2010-33

The Commonwealth of Massachusetts

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2010

Michael J. Roy
Dept. of Children and Families
Area Office

MA

Re: Appeal of - Final Decision

Dear Mr. Roy:

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: Jeanne Adamo, Hearing Officer
Terry O'Hare, Regional Director
Marianne Meacham, General Counsel
John Geenty, 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], MA.

Those present and participating at the hearing:

For the Appellant:

[redacted]	Appellant
Michael J. Roy	Department of Children and Families [redacted]
[redacted]	Psychologist – Counselor
[redacted]	Foster Mother
[redacted]	– Program Director

For the Department:

Bradley Crenshaw	Psychologist
John C. Geenty, Jr.	Attorney

At the hearing, the Department submitted Exhibits 1-5, and Exhibit 6 was submitted on behalf of the Appellant. The hearing lasted approximately one and a half hours. Michael Roy, [redacted], [redacted], and [redacted] testified on behalf of the Appellant. Bradley 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. Packet of correspondence between the Department and the Appellant including Notices of Fair Hearing dated [redacted] 2010 and [redacted] 2010; Notice of Receipt of Fair Hearing Request dated [redacted] 2010; Appellant's [redacted] 2010 appeal to request a fair hearing; [redacted] 2010 notice from the Department post Informal Conference denying eligibility; Attendance records from [redacted] 2010 Informal Conference; Notice of Informal Conference dated [redacted] 2010; Appellant's [redacted] 2010 request for an Informal Conference; and Department's [redacted] 2009 notice to the Appellant denying eligibility for services.

Exhibit 2. Curriculum Vitae for Bradley Crenshaw, Ph.D., Ph.D.

Exhibit 3. Psychological Evaluation dated [redacted] 2006 and [redacted] 2006 done when the Appellant was 15[redacted] years by [redacted] Ph.D., Licensed Psychologist. At the time of the evaluation, the Appellant was residing at the [redacted] where he had lived since he was six years old. Dr. [redacted] relayed some of the Appellant's background: He lived with [redacted] until the age of six at which time she was no longer able to care for him and contacted the Department of Social Services.[1] DCF placed the Appellant at the [redacted]. The Appellant had had a history of abuse and neglect, developmental delays, and severe behavior problems. He was born multiply drug addicted and had early developmental delays. He received

[1] The Department of Social Services changed its name to the Department of Children and Families (DCF), so I will refer to it as such in this decision.

Early Intervention services. He suffered [redacted] care. At the age of five he [redacted] which resulted in a traumatic brain injury (TBI) with loss of consciousness, a left occipital skull fracture, and multiple broken bones. He was diagnosed with ADHD and [redacted] at the age of six as well as some [redacted].

Dr. [redacted] reported on prior evaluations that consistently showed low average to borderline deficient cognitive functioning with particular impairments in the Appellant's language and verbal learning, processing speed, and attention and organization skills. On the Wechsler Preschool and Primary Scale of Intelligence-Revised (WPPSI-R) at the age of six, the Appellant had IQ scores of Full Scale 81, Verbal 76, and Performance 89. At age eight, his WISC-III IQ scores were Verbal 67 and Performance 87. No full scale score was given. When the Appellant was 12, his IQ scores on the WISC-III were Full Scale 71, Verbal 69, and Performance 78. Testing at that time showed significantly impaired emotional and behavioral control with poor social relatedness that led to a diagnosis of reactive attachment disorder. At the time of Dr. [redacted] evaluation the Appellant had made some progress and was said to have been increasingly sociable. His medications were Tenex, Trileptal, and Concerta.

Dr. [redacted] administered the WISC-IV. During testing the Appellant was cooperative and his attention appeared to be adequately managed by his medication. However Dr. [redacted] noted that he worked at a very slow pace. The Appellant's overall intellectual functioning fell in the low average to borderline deficient range with a Full Scale IQ score of 71. There was significant variability in his skills consistent with average range visual skills and significant disabilities in his verbally based learning and processing speed. His index scores were: Verbal Comprehension (VCI) 69, Perceptual Reasoning (PRI) 92, Working Memory (WMI) 83, and Processing Speed (PSI) 59.

