IN THE
COURT OF APPEALS OF MARYLAND

September Term, 1997

No. 44

DEPARTMENT OF HEALTH AND MENTAL HYGIENE,

Petitioner,

v.

DAVID MARTIN,

Respondent.

On Appeal from the Circuit Court for Anne Arundel County
(Bruce C. Williams, Judge)
Pursuant to a Writ of Certiorari to the Court of Special Appeals

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BRIEF OF THE AMERICAN CIVIL LIBERTIES UNION OF MARYLAND, THE AMERICAN ORTHOPSYCHIATRIC ASSOCIATION, AND THE JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW AS AMICI CURIAE IN SUPPORT OF RESPONDENT

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INTEREST OF AMICI

The American Civil Liberties Union of Maryland is the state affiliate of the American Civil Liberties Union (ACLU), a nationwide, nonprofit, nonpartisan organization with approximately 300,000 members. From its founding in 1920, the ACLU has devoted itself to protecting the constitutional rights and individual liberties of all Americans. Since 1963, the ACLU has studied issues relating to the involuntary commitment of psychiatric patients and advocated increased procedural protections for such patients. The ACLU of Maryland, which is comprised of almost 6,000 members, carries out the ACLU's mission in this state through an active program of litigation in defense of civil liberties.

The American Orthopsychiatric Association is an interdisciplinary organization of 10,500 psychiatrists, psychologists, social workers, nurses, sociologists and other professionals, many of whom are charged with day-to-day responsibility for providing treatment to psychiatric patients in public and private hospitals. The members of this organization are charged with day-to-day responsibility for providing treatment to residents of state mental institutions, and are familiar with both the problems of institutionalized patients and the use and misuse of psychotropic drugs in institutional settings.

The Judge David L. Bazelon Center for Mental Health Law (formerly the Mental Health Law Project) is a non-profit legal advocacy organization based in Washington, D.C. It has litigated numerous cases over the past twenty-five years

concerning the rights of people with mental illness or mental retardation, including the right to refuse treatment by antipsychotic drugs.

STATEMENT OF THE CASE

To avoid unnecessary duplication, amici adopt the Statement of the Case set forth in the Brief of Respondent.

QUESTION PRESENTED

Whether the State may forcibly medicate involuntarily committed patients with mental illness, who have elected to refuse treatment with psychotropic drugs and who have not been found incompetent to make treatment decisions about themselves, absent a finding that they present a danger to themselves or others within the hospital environment.

STATEMENT OF FACTS

To avoid unnecessary duplication, amici adopt the Statement of Facts set forth in the Brief of Respondent.

INTRODUCTION AND SUMMARY OF ARGUMENT

The State and amici supporting its position make two policy arguments in support of the State's statutory interpretation of Section 10-708 of the Maryland Code Health-General Article and its argument that this interpretation is constitutional: (1) the State should be able to forcibly inject patients with psychotropic drugs because forcible medication works, and (2) the State is in the best position to make treatment

decisions for involuntarily committed individuals. We concur that psychotropic drugs provide the most effective treatment for schizophrenia in the majority of cases. However, this case is not about the majority of cases or the most effective treatment regime. As Respondent explains, the vast majority of involuntarily committed patients in Maryland's mental hospitals voluntarily consent to treatment with psychotropic drugs.[1/] This case and the statute at issue are about the limited number of cases in which involuntarily committed patients refuse treatment with intrusive antipsychotic drugs.

We leave to the Respondent's Brief the issues of what the General Assembly meant when it passed § 10-708 to specify the circumstances under which involuntarily committed patients may be treated against their will and whether the State's interpretation and application of that statute are constitutionally permissible. In this brief, we write to respond to the policy arguments advanced by the State and amici supporting its view. Both before this Court and below, the State raises dire warnings about the "warehousing" of psychiatric patients and the detriment to treatment that Respondent's interpretation of the statute would cause. These arguments are advanced to persuade this Court that the correct interpretation of the statute advocated by Mr. Martin and adopted by the Court of Special Appeals cannot stand because it

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1/ See Resp't Br. at 21-22.

would produce bizarre and disastrous results. We write to show that, to the contrary, civil rights and therapeutic benefits are not necessarily in tension, and that the predicted dire consequences are both unlikely to occur and insufficient to overcome a competent patient's constitutionally protected interest in choosing among treatment regimes.

In Part I, we show that psychotropic drugs are a highly intrusive form of treatment with dangerous, sometimes irreversible side effects. We further explain that these drugs do not always result in effective treatment outcomes, especially when they are administered forcibly.

In Part II, we demonstrate that there are mentally ill individuals who remain competent to weigh and make treatment decisions for themselves. The decision to refuse is often rational and therapeutically appropriate, yielding therapeutic outcomes that can surpass those achieved by non-refusers.

ARGUMENT

I. Forcible Administration of Psychotropic Drugs to a Patient Who Refuses Them Is an Invasive Procedure That Is Not Always of Therapeutic Value and Presents Substantial Risks to the Patient.

Forcible administration of psychotropic drugs is a highly intrusive invasion of personal and bodily integrity. The forcible administration itself is by intramuscular injection that can be physically painful as well as frightening and humiliating. Once

in the patient's bloodstream, psychotropic drugs dramatically alter that individual's physical, mental and emotional state. "[T]he impact of the chemicals upon the brain is sufficient to undermine the foundations of personality." *In re Guardianship of Richard Roe, III*, 421 N.E.2d 40, 53 (Mass. 1981). If the benefits of such treatment were incontestable, as the State's amici at times seem to suggest, it might be easy to decide that the General Assembly had authorized such treatment for involuntarily committed patients whenever medically appropriate (leaving aside the constitutional issues that would arise from such an interpretation). As we show below, however, there is legitimate controversy over the efficacy of treatment with psychotropic drugs, especially when that treatment is administered against a patient's will. In addition, the drugs can produce devastating side effects that, for some, outweigh whatever benefit the drugs do provide.

