# The Commonwealth of Massachusetts

Executive Office of Health & Human Services
Department of Developmental Services
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2010

John Corneau, LSW
DCF/i Area Office

MA

**Re: Appeal of - Final Decision**

Dear Mr. Corneau:

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 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.

Elie M. Howe
Commissioner

EMflieew
cc: Elizabeth Silver, Hearing Officer
Terry O'Iiare, 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**

This decision is issued pursuant to MGL Cha ter 30A and the regulations promulgated thereto; 115 CMR 6.00 *et se* . A fair hearing was held on , 2009 at the DDS[1] Area Office, , MA.

Those present at the hearing:

| | |
|---|---|
| [redacted] | Appellant |
| | Foster-Mother of Appellant |
| | Foster-Father of Appellant |
| [redacted] | Family Services, for the Appellant |
| [redacted] | Department of Children and Families (Guardian of Appellant) |
| John Corneau | Attorney for DDS |
| John C. Geenty, Jr. | |
| Bradley Crenshaw | Psychologist for DDS |

At the hearing, the Department submitted Exhibits 1-9 plus a cover list of exhibits as well as a separate listing of the Appellant's IQ scores. The Appellant did not submit an additional exhibits. The hearing lasted approximately one hour and forty-five minutes. Mr. and Mrs. , Mr. , and Mr. Corneau testified on behalf of the Appellant, who added some testimony, and Dr. Crenshaw testified on behalf of the Department.

**ISSUE PRESENTED:**

The issue for this hearing is whether the Appellant, meets the definition of mental retardation and is thereby eligible for DDS services. As explained below, I find that the Appellant does not meet the definition of mental retardation and therefore is not eligible for services from the Department of Developmental Services.

**SUMMARY OF THE EVIDENCE**

**Exhibit 1.** Packet of notices and correspondence between the Department and the Appellant's guardian, John Corneau, for the Department of Children and Families. Documents include the following: Fair Hearing Notices; Appellant's , 2009 Hearing request; Department's 2009 acknowledgement of receipt of hearing request; Department's , 2009 letter post-Informal Conference denying eligibility; Informal Conference Report dated 2009; Correspondence dated , 2009 regarding Department's initial denial, Appellant's , 2009 request for an Informal Conference, and Department's , 2009 letter scheduling the Informal Conference for , 2009.

**Exhibit 2.** Curriculum Vitae of Brad Crenshaw, Ph.D., Ph.D.

**Exhibit 3.** Neuropsychological Evaluation dated when the Appellant was 10 years I old. The testing was done by Ph.D., Licensed Ps chologist, in order to evaluate the Appellant's cognitive, academic, and emotional functioning. Dr. provided some background information regarding the Appellant. He was born prematurely, had respiratory distress, and had to spend a month in the hospital. He had developmental delays and received early intervention services beginning at

[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.

the age of two. At some point he was removed from the care of his biological parents because of abuse or neglect. At the time of testing he was taking Adderall for inattention and overactivity.

Dr. reported on prior testing from 1994 by when the Appellant was 5 years old. On the Wechsler Pre-School and Primary Scale of Intelligence — Revised (WPPSI-R), the Appellant received scores of Verbal IQ 81, Performance IQ 86, and Full Scale IQ 81. He was reported to have had significant learning disabilities related to language, verbal memory, attention, and organization of information. He was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD).

Dr. also reported on testing from , 1997 done by the Public Schools when the Appellant was 9 years old. The Appellant's scores were Verbal IQ 64, Performance IQ 80, and Full Scale IQ 70. .

Dr. administered the WISC-III during which the Appellant had attention difficulties despite having taken medicine for inattention prior to testing. On the Conners' Continuous Performance Test (CPT) a test of attention and concentration, the Appellant revealed inattention and inconsistent responding, and several key indices on the test were suggestive of an attention disorder. On the WISC-III, the Appellant's scores were: Verbal IQ 80, Performance IQ 90, and Full Scale IQ 83. There was scatter in Verbal subtest scores ranging from a 3 on Digit Span to a 9 in Similarities, and on Performance subtests from a 7 on Object Assembly and Picture Arrangement to an 11 on Coding. Overall, the Appellant's scores fell within the low average to average range of intellectual functioning, but because of the scatter in subtest scores- Dr. said the summary scores were less meaningful indicators of true potential.

