

February 16, 2005

Disability Analyst  
Social Security Administration  
1059 First Street  
Gilroy, CA 95020  
(408) 842-4485

Dear Sir or Madam:

Claimant [REDACTED] [REDACTED] offers the following letter brief in support of his application for SSI benefits. Included with this letter brief are his application materials, including:

1. Medical & School Worksheet – Child
2. Disability Report – Child
3. Questionnaire for Children Claiming SSI Benefits
4. Statement of Sandhya Shankar, [REDACTED] licensed social worker at the Mental Health Clinic at Juvenile Hall
5. [REDACTED]'s most recent Individual Education Plan, dated February 7, 2005
6. Medical Records from Fremont Hospital, where [REDACTED] was evaluated due to a 5150 Hospitalization from June 19, 2004 – June 22, 2004
7. Medical Records from Medical Pavilion, where [REDACTED] was evaluated due to a second 5150 Hospitalization from July 29, 2004 – August 3, 2004
8. Progress Notes from Community Solutions, where [REDACTED] was referred after his second 5150 Hospitalization at Medical Pavilion
9. Initial Assessment from EMQ Children and Family Services
10. Mental Health Progress Notes from Dr. Bruce Wermuth, [REDACTED] evaluating psychiatrist at Community Solutions
11. Juvenile Court Report from Dr. Robert Perez, Clinical Psychologist and Clinical Neuropsychologist, who evaluated [REDACTED] at Santa Clara County Juvenile Hall
12. Psychoeducational Assessment Report by Rebecca O'Brien, Morgan Hill Unified School District, Special Education Department, dated 12/3/2004
13. Psychoeducational Assessment Report by Donna Oliver, Morgan Hill Unified School District, Special Education Department, dated 1/20/2005

### Medical History

[REDACTED] current psychiatric problems date back to June of 2004, although, [REDACTED] mother reports that he has had medical and psychiatric difficulties since he was a child. In addition, there is a family history of Bipolar disorder, anxiety, depression, sociopathy, and delusions. [REDACTED] mother reports that [REDACTED] has had difficulty relating to his peers, forming relationships, and expressing emotion since he was a child. In addition, when he was a child, he had a history of being cruel to animals.

[REDACTED] was out of school for a year prior to his first, diagnosed psychotic break in June 2004. Prior to [REDACTED] 7th grade year, in the Fall of 2000, [REDACTED] mother requested that [REDACTED] be evaluated for special education services, because [REDACTED] was failing in school. However, despite this request, [REDACTED] school failed to assess him for special education services until the end of his 8th grade year, in the Spring of 2002. The assessment result was that [REDACTED] had Attention Deficit Disorder, and no other diagnosis was made at this time. Rather than special education, [REDACTED] was put on a Section 504 plan. Under this plan, [REDACTED] was to receive aid in every class, to be placed in close proximity to his teacher so that he could have his behavior monitored, and to be given revised tests. [REDACTED] mother monitored his progress in school, and determined that the section 504 was not being implemented correctly and complained to the school. At this point, the school recommended that [REDACTED] repeat his 8th grade year, and that he be placed at South County Alternative School, where he would receive more specialized care. However, the attention and support that [REDACTED] received at South County were minimal, because [REDACTED] was put on Independent Study and only spent an hour or two with the teacher each day. At the end of the year, it was determined that [REDACTED] was still failing, and would have to repeat the 8th grade a second time. At this point, in the Spring of 2003, [REDACTED] refused to continue going to school, and the school provided no assistance to [REDACTED]'s mom in ensuring that [REDACTED] went to school.

In June 2004, [REDACTED] became delusional, believing that he had worms in his scrotum, and that cameras were hidden in the electrical outlets by the CIA and FBI. In addition, he had tactile hallucinations, believing that he had worms crawling over his body and invading his scrotum. He was reported to be squeezing his testicles to pull it out, so that the worms would not spread to his whole body. This incident led to [REDACTED]'s first 5150 hospitalization. Originally, [REDACTED] was taken

to Valley Medical Center in San Jose. However, Valley Medical did not have an adolescent psychiatric unit, and so after [REDACTED] was stabilized, he was transferred to Fremont Hospital in the Adolescent Lock Down Unit, where he remained for assessment and evaluation from June 19 – 22, 2004. The episode was characterized as his first psychotic break, and [REDACTED] did not return to pre-morbid level of functioning. During his stay at Fremont Hospital, [REDACTED] was observed and evaluated. His psychiatric diagnosis was deferred pending further evaluation. Upon discharge he was referred to Santa Clara County Outpatient Services and to a substance abuse program.

