THE COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss.

CIVIL SERVICE COMMISSION
One Ashburton Place, Room 503
Boston, MA 02108
(617) 727-2293

B.M.,
Appellant

v.

G1-10-XXX[1]

BOSTON POLICE DEPARTMENT,
Respondent

Appearance for Appellant:
Michael Rabieh, Esq.,
Lichten & Liss-Riordan, P.C.
100 Cambridge Street, 20th Floor
Boston, MA 02114

Appearance for Respondent:
Amanda Wall, Esq.
Boston Police Department
Office of the Legal Advisor
One Schroeder Plaza
Boston, MA 02120

Commissioner:
Paul M. Stein

DECISION

The Appellant, B.M., appealed to the Civil Service Commission (Commission), pursuant to G.L.c.31, §2(b), from a decision by the Boston Police Department (BPD), as delegated authority of the Personnel Administrator of the Massachusetts Human Resources Division (HRD), to bypass B.M. for original appointment to the position of Boston Police Officer based on the results of a pre-employment psychological screening. A full hearing was held on August 3 and 5, 2011 at the offices of the Commission and was digitally recorded. Fifteen (15) exhibits were entered into evidence at the hearing and three (3) additional exhibits (P.H.17A-17D, 18 &

[1] After careful review, the Commission opted to use a pseudonym for the Appellant to appropriately balance his privacy interests with the Commission's statutory obligation to provide the public with a transparent record of its deliberative process and interpretation of civil service law.

19 were marked after the hearing). BPD called one witness and B.M. called two witnesses and testified on his own behalf. The witnesses were not sequestered. Both parties subsequently submitted proposed decisions.

FINDINGS OF FACT

Based upon the Exhibits; testimony of the Appellant, U.S. Army Captain Matthew Christopher, Dr. Ronn Johnson, Ph.D. and Dr. Mark Schaeffer, Ph.D., and inferences reasonably drawn from that evidence as I find credible, I make the findings of fact set forth below.

1. The Appellant, B.M., was born and raised in Dorchester, Massachusetts. He struggled in elementary school and, eventually, was diagnosed with Attention Deficit/Hyperactivity Disorder (ADHD).[2] He was treated with therapy to learn reading and memory skills and was on a regimen of Ritalin and, later, Adderall, which remitted his symptoms. He was an average student with no history of disciplinary issues. After receiving approval from his doctor, he discontinued taking Adderall to improve his sleeping and in anticipation of joining the military, without noticeable effects on his academic performance or return of symptoms of ADHD. The Commission takes administrative notice that sleep disturbance is a common side effect of taking Adderall. (*Exh. P.H.19; Testimony of Appellant: Dr. Johnson & Dr. Schaefer; Administrative Notice [sideeffectbasd.com/Adderall-side-effects (visited 8/14/2013); webnd.com/ drugs/drug-32556-Amphetamine (visited 8/14/2013)*)

2. While in high school, B.M. spoke to a U.S. Marine Corps recruiter and decided he would enlist after graduation. He aspired to become a police officer and believed that military service would prepare him for that career. His mother objected to his enlistment, however, and, in order

[2] According to the Diagnostic and Statistical Manuel of Mental Disorders (DSM-IV), ADHD includes three sub-types, a Predominantly Inattentive type, a Predominantly Hyperactive-Impulsive Type and a Combined Type. Although which of these sub-types applied to B.M. was not stated explicitly, There is no evidence as to which of these sub-types applied to B.M. (*Exhs. 7,8,14,15,P.H.17B & P.H.19 Testimony of Appellant, Dr. Johnson & Dr. Schaefer*)

to follow her wishes, he agreed to go to college first, and enrolled in Norwich University, a military-style college in Northfield, Vermont. (*Exhs. 1, 8, 14,P.H.19 Testimony of Appellant, Dr. Johnson & Dr. Schaefer*)

3. B.M. liked his college military classes but otherwise did poorly, frequently partying and skipping classes. He was drinking beer with his rugby team and about 100 other underage students one night when the police arrived and everyone fled. B.M. obeyed the police order to stop and submitted to a breathalyzer test which showed no intoxication. He was charged with being a minor in possession of a malt beverage, paid a $100 fine, and performed community service. He left Norwich University after three semesters and enlisted in the Army. (*Exhs. 14, Testimony of Appellant*).