A. Antipsychotic Drugs Do Not Work For All Psychiatric Patients.

Antipsychotic drugs are not the "antibiotics" of mental illness. Unlike antibiotics, these drugs do not cure the underlying illness.[2/] At best, they control the symptoms of mental illness, and they do not always do that. Although antipsychotic drugs benefit a majority of patients, they provide no symptomatic relief for a

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2/ Robert M. Levy & Leonard S. Rubenstein, The Rights of People with Mental Disabilities 110 (1996).

substantial number of people, and they may actually aggravate the underlying condition of other patients. Studies have shown that approximately twenty to twenty-five percent of patients do not respond to treatment with antipsychotic drugs,[3/] and that up to ten percent of patients deteriorate while taking antipsychotic medication.[4/] Thus, a substantial proportion of patients experience no positive effect from these drugs. In addition, some studies have shown that about one in five patients improve without the help of drugs.[5/]

Even in those cases where antipsychotic drugs produce initial benefits, there is controversy about the long-term efficacy of drug treatment. "[S]ymptom reduction by

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3/ J.K. Wing, *Relapse in Schizophrenia*, 291 Brit. Med. J. 1219 (1985) (20-25% of schizophrenics are relatively unresponsive to treatment); Ross J. Baldessarini & Frances R. Frankenburg, *Clozapine: A Novel Antipsychotic Agent*, 324 New Eng. J. Med. 746 (1991) (20% of schizophrenic patients receive no benefit from psychotropic medication); Walter A. Brown & Lawrence R. Herz, *Response to Neuroleptic Drugs as a Device for Classifying Schizophrenia*, 15 Schizophrenia Bull. 123 (1989) (approximately 20% of schizophrenics are resistant even to high doses of psychotropic medication). One study has placed the number of schizophrenic patients resistant to the benefits of antipsychotic medication as high as 41%. T. Kolakowska *et al.*, *Schizophrenia with Good and Poor Outcome*, 146 Brit. J. Psychiatry 229 (1985).

4/ Robert F. Prien *et al.*, *High Dose Trifluoperazine Therapy in Chronic Schizophrenia*, 126 Am. J. Psychiatry 305 (1969).

5/ Wayne S. Fenton & Thomas H. McGlashan, *Sustained Remission in Drug-Free Schizophrenic Patients*, 144 Am. J. Psychiatry 1306 (1987); Gerard E. Hogarty *et al.*, *Drugs and Sociotherapy in the Aftercare of Schizophrenic Patients II: Two-Year Relapse Rates*, 31 Archives Gen. Psychiatry 603, 607 (1974).

itself is not synonymous with successful treatment."[6] Successful treatment ultimately means living independently outside the hospital, and drugs can make this goal more daunting and unmanageable. Neuroleptics "'inhibit a patient's ability to learn social skills needed to fully recover from psychosis.' * * * Side effects such as akinesia and akathisia have the inevitable effect of retarding social skill progress and of making ex-patients even less employable once they are deinstitutionalized."[7] There is evidence that reliance on psychotropic drugs for therapy fosters patient dependency on the hospital and tends to increase the likelihood of rehospitalization.[8]

In sum, antipsychotic drugs do not always work, and even when they effectively ameliorate symptoms initially, they may not provide long-term relief from the underlying condition.

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[6] Samuel J. Keith, *Drugs: Not the Only Treatment*, 33 Hosp. & Community Psychiatry 793 (1982).

[7] Michael L. Perlin, *Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization*, 28 Hous. L. Rev. 63, 104 (1991) (quoting *Rennie* v. *Klein*, 476 F. Supp. 1294, 1299 (D.N.J. 1979)) (internal citations omitted).

[8] J. Sanbourne Bockoven & Harry C. Solomon, *Comparison of Two Five-Year Follow-up Studies: 1947 to 1952 and 1967 to 1972*, 132 Am. J. Psychiatry 796 (1975).

B. Antipsychotic Drugs Are Least Effective When Administered Against the Patient's Expressed Will.

In a variety of treatment contexts, the patient's attitude and expectations about treatment have important consequences for the efficacy of treatment. Patient acceptance of treatment is generally an important determinant of treatment success.[9/] This widely accepted general proposition has particularly important implications in the administration of psychotropic drugs, because there is no reliable method for doctors to predict who will be helped by such medication and who will not. In fact, the best predictor of whether an antipsychotic drug will be beneficial to a patient often lies in the patient's own subjective response to the drug.[10/] In one typical study, patients were asked to report their reaction to a regimen of a designated antipsychotic drug. Patients who expressed an initial negative reaction to the medication had

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9/ See generally Bruce J. Winick, *The Right to Refuse Mental Health Treatment: A Therapeutic Jurisprudence Analysis*, 17 Int'l J.L. & Psychiatry 99, 102 (1994); Harris Dienstfrey, Where the Mind Meets the Body: Type A, the Relaxation Response, Psychoneuroimmuniology, Biofeedback, Neuropeptides, Hypnosis, Imagery and the Search for the Mind's Effect on Physical Health (1991); Norman Cousins, Head First: The Biology of Hope (1989); Helen Flanders Dunbar, Emotions and Bodily Changes (4th ed. 1954).

10/ Theodore Van Putten & Philip R.A. May, *Subjective Response as a Predictor of Outcome in Pharmacotherapy*, 35 Archives Gen. Psychiatry 477 (1978); Theodore Van Putten *et al.*, *Subjective Response to Antipsychotic Drugs*, 38 Archives Gen. Psychiatry 187 (1981); Man Mohan Singh, *Dysphoric Response to Neuroleptic Treatment in Schizophrenia and its Prognostic Significance*, 37 Diseases of the Nervous Sys. 191 (1976).

substantially worse treatment outcomes than patients who expressed an initial positive response to the medication: only *fourteen percent* of negative responders showed unequivocal improvement on medication, in contrast with *seventy-four percent* of positive responders.[11/] Some negative responders, "although cooperative and calm to start with, became acutely panicked and objectively more disorganized several hours after the first dose."[12/]

Moreover, forcible administration can undermine the ultimate long-term treatment goal of patient independence. The patient's voluntary compliance with the treatment regimen is critical to accomplishing this goal. The most significant predictor of whether patients will voluntarily adhere to a treatment regimen outside the hospital is the patients' perceived past benefit of the medications.[13/] Forcible medication can create extremely negative associations with medication that not only discourage individuals from voluntarily complying with their treatment regimens, but also from seeking treatment in the mental health system when it is subsequently needed after release. To be sure, forcible medication assures compliance while the individual is in the hospital and under a forcible medication order. However, it

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11/ Theodore Van Putten *et al.*, *Subjective Response to Antipsychotic Drugs*, 38 Archives Gen. Psychiatry 187, 189 (1981).

12/ *Id.*

13/ Michael Irwin *et al.*, *Psychotic Patients' Understanding of Informed Consent*, 142 Am. J. Psychiatry 1351, 1354 (1985).

prevents the formation of patterns of behavior that will lead the patient to take the medication voluntarily in the community.

The degrading experience of being forcibly medicated coupled with the powerful effects of the drugs can be so traumatic that some patients may reject further treatment altogether. Research has shown that many mentally ill homeless individuals have "opted out" of the mental health system after being forcibly medicated. These individuals choose life in the streets to the alternative of institutionalization in part to avoid compulsory administration of psychotropic medications.[14/]

In sum, medicating a patient against his or her will often simply does not work and can sometimes work at cross purposes with the goal of independent living.