[REDACTED] experienced his second psychotic break approximately five and a half weeks later. This psychotic break was characterized by [REDACTED] becoming agitated, complaining of screws being cameras, tearing out electrical outlets in his home and stating that people wearing black were from the CIA or FBI and trying to harm him and his family. He began hiding brooms and knives, and jumped out of a window. This led to [REDACTED]'s second 5150 hospitalization at John Muir/Mt. Diablo Health System Medical Pavilion from July 29 – August 3, 2004. During his stay at the Medical Pavilion, [REDACTED] underwent an initial psychiatric evaluation, where he was diagnosed with Psychotic Disorder, Not Otherwise Classified, prescribed Risperdal, and admitted to the adolescent unit. [REDACTED] remained at the Medical Pavilion for three days, and was discharged with orders to follow up with Community Solutions, stating that he would need a psychiatrist who could continue to adjust his medication. In addition, he was assessed as needing individual and family therapy.

Following his discharge from the Medical Pavilion, [REDACTED] was charged with possession of a dirk/dagger on August 10, 2004 and for participation in a residential burglary in August 19, 2004. According to the Juvenile Court Report, [REDACTED]'s case was “complicated by the apparent presence of polysubstance abuse and by the fact that the minor’s been psychiatrically hospitalized on 2 occasions over the past 6 months.” [REDACTED]'s caseworker and doctor at the Mental Health Clinic at Juvenile Hall attribute his drug abuse to an attempt to self medicate and get relief from his psychiatric symptoms. During his stay at Juvenile Hall, [REDACTED] was diagnosed as having Paranoid Schizophrenia and Mood Disorder, Not otherwise specified.

[REDACTED] has recently received a new Individual Education Plan, and on Monday, February 14, 2005, [REDACTED] started school at Gateway, which is a county classroom located at Live Oak High

School in Morgan Hill. [REDACTED] is unable to attend a regular classroom because (1) his disturbance is of such severity that his educational needs cannot be met in the regular classroom, (2) his educational difficulties are not due primarily to the social maladjustments, (3) his educational difficulties are not primarily the result of a behavior disorder, (4) his behavior has been observed for a period of time longer than six months, and to a marked degree, (5) his inability to learn cannot be explained by intellectual or sensory factors or by limited school experience or poor attendance, and (6) his deficits adversely affect his educational performance and his needs cannot be solely met within the regular classroom setting. [REDACTED]'s specialized classroom provides weekly individual and group therapy. In addition, his classroom is small and self-contained, with a small teacher to pupil ratio. [REDACTED]'s placement was the result of an individual education team meeting, that included [REDACTED]'s probation officer, county officials, school psychologists, and case worker from the Mental Health Clinic at Juvenile Hall.

[REDACTED] [REDACTED] is Disabled Pursuant to Listing 112.03 Schizophrenic, Delusional (Paranoid), Schizoaffective, and Other Psychotic Disorders

[REDACTED] [REDACTED] is not participating in a substantial gainful activity, and has a severe impairment or combination of impairments that meets listing 112.03. Eight months ago, [REDACTED] experienced a psychotic break and has not returned to pre-morbid level of functioning. His psychotic breaks included medically documented persistence of delusions and hallucinations, including a belief that he had worms in his scrotum, that cameras were hidden in electrical outlets, that everyone in black was from either the CIA or FBI and was trying to harm him and his family. In addition, [REDACTED] had tactile hallucinations that he had worms crawling over his body invading his scrotum. These medically documented hallucinations and delusions, which are only controlled with the use of anti-psychotic medications, are sufficient to meet the requirements of A.1 of listing 112.03.

In addition, [REDACTED] presented with severe mood swings, agitation, physical restlessness and aggressive outbursts. He has locked himself in the bathroom, jumped out of a window, and has thrown objects around as a result of his mood swings. His mood swings result in his behavior

quickly changing from passive to violent. In his initial psychiatric assessment at the Medical Pavilion, [REDACTED] was assessed as “angry, irritable, and seems like he could explode at any moment.” Further, in the Progress Notes written by [REDACTED]’s social worker at Community Solutions, [REDACTED] was determined to be “depressed and withdrawn and dependent on mother like a much younger child.” [REDACTED]’s mother has also reported that [REDACTED] is emotionally withdrawn and has difficulty relating to peers. [REDACTED]’s medically documented mood swings, rages, and violent behavior meet the criteria outlined in section A.2 of listing 112.03. Further, his medically documented emotional withdrawal, depression, and dependency on his mother like a much younger child, meets the criteria outlined in section A.5 of listing 112.03.