With respect to adaptive functioning, on the Vineland Adaptive Behavior Scales, the reported scores were Communication 58, Daily Living 62, and Socialization 72.[2]

**Exhibit 4.** Neuropsychological Evaluation dated, 2002 by , M.A., and , Ph.D., when the Appellant was 13 years old. Ms. rep orted on the background. In addition to the information described in Exhibit 3 Appellant's noted the above, Ms. Appellant was removed from the care of his biological parents in 1997 and had been in numerous foster care placements since. DSS has had permanent guardianshilim since December 1997. He has received special education services since entering school. Ms. =II reported on the results of a administered by the Public Schools just 10 days earlier, on , 2002. On that testing, the Appellant had scores of Verbal IQ 84, Performance IQ 89, and Full Scale IQ 85. She summarized the results of prior testing as showing global academic delays, low average to extremely below average intellectual abilities, language difficulties, and significant issues with attention, executive functioning, and short-term memory. In addition, she said the Appellant had psychological issues including anxiety and PTSD, and was taking Adderall, Zyprexa, Clonidine and Trazodone.

Ms. administered the Stanford-Binet Intelligence Scale-Fourth Edition (SB-4) during which the Appellant was very fidgety, easily distracted, and had difficulty remaining focused. He had significant attention difficulties with all aspects of his performance on attention-related tasks and throughout testing. Mrs. tried to administer the Conners' Continuous Performance Test-II (CPT-II) but the Appellant abandoned the test. Results of the BASC (rated by his foster parents) showed that the Appellant exhibited significant symptoms of anxiety, withdrawal, atypical behavior, and attention problems. His scores on the SB-4 were: Test Composite IQ 75, Verbal Reasoning IQ 88, AbstractNisual Reasoning IQ 78,-and Short-Term Memory IQ 66. Again the Appellant had significant variability in his subtest scores. Overall, the Appellant demonstrated intellectual abilities in the low to extremely below average range.

[2] There is a page missing from this report that presumably supplies the Composite score for the Vineland. No one at the hearing had a copy of this missing page. Dr. Crenshaw testified that given the available scores, the Appellant's GAC would

fall under 70. *See, infra,* page 7.

Exhibit 5. Neuropsychological Assessment dated , 2005 when the Appellant was 16 years . The assessment was done by , Psy.D. and , Ed.D, in order to determine whether a recorded change in Full Scale IQ scores over the prior five years was significant and also to clarify the Appellant's dia nosis. Previouirie Airgilhad been diagnosed with ADHD, PTSD, Anxiety based disorder, and in 2003 Dr. at Hospital indicated that the A pellant met the criteria for Schizophrenia. In an April 2002 consultation, Dr. at Hospital Pediatric Neurology Department was not able to support evidence of Fetal Alcohol Syndrome.

reported on prior testing in 2005. In when the Appellant was 16 years old, the [redacted] public schools administered the Wechsler Intelligence Scale for Children, Fourth Edition (WISC-IV). The Appellant had a Full Scale IQ score of 63 and Index scores of Verbal Comprehension 85, • Perceptual Reasoning 67, Working Memory 50, and Processing Speed 75.

Dr. administered the Wechsler Adult Intelligence Scale — Third Edition (WAIS-III) to the Appellant, and considered the results to be a valid and accurate reflection of the Appellant's abilities. His scores on the WAIS-III were: Verbal IQ 74, Performance IQ 69, and Full Scale IQ 69. The Index scores were: Verbal Comprehension 84, Perceptual Organization 72, Working Memory 63, and Processing Sie¡e.176. Overall, testing revealed below average functioning in all intellectual domains. In summary, Dr. reviewed the Appellant's strengths (verbal knowledge and on a task of vigilance, accuracy and response), and weaknesses including executive functioning (organization, working memory and processing speed). He questioned the Appellant's diagnosis of Schizophrenia given that testing did not reveal psychotic processes, and wondered whether a variety of other factors, such as the Appellant's cognitive limitations in understanding appropriate behavior, the behavioral role models he experienced from his biological parents, or his anxiety that stemmed from PTSD, may have caused the behavior that appeared as psychotic. On the other hand, Dr. noted that medication could explain the lack of psychotic thinking.