C. Whatever the Possible Benefit of the Drugs, the Potential Cost in Side Effects Can Be Devastating.

Although there is some variation among medications, antipsychotic drugs are capable of producing a wide variety of side effects. These side effects can occur even when the drugs are prescribed and administered correctly.[15/]

[14/] Pamela J. Fischer & William R. Breakey, *Homelessness and Mental Health: An Overview*, 14 Int'l J. Mental Health 6, 29 (Winter 1985-86).

[15/] Dennis E. Cichon, *The Right to "Just Say No": A History and Analysis of the Right to Refuse Antipsychotic Drugs*, 53 La. L. Rev. 283, 297 (1992).

Patients commonly experience side effects such as dizziness, drowsiness, dry mouth and throat, stuffy nose, urinary retention, constipation and blurred vision.[16] The drugs may cause sexual dysfunction, menstrual irregularities in females, skin disorders, and various other endocrine and hormonal disorders.[17] Even such relatively moderate side effects "can be a source of acute distress to patients who are struggling to feel wide awake and think more clearly"[18] in order to work through their disorders. Antipsychotic drugs may also cause a variety of blood disorders, the most serious of which causes a decrease in the white blood cell count. This condition, agranulocytosis, places the patient in danger of contracting life-threatening infections, and it must be detected within one to two weeks of onset in order to be effectively cured.[19]

Antipsychotic drugs also affect the patient's ability to regulate thought, emotion and emotional expression and the patient's response to external stimuli.[20] The drugs tend to induce psychomotor slowing, emotional quieting, reduction of

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16/ Robert M. Julien, A Primer of Drug Action 229 (1992).

17/ Cichon, *supra* note 15, at 298.

18/ Levy & Rubenstein, *supra* note 2, at 112.

19/ Cichon, *supra* note 15, at 298-99.

20/ Julien, *supra* note 16, at 229-30.

initiative, and indifference to external stimuli.[21] "[T]he psychological syndrome that is induced by these drugs is not usually considered to be particularly pleasant,"[22] and is seen by many patients as an unnerving assault on their personality.

In addition to these effects, neuroleptics produce two main kinds of motor disturbances: (1) parkinsonian-like symptoms and (2) tardive dyskinesia.[23] Parkinsonian-like symptoms include: hand tremors, drooling, cogwheel rigidity, loss of spontaneous and associated movements, blank stare, dulled facial expressions and stooped posture.[24] Although these symptoms are usually reversible, they can be extremely unpleasant, and they occur in a substantial proportion of patients on neuroleptics.[25]

One of the most common parkinsonian-like side effects is akathisia. It affects twenty percent of patients on antipsychotic medication, and it strikes only a few days after treatment initiation. Symptoms range from "a subjective feeling of muscular discomfort to an agitated, desperate, markedly dysphoric pacing with hand-wringing

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[21] *Id.* at 230.

[22] *Id.*

[23] See Joint Record Extract in Court of Special Appeals at E-50 (State psychiatrist acknowledging these side effects).

[24] Julien, *supra* note 16, at 230-31.

[25] *Id.* at 231.

and weeping."[26] It often includes "feelings of fright, rage, terror, or sexual torment."[27] One patient suffering from akathisia described it as "an inner shakiness * * * an inner agitation. It makes me feel more vulnerable. It's like an unprotected feeling. The inner antsiness reaches a point where it's like I'm standing raw in front of the world like a little child * * * like I'm standing naked in front of everybody."[28] The distressing symptoms of akathisia have caused patients to attempt suicide.[29] Tragically, hospital staff often mistake the symptoms of akathisia for symptoms of the patient's disorder and increase the patient's dose of medication in response, which only exacerbates the akathisia.[30]

The second major type of motor disturbance neuroleptic patients may experience is tardive dyskinesia, "a neurological syndrome characterized by involuntary, rhythmic, and often grotesque movements of the face, lips, tongue,

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[26] Alan F. Schatzberg & Jonathan O. Cole, Manual of Clinical Psychopharmacology 95 (1986).

[27] Marcus A. Krupp *et al.*, Current Medical Diagnosis & Treatment 1987 628 (1987).

[28] Cichon, *supra* note 15, at 302 (quoting Theodore Van Putten *et al.*, *Subjective Response to Antipsychotic Drugs*, 38 Archives Gen. Psychiatry 187, 189-90 (1981)).

[29] Robert Drake & Joshua Ehrlich, *Suicide Attempts Associated with Akathisia*, 142 Am. J. Psychiatry 499 (1985).

[30] Peter J. Weiden *et al.*, *Clinical Nonrecognition of Neuroleptic-Induced Movement Disorders: A Cautionary Study*, 144 Am. J. Psychiatry 1148, 1150-51 (1987) (finding a 65% nonrecognition rate by clinical psychiatrists).

fingers, hands, legs, and pelvis."[31] These symptoms can be severely disabling.[32] Like akathisia, tardive dyskinesia often goes undetected, because the drugs tend to mask its symptoms. Unlike akathisia, tardive dyskinesia is irreversible in most cases, even after the patient stops taking neuroleptic medication.[33] The disfigurement it can cause makes assimilation into the community extremely difficult for patients.

Tardive dyskinesia occurs at high rates among patients on medication. A review of the scientific literature led the U.S. Supreme Court to conclude that ten to twenty-five percent of all patients treated with neuroleptics contract tardive dyskinesia.[34] Some studies suggest that the incidence is much higher: one placed the estimate at twenty to forty percent,[35] and another as high as fifty to sixty percent.[36] Unfortunately, separate studies reveal that psychiatrists fail to notice symptoms of tardive dyskinesia in an overwhelming majority of cases -- 75 percent[37] and 90

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[31] Levy & Rubenstein, *supra* note 2, at 112.

[32] Julien, *supra* note 16, at 231.

[33] Dilip V. Jeste *et al.*, *The Biology and Experimental Treatment of Tardive Dyskinesia and Other Related Movement Disorders*, *in* 8 American Handbook of Psychiatry 536 (Philip A. Berger & Keith H. Brodie eds., 2d ed. 1986).

[34] *Washington* v. *Harper*, 494 U.S. 210, 230 (1990).

[35] Howard H. Goldman, Review of General Psychiatry 596 (1984).

[36] Schatzberg & Cole, *supra* note 26, at 98.

[37] Cichon, *supra* note 15, at 307 (citing Hansen, Casey & Weigel, *TD*

(continued...)

percent,[38] respectively -- placing patients at a severe risk of contracting this incurable and debilitating disease.