4. B.M. returned to Dorchester where he hung out with friends awaiting his call to military service. He served on active duty with the U.S. Army for five years beginning in August 2003. He was offered the choice of assignment as a military police officer or a medic, and he chose the latter. He went through a 16 week training that included both rigorous academic and hands-on medical practice. He completed the training successfully and served two tours in Iraq as a combat medic, one in charge of a forward aid station and a second tour as a combat medic embedded with an infantry unit. He was required to participate in direct combat missions, assist wounded soldiers while under fire and perform emergency treatment of life-threatening injuries. He also conducted medical clinics for both soldiers and Iraqi civilians. He carried a rifle and a sidearm. (*Exhs. 1 & 2: Testimony of Appellant & Capt. Christopher*)

5. B.M.'s work as a combat medic required concentration, a lot of precision, attention to detail and good memory skills. For example, he was required to keep careful track of the medical supplies needed to be kept in stock, which included prescription drugs and narcotics. As an

infantry combat medic, B.M. had to remember the medical history of all forty soldiers in his unit, since their lives depended on knowing what allergies they each may have had should they need emergency medical treatment on the battlefield. He was promoted four times while on active duty, and achieved the rank of Sergeant/Health Care Specialist (E-5) which is a feat rarely achieved by an army medic. He was envied by his infantry colleagues because he qualified with the M-16 and M-4 rifles at the level of "expert" which demonstrates above-average degree of proficiency after considerable practice. He was Honorably Discharged in November 2008. (*Exhs. 1 & 2: Testimony of Appellant & Capt. Christopher*)

6. Soldiers are not allowed alcohol while "in theatre" (except for two beers on Super Bowl Sunday), which is a strictly enforced rule. B.M. had no difficulty complying with this rule and he abstained from drinking while stationed in Iraq. Upon his return, he did drink frequently for a while, which is not uncommon for soldiers returning from a combat theatre. His frequency of drinking decreased over time and he stopped drinking entirely when he began to prepare for admission to the police academy. He last consumed five or more beers in 2009 on St. Patrick's Day. (*Exh 8;Testimony of Appellant, Capt. Christopher & Dr. Johnson*)

7. B.M. admits to having hangovers on occasion, but he never engaged in "Binge Drinking" in which he tried to consume a large number of drinks in a short period of time with the intent of getting high. Save for the one incident in college, he has never been involved in any motor vehicle accident, driving offense, fight or disciplinary matter in which alcohol was involved. (*Exhs. 1, 2; Testimony of Appellant & Dr. Schaefer*)

8. Following his discharge from active duty, B.M. continued his military service and joined a unit of the Army National Guard where he is a battalion sergeant, responsible for the unit's paperwork and training of the soldiers in his unit in combat medical care. He was selected to

organize and led an honor guard to perform a military funeral for a fallen solder, which required 9 hours of intense training to learn the complex logistics for such a ceremony, which he pulled off successfully. (*Exh. 1*; *Testimony of Appellant & US Army Capt. Christopher*)

9. B.M.'s National Guard commanding officer, Capt. Matthew Christopher, testified at the Commission hearing about B.M.'s job performance. Based on his observations of B.M. while under his direct supervision, which included a period of time prior to the date he was bypassed, he quickly found him a dependable soldier whom he regarded as very responsible and diligent. He observed no indications that B.M. has a problem with drugs, alcohol, stress, inattentiveness or attention to detail. (*Testimony of Capt. Christopher*)

10. B.M. has returned to college and has been studying for a degree in criminal justice while working full-time in his family's funeral home business. His academic performance has been satisfactory. (*Exhs 1, 2 & 14; Testimony of Appellant & Dr. Schaefer*)

11. B.M. participates in community volunteer activities, including the Savin Hill Civic Association and the Savin Hill Baseball League. (*Testimony of Appellant*)

12. I saw no sign of inattentiveness, forgetfulness or hypersensitivity in B.M.'s appearance at the Commission hearing. To the contrary, he was a particularly candid, self-assured witness with a keen memory for events, be they as far back as his childhood recollections or as recent as his interviews with the BPD detective and psychological screeners. (*Testimony of Appellant*)

<u>The Appellant's Applications for Appointment to the BPD</u>

13. In April 2009, B.M. studied for and took the civil service examination for entry level police officer. He achieved a score of 99 (out of a possible 100). (*Testimony of Appellant*)

14. In April 2010, B.M.'s name appeared on HRD Certification No. 290999 issued to BPD. He completed the standard BPD Student Officer Application, which included the required

neighborhood and character letters of reference, including a reference from his future mother-in-law, all of which were uniformly positive. (*Exh. 1 & P.H.18*)

15. B.M.'s application was scrutinized by a thorough background investigation conducted by BPD Detective Kenneth Westhaver of the BPD's Recruit Investigations Unit (RIU). Detective Westhaver's report noted the uniformly positive information about B.M.'s military record and his references. His academic record was noted, as was his driving history, and his sealed record for a charge of a minor in possession of alcohol while he was at Norwich University. The later incident was fully explained to Det. Westhaver by B.M. during his background interview. Det. Westaver's report noted nothing problematic about anything in B.M.'s record. (*Exh. 2; Testimony of Appellant*)

16. Following submission and review of the RIU investigation report, the BPD extended B.M. a conditional offer of employment, subject to completing a medical/psychological examination and a physical ability test. (*Undisputed Fact*)