Dr. did not think that the Appellant's diagnosis of ADHD was appropriate. To make such a diagnosis he said all other cognitive domains must be functioning within normal limits. While the Appellant had symptoms consistent with ADHD, he had significant deficits in a variety of areas (visual spatial, visual motor, processing speed, and some vulnerability in verbal skills). Accordingly, Dr. didn't think a diagnosis of ADHD was appropriate and that the Appellant's presentation was more likely the result of developmental delays. He compared the results of his present WAIS-III testing results (borderline Full Scale IQ) with prior testing scores that were in the well below average range without going below the borderline range. He concluded that the Appellant suffered significant cognitive impairments but that his overall functioning appeared too high to fall within the range of mentally retarded, although he also noted that it was likely that the Appellant's cognitive deficits were the result of developmental factors.

Exhibit 6.Hospital's Neuro s chological Evaluation dated I n ¡ , 2009 when the Appellant was 20 years old. , Ph.D, and , Ph.D., evaluated the Appellant on the recommendation of his psychiatrist because of concerns regarding the Appellant's level of cognitive functioning and to provide treatment planning. Dr. provided similar background information as was noted in the above exhibits. In addition, she provided detailed psychiatric history including the Appellant's past diagnoses at varying times (ADHD, PTSD, Schizophrenia, Mood Disorder NOS, Ps chotic Disorder, NOS, and R/O Dissociative Identity Disorder). He was hospitalized at in 2001 and again in 2002 for adjustment of medications. He was taking Wellbutrin and Abilify at the time of this report.

Dr. administered the Wechsler Adult Intelligence Scale — Fourth Edition (WAIS-IV). She noted that the Appellant was not distractible and sustained his attention over the course of the evaluation. Thus, the results were considered to be valid and accurate. The Appellant's Full Scale IQ score was 67, and his Index scores were: Verbal Comprehension 72, Perceptual Reasoning 75, Working Memory 66, and Processing Speed 76.

In addition to the WAIS-IV, Dr. had the Appellant's foster parents complete an Adaptive Behavior Assessment System — Second Edition (ABAS-II) to rate the Appellant's adaptive functioning. His Composite scores were Conceptual 70, Social 66, and Practical 63. His overall level of adaptNe functioning was in the extremely low range with a GAC of 64.

Dr. summarized test results as showing overall cognitive functioning in the extremely low range. She said the Appellant's Full Scale IQ appeared to be valid and that the Appellant's performance shared a similar pattern with his previous assessment with the exception of his verbal reasoning ability which appeared to be weaker. She said the combination of the Appellant's overall cognitive functioning and his significant, longstanding adaptive functioning impairments were consistent with a diagnosis of Mild Mental Retardation.

Exhibit 7. Adaptive Behavior Assessment System — Second Edition (ABAS-II) dated 2009, again rated by the Appellant's foster parents. On this ABAS-II, the Appellant's Composite scores were Conceptual 72, Social 72, and Practical 70. His GAC score, that is, his overall level of adaptive functioning, was 64.

Exhibits 8. 2009 email to at Family Services from John Comeau , Ongoing Social Worker, DSS . The email notifies Ms. that the Appellant was accepted for adult DMH services.

**Exhibit 9.** Eligibility Report dated , 2009 prepared by Bradley Crenshaw, Ph.D. Dr. Crenshaw reviewed the numerous evaluation test scores and also arranged the Full Scale IQ scores chronologically so they could be compared over time. He also arranged the Verbal and Performance IQ scores to show the pattern of cognitive performance across tests. Dr. Crenshaw found a consistent pattern of verbal reasoning being within the Low Average range and visual spatial planning varying between the Borderline to Low Average range. He said the Appellant's failure to pay attention to a problem was attributable to the Appellant's untreated ADHD, not to a lack of cognitive power. Accordingly, Dr. Crenshaw recommended that the Appellant did not meet Department eligibility criteria.