On the Behavior Assessment System for Children (BASC-2), which was completed by the Appellant's [redacted] and classroom teacher, the Appellant demonstrated significantly more behavior problems than other youths his age, still falling in the clinically elevated range.[2]

In summary, Dr. [redacted] noted that the Appellant had a history of family instability and abuse, prenatal drug exposure, head trauma, and developmental delays. Consistent with previous diagnoses of ADHD, verbal learning disability and reactive attachment disorder, the Appellant continued to exhibit significant learning disabilities, behavior problems, and poor social relatedness. Dr. [redacted] indicated that overall the Appellant's profile suggested that he remained a slow learner who functioned in the low average to borderline deficient range of intelligence. He did best on visual and hands-on tasks, but continued to have significant difficulty with language, verbal learning, and processing speed, consistent with disabilities in these areas. Dr. [redacted] diagnostic impression was Reactive Attachment Disorder, ADHD, Verbal Learning Disability, and [redacted].

Exhibit 4. School Psychologist's Report (Re-evaluation) done on [redacted] 2009 by [redacted], Ph.D. when the Appellant was 18[redacted] years. At the time of this evaluation, the Appellant was receiving special education services based on an emotional disability. Dr. [redacted] reported on the results of the Woodcock-Johnson educational evaluation administered in [redacted] 2004 that indicated that the Appellant had earned average scores in Broad Reading (24th percentile) and Math (32nd percentile), and a low average score on Written Language (14th percentile).

During the Wechsler Abbreviated Scale of Intelligence (WASI) administered by Dr. [redacted], the Appellant was cooperative, friendly, and attentive, although he did display a somewhat slow response to verbal tasks. Dr. [redacted] believed the test results were valid and a reliable estimate of the Appellant's actual abilities. The Appellant's overall Full Scale score of 91 was in the low average/average range (27th percentile). He

[2] At the outset of the hearing the Department's attorney indicated that the Department conceded that the Appellant met the adaptive limitations prong of its definition of mental retardation. Accordingly, I will not review results of adaptive functioning in great detail.

demonstrated significant variability between the two subscales. His Verbal score of 83 was in the borderline/low average range (13th percentile) while the Performance score of 102 was solidly in the average range (55th percentile). Dr. [redacted] noted that overall the Appellant's scores were somewhat higher than those reported in the past but the Appellant's profile of weaker Verbal skills, especially Vocabulary skills, remained consistent with prior evaluations.

Dr. [redacted] also administered academic testing using the Wechsler Individual Achievement Test-Second Edition (WIAT-II). The Appellant earned borderline/average scores on both Word Reading (79) and Spelling (78), and an extremely low/borderline score of 69 on Numerical Operations. Finally, Dr. [redacted] administered the Behavior Assessment System for Children, Second Edition (BASC-II) as rated by one of the Appellant's teachers and by the Appellant. He concluded that the Appellant was perceived to display behaviors similar to those displayed by age peers who experience disorders such as ADHD and [redacted] as well as Depression.

Exhibit 5. Eligibility Report prepared by Dr. Bradley Crenshaw on [redacted]2009. Dr. Crenshaw reviewed the results of the various cognitive assessments presented to the Department as summarized above and concluded that that Appellant did show suppressions in his adaptive behaviors, but also concluded that his intellectual power was consistently measured above the Department's cutoff. Dr. Crenshaw stated that the pattern of cognitive factor scores indicated suppressions in the Appellant's conceptual organization of his linguistic experience, probably consequent to [redacted] at age five, but he had normative cognitive abilities in his visual-spatial processing. Consequently, Dr. Crenshaw found no global suppression of intellect and therefore recommended that the Appellant did not meet the Department's criteria for Adult DDS services.

Exhibit 6. Evaluation done by [redacted], Ph.D., over the course of seven sessions beginning [redacted]2008 and ending [redacted]2009. During this time the Appellant ranged in age from 17[redacted] to 18[redacted] years. He had been referred for evaluation to assess his developmental and adaptive functioning to assist in long range planning. Dr. [redacted] did not administer any cognitive testing.

Dr. [redacted] reviewed the Appellant's background as relayed above, including the receipt of Early Intervention services through [redacted]. In 1993, at the age of three, the Appellant was enrolled in [redacted] where he presented as significantly delayed, with poor communication and motor skills, and autistic-like features ([redacted]). After the [redacted] could not continue to care for the Appellant he was released for adoption and lived in a home for some of the 1996 year. However, he began to display many difficult behavior problems there and at school including [redacted] These problems led to his placement at [redacted]. In 2006 the Appellant graduated to the [redacted] and also entered a [redacted]. DCF has continued to be the Appellant's guardian and they are having ongoing discussions with the Appellant's [redacted] about the role she might play long-term. However, it is clear that the Appellant cannot live with her.