In addition to meeting more than one of the requirements of section A of listing 112.03, [REDACTED]’s condition also has resulted in at least two of the impairments required in section B of 112.02. First, [REDACTED] is markedly impaired in social functioning, as documented by his therapists, caseworkers and family. In December 2004, [REDACTED] and his mother completed the Behavior Assessment System for Children (BASC) rating scales. The BASC is an integrated system designed to facilitate the differential diagnosis and classification of a variety of emotional and behavioral concerns. Scores in the clinically significant range suggest a high level of maladjustment. According to the BASC completed by [REDACTED]’s mother, [REDACTED] had clinically significant risks in the areas of aggression, conduct problems, and behavioral symptoms. These ratings were confirmed by a second BASC assessment conducted in January 2005. In addition, Ms. [REDACTED] also completed the SAED in December 2004, and her scaled responses about [REDACTED] indicate that he was at clinically significant risk indicating a possible emotional and/or behavioral impairment in the area of social maladjustment.

Consistent with Ms. [REDACTED] reports on the BASC and SAED, [REDACTED]’s caseworker at the Mental Health Clinic at Juvenile Hall has also reported that “he continues to be distrustful and suspicious of peers and adults. He misperceives the cues from the environment and acts out based on these misperceptions. This has precipitated many conflicts interpersonally especially with his mother and escalated to verbal and physical altercations frequently.” Letter from Sandhya Shankar, p. 1. [REDACTED]’s misperception of those around him, his conflicts with others, and the behavioral symptoms reported by [REDACTED]’s mother all demonstrate impairment in age-

appropriate social functioning. Sandhya further reports that [REDACTED] is unable to tolerate community stimulation and becomes easily provoked. This observation resulted in Sandhya's recommendation that [REDACTED] be placed in a classroom like those available for Emotionally Disturbed children, which is similar to the classroom that [REDACTED]'s IEP team recently agreed upon.

Priscilla Merek, one of the social workers at Community Solutions who has evaluated and treated [REDACTED], has also assessed [REDACTED] as a severe risk of danger to others at this time. According to her report, [REDACTED] was unable to find ways to handle his anger, had poor insight and judgment, and required a safety plan. Finally, [REDACTED]'s discharge diagnoses from Fremont hospital, where a psychiatric diagnosis was deferred, found that [REDACTED] had problems related to social environment. Following [REDACTED]'s discharge from Fremont, [REDACTED] underwent additional testing and evaluation, a second 5150 hospitalization, and was accepted into the Juvenile Mental Health Court following his arrest. These subsequent evaluations confirmed [REDACTED]'s problems in social environments, and resulted in a [REDACTED]'s ultimate diagnosis as paranoid schizophrenic.

The evaluations of Sandhya Shankar and Priscilla Merek are consistent with the evaluations of [REDACTED]'s education team, which just recently finalized a new Individual Education Plan for [REDACTED]. [REDACTED] is unable to attend school in a regular classroom. As documented by his Individual Education Plan, his mental health caseworker, and his mother, [REDACTED] requires a small, self-contained classroom with a low student teacher ratio. In addition, he requires therapeutic interventions and support to be available in his classroom. This classroom setting is necessary because [REDACTED] has difficulty interacting with other students and reacting to others appropriately. The standardized testing completed by [REDACTED]'s mother, his IEP, and the report of his mental health caseworker all confirm that [REDACTED] has marked impairment in age-appropriate social functioning.

In addition, [REDACTED] has a marked impairment in age-appropriate personal functioning. As discussed previously, [REDACTED] and his mother completed the BASC rating scales. In addition to the scales that suggested that [REDACTED] had a clinically significant risk of behaviors demonstrating a marked impairment in social functioning, [REDACTED]'s mother's test also resulted in clinically significant ratings in areas of personal functioning including anxiety, depression, somatization, attention problems, learning problems, atypicality, attention problems, externalizing problems,

and internalizing problems. These results were confirmed when [REDACTED]'s mother completed the BASC for a second time in January 2005. In addition, as discussed above, Ms. [REDACTED] also completed the SAED, and her scaled responses about [REDACTED] indicate that he also had clinically significant risks in his personal functioning including pervasive mood of unhappiness or depression, and a tendency to develop physical symptoms or fears. Ms. [REDACTED]'s report is corroborated by the risk assessment completed by Priscilla Merek, [REDACTED]'s social worker at Community Solutions. According to Ms. Merek's risk assessment, [REDACTED] appeared depressed and withdrawn, and was unable to control himself when he was advised that he would be hospitalized.