TESTIMONY

The above exhibits were entered into the record and the parties and their witnesses were sworn in. Both parties made a brief opening statement. Mr. agreed to be the spokesperson for the Appellant.

At the outset, Dr. Crenshaw gave an overview of the Department's regulatory criteria. There was some conversation between the parties regarding the significance of the full scale IQ score. Dr. Crenshaw said the full scale score is the sum of four factor scores, but there were times when the full scale score does not pertain because it does not represent the variation within the factor scores. Mr. referred to the Department regulations that define mental retardation as having a full scale score of 70 or below, and noted that the Appellant's last three test results had full scale IQ scores under 70. Dr. Crenshaw said tests can be validly administered but the scores don't necessarily validly represent intellectual capacity, so it is necessary to interpret the scores in light of other factors. He said the numbers aren't just black and white — there are interpretive factors that a psychologist can provide. Mr. noted, and Dr. Crenshaw agreed, that some scores were above 70, some were below 70, and that different psychologists could interpret the results differently. There was also some discussion regarding the difficulty in teasing out which aspects of the Appellant's cognitive functioning were attributable to mental illness versus mental retardation.

With respect to adaptive functionin , Mr. discussed two of the assessments in the record. On the ABAS-II done as part of the evaluation (Exh 6), the Appellant had a GAC score of 64 (1st percentile), which is in the extremely low range. He also reviewed the Vineland done in 1999 where the Appellant's scores were at or below the 70 threshold (Exh 3).

Mrs. testified that she and her husband had been foster parents for just over 10 years. She said the Appellant's Schizophrenia has been stable for three years, but there's been a decline in his cognitive functioning, which is why Dr. recommended having another evaluation. She said she and her husband have noticed a decline in the Appellant's adaptability and his cognitive functioning.

With respect to adaptive limitations, Mrs. described the Appellant as trusting and can be taken advantage of. He likes to please people. Mr. Comeau, who's worked with the Appellant for 10 years, concurred with this assessment.

Mr. said the Appellant has had the same work schedule for the last three years. His bus picks him up at a designated time in the morning, but the Appellant will stand outside for up to two hours waiting for it because he doesn't understand what time it comes. He said the Appellant has a hard time with money and is unsure of change. He has his own bank account but needs help negotiating transactions. He'll walk out of the bank with money openly showing in his hand. He needs to be reminded to bathe, get a haircut, brush his teeth, and shave. The Appellant has a few friends who live within the community, all of whom are megihallenged, but the Appellant prefers to be home in his room rather than out with these friends. The s have to push the Appellant to go to social events sponsored by ARC.

Mr. Comeau testified that he has worked with the Appellant for about 10 years, first as an employee with and then later when he became employed by DSS. He helped place the Appellant with the 's. He said this arrangement has worked really well, and that because of the intense supports provided by the 's the Appellant has avoided residential placement.

Mr. Comeau said the Appellant has received special education services his entire education. He was in self-contained classrooms. At the end of his schooling he did a work-study program but had trouble completing assignments. He's been given a lot of opportunities to succeed and he tries hard, but he needs a lot of structure and supervision. Sometimes he needs someone to speak for him. He presents higher functioning than he is. Mr. Cor neau said it's difficult to get the Appellant to answer questions, even something as straightforward as "do you have homework." Mr. Corneau said the Appellant will stare for a while, and minutes later will answer the question. He said it's hard to get answers or communicate with the Appellant.

Mr. Comeau said the Appellant attended and graduated from High School. He passed the MCAS, although there were uestions about the validi of assin ades. He said the year the Appellant took the MCAS . Apparently the Appellant's twin brother, who is higher functioning than the Appellant, did not pass the MCAS.

Tillant added testimony that he worked at washing dishes in the . He said he works every day except , and knew the names of the days he worked. He gets paid for working and he likes his job. He said he takes the bus — the dollar ride — every day. They pick him up and drop him off in both directions.