Dr. [redacted] provided clinical impressions and reviewed the evaluation and BASC done by Dr. [redacted] in [redacted] 2006 (Exhibit 3). Dr. [redacted] also administered the Vineland Adaptive Behavior Scales on which the Appellant's ranks on Communication and Daily Living Skills were at 1%, and his ranks on Socialization and Adaptive Composite were less than 1%. Dr. [redacted] noted that the Appellant had made some progress with his adaptive skills over the prior year but he continued to have globally delayed adaptive abilities.

In conclusion, Dr. [redacted] said that the Appellant presented a complicated profile of clinical needs and functional challenges, as well as a significant safety risk in his daily life if he did not have intensive supervision. He said the Appellant suffers from both constitutional and past environmental problems that severely impair his cognitive and adaptive functioning. Dr. [redacted] said the Appellant's global cognitive functioning fell in the

low borderline retarded range while his adaptive functioning fell in the five- to six-year old developmental range.

TESTIMONY

Exhibits 1-6 were entered into the record. The Appellant, Michael J. Roy, [redacted], [redacted], [redacted], and Bradley Crenshaw were sworn in.

The parties made brief opening statements. The Department's attorney indicated that the Department conceded that the Appellant was domiciled in Massachusetts and that the scores on his adaptive functioning assessments met the Department's requirements. However, the Department believed the Appellant did not meet the cognitive functioning prong of its regulations.

Before the Appellant's witnesses testified, they requested a brief explanation from Dr. Crenshaw regarding the Department regulations regarding its cognitive requirements.

Mr. Roy from DCF testified first for the Appellant. He said that the Appellant's test scores are different in different areas. With respect to cognitive abilities, Mr. Roy said he had serious concerns about the Appellant if he was left to his own abilities to function in a real world. He had concerns because of the Appellant's impulsivity and because of his inability to make decisions on his own without supervision in a structured arrangement.

Dr. [redacted] next testified for the Appellant. He is a licensed psychologist [redacted]. Dr. [redacted] earned his Bachelor's Degree from [redacted] and his Doctorate from the [redacted]. He has done a lot of work with mentally delayed adults, people with brain injuries, and people with histories of child abuse and neglect. Dr. [redacted] has worked at [redacted] since 1983 during which time he has worked with young people with combinations of environmental and organic damage.

Dr. [redacted] testified that he has known the Appellant since he was two years old. Dr. [redacted] said the Appellant suffered profound brain damage. He said when his mother was pregnant with the Appellant, she was living on the streets, she failed to get any prenatal care, and she neglected herself and used drugs. He said the Appellant was [redacted]. Dr. [redacted] said that as a young child the Appellant [redacted]. When he was young Dr. [redacted] said the Appellant displayed a number of very serious organic neurological issues [redacted] and everything was significantly delayed. He required a lot of attention both in his home environment and in school. Dr. [redacted] said the Appellant has always needed an extremely supportive and closely structured educational setting, and even in that kind of setting he has had a great deal of difficulty learning. He was unable to function in a home setting, so at the age of about seven he entered [redacted].

Dr. [redacted] testified that he has concerns about the Appellant's behavioral issues, but he understands the Department's denial was based on the Appellant's cognitive functioning. He hoped that the Department's name change signaled that it would provide assistance for the Appellant who is dealing with brain damage. He said the Appellant is a strong person and has made good progress, but the fact that he was in residential placement indicates the severity of his situation. Dr. [redacted] said DCF has a pretty significant history of wanting to avoid placing kids in residential treatment, so the Appellant's placement at [redacted], the most intensive level of care for anyone in DCF custody short of a hospital, indicates the extreme nature of the Appellant's needs. The Appellant has required a high level of monitoring and has been in special school programming. He was in a school with only [redacted] other children. Dr. [redacted] said the Appellant has learned a lot, and like many of kids with brain damage the Appellant has the potential to keep learning, but to make the gains he has made he

needed a level of adaptive support that even most of the others kids at [redacted] haven't needed. Until more recently the Appellant wasn't able to function in a community school setting.