Finally, in a small percentage of cases, antipsychotic drugs cause neuroleptic malignant syndrome, which can cause permanent neurological damage or death.[39] It appears in between 1.2 and 2.4 percent of cases,[40] although it "continues to be underdiagnosed by clinicians, even in sophisticated hospital settings. Due to the explosive course of this condition, lack of early recognition can prove fatal."[41]

In the past, all mentally ill individuals who took psychotropic drugs, whether voluntarily or through force, were exposed to the same serious side effects and risks. However, new drugs such as Clozapine, Risperidone, and Olanzapine have substantially reduced the risks and side effects traditionally associated with neuroleptics.[42] These newer drugs cannot now be administered by needle, and thus

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[37] (...continued)
Prevalence: Research and Clinical Differences, New Research Abstracts, 139th Annual Meeting of the American Psychiatric Assoc. (1986)).

[38] Peter J. Weiden *et al.*, *Clinical Nonrecognition of Neuroleptic-Induced Movement Disorders: A Cautionary Study*, 144 Am. J. Psychiatry 1148, 1150 (1987).

[39] Barry H. Guze & Lewis R. Baxter, *Neuroleptic Malignant Syndrome*, 313 New Eng. J. Med. 163 (1985).

[40] Levy & Rubenstein, *supra* note 2, at 113 (internal citations omitted).

[41] *Id.*

[42] Richard L. Borison, *Recent Advances in the Pharmacotherapy of*
(continued...)

can be administered only with the patient's consent. Accordingly, at the present time, patients who are forcibly medicated under § 10-708 can receive only the older, more dangerous psychotropic drugs. They are exposed to greater risk and must suffer from more severe side effects than patients who voluntarily take the newer medications. The pharmacological advances in drugs that can be administered only voluntarily increase the need for treating professionals to persuade their patients to accept voluntary administration of drugs so that patients are not subject to disparate risks based solely on their willingness to assent to treatment.

In sum, the risk of side effects from antipsychotic drugs is significant and severe. Weighing these costs with the uncertain benefits of the drugs is a difficult and deeply personal decision for any patient. In this context, the patient's informed consent is of paramount importance.

II. Many Mentally Ill Patients Are Capable of Making Rational Treatment Decisions About Themselves, and They Should Be Permitted To Do So If They Do Not Demonstrate a Danger Within the Institution.

As shown in Part I above, neuroleptics are powerful drugs of varying therapeutic value and with significant risks and potential side effects. Consequently, many medical and personal factors must be considered in deciding whether to take

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42/ (...continued)
Schizophrenia, 4 Harv. Rev. Psychiatry 255 (1997).

them. For these reasons, it is important to allow competent patients to weigh these variables and make these decisions for themselves to the maximum extent possible. As we show below, involuntarily committed individuals with mental illness are presumed competent under Maryland law, and research has shown that this presumption is warranted. Individuals with mental illness can often make rational and valuable contributions to their own treatment, and may actually fare better than individuals who are passively compliant in their treatment.

A. Unless They Have Been Found Incompetent, Individuals with Mental Illness Are Presumed Competent Under Maryland Law, Even If Involuntarily Committed.

There has been a "nearly unanimous modern trend in the courts, and among psychiatric and legal commentators, * * * to recognize that there is no significant relationship between the need for hospitalization of mentally ill patients and their ability to make treatment decisions." *Rivers* v. *Katz*, 495 N.E.2d 337, 342 (N.Y. 1986). Individuals who suffer from mental illness are not necessarily incapable of making rational treatment decisions about themselves, even when their illness is severe enough to warrant involuntary commitment.

Maryland follows "the universally recognized rule that a physician, treating a mentally competent adult under non-emergency circumstances, cannot properly undertake to perform surgery or administer other therapy without the prior consent of

his patient." *Sard* v. *Hardy*, 379 A.2d 1014, 1019 (Md. 1977). "The fountainhead of the doctrine * * * is the patient's right to exercise control over his own body, * * * by deciding for himself whether or not to submit to the particular therapy." *Id.* "A corollary to the doctrine is the patient's right, in general, to refuse treatment and to withdraw consent to treatment once begun." *Mack* v. *Mack*, 618 A.2d 744, 755 (Md. 1993).[43/]

Involuntary commitment to a mental institution does not render an individual incompetent. As the Court of Special Appeals ruled in another case: "The law of Maryland presumes that adults are competent to make their own informed decisions, and this presumption of competency does not disappear upon an involuntary admission to a mental health facility for psychiatric treatment, absent a proper determination otherwise." *Beeman* v. *Department of Health & Mental Hygiene*, 666 A.2d 1314, 1325 (Md. Ct. Spec. App. 1995) (citing Health-General § 5-601(f)); accord *Williams* v. *Wilzack*, 573 A.2d 809, 820 n.8 (Md. 1990). Consequently, the State must overcome this presumption if it wishes to override the treatment preferences of an individual in a non-emergency situation such as that contemplated

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[43/] The State's amici argue without support that patients who refuse medication and are consequently unable to leave the hospital may sue institutions for damages. Maryland Psychiatric Society *et al.*, Br. at 9 n.2. They fail to explain why such a patient would have a cause of action against an institution which had determined the patient to be competent and so accepted his or her refusal to take medication.

by § 10-708(g) unless it conclusively demonstrates that § 10-708 was intended to displace the common law presumption of competency for these patients.[44/]

B. Research and Professional Practice Supports the Legal Presumption of Competency and Reveals That Many Mentally Ill Individuals Remain Capable of Comprehending Treatment Alternatives and Making Reasoned Treatment Decisions.

Mental illness is highly selective, typically damaging some areas of functioning while leaving others unimpaired.[45/] "Clinical evidence suggests that despite alterations in thinking and mood, psychiatric patients are not automatically less capable than others of making health care decisions."[46/]

A recent study investigated the competence levels of hospitalized patients with mental illness as compared with physically ill hospitalized patients and a control population of non-ill, non-hospitalized individuals. The study measured competence

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[44/] This would be a different case if the proceedings below had included a finding that Mr. Martin was incompetent to make decisions about his course of treatment. As the record stands, however, no such allegation or finding was made, either by the Clinical Review Panel, the ALJ or by any court.