17. The BPD conducts the psychological screening of police officer candidates pursuant to the terms of HRD's Medical and Physical Fitness Standards Tests for Municipal Public Safety Personnel, which are described in HRD's Physician's Guide – Initial-Hire Medical Standards (HRD Medical Standards). (*Exh.9*)

18. The HRD Medical Standards state:

> "Each municipal police department shall establish and implement a pre-placement medical evaluation process for candidates. During medical evaluation, *the physician shall evaluate each individual to ascertain the presence of any medical conditions* listed in these standards, or any medical conditions not listed *which would prevent the individual from performing the essential job functions without posing significant risk. It is our intent to encourage the use of professional judgment regarding medical conditions that are not specifically listed*. A candidate shall not be certified as meeting the medical requirements of these standards if the physician determines that the candidate has any Category A medical condition specified in these standards. Furthermore, *a candidate shall not be certified as meeting the medical requirements of these standards if the physician*

determines that the candidate has a Category B medical condition that is of sufficient severity to prevent the candidate from performing the essential functions of a police officer without posing a significant risk to the safety and health of him/herself or others."

(Exh. 9, p. 5) (*emphasis added*)

19. Category A and Category B "Psychiatric" medical conditions are defined as follows:

> Category A medical conditions shall include: a. disorders of behavior, b. anxiety disorders, c. disorders of thought, d. disorders of mood, e. disorders of personality.
>
> Category B medical conditions shall include: a. a history of any psychiatric condition, behavior disorder, or substance abuse problem not covered in Category A. Such history shall be evaluated based on that individual's history, current status, prognosis, and ability to respond to the stressors of the job, b. any other psychiatric condition that results in an individual not being about to perform as a police officer.

(*Exh. 9, p.16*)

20. The purpose of a psychological evaluation is to identify job-related dysfunctions that "rule out" a candidate from serving as a police officer. A current diagnosis of a mental disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association is sufficient to qualify as a Category A medical condition. A Category B psychiatric condition is manifest by substance abuse or any other job-related patterns of behavior or cognitive dysfunction that are present and justify a clinical judgment that a candidate's current impairment will interfere with his or her ability to perform the essential functions of the job of a police office. (*Testimony of Dr. Johnson & Dr. Schaefer*)

21. In or about July 2004, BPD submitted, and HRD approved, the BPD's Proposed Psychological Screening Plan, which provided for a three-phase testing and interview process.

> Phase I – Administration of two written, computer scored psychological tests – the Minnesota Multiphasic-Personality Inventory – 2 (MMPI-2), and Personality Assessment Inventory (PIA). In addition, candidates are required to complete a biographical history questionnaire.
>
> Phase II – A thirty (30) minute interview performed by the BPD's staff psychiatrist .
>
> Phase III – If the Phase II interview raised any suitability issues, a second "in-depth clinical interview" by a Board Certified Psychiatrist, who generates a comprehensive report. The BPD staff psychiatrist will review this report and concurrence will be recorded.

(*Exh.10)*

22. On July 1, 2010, BPD's Director of Human Resources submitted a revised psychological screening plan to HRD, and requested HRD's review and approval "as soon as possible, as we have begun processing for another recruit class and will soon be required to engage in the psychological and medical screening components." (*Exh.11*)

23. The revised plan continued the basic three-phase components of the 2004 plan, with three principal substantive changes: (a) the MMPI-2 [Restructured Form] (MMPI-2RF) replaced the MMPI-2 as one of the two written test instruments to be used,[3] (b) the initial or second screening interview could be performed by either a licensed psychiatric or a "doctoral level" psychologist, and (c) a BPD staff psychiatrist was no longer required to document concurrence with a second level screening recommendation. (*Exh.11*)

24. HRD formally approved the BPD's revised plan for psychological screening of candidates on June 30, 2011. (*Exhs 1 & .18*)

25. B.M. took the two written psychological tests prescribed by the BPD revised psychological screening plan, the MMPI-2RF and the PAI. He was allowed to reschedule his taking these tests because he had gotten a severe sunburn just before the originally scheduled date he was due to appear. *(Exhs. 3 & 4; Testimony of Appellant)*

26. B.M.'s MMPI2-RF test results disclosed no substantive behavioral concerns. There were "no indications of somatic, cognitive, emotional, thought or behavioral dysfunction" and "no specific psycho diagnostic recommendations". Although there were "flag" indicators in the elevated scores of two of the "validity" scales – which suggest the test taker may have been

[3] The MMPI-2RF and the MMPI-2 are substantially similar, with the MMPI-2RF being a new, condensed version. I do not find that the differences in the two versions have any material bearing on this appeal. Both tests involve a series of true-false questions or "items" which are scored in the same categories of clinical scales and both include a series of validity scales that help assess whether the test results suggest that the test taker has consciously or unconsciously skewed the results. (*Testimony of Dr. Johnson & Dr. Schaefer*)

motivated to put himself in a positive light – these scores were not elevated to a significant level and were generally consistent with other applicants for public safety jobs who had taken the same test. (*Exh. 3; Testimony of Dr. Johnson 7 Dr. Schaefer)*