Dr. [redacted] said the state has invested a lot of resources in the Appellant and it's only because of that amount of services that his test scores have improved. But Dr. [redacted] testified that the Appellant's adaptive functioning was the concern as the Appellant matured. He said it was fortunate that the Appellant got into the [redacted] and that now he is in a [redacted], but Dr. [redacted] was very concerned about what will happen to the Appellant as an adult. He said the Appellant is under DCF guardianship – it's not voluntary – and while Dr. [redacted] anticipates the Appellant will remain under DCF guardianship, the question is what level of service he'll get.

Dr. [redacted] stressed the fact that the Appellant shows the signs of profound brain damage. He said the Appellant has some strengths and some ability to be coached, but these strengths do not translate to his adaptive functioning, which is what he needs as he gets older. Dr. [redacted] testified to the concern they have for the Appellant even over the next couple of years. He said the Appellant isn't someone who is just borderline range or has motivational issues or trauma history; he said the Appellant is someone who might have an autism spectrum diagnosis because of social reciprocity issues and difficulties in many of his core functions. In conclusion, Dr. [redacted] acknowledged that the Appellant has made some strides but said he will face lifelong challenges because of his brain damage.

On cross-examination, Dr. [redacted] acknowledged that there was no diagnosis of mental retardation on Dr. [redacted]'s 2009 evaluation or on Dr. [redacted]'s 2006 evaluation.

[redacted] testified next for the Appellant. She said the [redacted] is a [redacted] specializing in children who have combinations of impairments including mental health adaptive functioning, physical health, and mental retardation. The Appellant is living in [redacted] home. Ms. [redacted] said it is [redacted] with staff supports provided to the home. On the average there are about 20 hours of staffing per child. The Appellant's home has 3–4 children, so there is a total of 60-80 hours of staffing in the home each week to insure continued work on treatment goals, safety, and supervision of the children. Ms. [redacted] said that [redacted] also provides secondary therapeutic activities including [redacted] to help the children work on their adaptive skills.

[redacted], who also works for the [redacted], testified next on behalf of the Appellant. She said she has been doing this work for 22 years. Ms. [redacted] said the Appellant, who has been delightful, has been with them since [redacted]. She said the bulk of staffing is for him, and that because of his behaviors he requires 24/7 one-on-one help, even within the home setting. She said the Appellant doesn't present as mean or set out to do bad things, but bad things happen. She said he could not go through a day, or even breakfast for that matter, without being supervised. This is not because the Appellant refuses to do things, it's because he is not able to do things. Ms. [redacted] said the Appellant cannot make appropriate choices and her concern is that he won't be able to be on his own when he turns 22. Ms. [redacted] said the Appellant is attending the [redacted] and is supervised all of the time. Her concern is that the Appellant could end up in prison unless he is supervised and monitored.

Bradley Crenshaw testified on behalf of the Department. He is a neuropsychologist and is the psychologist in the intake and eligibility division, which entails review of information presented to the Department in support of applications for services. He said he reviews about 100 applications/month and has testified and given expert opinion at hearings. Dr. Crenshaw was qualified as an expert.

Dr. Crenshaw testified that he was familiar with the Appellant's application. He reviewed Exhibit 3, which was the psychological evaluation done by [redacted]. Dr. Crenshaw said Dr. [redacted] administered a Wechsler Intelligence Scale – 4th Edition in which the Appellant's scores were Perceptual Reasoning (PRI) 92, Working Memory (WMI) 83, Verbal Comprehension (VCI) 69, Processing Speed (PSI) 59, and Full Scale IQ 71. He

said there was quite a significant disparity between factor scores, which was essentially within normal limits for perceptual reasoning but two standard deviations below the norm for verbal comprehension. Dr. Crenshaw said the Appellant's attention span was also normative but the speed with which he worked was compromised.

Dr. Crenshaw reviewed other test scores from prior evaluations. At the age of six the Appellant was given a Wechsler Preschool and Primary Scale of Intelligence – Revised (WPPSI-R) on which he obtained a Full Scale IQ of 81, Verbal IQ of 76, and Performance IQ of 89. At age eight the Appellant was given a WISC-III on which his scores were Verbal IQ 67 and Performance IQ 87. Dr. Crenshaw said the Full Scale IQ was not calculated presumably because of the 20-point disparity between the factor scores. Finally, at 12 the Appellant was given a WISC-III on which he had a Full Scale IQ score of 71, a Verbal IQ score of 69, and a Performance IQ score of 78. Dr. Crenshaw said the Appellant showed suppressed language skills but much more sophisticated visual-spatial planning and conceptual organization.