[45/] Alexander D. Brooks, *The Constitutional Right to Refuse Antipsychotic Medications*, 8 Bull. Am. Acad. Psychiatry & L. 179, 191 (1981)

[46/] Karen McKinnon *et al*, *Rivers in Practice, Clinicians' Assessments of Patients' Decision-Making Capacity*, 40 Hosp. & Community Psychiatry 1159, 1159 (1989). See also Barbara Stanley *et al.*, *Preliminary Findings on Psychiatric Patients as Research participants: A Population at Risk?*, 138 Am. J. Psychiatry 669, 671 (1981) (finding mentally ill population to be as competent to make treatment decisions as comparable medically ill population).

based on four factors that, in some combination, comprise legal standards of competency in most states: (1) ability to communicate a choice; (2) ability to understand relevant information; (3) ability to appreciate the situation and its likely consequences; (4) ability to manipulate information rationally.[47/]

The study found a majority of the mentally ill patients competent to make treatment decisions under these standards. On any given measure of competence, schizophrenic patients scored comparably with the physically ill patients and the non-patients. Further, when taking all measures into account,

> [n]early one half of the schizophrenia group and 76% of the depression group performed in the 'adequate' range * * * across all decision-making measures, and a significant portion performed at or above the mean for persons without mental illness. When performance on a single measure is examined, as may be relevant, for example, in jurisdictions that have adopted only an understanding standard for legal competence, the rate of adequate performance rose to roughly 75% for patients with schizophrenia and to approximately 90% or more for patients with depression. Thus, the justification for a blanket denial of the right to consent to or refuse treatment for persons hospitalized because of mental illness cannot be based on the assumption that they uniformly lack decision-making capacity.[48/]

[47/] Paul S. Appelbaum & Thomas Grisso, *The MacArthur Treatment Competence Study. I: Mental Illness and Competence to Consent to Treatment*, 19 Law & Hum. Behav. 105, 109 (1995).

[48/] Thomas Grisso & Paul S. Appelbaum, *The MacArthur Treatment Competence Study. III: Abilities of Patients to Consent to Psychiatric and Medical Treatments*, 19 Law & Hum. Behav. 149, 171 (1995).

Suggested psychiatric practice is consistent with these findings. The American Psychiatric Association's "Practice Guideline for the Treatment of Patients with Schizophrenia" directs physicians to first assess the patient's competency before ordering involuntary medication in a nonemergency situation.[49/] "When an acutely psychotic patient refuses medication and is dangerous, the physician may consider administering it despite the patient's objection. In less emergent [*sic*] circumstances, the physician should assess the patient's competency to refuse medication, while continuing to attempt to enlist the patient's cooperation with treatment."[50/] These professional guidelines are consistent with the standard for forced medication advocated by Respondent: the doctor should not forcibly medicate a competent patient unless that patient is currently dangerous.

C. Decisions to Refuse Antipsychotic Drugs Are Often Rational, Valid and Therapeutically Valuable, and Respecting Them Can Lead to Better Long-Term Treatment Outcomes.

Actual drug refusals by mentally ill patients tend to confirm that many such patients are competent to make treatment decisions. In fact, they suggest that drug refusals may be essential to the treatment process. Patients' drug refusals are often made for considered and legitimate reasons that can have important implications for

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[49/] American Psychiatric Association, *Practice Guideline for the Treatment of Patients with Schizophrenia* 3 (1997).

[50/] *Id.*

treatment success. Refusals force a dialogue about important medical variables such as prescription, dosage and side effects. Dialogue, in turn, strengthens the relationship between the mental health provider and the patient and invests the patient in his or her treatment in a way that increases the likelihood of voluntary compliance outside the hospital.

The right to refuse establishes the conditions necessary for the development of a productive therapeutic alliance. A therapeutic alliance is the collusion between the mental health professional and the patient against the patient's illness, and it is central to the treatment of emotionally disturbed patients.[51] The very existence of the right to refuse treatment bolsters the therapeutic alliance by assuring patients that they have input into their treatment. This can be critical for patients who have been stripped of significant autonomy through the involuntary commitment process. "Consequently, the physician must take into account not only the pharmacological and therapeutic effects of the antipsychotic drug itself, but also the effect that the administration of the drug will have on the therapeutic alliance."[52]

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[51] Thomas G. Gutheil *et al.*, *Legal Guardianship in Drug Refusal: An Illusory Solution*, 137 Am. J. Psychiatry 347, 349 (1980).

[52] Richard Cole, *Patients' Rights vs. Doctors' Rights: Which Should Take Precedence?*, *in* Refusing Treatment in Mental Health Institutions: Values in Conflict 56, 59 (A. Edward Doudera & Judith P. Swazey eds., 1982).

Patient drug refusals can serve to strengthen this alliance -- they should be viewed as an opportunity rather than an obstacle. When mental health professionals view a patient's refusal as a chance to communicate with the patient about the patient's medication and condition, drug refusal can be resolved to the advantage of all parties involved. In fact, Dr. Paul Appelbaum, a prominent proponent of involuntary medication, concluded after studying drug refusers: "Not only is permitting limited refusal generally innocuous, but some definite gains may accrue from the accompanying negotiations."[53/]

One likely outcome of negotiations between doctor and patient is that the two will come to an agreement about treatment. Most refusers do not persist in their refusal,[54/] and communicating with patients about the benefits and risks of drug therapy usually persuades them to undergo it voluntarily.[55/] "Once patients are sure that they have real control over their medication, that they can in fact refuse the medication, they often feel safer in agreeing to take the medication."[56/] As one psychiatrist noted, "[i]t is surprising how much 'compliance' is produced when the

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53/ Paul S. Appelbaum and Thomas G. Gutheil, *Drug Refusal: A Study of Psychiatric Inpatients*, 137 Am. J. Psychiatry 340, 345 (1980).

54/ *Id.* at 342, 343.

55/ *Id.* at 345.

56/ Ronald J. Diamond, *Enhancing Medication Use in Schizophrenic Patients*, 44 J. Clinical Psychiatry 7, 13 (June 1983).

patient is convinced that you are really on his side rather than just looking out for his 'best interests' as you, the psychiatrist, see them."[57] Achieving voluntary compliance is especially important now that safer drugs with fewer side effects are available but can only be administered voluntarily.[58]

Another possible outcome is that the patient's medication may be altered as a result of doctor-patient negotiations. As discussed in Part I(C), supra, many serious side effects of neuroleptics are often masked or misdiagnosed. Consequently, the patient's input can be crucial to calibrating the proper treatment. Drug refusals are not always simply a product of symptomatic behavior. In fact, they often signal real problems with dosage, side effects or prescription that hospital staff might not otherwise notice. Many patients have an extensive history with antipsychotic drugs and can provide valuable assistance to the doctor in adjusting dose, alleviating side effects, and producing optimal treatment outcomes. In many cases, drug refusal may be the best or the only way for a patient who is relatively powerless in the institution and unfamiliar with medical jargon to communicate that something is wrong.

A significant proportion of refusals are associated with side effects experienced by the patients. One study indicated that drug refusers were four and a half times

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[57] Donal Conley, *A Szaszian Approach to the Right to Refuse Treatment, in* The Right to Refuse Antipsychotic Medication 62 (1986).