27. B.M.'s PAI test results produced a strikingly different profile which characterized B.M. as a "high risk" for "integrity problems", "anger management problems", "alcohol use concerns" and "substance abuse proclivity" and "moderate" risk for "job-related problems" and "illegal drug use concerns". On the other hand, the PAI Interpersonal Style Circumplex placed B.M. in the "Warm Control quadrant, with 70% of all public safety applicants who took the test, and which the report stated "are the least likely to be rated as "poorly" suited" by psychologists experienced in public safety screening. (*Exh. 4*)

28. The PAI test is a proprietary psychological test instrument prepared by Michael D. Roberts, PhD. Although it is a widely used test, the methodology that underlies the computer-generated conclusions in the interpretive report is not known to have been subjected to peer review. (*Exh. 4: Testimony of Dr. Johnson*)

29. In B.M.'s case, his PAI profile was driven by some unusually elevated scales purporting to measure alcohol and drug abuse and aggressive behavior patterns, as well as endorsement of certain "critical items". (*Exh. 4: Testimony of Dr. Johnson & Dr. Schaefer*)

30. B.M.'s unusual answers to many "critical items" that most test takers would have answered differently have a clearly benign explanation. For example, he answered "False" to: "My drinking has never gotten me into trouble" (9% of the test takers answered that way) and "False" to :"I've never been in trouble with the law." In fact, his answers were honest – given his college experience. Similarly, he answered "False" to the question: "I never use drugs to help me cope with the world," which is the answer only 16% gave. Since he had taken

medication for ADHD as a child, this answer was technically true. After Dr. Schaefer reviewed these questions and answers with B.M., he realized that he misunderstood the questions and did not give the answer he intended. (*Exh. 4; Testimony of Appellant & Dr. Schaefer*)

31. On September 13, 2010, B.M. was sent to see Dr. Marcia Scott who conducted his first level screening. Dr. Scott did not appear to testify at the Commission hearing. Her report contains numerous unsubstantiated characterizations and factual errors. At the end of her interview, Dr. Scott told B.M. that he had a severe reading problem and she didn't think he would do well at the police academy. Based on the clear and convincing percipient testimony from B.M. concerning this interview, and the other credible evidence in the record, I give no weight to Dr. Scott's largely subjective interview impressions and unpersuasive conclusions contained in her report that were not corroborated, and in many cases, refuted, by other evidence. (*Exh.7; Testimony of Appellant*)

32. After BPD received Dr. Scott's report, B.M. was sent to Dr. Ronn Johnson, Ph.D, for a second level screening interview. Dr. Johnson is a licensed clinical psychologist who is employed as an associate professor of psychology at the University of San Diego. He performs pre-employment and fitness for duty psychological evaluations, primarily as a "first level" screener, for approximately twenty (20) law enforcement agencies, including the San Francisco, Los Angeles and New York police departments. He estimated that he has done approximately 11,000 such pre-employment screenings in his career. (*Exh. 17; Testimony of Dr. Johnson*)

33. Dr. Johnson receives the candidates' test results and the first-level screener's report along with the candidates' Student Officer Application packets before beginning his scheduled interviews. (*Testimony of Dr. Johnson*)

34. Dr. Johnson met B.M. at BPD headquarters on October 23, 2010. In his report issued the next day, he reported that:

> "There was no indication of impairment to motor functioning, speech or language. During the actual interview, he appeared able to display an acceptable level of confidence. His eye contact and affect were appropriate. B.M. was oriented as to person, time and place. There were no observable signs of unusual perceptual experiences. There were no noteworthy communication, demeanor, mood, or relationship style factors observed during the interview."

(*Exh.8*)

35. Dr. Johnson concluded that B.M. was "NOT RECOMMENDED as suitable for hire as an armed police officer with the BPD." This conclusion was based on "concerns" that: (1) B.M.'s test results (mainly the PAI) were potential signs of "integrity issues" and "antisocial attitudes, aggressiveness, blame-avoidance and substance abuse"; (2) his inability to make a connection between his "untreated ADD and. . . .his academic underachievement and impulsive decision to leave college in the wake of failure and escape into the military."; (3) his self-reported "worrisome alcohol use patterns" and perceived underreporting use of alcohol and possible binge drinking; (4) the belief that 52% of persons with untreated ADD will have drug or alcohol problems; and (5) "chronic problems with forgetting things and memory. . . noticed in the military, family members and himself." (*Exh. 8; Testimony of Dr. Johnson*)

36. Dr. Johnson acknowledged that B.M. was able to achieve "some degree of success in the military" and that his "military service is laudable but there were signs of difficulty noted while in the service. The demands of an armed police officer are different." (*Exh. 8*)

37. After completing the oral interview, Dr. Johnson gave B.M. a set of written questions which he was required to answer in writing. These questions included:

- "Write at least two paragraphs that explain why you believe that you are qualified for the applied for BPD position.
- Please identify and explain what was happening at school and home that lead you to being placed on medication."