Dr. Crenshaw next reviewed Exhibit 4, which was a report by Dr. [redacted], School Psychologist, done [redacted] 2009 when the Appellant was 18[redacted] years old. Dr. [redacted] administered the Wechsler Abbreviated Scale of Intelligence (WASI) on which the Appellant's scores were Verbal IQ 83, Performance IQ 102, and Full Scale IQ 91. Dr. Crenshaw said the results showed the same pattern on prior tests, which was that the Appellant's language scores were suppressed compared to his normative visual-spatial organization and planning. Dr. Crenshaw said the Full Scale IQ score was within normal limits and that with this evaluation the Appellant showed increased developmental skill.

In response to a question from this hearing officer, Dr. Crenshaw explained that what is "abbreviated" about the WASI is that attention and processing speed factors are removed so the WASI tests only verbal and performance, which is what Dr. Crenshaw characterized as core power. He explained that there is no abbreviation of the verbal and performance factors and in fact there are more questions in the verbal category than there are on the WISC. So what is abbreviated is not the measurement of those factors, but which factors are measured at all.

Dr. Crenshaw next reviewed the Eligibility Report he prepared on [redacted] 2009 (Exh 5). He concluded in his report that the Appellant did not fit the Department's cognitive criteria on any of the tests, and accordingly he was not eligible for Department services. Dr. Crenshaw also reviewed Dr. [redacted]'s report (Exh 6) in which Dr. [redacted] administered the Vineland. Dr. Crenshaw said the report indicated that the Appellant's adaptive behaviors are compromised, which is why the Department conceded that the Appellant met its adaptive functioning criteria.

Cross-examination consisted of much discussion and conversation primarily between Dr. Crenshaw and Dr. [redacted], although Mr. Roy and Ms. [redacted] also asked Dr. Crenshaw questions. Mr. Roy wanted to know if there was any additional information that DCF could submit that would make a difference, but Dr. Crenshaw said the information the Department had was sufficient for making a determination.

There was a question about the fact that the WASI lacked the processing measure, to which Dr. Crenshaw said the processing piece of testing looks at the speed with which one applies one's intellect, which is distinct from the intellect one has to apply. Dr. Crenshaw's example was that he might know how to make Thanksgiving dinner but if he does it slowly it doesn't alter the fact that he knows how to do it. He might be distracted, or he might prefer to cook in a smoker rather than oven, but the speed of doing the task is not the same as the knowledge base.

With respect to making appropriate and safe decisions, Dr. Crenshaw explained that the Department conceded the Appellant met the adaptive functioning prong of its regulations. He also said the Department understood the difficulties everyone who testified at the hearing expressed, which is that the Appellant will not be able to live independently. However, Dr. Crenshaw said that the Appellant was a diagnostically complicated person. There were questions of autism and he had a severe traumatic brain injury with a left occipital fracture and consequent

hemiparesis, which meant that the Appellant's body was neurologically damaged. Dr. Crenshaw said the brain damage also corresponded to the pattern of suppressed skills seen in testing. The Appellant's brain damage is on the same side as the language center.

In response to Dr. [redacted] hope that the Department's name change signaled its ability and willingness to help someone with brain damage, Dr. Crenshaw explained that although the Department name has changed there has not yet been any substantive change in the individuals it serves, and the regulations restrict services to people who are mentally retarded. It does not serve people with other competing diagnoses, even if those other diagnoses impair intellectual functioning.

Dr. [redacted] raised the point that the Appellant did not always have IQ test scores in the 80's or 90's – this was fairly recent, and that historically he had two Full Scale IQ scores at 71 (in 2002 and 2006, see Exh 3). Further, the recent testing where the Appellant did better did not include the full battery of tests. The parts that were left out were the parts on which the Appellant scored lower, which would bring his overall score down to approximately the threshold score required by the Department.

Dr. Crenshaw restated Dr. [redacted] question as being how to weight the Appellant's performance scales versus his cognitive scales on the full batteries. He said the Department criteria focuses on cognitive power, but not the application of power. So for example, Attention Deficit Disorder is the diagnostic feature when someone's attention span is compromised but his intellect is fine. The individual is not mentally retarded; he has attention problems. Dr. Crenshaw disagreed with Dr. [redacted] statement that the Appellant's score of 59 on processing is part of intelligence measuring. He explained that there are multiple factors on a test, and even though some factors may be removed from a test the test is still a valid IQ test.