[58] See discussion, *infra*, in Part I(C).

more likely than compliers to have experienced serious motor-disturbance side effects on antipsychotic medication.[59/] Another revealed a strong correlation between drug refusals and histories of severe side effects, suggesting a rational basis for the refusals.[60/]

As discussed above, akathisia strikes one in five patients on antipsychotic medication and is often difficult for hospital staff to recognize, because its symptoms are highly subjective and they often mirror the symptoms of the underlying condition.[61/] Research has indicated that a significant number of drug refusals are, in fact, associated with akathisia.[62/] The patients studied were found to have requested increased doses of anti-parkinsonian agents and even privately hoarded these medications for their own use, suggesting that the patients could distinguish between their side effects and their mental illness symptoms, and confirming that the refusals were based on the side effect and not on the symptoms.[63/]

[59/] Theodore Van Putten, *Why Do Schizophrenic Patients Refuse to Take Their Drugs?*, 31 Archives Gen. Psychiatry 67, 70 (1974).

[60/] Stephen R. Marder *et al.*, *A Comparison of Patients Who Refuse and Consent to Neuroleptic Treatment*, 140 Am. J. Psychiatry 470, 472 (1983).

[61/] See discussion, *infra*, Part I(C).

[62/] Van Putten, *supra* note 59, at 71.

[63/] *Id.* at 70.

Other drug refusals are related to the incorrect prescription or dosage of a particular antipsychotic medication. Patients, especially those with affective disorders that are not amenable to treatment with neuroleptics, are often misdiagnosed and incorrectly prescribed antipsychotic medication.[64/] Although we recognize that Section 10-708 does not permit administration of medically inappropriate prescriptions, mistakes can occur, and their consequences can be devastating where patient refusal does not serve as a check on professional judgment. For instance, in one case, hospital staff forcibly administered Thorazine to a patient with an affective disorder who also had tardive dyskinesia. The patient indicated that she would be willing to accept lithium, a drug appropriate for her condition, but refused the prescription of Thorazine, recognizing it as unsuitable for treating her condition and likely to aggravate her tardive dyskinesia. When subsequently questioned about their decision to forcibly inject the patient with Thorazine, hospital staff indicated that they thought she had faked the spasms and facial grimaces characteristic of tardive

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64/ Studies have shown that schizophrenia is grossly overdiagnosed, and patients suffering from affective disorders are at the greatest risk of misdiagnosis. Pope & Lipinski, *Diagnosis in Schizophrenia and Manic-Depressive Illnesses*, 35 Archives of General Psychiatry 811 (1978) (at least 100,000 patients suffering from affective disorder diagnosed as schizophrenics in this country). These patients are often mistakenly prescribed neuroleptics, which subject them to deterioration of their condition. Alan A. Lipton & Franklin S. Simon, *Psychiatric Diagnosis in a State Hospital: Manhattan State Revisited*, 36 Hospital and Community Psychiatry 368, 372 (1985).

dyskinesia in order to avoid administration of Thorazine. An independent psychiatrist later characterized the hospital's conduct as "grossly irresponsible" and confirmed that the patient's refusal was appropriate.[65/]

Even where the medication prescribed is appropriate for the patient's disorder, the dosage may be improper. One study found that a group of patients who secretly took a smaller dosage of neuroleptics than they had been prescribed actually functioned better on the lower dose.[66/] This research suggests that patients are sometimes in a better position to calibrate the dosage of these powerful drugs, and doctors should receive the benefit of the patients' experience.

In addition to these immediate treatment benefits, a therapeutic alliance characterized by respect and communication can produce positive results that outlast institutionalization, and this can be critical for long-term treatment success. Patients who exercise their right to refuse and participate assertively in their own treatment are more likely to succeed outside the hospital environment as independent members of the community.

Ultimately, the patient's willingness and ability to comply with a treatment regimen outside the hospital will determine the success or failure of the treatment.

[65/] Stanley S. Brotman, *Behind the Bench on Rennie v. Klein, in* Refusing Treatment in Mental Health Institutions: Values in Conflict 31, 34 (A. Edward Doudera and Judith P. Swazey eds., 1982).

[66/] Van Putten, *supra* note 59, at 70.

> A patient who experiences adverse reactions to * * * drug therapy, especially if frightened by her psychiatric hospitalization, is likely to lose confidence in health professionals. Her future compliance with therapy could be undermined. Even worse, she may become hostile and refuse further treatment, thereby risking a vicious cycle of more intensive efforts to treat her putative irrationality.[67]

Studies have shown that compliance with antipsychotic medication is enhanced by increased doctor-patient communication and negotiation. "Patient involvement in decisions about medication * * * is critically important to compliance."[68]

In sum, drug refusers often fare better both in and out of the hospital than compliant patients. One study compared in-hospital and post-hospital treatment outcomes of refusers and compliers.[69] It revealed that, overall, these two groups were "remarkably similar in all important outcome measures."[70] However, the two groups differed significantly in their ability to cope outside the hospital environment. Readmitted refusers had functioned in the community twice as long as readmitted compliers.[71] Moreover, even patients who had refused and later consented to

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[67] Frank J. Ayd, *Problems with Orders for Medication as Needed*, 142 Am. J. Psychiatry 939, 942 (1985).

[68] Diamond, *supra* note 56, at 14.

[69] Irwin N. Hassenfeld & Barbara Grumet, *A Study of the Right to Refuse Treatment*, 12 Bull. Am. Acad. Psychiatry & L. 65, 68 (1984).

[70] *Id.* at 72.

[71] *Id.*

treatment fared better outside the hospital than those who never refused.[72] The researchers suggested that "a healthy skepticism about doctors, medicine and psychiatry and some sense of themselves as not without power and control over their lives * * * may have helped the 'refusers' to better cope with life outside the hospital."[73]

CONCLUSION

Schizophrenia and other major mental illnesses are often long-term conditions that require long-term solutions rather than merely reaction to perceived short-term need. Achieving long-term solutions is not, as the State and amici that support its position suggest, a zero-sum game pitting individuals' rights to freedom from confinement against their rights to bodily integrity. Rather, these rights intersect in complicated and unpredictable ways. From a therapeutic standpoint, the exercise of the right to refuse treatment is often an important step toward achieving the very freedom the State purports to defend. Consequently, when patients assert the right to refuse, their choice should be respected unless it has been shown that they are not competent to decide or they present a danger in the institution. As Respondent has argued and the Court of Special Appeals has found, such a course is required in Maryland under Section 10-708. Amici have shown here that this interpretation of

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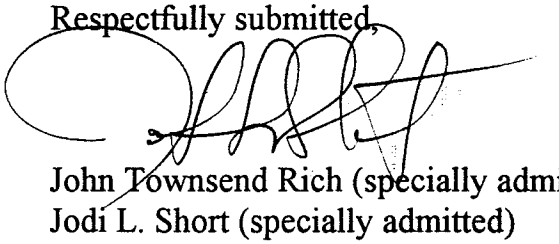
[72] *Id.*

[73] *Id.*

Section 10-708 is sound policy that will not result in disastrous consequences for the State or for involuntarily committed patients.