- Please explain two work-related problems that occurred because you were not paying attention or focused on what was required.

B.M. prepared clear and cogent written responses to each of these questions as directed, left the form in a box for Dr. Johnson, who had started another screening interview. There is no reference or analysis in Dr. Johnson's report to this document and no evidence that Dr. Johnson made use of this document prior to reaching his conclusion to disqualify B.M. (*Exhs 8,19; Testimony of Appellant & Dr. Johnson*),

38. On December 13, 2010, the BPD's Director of Human Resources, Robin W. Hunt, wrote to inform B.M. that the BPD had determined that he "cannot adequately perform the essential functions" of a BPD police officer and "a reasonable accommodation is not possible." As the reason for this decision, the BPD quoted from Dr. Johnson's report, in which Dr. Scott was said to have concurred:

> 'There is current evidence of an Axis I mental disorder or current mental impairment. There is a well-established pattern of behavior and thinking that would significantly interfere with this recruit's ability to consistently perform the duties and manage the stress of an armed police officer. He was diagnosed and treated for ADD while in elementary school. He was treated up until 1999 or 2000 when he decided to discontinue the Adderall. His academic underachievement, failure in college, fueled by a rather unplanned decision to join the military, but (sic) are symptoms of untreated ADD. . . . He may make an effort to whittle down his job duties as a police officer into more manageable chunks but the ADD may cause him to fail to properly act (i.e., prematurely form closure) on the more accurate data available at the time that is required in carry (sic) out police duties. . . . He may seem inflexible or overlook important details. In summary, B.M.'s psychological testing, history, and clinical presentation contain a consistent picture of a man with untreated maladaptive job-relevant psychopathology. The relevance of this information is consistent with the psychological recommendation. That is, this applicant is not recommended as suitable for hire as an armed police officer with the Boston Police Department."

This Appeal duly ensued. (*Exh. 12: Claim of Appeal*)

39. At the Commission hearing, Dr. Johnson stated that the "Axis I" disorder he had in mind was not ADHD, but some other undefined "anxiety disorder" that did not specifically fit the criteria of any specific diagnosis found in the DSM-IV. He opined that he did not believe a

Category A mental disorder within the meaning of the HRD Medical Guidelines needed to be one contained within the DSM-IV, but could be based on an individualized opinion derived from other source materials as well. Dr. Schaefer took a different view of the intent of the guidelines, and construed a Category A medical condition to be condition upon which a professional medical consensus had formed that it was a per se disqualifier, and, thus, it had to fit the criterion of some generally recognized mental disorder as defined by the DSM-IV. (*Testimony of Dr. Johnson & Dr. Schaefer*)

40. Dr. Johnson based his conclusion that B.M. had some undiagnosed form of "anxiety disorder" on certain published materials which he cited during his testimony and which were subsequently provided and marked into evidence. These materials included three journal articles and two abstracts. (*Exhs. 17A through 17D; Testimony of Dr. Johnson*).

41. Only one of the articles on which Dr. Johnson relied actually involved persons with an anxiety disorder. This study, by Ameringen, et al, looked at a <u>clinical</u> population of <u>patients</u> who had been diagnosed with an anxiety disorder meeting the DSM-IV and other criteria and found that a sub-group of about one third of those <u>patients</u> also met the criteria for adult ADHD, and about a third of <u>that</u> sub-group of patients also had been diagnosed with ADHD as children. Overall, the study said the "prevalence of ADHD into adulthood is estimated to be between "2 and 7%". (*Exh. 17B*)

42. Another journal article, by Faranoe, et al, looked at the implications for "late onset" of ADHD and various forms of substance abuse among adults. Again, the methodology of this study used DSM-IV criteria to classify the subjects of the study and was focused mainly on comparing behavior patterns between those diagnosed with ADHD before and after age 7. According to the study, in comparing current (past month) use patterns reported by ADHD vs.

non-ADHD diagnosed individuals, the “only significant finding was for cigarette use . . . all ADHD groups smoked more that the non ADHD groups.” (*Exh. 17A*)

43. The third journal article, by Biederman, et al, involved a 10-year follow-up study of boys with ADHD, as defined by the DSM-IV criteria, and a control group of non-ADHD boys, that followed them to an average age of 22. This study confirmed the findings of others that “ADHD lessens with age”, that 65% of the ADHD group no longer met full DSM-IV criteria (called “syndrome remission”) and that 22% were “fully remitted.” For those who continued to exhibit some, but less than full, DMS-IV diagnostic criteria, only 15% were “functionally impaired.” The prevalence of continuing symptoms of ADHD in adulthood was correlated to the existence of additional comorbidity (other current DSM-IV diagnoses) and a prior familial history of the disorder in those adult individuals. (*Exh. 17B*)