In further response to Dr. [redacted] urging that the full scale IQ scores of 71 were the relevant overall scores that essentially met the Department criteria, Dr. Crenshaw explained that there are many reasons why a full scale score would not pertain. One is because there is such a big discrepancy among the factor scores the full scale score is not interpretable. He explained that the full scale score is meant to reflect a consistency of intellectual functioning. An example of this is seen in school grading where there's an expectation that an average score reflects a consistency of performance. However, if a student gets an A+ on half his tests but flunks the other half, the C+ doesn't reflect that student's true capacity. Therefore, Dr. Crenshaw said that in some instances the discrepancy between the Appellant's factors scores was such that the full scale score did not pertain.

Dr. Crenshaw said the other broader issue is the full scale score also needs to reflect the diagnostic contributions to the average. In other words, if someone has normative intellect but attention deficits, he is not mentally retarded even though the full scale score is reduced. The diagnoses of autism or psychosis influence test results. This is why there are multiple factors on the design of these IQ tests because they look at different capacities and the diagnostic contribution to overall functioning.

Dr. [redacted] continued to suggest that the full scale IQ score of 71 is a unified score and the Department also requires a unified score. Looking at the entire life and testing history of the Appellant, Dr. [redacted] argued that the Appellant met the Department's requirements. Dr. Crenshaw responded that it is important not to obscure overall functional capacities, which are diagnostically complicated, with what the Department has determined is the clientele it serves, which are mentally retarded individuals. Mental retardation is a diagnosis having to do with intellectual power, a cognitive issue, not with attention issues, not with executive functioning issues, not with psychiatric issues, not with motivational issues, and not with any other issues in the DSM. He said mental retardation is very specific to cognitive power. With respect to the Appellant's cognitive power, test results show an individual who is consistently within normal limits in his visual processing and consistently compromised in his verbal skills, which is probably most likely attributable to his TBI. There was a focal injury with the TBI and left-sided occipital fracture that has limited the Appellant's functioning, but it has not globally suppressed his intellectual power. It's not retardation. Dr. Crenshaw noted that other evaluators have looked at

the same data the Department reviewed and also arrived at diagnoses other than mental retardation. Dr. Crenshaw said that the most consistent and appropriate diagnosis is a verbal learning disability, which was Dr. [redacted] diagnosis.

Both parties made brief closing statements.

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 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. Born [redacted] 1990, he is 19 years old. He meets the domicile requirement of the Department and, as the Department conceded, he also meets the adaptive functioning prong of the Department's regulations. However, for the reasons set forth below, I find that the Appellant does not meet the Department's definition of mental retardation.

The record in this case reflects that when the Appellant's biological mother was pregnant with the Appellant, she was living on the streets, neglecting herself, failing to get any prenatal care, and was multiply drug-addicted. The Appellant was thus born multiply drug-addicted and had severe early developmental delays and severe behavior problems. Because of his significant delays, he received Early Intervention services from the [redacted] and at the age of three he was enrolled in [redacted] where he presented with significant delays, poor communication and motor skills, and autistic-like features including [redacted].

The Appellant initially lived with [redacted] until he was about six years old when she became unable to care for him any longer. The Appellant was released for adoption and lived briefly in a home, but because of serious behavior problems including [redacted], the Appellant was removed from that home, taken into DCF custody, and placed at [redacted]. He remained at [redacted] until 2006 when he graduated to the [redacted] and entered a [redacted] for youth with developmental and behavioral difficulties. DCF has continued to be the Appellant's guardian throughout this time. As of [redacted] 2009 the Appellant was residing with [redacted] that provides residential care with individual staffing as well as therapeutic activities to help children work on their adaptive skills. He attended the [redacted] for some years until he aged out, and at the time of the hearing was attending the [redacted] and where he was supervised continuously.

Adaptive Functioning

As noted, the Department indicated that it conceded that the Appellant meets the Department criteria with respect to adaptive functioning. Accordingly, I will not review this aspect of eligibility criteria in detail, but will note three aspects in the record addressing adaptive functioning. First, the Department based its position primarily on the Vineland Adaptive Behavior Scales administered by Dr. [redacted] on which the Appellant's ranks on Communication and Daily Living Skills were at 1%, and his ranks on Socialization and Adaptive Composite were less than 1%. Dr. [redacted] noted that the Appellant had made some progress with his adaptive skills over the prior year but he continued to have globally delayed adaptive abilities.