Respectfully submitted,



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APPENDIX

Editor's note. — Chapter 405, Acts 1983, transferred former § 10-707 of this article to be § 10-710 of this article.

§ 10-708. Refusal of medication; clinical review panel [Section subject to termination].

(a) *Definitions.* — (1) In this section the following words have the meanings indicated.

(2) "Panel" means a clinical review panel that determines, under the provisions of this section, whether to approve that medication be administered to an individual who objects to the medication.

(3) "Medication" means psychiatric medication prescribed for the treatment of a mental disorder.

(4) "Lay advisor" means an individual at a facility, who is knowledgeable about mental health practice and who assists individuals with rights complaints.

(b) *Medication authorized.* — Medication may not be administered to an individual who refuses the medication, except:

(1) In an emergency, on the order of a physician where the individual presents a danger to the life or safety of the individual or others; or

(2) In a nonemergency, when the individual is hospitalized involuntarily or committed for treatment by order of a court and the medication is approved by a panel under the provisions of this section.

(c) *Composition of panel.* — (1) A panel shall consist of the following individuals appointed by the chief executive officer of the facility or the chief executive officer's designee, one of whom shall be appointed chairperson:

(i) The clinical director of the psychiatric unit, if the clinical director is a physician, or a physician designated by the clinical director;

(ii) A psychiatrist; and

(iii) A mental health professional, other than a physician.

(2) If a member of the clinical review panel also is directly responsible for implementing the individualized treatment plan for the individual under review, the chief executive officer of the facility or the chief executive officer's designee shall designate another panel member for that specific review.

(d) *Notice of panel.* — (1) The chief executive officer of the facility or the chief executive officer's designee shall give the individual and the lay advisor written notice at least 24 hours prior to convening a panel.

(2) Except in an emergency under subsection (b) (1) of this section, medication or medications being refused may not be administered to an individual prior to the decision of the panel.

(e) *Composition of notice; rights of an individual at a panel; authority of chairperson.* — (1) The notice under subsection (d) (1) of this section shall include the following information:

(i) The date, time, and location that the panel will convene;

(ii) The purpose of the panel; and

(iii) A complete description of the rights of an individual under paragraph (2) of this subsection.

(2) At a panel, an individual has the following rights:

(i) To attend the meeting of the panel, excluding the discussion conducted to arrive at a decision;

(ii) To present information, including witnesses;

(iii) To ask questions of any person presenting information to the panel;

(iv) To request assistance from a lay advisor; and

(v) To be informed of:

1. The name, address, and telephone number of the lay advisor;

2. The individual's diagnosis; and

3. An explanation of the clinical need for the medication or medications, including potential side effects, and material risks and benefits of taking or refusing the medication.

(3) The chairperson of the panel may:

(i) Postpone or continue the panel for good cause, for a reasonable time; and

(ii) Take appropriate measures necessary to conduct the panel in an orderly manner.

(f) *Duties of the panel.* — Prior to determining whether to approve the administration of medication, the panel shall:

(1) Review the individual's clinical record, as appropriate;

(2) Assist the individual and the treating physician to arrive at a mutually agreeable treatment plan; and

(3) Meet for the purpose of receiving information and clinically assessing the individual's need for medication by:

(i) Consulting with the individual regarding the reason or reasons for refusing the medication or medications and the individual's willingness to accept alternative treatment, including other medication;

(ii) Consulting with facility personnel who are responsible for initiating and implementing the individual's treatment plan, including discussion of the current treatment plan and alternative modes of treatment, including medications that were considered;

(iii) Receiving information presented by the individual and other persons participating in the panel;

(iv) Providing the individual with an opportunity to ask questions of anyone presenting information to the panel; and

(v) Reviewing the potential consequences of requiring the administration of medication and of withholding the medication from the individual.

(g) *Approval of medication by panel.* — The panel may approve the administration of medication or medications and may recommend and approve alternative medications if the panel determines that:

(1) The medication is prescribed by a psychiatrist for the purpose of treating the individual's mental disorder;

(2) The administration of medication represents a reasonable exercise of professional judgment; and

(3) Without the medication, the individual is at substantial risk of continued hospitalization because of:

(i) Remaining seriously mentally ill with no significant relief of the mental illness symptoms that cause the individual to be a danger to the individual or to others;

(ii) Remaining seriously mentally ill for a significantly longer period of time with mental illness symptoms that cause the individual to be a danger to the individual or to others; or

(iii) Relapsing into a condition in which the individual is in danger of serious physical harm resulting from the individual's inability to provide for the individual's essential human needs of health or safety.

(h) *Bases of panel's decision.* — (1) A panel shall base its decision on its clinical assessment of the information contained in the individual's record and information presented to the panel.

(2) A panel may meet privately to reach a decision.

(3) A panel may not approve the administration of medication where alternative treatments are available and are acceptable to both the individual and the facility personnel who are directly responsible for implementing the individual's treatment plan.

(i) *Documentation by panel.* — (1) A panel shall document its consideration of the issues and the basis for its decision on the administration of medication or medications.

(2) A panel shall provide a written decision on the administration of medication or medications, and the decision shall be provided to the individual, the lay advisor, and the individual's treatment team for inclusion in the individual's medical record.

(3) If a panel approves the administration of medication, the decision shall specify:

(i) The medication or medications approved and the dosage and frequency range;

(ii) The duration of the approval, not to exceed the maximum time provided under subsection (m) of this section; and

(iii) The reason that alternative treatments, including the medication, if any, were rejected by the panel.

(4) If a panel approves the administration of medication, the decision shall contain:

(i) Notice of the right to request a hearing under subsection (k) of this section;

(ii) The right to request representation or assistance of a lawyer or other advocate of the individual's choice; and

(iii) The name, address, and telephone number of the designated State protection and advocacy agency and the Lawyer Referral Service.

(j) *Duties of lay advisor.* — If a panel approves the administration of medication, the lay advisor promptly shall:

(1) Inform the individual of the individual's right to appeal the decision under subsection (k) of this section;

(2) Insure that the individual has access to a telephone as provided under § 10-702 (b) of this subtitle;

(3) If the individual requests a hearing, notify the chief executive officer of the facility or the chief executive officer's designee pursuant to subsection (k) (1) of this section and give the individual written notice of the date, time, and location of the hearing;

(4) Advise the individual of the provision for renewal of an approval under subsection (m) of this section.

(k) *Request for an administrative hearing.* — (1) An individual may request an administrative hearing to appeal the panel's decision by filing a request for hearing with the chief executive officer of the facility or the chief executive officer's designee within 48 hours of receipt of the decision of the panel.

(2) Within 24 hours of receipt of a request for hearing, the chief executive officer of the facility or the chief executive officer's designee shall forward the request to the Office of Administrative Hearings.