44. The two abstracts reported that children with ADHD are “significantly more likely” to develop substance abuse disorders than children without ADHD”, but these documents contain no information as to the methodology or quantitative results of these studies. (*Exhs. 17C & 17D*)

45. The DSM-IV describes the “essential feature” of ADHD as a “persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequently displayed and more severe than typically observed in individuals at a comparable level of development”. There must be “clear evidence of clinically significant impairment” in at least two of the domains of “social, academic, or occupational functioning” In a majority of cases seen in clinical settings, the disorder is relatively stable through early adolescence and, in most individuals, symptoms attenuate during late adolescence and adulthood. A minority of adults will experience the full symptoms and some will retain a few, but not all of the symptoms, in which case the diagnosis of ADHD in Partial Remission is used. The DSM-IV states:

> "Caution should be exercised in making the diagnosis of Attention Deficit/Hyperactivity Disorder in adults solely on the basis of the adult's recall of being inattentive or hyperactive as a child, because the validity of such retrospective data is often problematic."

(*Exh. 15: Testimony of Dr. Johnson & Dr. Schaefer*)

46. ADHD is successfully treated by medication, such as Ritalin and Adderall. (*Testimony of Dr. Johnson & Dr. Schaefer*)

LEGAL STANDARD

Bypass appeals are governed by G.L.c.31, Section 27, which provides:

> "If an appointing authority makes an original or promotional appointment from certification of any qualified person other than the qualified person whose name appears highest [on the certification], and the person whose name is highest is willing to accept such appointment, the appointing authority shall immediately file . . . a written statement of his reasons for appointing the person whose name was not highest."

The task of the Commission when hearing a bypass appeal is "to determine . . . whether the appointing authority sustained its burden of proving, by a preponderance of the evidence, that there was reasonable justification" for the decision to bypass the candidate . . . . Reasonable justification in this context means 'done upon adequate reasons sufficiently supported by credible evidence, when weighed by an unprejudiced mind, guided by common sense and by correct rules of law.' " E.g., Brackett v. Civil Service Comm'n, 447 Mass. 233, 543 (2006) and cases cited. See also Mayor of Revere v. Civil Service Comm'n, 31 Mass.App.Ct. 315, 321 (1991) (discussing preponderance of the evidence test); Selectmen of Wakefield v. Judge of First Dist. Ct., 262 Mass. 477, 482 (1928) (same)

"In determining whether [an appointing authority] has shown reasonable justification for a bypass, the commission's primary concern is to ensure that the appointing authority's action comports with 'basic merit principles,' as defined in G.L.c.31,§1." Police Dep't of Boston v. Kavaleski, 463 Mass. 680, 688 (2012) citing Massachusetts Ass'n of Minority Law Enforcement

Officers v. Abban , 434 Mass. 256, 259 (2001). In conducting this inquiry, the Commission "finds the facts afresh", and is not limited to the evidence that was before the appointing authority. E.g., Beverly v. Civil Service Comm'n 78 Mass.App.Ct. 182 (2010); Leominster v. Stratton, 58 Mass.App.Ct. 726, 727-28 (2003) See also Tuohey v. Massachusetts Bay Transp. Auth., 19 MCSR 53 (2006) ("An Appointing Authority must proffer objectively legitimate reasons for the bypass"); Borelli v. MBTA, 1 MCSR 6 (1988) (bypass improper if "the reasons offered by the appointing authority were untrue, apply equally to the higher ranking, bypassed candidate, are incapable of substantiation, or are a pretext for other impermissible reasons.")

It is the purview of the hearing officer to determine the credibility of the witnesses who appear before the Commission. "[T]he assessing of the credibility of witnesses is a preserve of the [commission] upon which a court conducting judicial review treads with great reluctance." E.g., Leominster v. Stratton, 58 Mass.App.Ct. 726, 729 (2003) See Embers of Salisbury, Inc. v. Alcoholic Beverages Control Comm'n, 401 Mass. 526, 529 (1988); Doherty v. Retirement Bd. Of Medford, 425 Mass. 130, 141 (1997). See also Covell v. Dep't of Social Services, 439 Mass. 766, 787 (2003) (decision relying on an assessment of the relative credibility of witnesses cannot be made by someone who was not present at the hearing)

When an appointing authority relies on expert opinion of a pre-employment psychological evaluation as the justification for a bypass decision, the Commission is mindful that the function of the psychological screening process is "narrowly circumscribed", i.e., the psychological screener's "sole task [is] to determine whether [the candidate] had a psychiatric condition that would prevent [the candidate] from performing, even with reasonable accommodation, the essential functions of the job." Police Dep't of Boston v. Kavaleski, 463 Mass. 680, 694 (2012). The role of the psychological evaluation is to ascertain whether the candidate's "history, current

status, prognosis and ability to respond to the stressors of the job" affirmatively prove the existence of a specific "disqualifying" psychiatric condition; it is not sufficient for the evaluator to find a candidate's psychological profile "not inconsistent" with a disqualifying condition or one the evaluator thought "may" be present and it is not appropriate for the evaluator to look for the presence of "qualifying traits" or to make "substantially subjective determinations" about a candidate's suitability for police work. Id., 463 Mass. at 692-695.