Second, there are two BASC-IIs in the record, one from 2006 (Exh 3) and the other from 2009 (Exh 4). On the 2006 BASC-II, which Dr. [redacted] had completed by the Appellant's house parent and classroom teacher, the Appellant demonstrated significantly more behavior problems than other youths his age, with his behaviors falling in the clinically elevated range. When Dr. [redacted] administered the BASC-II in 2009, which was rated by one of the Appellant's teachers and by the Appellant, the Appellant was perceived to display behaviors

similar to those displayed by age peers who experience disorders such as ADHD and Dysthymic Disorder as well as Depression.

Finally, I note the testimony particularly from Dr. [redacted] and Ms. [redacted] who both credibly described the severe extent and nature of the Appellant's significant limitations in adaptive functioning.

Cognitive Functioning

Although they differ on the significance of test results, both Dr. [redacted] and Dr. Crenshaw agreed that over time the Appellant's test scores on cognitive testing have improved. We have the benefit of several IQ tests in the record, which are summarized below.

Year/age	Test	Exh#	FSIQ	Verbal	Perf	VCI	PRI	WMI	PSI
1993?[3] (6.?)	WPPSI-R	3	81	76	89				
1998? (8.?)	WISC-III	3		67	87				
2002? (12.?)	WISC-III	3	71	69	78				
2006 (15[redacted])	WISC-IV	3	71			69	92	83	59
2009 (18[redacted])	WASI	4	91	83	102				

Dr. [redacted] (Exh 3) concluded that the Appellant's profile suggested that he remained a slow learner who functioned in the low average to borderline deficient range of intelligence. He did best on visual and hands-on tasks, and Dr. [redacted] predicted that the Appellant would likely continue to have significant difficulty with language and verbal learning and keeping up with a regular classroom pace. Dr. [redacted] diagnosed the Appellant with Reactive Attachment Disorder, ADHD, Verbal Learning Disability, and [redacted], but not with mental retardation.

Dr. [redacted] (Exh 4) determined that the Appellant's overall full scale IQ score of 91 was in the low average/average range (27th percentile) but that the Appellant demonstrated significant variability between the two subscales. His Verbal IQ score of 83 was in the borderline/low average range (13th percentile) while the Performance IQ score of 102 was solidly in the average range (55th percentile). Dr. [redacted] noted that overall the Appellant's scores were somewhat higher than those reported in the past but the Appellant's profile of weaker Verbal skills, especially Vocabulary skills, remained consistent with prior evaluations. Dr. [redacted] reported the Appellant's diagnoses as Reactive Attachment Disorder, ADHD, [redacted], Traumatic Brain Injury, and Verbal Learning Disability. He did not diagnose the Appellant with mental retardation.

The Appellant also was given academic tests. In [redacted] 2004 on the Woodcock-Johnson (reported on in Exh 4), the Appellant had earned average scores in Broad Reading (24th percentile) and Math (32nd percentile), and a low average score on Written Language (14th percentile). On the WIAT-II in 2009 (Exh 4), the Appellant earned borderline/average scores on both Word Reading (79) and Spelling (78), and an extremely low/borderline score of 69 on Numerical Operations.

On the basis of the above tests, Dr. Crenshaw concluded that the Appellant was not mentally retarded as defined by the Department regulations. Dr. [redacted] challenged this conclusion and urged that the two full scale IQ scores of 71 essentially met the Department's criteria for eligibility. I disagree and find that the Appellant is not mentally retarded within the meaning of the Department regulations.

[3] When reviewing prior testing Dr. [redacted] did not give dates of testing or the exact age of the Appellant at the time of testing. Hence, the question marks reflect this inexactness.

Mental retardation is defined in the regulations as ". . . significantly sub-average intellectual functioning . . . . [that] manifests before age 18 . . . ." 115 CMR 2.01. Significantly sub-average intellectual functioning is defined as ". . . 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." 115 CMR 2.01.

In this case, the Appellant's full scale IQ test scores ranged from 71 in 2002 to 91 in 2009. As there is no suggestion of compromise to any of the testing, all of the above reported tests appear valid.

