout all of the cognitive testing.

We have the benefit of a number of cognitive tests that provide the following results from the time the Appellant was about 11 years old through 18[redacted] years old.

Year/age	Test	Exh#	FSIQ	VCI	PSI	PRI	WMI	Verbal	Performance
1. 2003 (11[redacted])	WASI	3						borderline	average
2. 2006 (14[redacted])	WISC-IV	4	54	59	53	79	54		
3. 2006 (15[redacted])	WISC-IV	5	63	61	68	82	71		
4. 2009 (18[redacted])	WAIS-IV	6	74	74	76	90	71		
5. 2009 (18[redacted])	WASI	7	87					74	106

The Appellant's test results are variable. I recognize that most of his full scale IQ scores mostly fall near or below 70, but the most recent tests, done when the Appellant was in his later developmental years, were above the Department's regulatory threshold for defining significantly sub-average intellectual functioning. Even if they were within the Department's eligibility threshold, however, I do not consider the full scale IQ determinative when making the decision in this case. When there is the kind of split between verbal and performance scores as seen in the Appellant's test results, the averaged full scale score is not representative of overall intellectual functioning. As noted by Dr. Crenshaw, averaging scores disguises particular areas of impairment as well as particular areas of strength. Therefore, instead of considering the full scale IQ scores, I look to the factor scores, which provide a more meaningful view of intellectual functioning.

In the review of the factor scores, it is seen that the Appellant showed pronounced abilities in some areas (visual spatial processing) and very pronounced disabilities in others (verbal abilities). That split remained constant throughout testing and was noted by each examiner. Dr. Crenshaw said that this disparity is characteristic of a verbal learning disability.

In looking at the Appellant's verbal scores -- borderline, 59, 61, 74, and 74 -- we see scores in the extremely low to low end of borderline range. On the other hand, the Appellant's performance scores -- average, 79, 82, 90, and 106 -- are generally in the low average to average range. Thus, the Appellant has demonstrated at least some cognitive functioning outside the range of mental retardation. The examiner in the most recent testing also concurred that it would not be appropriate to describe the Appellant as mildly mentally retarded because test results indicated a language based disability (Exh 7).

It is clear that the Appellant has significant adaptive limitations. Given these limitations as well as the symptoms derived from his PDD, ADHD, ODD and Tourette's syndrome, the Appellant and will not be able to manage living independently and will likely need supports throughout his life. The question that I must focus on, though, is whether these adaptive limitations are related to and exist concurrently with significant sub-average intellectual functioning.

The Appellant has recognized cognitive limitations in the verbal area. His performance scores, on the other hand, are in the low average to average range, significantly above the Department's threshold for eligibility. This split, which is long-standing for the Appellant, is more characteristic of a verbal learning disability than mental retardation. Given his performance scores, the variability between the verbal and performance scores, and the testimony of the Department's psychologist, I cannot find that the Appellant has demonstrated that he has sub-average intellectual functioning. The usual profile of someone with mental retardation is that of someone with similar scores across all testing, both verbal *and* performance. Inasmuch as the Appellant's performance scores are consistently in the low average to average range and thus above the Department's eligibility level, I find that the Appellant has not shown he has sub-average intellectual functioning.

CONCLUSION

Based on my determination that the Appellant has not shown that he has sub-average intellectual functioning, he has not been able to show by a preponderance of the evidence that he meets the Department's definition of mental retardation. Therefore, I conclude he is not eligible for DDS services.

APPEAL RIGHTS

Any person aggrieved by a final decision of the Department may appeal to the Superior Court in accordance with M.G.L c. 30A and 115 CMR 6.34(5).

Date: _____

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Elizabeth A. Silver
Hearing Officer