Mr. said the Appellant's work program is sponsored by the Massachusetts Rehabilitation Commission and administered by the ARC. The Appellant receives intensive job coaching. Prior to his current job the Appellant worked at the ARC doing piece work, but that job was de-funded. Mr. said there are a lot of supports helping the Appellant without which it would be much more difficult for him to navigate daily living in an effective and safe way.

Dr. Brad Crenshaw testified for the Department. He is the DDS psychologist for intake and eligibility for the central and western regions of Massachusetts. After reviewing his credentials he was declared an expert witness. Dr. Crenshaw testified that he reviewed the Appellant's entire file and came to a recommendation that he was not eligible for DDS services.

In a review of the exhibits in the record, Dr. Crenshaw first discussed Exhibit 3, the 1999 Neuropsychological Evaluation. In that report the evaluator provided scores from prior testing, including the WPPSI-R from 1994 on which the Appellant received scores of Full Scale IQ 81, Verbal IQ 81, Performance IQ 86, and a WISC from 1997 on which the Appellant had scores of Full Scale 70, Verbal 64, and Performance 80.

Dr. Crenshaw then reviewed the testing done with this report. He said the Appellant was given the WISC-III, on which he received a Full Scale IQ score of 83, which was within the low average to average range of intellectual functioning. His Verbal IQ score was 80 and his Performance IQ score was 90. From this performance, Dr. Crenshaw testified that the Appellant fell outside the regulatory threshold for Department services. Dr. Crenshaw also noted that the Appellant had attention difficulty during testing, despite having taken medication for inattention prior to testing.

Dr. Crenshaw next reviewed Exhibit 4, the Neuropsychological Evaluation done 2002. He said the evaluator reported the results of a WISC-III given to the Appellant just a few days prior to this evaluation.[3] Dr. Crenshaw reviewed the Appellant's scores of Full Scale IQ 85, Verbal IQ 84, and Performance IQ 89.

Dr. Crenshaw testified that the evaluator administered the Stanford-Binet because less than a year had elapsed since the Appellant was given the WISC. On the SB-4, the Appellant's Test Composite score was 75, his Verbal Reasoning score was 88, his Abstract/Visual Reasoning score was 78, and his Short-Term Memory score was 66. Dr. Crenshaw testified that these scores were consistent with the prior WISC scores in terms of the absolute scores and the pattern of scores. He said the Appellant was scoring in the low average to borderline range and that his attention was significantly reduced.

Dr. Crenshaw next reviewed Exhibit 5, the Neuropsychological Assessment dated , 2005. In that assessment, the evaluator administered the Wechsler Adult Intelligence Scale - Third Edition (WAIS-III). This report also provided results of prior testinglot otherwise in the record. The Public Schools administered a WISC-IV to the Appellant in INE 2005 when he was 16 years old. His scores on that test were Full Scale IQ of 63, Verbal Comprehension 85, Perceptual Reasoning 67, Working Memory Composite 50, and Processing Speed 75.

Dr. Crenshaw reported the Appellant's scores on the WAIS-III as Full Scale IQ 69, Verbal IQ 74, and Performance IQ 69. The factor scores were: Verbal Comprehension 84, Perceptual Organization 72, Working Memory 63, and Processing Speed. Dr. Crenshaw noted that if the Appellant's attention (WMI-63) and verbal skills (VCI-84) were combined, the result would be a score of 74. However, if the verbal intellect was looked at on its own, that pure factor was 84.

Next Dr. Crenshaw reviewed Exhibit 6, an evaluation done at Hospital dated 2009. The Appellant was 20 years old at the time of the evaluation, which means that the evaluation fell outside the developmental period. Dr. Crenshaw thought this was significant because Department regulations require mental retardation to manifest before the age of 18. The Appellant's scores on the WAIS-IV were Full Scale IQ 67, Verbal Comprehension Index 72, Perceptual Reasoning Index 75, Working Memory Index 66, and Processing Speed Index 76. Dr. Crenshaw noted that the Appellant's verbal comprehension declined for the first time.