While the Appellant did have two test scores that are close to the Department's threshold of 70, and would not, in this hearing officer's opinion, eliminate the Appellant from qualifying for services were he otherwise eligible, the results of the factor scores within these tests, as well as the results of the other tests in which the Appellant's full scale IQ scores were 81 and 91, indicate that the Appellant is not mentally retarded. As Dr. Crenshaw explained, the Appellant consistently showed suppressed language skills but a much more sophisticated and normative visual-spatial planning and conceptual organization. Each of the tests revealed this similar pattern. This was especially apparent in the WASI, where attention and processing speed factors were removed leaving the Appellant's full scale score in the low average/average range. As Dr. Crenshaw explained, the processing factor looks at the speed with which one applies one's intellect, which is distinct from the intellect one has to apply.

Dr. Crenshaw acknowledged that the Appellant has serious adaptive functioning limitations. But he said these limitations result from other diagnoses the Appellant has, not mental retardation. Dr. Crenshaw noted that the Appellant's condition raised questions of autism and he had a severe Traumatic Brain Injury with a left occipital fracture and consequent hemiparesis. Dr. Crenshaw explained that this meant that the Appellant's body was damaged neurologically, and the brain damage, which is on the same side as the language center, corresponds to the pattern of suppressed skills seen in testing.

Dr. Crenshaw also clarified that even though the Department changed its name, its regulations have not changed substantively, so the question remained whether the Appellant meets the Department's definition of mental retardation, as those are the only individuals it serves. He said the Department does not serve people with other competing diagnoses, even if those other diagnoses impair intellectual functioning.

In making the determination that the Appellant was not mentally retarded, Dr. Crenshaw said the Department criteria focuses on cognitive power, not the application of that power. He said that there are many reasons why a full scale score (such as the Appellant's full scale scores of 71) would not pertain. One is when there is such a large discrepancy among the factor scores so the full scale score is not interpretable. Another is if some other diagnosis, such as autism or psychosis, influences the test results. As Dr. Crenshaw explained, mental retardation is a diagnosis having to do with intellectual power, that is, a cognitive issue. Mental retardation does not have to do with attention issues, executive functioning issues, psychiatric issues, motivational issues, or any other issues in the DSM. It is very specific to cognitive power.

In this case, Dr. Crenshaw said that looking at cognitive power, the Appellant's results show him to be an individual who is consistently within normal limits in his visual processing and consistently compromised in his verbal skills, which is probably most likely attributable to his traumatic brain injury, which has limited the Appellant's functioning but has not globally suppressed his intellectual power. It is not mental retardation.

As Dr. Crenshaw pointed out, none of the evaluators who tested the Appellant arrived at a diagnosis of mental retardation. The more accurate diagnosis in the Appellant's case, as noted both by Dr. [redacted] and Dr. [redacted], is a verbal learning disability.

I am persuaded by Dr. Crenshaw's explanation of the Appellant's condition and his conclusions that the Appellant is not mentally retarded. Dr. Crenshaw is a qualified practitioner who is an expert in his field. I find that his interpretation of the Appellant's test results is reasonable and credible.

There is no question that the Appellant has significant limitations in adaptive functioning and I am convinced that he is incapable of living independently and will need significant supports to attend to his own needs on an ongoing, daily basis. Even with such severe adaptive limitations, however, Department laws and regulations are clear that limitations in adaptive functioning, even in those cases as severe as the Appellant's, are insufficient alone to meet the Department's eligibility criteria. An applicant must meet the definition of mental retardation to be eligible for services, and this definition extends beyond significant limitations in adaptive functioning. Mental retardation is defined as significantly sub-average intellectual functioning that *exists concurrently and is related to* significant limitations in adaptive functioning. Thus, to be eligible for Department services, one must establish that he has the requisite cognitive limitations that exist alongside and related to adaptive limitations. Department regulations are not satisfied if significant adaptive limitations result from some reason other than limitations in cognitive functioning, as would be the case, for example, if autism or a traumatic brain injury were the underlying cause for the adaptive limitations.

The Appellant has the burden of proving beyond a preponderance of the evidence that he meets the Department's eligibility criteria. In this case, because he has been unable to show that he has sub-average intellectual functioning, the Appellant has not met his burden in this case.

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: [redacted] 2010

Elizabeth A. Silver
Hearing Officer