[REDACTED]'s impairment in age-appropriate personal functioning has led to his inability to cope in a regular classroom setting. As discussed previously, [REDACTED] requires a small, self-contained classroom. This is due in part to his impairment in age-appropriate social functioning, but also is related to his impairment in age-appropriate personal functioning. [REDACTED] has episodes of rage and severe mood swings, which are confirmed by his caseworker at the Mental Health Clinic at Juvenile Hall, his Initial Psychiatric Assessment by Dr. Grimley at the Medical Pavilion, and his social workers Priscilla Merek and John Shafer at Community Solutions. [REDACTED]'s inability to control his moods, his depression, withdrawal and anxiety are well-documented by almost every individual that has worked with [REDACTED]. His inability to act in an age-appropriate manner has led to his placement in a specialized classroom, hospitalizations on two occasions, and therapeutic supports.

[REDACTED] [REDACTED] is Disabled Pursuant to Listing 112.04 Mood Disorders

[REDACTED]'s condition also meets the requirements of Listing 112.04, mood disorders. According to the Listings, a mood disorder is "characterized by a disturbance of mood... accompanied by a full or partial manic or depressive syndrome." In order to meet the Listing criteria, [REDACTED] must have a medically documented major depressive syndrome, manic syndrome, or bipolar or cyclothymic syndrome. [REDACTED]'s medical records document many of the criteria for major depressive syndrome. For instance, several of the social workers and doctors that have evaluated [REDACTED] note that he is depressed or irritable, which is listed as one of the characteristics

listed under 112.04 A.1. [REDACTED]'s social worker at Community Solutions wrote in [REDACTED]'s Progress Notes that [REDACTED] appeared depressed and withdrawn during most of the interview and lost control when advised he would be hospitalized. Further, [REDACTED]'s counselor at EMQ noted in his initial assessment that "[REDACTED] does not have any close friends but claims he would like friends. He says he takes awhile to open up and trust people."

[REDACTED] also has difficulty thinking or concentrating, and requires a small, self-contained classroom with a low teacher to student ratio to help him to stay on task. [REDACTED]'s therapists have noted that he has poor organization or study skills that contribute to academic underachievement. [REDACTED]'s difficulty in organizing his work is a result of his difficulty in concentrating and his mood swings.

[REDACTED]'s hallucinations, delusions and paranoid thinking are well-documented in his medical records. He has had delusions that he had worms in his scrotum, cameras hidden in the electrical outlets by the CIA and FBI, tactile hallucinations that he had worms crawling over his body and invading his scrotum. Further, he has experienced auditory and visual hallucinations and paranoid delusions. [REDACTED]'s hallucinations and delusions led to both of his 5150 hospitalizations, and have been discussed by virtually every person that has evaluated [REDACTED].

[REDACTED] also exhibits many of the characteristics of manic syndrome. First, his severe mood swings, agitation, physical restlessness and aggressive outbursts are well-documented by his caseworker at the Mental Health Clinic at Juvenile Hall and his therapists at Community Solutions and EMQ. Second, [REDACTED] is also easily distracted, as noted by his caseworker who states that [REDACTED] is unable "to tolerate community stimulation and becomes easily provoked." Sandhya's letter, p. 2. [REDACTED]'s classroom setting is structured to reduce his distractibility, because it is a small, self-contained classroom. Third, as discussed previously, [REDACTED]'s hallucinations, delusions and paranoid thinking are well documented.

[REDACTED]'s marked impairments in age-appropriate social functioning and age-appropriate personal functioning were discussed previously. His marked impairments in these areas combined with his depressive and manic characteristics support a finding that [REDACTED] has a mood disorder as listed at 112.04.

Conclusion

[REDACTED] [REDACTED] is a 17-year old child who has been diagnosed with paranoid schizophrenia and with a mood disorder, not otherwise classified. [REDACTED]'s mental disorders have resulted in marked impairments in [REDACTED]'s ability to function socially and personally in an age-appropriate manner. He is not able to attend a regular classroom, and instead is receiving special education services and has been placed in a classroom for children with emotional disturbances. [REDACTED]'s therapists and doctors have assessed him to be a severe risk to himself and others without intensive therapeutic intervention. Without his medication, [REDACTED] experiences delusions and hallucinations, and his medication requires careful monitoring and adjustment. Even with the medication, [REDACTED] experiences psychotic breaks, including a recent break on February 8, 2005. When these episodes occur, [REDACTED] requires therapy, close supervision, and, in two instances to date, hospitalization. For these reasons, [REDACTED] is unable to care for himself as a healthy 17-year old would, and depends on his mother like that of a much younger child. [REDACTED]'s condition is not expected to improve, and he will continue to require a specialized classroom, close supervision, therapeutic supports, medical treatment, medication and weekly therapy sessions with a multitude of therapists. For these reasons, [REDACTED] should be determined eligible for Supplemental Security Benefits.

If you have any questions concerning [REDACTED]'s impairments or need additional information, please do not hesitate to contact me. In addition, please send all correspondence regarding [REDACTED]'s application to my attention. Thank you for your time and consideration.

Sincerely,