Dr. Crenshaw next reviewed Exhibit 7, the Adaptive Behavior Assessment System - Second Edition (ABAS-II). The ABAS-II is a formal evaluation done through a structured interview of people who know the Appellant well and yields an objective measure of behavior. Dr. Crenshaw testified that the Appellant's

[3] The WISC-III was administered by the Public Schools on , 2002. *See,* Exhibit 4, *supra.*

scores of GAC 64, Conceptual 72, Social 72, and Practical 70 confirm that his behavior is disruptive, which Dr. Crenshaw said was attributable to the Appellant's multiple behavioral diagnoses.

Finally Dr. Crenshaw reviewed his Eligibility Report (Exhibit 9) that he completed after reviewing all the information in the Appellant's file. His impression was that the Appellant's cognition historically was in the borderline low average range, and as a consequence he was not eligible for services through DDS.

On cross-examination, Mr. pointed out that even though one evaluation was done after the Appellant turned 18, there were still two evaluations in the record in which the Appellant had full scale IQ scores below 70.

Upon questioning, Dr. Crenshaw addressed the Vineland reported on in Exhibit 3. He said the Appellant's Communication was suppressed, but he didn't know what was suppressing it. The same thing was the case with Daily Living Skills. Dr. Crenshaw said the Appellant's Socialization score was marginally better, but all of the domains were low which meant the Appellant was struggling behaviorally in those domains. Dr. Crenshaw noted the missing GAC composite score from the test results, but said he imagined it would be below 70.

There was discussion regarding the range of scores, confidence intervals, and the most appropriate score within the range to consider. Dr. Crenshaw said the whole point of confidence intervals is that it varies above as well as below, so the scores that are given are considered the most likely scores. In the Appellant's case, even though the Full Scale IQ was 67 on the WAIS-IV (Exh 6), the factor scores of VCI and PRI were 72 and 75 respectively, so both intellectual channels were within the borderline range. What brought down the Appellant's full scale IQ was his attention score of 66, something that is seen throughout the record. Dr. Crenshaw said the Appellant has difficulty focusing and organizing what he knows, which reduces the efficacy of his performance, so these IQ scores could be interpreted as underestimating the Appellant's cognitive ability. Dr. Crenshaw said it's important to split out the factor scores to find out what is going on. In the Appellant's case, the question is whether he does not have the information or whether he has it but there is something impairing his ability to access the information he possesses. Dr. Crenshaw said this is not an academic question, it is what determines the proper interventions. The factor scores get more particular to represent the different features of cognition, the sum of which is disruptive behavior.

Mrs. discussed her opinion that the Appellant needed DMR services because of his cognitive limitations, and that DMH services were not appropriate for him. Mr. was concerned that ifthe Appellant had to get services from DMH instead of DDS, the only way he could get adult foster care services was to go to and leave the home of his foster parents because doesn't offer this type of services. But Mr. Comeau would not want to move the Appellant out of his living situation with the s because it's been so good for him.

The 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 . . . .

**Finding of Fact and Conclusions of Law**

The Appellant, born , 1988, is 21 years old. He lives with his foster parents in , MA and meets the domicile requirements of the Department. He was born prematurely, had respiratory distress, and spent a month in the hospital. Because of delayed language development he began early intervention services at the age of two. The Appellant received special education services in a self-contained classroom since the beginning of his schooling. He was removed from the home of his biological parents at the age of

eight because of abuse or neglect and went under the uardianship of DCF. For the last ten years has lived with his current foster parents. He graduated from High School and, with a significant amount of support throw h the Massachusetts Rehabilitation Commission, the A ellant currently works

washing dishes at at

There is no question the Appellant has significant limitations of adaptive functioning that meet the Department's criteria in terms of raw numbers. The record includes three adaptive functioning assessments with the following results.

| Year | Test | Exh# | GAC | Communication | Living | Socialization |
|---|---|---|---|---|---|---|
| 1. 1999 | Vineland | 3 | <70[4] | 58 | 62 | 72 |
| | | | | Conceptual | Practical | Social |
| 2.2009 | ABAS-II | 6 | 64 | 70 | 63 | 66 |
| 3.2009 | ABAS-II | 7 | 64 | 72 | 70 | 72 |

The Appellant's GAC scores of below 70, 64, and 64 on these assessments meet the Department's requirement of scores of 70 or below, but critically they do not provide the *source* of the adaptive limitations. The additional inquiry that must be made is 1) whether the Appellant has cognitive limitations that meet the Department's criteria (IQ scores at 70 or below) and if so; 2) whether those scores are representative of overall limitations of cognitive functioning or whether the low scores are the result of the influence of other factors. Finally, should these questions be resolved in the Appellant's favor with respect to this appeal, the inquiry would proceed to 3) whether the Appellant's adaptive limitations flow from and are related to his cognitive limitations.