While there is some room for consideration of a recruit's history of risky behavior in the context of a separate search for evidence of a current psychiatric medical condition, the HRD Medical Guidelines clearly require more than simply having a psychological evaluator offer his or her subjective "concerns" about a candidate's interview performance or past conduct that the BPD already knew about and found not to be disqualifying. In Goff v. Fall River Police Dep't, CSC No. G1-12-263, 26 MCSR 228 (2013) citing Roberts v. Boston Police Dep't, 21 MCSR 536 (2008), the Commission construed a Category B medical condition to mean:

> "An applicant may be disqualified for having a Category B "psychiatric condition" so long as the applicant has a "psychiatric condition" which has manifested itself by a preponderance of scientifically reliable and credible proof of deficient mental health behavior, but not necessarily proof of a psychiatric "disorder" found within the DSM-IV. Should the occasion present itself in future cases, the Commission may consider further refinement of this definition, as well as further inquiry into the scientifically appropriate role of clinical interview impressions and standardized testing in the evaluation process, with a view to seeking greater clarity on these subjects that will preserve the balance necessary to respect the legitimate purposes of PSP screening while promoting requirements of the basis merit principle that eschews public employment decisions when they are arbitrary and capricious or incapable of fair and objective substantiation."

Moreover, under HRD's Medical Guidelines, a candidate's psychiatric condition must be of "sufficient severity to prevent the candidate from performing the essential functions of a police officer without posing a significant risk to the safety and health of him/herself or others." Finally, the BPD's screening plan requires that a candidate's condition must be one that cannot

be ameliorated by "reasonable accommodation." Goff v. Fall River Police Dep't, CSC No. G1-12-263, 26 MCSR 228 (2013)

The opinions of expert witnesses have no special "magic qualities" and the Commission, as the trier of the facts, may decline to adopt them in whole or in part and may give them such weight as they deserve. See, e.g., Police Dep't of Boston v. Kavaleski, 460 Mass. 680, 694-695 (2012) and cases cited; Commonwealth v. Gaynor, 443 Mass. 245, 266 (2005); Ward v. Commonwealth, 407 Mass. 434, 438 (1990); New Boston Garden Corp. v. Board of Assessors, 383 Mass. 456, 467-73 (1891); Turners Falls Ltd. Partnership v. Board of Assessors, 54 Mass.App.Ct. 732,737-38, rev. den., 437 Mass. 1109 (2002). Dewan v. Dewan, 30 Mass.App.Ct. 133, 135, rev.den., 409 Mass. 1104 (1991).

ANALYSIS

The BPD has failed to prove by a preponderance of the evidence that B.M. possessed a disqualifying psychiatric condition that justified the decision to bypass him for appointment to the position of BPD Police Officer. [4]

First, the preponderance of evidence does not establish that B.M. suffers from a Category A medical condition that would constitute an automatic per se disqualification for appointment or a Category B medical condition as defined by the HRD Medical Guidelines. In particular, there is no credible evidence that supports the conclusion that B.M. currently has any medical condition that would qualify as a clinically-recognized "anxiety disorder" or that his "untreated" ADHD was a current disqualifying medical condition. Dr. Johnson couched his opinions as "concerns"

[4] The Appellant argued that the BPD improperly used its 2010 screening process to disqualify B.M. before HRD had approved it and that the HRD Medical Guidelines and the BPD's then approved version did not authorize a psychologist, rather than a physician, to determine whether the candidate was medically unfit, and, therefore, the BPD's bypass decision is invalid on those grounds. In general, the Commission defers to the reasoned decisions of HRD on such technical matters, and this appeal presents no reason to address these questions as the remedy for any such procedural error, if any, would not differ from the remedy to be ordered here on the merits.

and “questions” based almost entirely on B.M.’s interview performance and “flags” raised by his PAI test results. These “concerns” and “flags”, which purportedly suggest that B.M. might “experience difficulties” as a police officer, are based on no specific examples, much less any rationally discernible pattern of dysfunctional behavior. Moreover, Dr. Johnson never opined that B.M.’s ADHD or other unspecified behavior disorder put his safety or the safety of others at risk were he appointed as a police officer and, even if he had, I find no credible basis to believe he was such a risk, particularly given his impressive military record as a combat medic and trainer, his current satisfactory academic progress toward a degree in criminal justice, and my personal observations of his attentive and composed demeanor during his appearance at the Commission hearing.[5].