We have the benefit of numerous cognitive evaluations that respond to the question of the Appellant's test scores.

| Year/age | Test | Exh# | VIQ | PIQ | FSIQ |
|---|---|---|---|---|---|
| | | 3 | 81 | 86 | 81 |
| $t_{it}$ | | 3 | 64 | 80 | 70 |
| | | 3 | 80 | 90 | 83 |
| 1. 1994 (5. | WPPSI-R | 4 | 84 | 89 | 85 |
| 2. 1997 (9. | WISC-III | | | | |

| Year/age | Test | Exh# | Composite | VR | AVR | | S-TM |
|---|---|---|---|---|---|---|---|
| 5.2002 (131) | SB-4 | 4 | 75 | 88 | 78 | | 66 |

| Year/age | Test | Exh# | VIQ | PIQ | FSIQ | VCI | POI | PSI | PRI | WMI |
|---|---|---|---|---|---|---|---|---|---|---|
| | | 5 | | | 63 | 85 | | 75 | 67 | 50 |
| $li_t$ | | 5 | 74 | 69 | 69 | 84 | 72 | 76 | | 63 |
| 6.2005 (16. | WISC-IV | 6 | | | 67 | 72 | | 76 | 75 | 66 |
| 7. 2005 (16. | WAIS-III | | | | | | | | | |

It can be seen that in his earlier developmental years (0-13), the Appellant's Full Scale IQ scores ranged from 70 to 85, then after the age of 16 dropped to 63-69 as he reached and then passed age 18, the end of the developmental period. The earlier scores (other than the WISC-III in 1997) are above the Department's eligibility criteria, so the Appellant would not have met the definition of mental retardation or been eligible for services based on these test results. In later years, though, his scores declined to the point where they fell within the Department's numeric range of eligibility. With this decline, the question that presents itself is whether the Appellant's cognitive functioning declined to the point where he met the definition of mental

[4] As noted above, page 15 of Exhibit 3 is missing, which presumably includes the GAC score that Dr. Crenshaw assumed would fall under 70.

retardation, or whether the decline in scores is explicable for some reasons unrelated to cognitive functioning. In other words, it is necessary to try to flesh out the reason for the Appellant's decline in scores after 2002, which involves determining whether his lower scores are based on limited cognitive functioning reflecting mental retardation, or whether the Appellant had the information stored but was having difficulty accessing that information for some reason(s) unrelated to cognitive functioning.

The Department psychologist has argued the latter, and suggested that both attentional difficulties and psychological issues provide the reasons for the Appellant's decline. In testimony and his Eligibility Report (Exh 9), Dr. Crenshaw offered the Appellant's verbal and performance scores, isolated from working memory and other attentional tests, as the core tests of intellectual functioning to show the Appellant's actual cognitive functioning was not captured by the full scale scores. The Appellant's verbal scores were 81, 64, 80, 84, 88, 85, 84, and 72 and the performance scores were 86, 80, 90, 89, 78, 67, 72, and 75. Thus, with the exception of one verbal score of 64 in 1997 on the WISC-III and one performance score of 67 in 2005 on the WISC-IV, the Appellant's scores of core intellectual functioning were all above the Department's threshold criteria. In the last evaluation prior to the Appellant turning 18 (Exh 5), Dr. also indicated that he believed the Appellant's overall functioning appeared too high to fall within the range of mentally retarded.