Second, the subjective impressions expressed by Dr. Scott and Dr. Johnson also are wholly implausible in view of the BPD recruit investigator’s findings and other facts in the record about B.M. which Dr. Johnson and Dr. Scott either failed to consider or chose to overlook or simply got wrong. For example, Dr. Johnson knew little about B.M.’s work as a combat medic and equated it with the job of manning a state-side medical clinic. The evidence of “forgetfulness” involved B.M.’s admission to sometimes forgetting something when he goes grocery shopping or making a wrong turn and getting lost in an unfamiliar area, none of which can rationally infer pathological mental dysfunction. Nor is there any doubt that B.M. planned to join the military in high school and his enlistment as a combat medic after quitting college was clearly not “unplanned” or an “escape”, as Dr. Johnson asserted.

[5] I do not accept Dr. Johnson’s contention that a per se Category A medical condition can be established through an evaluator’s individualized interpretation of what constitutes such a condition, as opposed to a condition that has achieved generally-accepted recognition through inclusion in the DSM-IV or comparable mental health treatise. It is more consistent with the intent of the HRD Guidelines that, if such individualized disorders are appropriate at all, they would would fit more naturally in the realm of a Category B, rather than a per se Category A condition. Since the condition as described by Dr. Johnson does not hold up even on the evidence he proffered to support it, either as a Category A or Category B condition, this apparent flaw in his analysis needs no further discussion here.

Similarly, B.M. never failed to show up for "his physical exam" as Dr. Scott claimed (clearly misconstruing his rescheduling the psychological testing), I do not believe he complained to her with "anger" " that his family funeral business "would never be mine", when he never aspired to go into the business that was run by his older brother and never expressed an interest in doing so, but always wanted to become a police officer as did another brother, Patrick. Nor do I credit Dr. Scott's statement that he did not have "any reason or rationale for stopping" his regimen of medicine prescribed for ADHD (his doctor approved it), did not even consider restarting when he was not doing well in a very expensive HS" (conclusion based on flawed premises), and "made no connection between his failure and signing up for the military"(another conclusion based on a flawed premise). While his behavior in college was clearly not laudatory, there is no credible evidence to connect his childhood ADHD or his physician-approved decision to discontinue medication, with his mediocre (but satisfactory) record in high school or subsequent lack of motivation and neglect of his studies in college.

Moreover, the BPD was clearly appraised of the full extent of these events in B.M.'s earlier years, and did not find them, individually or collectively, to be problematic when it made a conditional offer of employment to him.

In sum, the BPD impermissibly found B.M. unfit solely because of the unsubstantiated and logically flawed hypotheses of Dr. Scott and Dr. Johnson that, because he had been diagnosed with, and successfully treated for ADHD as a child, he, therefore, probably had an undisclosed abuse problem and other undesirable personality traits. The credible evidence proffered by the BPD falls short of the standard required to prove that B.M. currently suffers from a disqualifying psychiatric condition that puts him or others at risk of harm to their health or safety as required by the HRD Medical Guidelines and applicable civil service law.

CONCLUSION

Pursuant to the powers of relief inherent in Chapter 310 of the Acts of 1993, the name of the Appellant, B.M., shall be placed at the top of the all future certifications for original appointment to the position of Police Officer in the BPD until he is selected for appointment or bypassed. If and when B.M. is selected for appointment and commences employment as a BPD police officer, his civil service records shall be retroactively adjusted to show, for seniority purposes, as his starting date, the earliest Employment Date of the other persons employed from Certification 290999. Finally, the BPD may elect to require B.M. to submit to an appropriate psychiatric medical screening in accordance with current BPD policy; provided, however, that such screening shall be performed, de novo, by qualified professional(s) selected by the BPD other than a mental health professional who has previously performed a first level or second level screening of B.M.

For all of the above reasons, the appeal of the Appellant B.M., under Docket No. G1-10-XXX, is ***allowed.***

Civil Service Commission

Paul M. Stein
Commissioner

By a vote of the Civil Service Commission (Bowman, Chairman; Ittleman, Marquis, McDowell and Stein, Commissioners) on August 22, 2013

A true record. Attest:

____
Commissioner

Either party may file a motion for reconsideration within ten days of the receipt of this Commission order or decision. Under the pertinent provisions of the Code of Mass. Regulations, 801 CMR 1.01(7)(l), the motion must identify a clerical or mechanical error in this order or decision or a significant factor the Agency or the Presiding

Officer may have overlooked in deciding the case. A motion for reconsideration does not toll the statutorily prescribed thirty-day time limit for seeking judicial review of this Commission order or decision.

Under the provisions of G.L c. 31, § 44, any party aggrieved by this Commission order or decision may initiate proceedings for judicial review under G.L. c. 30A, § 14 in the superior court within thirty (30) days after receipt of this order or decision. Commencement of such proceeding shall not, unless specifically ordered by the court,

Notice to:
Michael Rabeih, Esq.(for Appellant)
Amanda Wall, Esq. [for Appointing Authority]
John Marra, Esq. [HRD]