In trying to bring some explanation to these scores, Dr. Crenshaw referred to the Appellant's attentional problems as the source of lower scores, not his lack of cognitive limitations. Throughout his testing history, the Appellant consistently demonstrated attentional issues. Exhibit 3 relayed the following information: In the earliest testing from 1994, the Appellant was reported to have significant learning disabilities related to language, verbal memory, attention, and organization of information. In 1999 at the time of testing, the Appellant's teacher described him as spacey and inattentive. He was taking Adderall for inattention and overactivity. During testing, attention difficulty was apparent despite having taken medicine for inattention prior to testing. On the Conners' Continuous Performance Test (CPT) a test of attention and concentration, the Appellant revealed inattention and inconsistent responding, and several key indices on the test were suggestive of an attention disorder.

Exhibit 4 showed that during testing, the Appellant was very fidgety, easily distracted, and had difficulty remaining focused. On attention related tasks and throughout testing, the Appellant had significant attention difficulties with all aspects of his performance. The examiner tried to administer the Conners' Continuous Performance Test-II (CPT-II) but the Appellant abandoned the test. Results of the BASC (rated by his foster parents) showed that the Appellant exhibited significant symptoms of anxiety, withdrawal, atypical behavior, and attention problems.

The Appellant has had a long history of psychological issues that could also account for or contribute to his lower IQ scores. In 1999 on the ADHD Rating Scale, he had a significant number of behaviors endorsed to meet the ADHD criteria (Exh 3). He was reported to have anxiety and PTSD related symptoms and was taking Adderall, Zyprexa, Clonidine and Trazodone (Exh 4). The 2005 evaluation reports that the Appellant had previously been diagnosed with ADHD, PTSD, Mood Disorder, NOS, Psychotic Disorder NOS, Rule Out Dissociative Identity Disorder, and an Anxiety based disorder, and that in 2003 he was diagnosed with Schizophrenia (Exh 5). At the time of the 2005 testing, though, the examiner questioned the diagnosis of Schizophrenia, although he acknowledged that the medications the Appellant was taking may have acted to contain the psychotic processes. That same examiner rejected the diagnosis of ADHD in favor of attributing the Appellant's presentation to developmental delays and recommended a psychopharmacological consultation to explore differential diagnosis. At the time of the 2005 testing the Appellant was taking Abilify and Trazodone (Exh 5). As of the most recent report in 2009 (Exh 6), the Appellant was taking Wellbutrin and Abilify.

Where there are psychological, behavioral, and cognitive issues intersecting and overlapping in cases such as this one, it may not be possible to determine conclusively the cause for declining scores. What does seem evident in this case is that the Appellant faces attentional and psychological issues that likely interfere with

his test results. The fact that DMH has accepted him for adult services (Exh 8) supports this conclusion. Further, with one exception each on the Appellant's verbal and performance test scores, these core intellectual scores are all above the Department's eligibility criteria. Isolating these tests scores screens out the Appellant's attentional or behavioral problems noted above. In doing so, we see test scores that demonstrate cognitive capacity exceeding the Department's definition of mental retardation. In this regard I find the testimony of Dr. Crenshaw compelling on the issue of the Appellant's intellectual functioning, and accordingly find that he is not cognitively limited to the degree required by Department regulations to meet the definition of mental retardation.

The Appellant has the burden of establishing eligibility by a preponderance of the evidence, but I cannot find that he has been able to meet this burden. For the reasons set forth above, I find that the Appellant's cognitive limitations do not meet the Department's criteria, and accordingly I do not reach the question of whether his adaptive limitations exist concurrently and related to cognitive limitations. However, as noted above, the Appellant does have significant limitations in adaptive functioning and will need services presumably throughout his life. It is gratifying that DMH has accepted him and based on the evidence and testimony in this case, that appears to be an appropriate placement.[5]

**Conclusion**

Based on my determination that the Appellant does not have 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: _____ _____

Elizabeth A. Silver
Hearing Officer

[5] In making this decision I am mindful of and sympathetic to the concerns expressed by Mr. Comeau regarding the difficult choice the Appellant will face between accessing DMH adult foster care services in and remaining with the s in . Clearly the 's have been an exemplary placement for the Appellant and should be commended for their constant and significant level of care and support of the Appellant as well as their obvious affection for him. I hope that there can be some resolution to this issue that allows for the Appellant to access meaningful DMH services while remaining in the s care.