(3) An initial panel decision authorizing the administration of medication shall be stayed for 48 hours. If a request for hearing is filed, the stay shall remain in effect until the issuance of the administrative decision.

(4) The Office of Administrative Hearings shall conduct a hearing and issue a decision within 7 calendar days of the decision by the panel.

(5) The administrative hearing may be postponed by agreement of the parties or for good cause shown.

(6) The administrative law judge shall conduct a de novo hearing to determine if the standards and procedures in this section are met.

(7) At the hearing, the individual representing the facility:

(i) May introduce the decision of the panel as evidence; and

(ii) Shall prove, by a preponderance of the evidence, that the standards and procedures of this section have been met.

(8) The administrative law judge shall state on the record the findings of fact and conclusions of law.

(9) The determination of the administrative law judge is a final decision for the purpose of judicial review of a final decision under the Administrative Procedure Act.

(l) *Appeal.* — (1) Within 14 calendar days from the decision of the administrative law judge, the individual or the facility may appeal the decision and the appeal shall be to the circuit court on the record from the hearing conducted by the Office of Administrative Hearings.

(2) The scope of review shall be as a contested case under the Administrative Procedure Act.

(3) (i) Review shall be on the audiophonic tape without the necessity of transcription of the tape, unless either party to the appeal requests transcription of the tape.

(ii) A request for transcription of the tape shall be made at the time the appeal is filed.

(iii) The Office of Administrative Hearings shall prepare the transcription prior to the appeal hearing, and the party requesting the transcription shall bear the cost of transcription.

(4) The circuit court shall hear and issue a decision on an appeal within 7 calendar days from the date the appeal was filed.

(m) *Time period of treatment: renewal.* — (1) Treatment pursuant to this section may not be approved for longer than 90 days.

(2) (i) Prior to expiration of an approval period and if the individual continues to refuse medication, a panel may be convened to decide whether renewal is warranted.

(ii) Notwithstanding the provisions of paragraph (1) of this subsection, if a clinical review panel approves the renewal of the administration of medication or medications, the administration of medication or medications need not be interrupted if the individual appeals the renewal of approval.

(n) *Documentation by treating physician.* — When medication is ordered pursuant to the approval of a panel under this section and at a minimum of every 15 days, the treating physician shall document any known benefits and side effects to the individual. (1991, ch. 385.)

Editor's note. — Section 2, ch. 385, Acts 1991, as amended by § 1, ch. 135, Acts 1993, effective July 1, 1993, provides that "this Act shall take effect July 1, 1991. This Act shall remain effective for a period of 4 years and at the end of January 1, 1995, an evaluation report on this Act recommending reestablishment or termination of this Act shall be prepared by the Secretary of Health and Mental Hygiene in consultation with the Maryland Hospital Association, the State designated protection advocacy agency, and other affected parties, and shall be submitted to the Governor and the General Assembly."

Maryland Law Review. — For survey, "Developments in Maryland Law, 1989-90," see 50 Md. L. Rev. 1027 (1991).

Constitutionality. — Provisions governing the forcible administration of antipsychotic medication to involuntarily committed mental patients in nonemergency situations, and specifically this section did not afford the patient the requisite procedural due process protections. Williams v. Wilzack, 319 Md. 485, 573 A.2d 809 (1990).

Construction with other sections. — Nothing in § 10-704 of this article circumscribed the authority granted by a former version of this section to administer antipsychotic drugs for treatment purposes. Williams v. Wilzack, 319 Md. 485, 573 A.2d 809 (1990).

Finding of incompetency. — Nothing in this section requires that the inmate be adjudged incompetent before drugs may be involuntarily administered to him. The fact that the inmate has been involuntarily institutionalized in a psychiatric facility is not tantamount to a finding that he is mentally incompetent to make treatment decisions. Williams v. Wilzack, 319 Md. 485, 573 A.2d 809 (1990).

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 10th day of November, 1997, copies of the Brief of the American Civil Liberties Union of Maryland, The American Orthopsychiatric Association, and the Judge David L. Bazelon Center for Mental Health Law as Amici Curiae in Support of Respondent were mailed, first-class postage prepaid to:

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IN THE

COURT OF SPECIAL APPEALS OF MARYLAND

September Term, 1996

No. 581

DAVID MARTIN,

Appellant

v.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE,

Appellee

APPEAL FROM THE CIRCUIT COURT FOR ANNE ARUNDEL COUNTY, MARYLAND

(Honorable Bruce Williams, Judge)

APPELLANT'S BRIEF

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STATEMENT OF THE CASE

Appellant David Martin is a former involuntarily hospitalized patient at Crownsville Hospital Center (Crownsville), a Maryland state psychiatric hospital. Mr. Martin was committed to Crownsville for treatment on June 11, 1995. While at Crownsville, Mr. Martin was subjected to involuntary medication pursuant to Maryland Annotated Code Health-General Article, Section 10-708.

On July 3, 1995, a Clinical Review Panel was convened in accordance with Section 10-708 to determine whether psychotropic medication could be administered to Mr. Martin against his will. (E. 91-93). The panel concluded that Mr. Martin should be forced to take medications. (E. 91-93). Mr. Martin appealed the decision of the Clinical Review Panel to an Administrative Law Judge (ALJ) who held a hearing on July 20, 1995. (E. 94).

The ALJ approved the forcible medication of Mr. Martin although finding that he had posed no danger to himself or others while in Crownsville. The ALJ found that under § 10-708, it was sufficient to find that Mr. Martin would be a danger to himself if released to the community. Mr. Martin appealed the ALJ's decision to the Anne Arundel County Circuit Court on July 21, 1995. On July 28, 1995, the Circuit Court granted a stay of the medication order pending the appeal.

On October 19, 1995, Anne Arundel Circuit Court Judge Bruce Williams upheld the ALJ's decision, finding that the State's

burden under Section 10-708 was to establish that Mr. Martin needed treatment for a condition which would cause him to be a danger to himself or others if he was released to the community-at-large. (E. 6).

Mr. Martin filed this appeal on November 14, 1995 on the grounds that the Circuit Court's decision violated Maryland law and the United States Constitution.

ISSUES PRESENTED

1. Whether MD. CODE ANN. HEALTH-GEN. § 10-708 requires that an individual be currently dangerous to himself or others within the facility to which he is confined before he can be administered psychotropic drugs against his will?

2. Whether an involuntary psychiatric patient's constitutional right to refuse psychotropic drugs can be overcome solely by the State's interest in providing treatment with drugs that are medically appropriate?

STATEMENT OF FACTS

On June 11, 1995, David Martin was admitted to Crownsville Hospital Center (Crownsville), a Maryland State psychiatric hospital. He was committed there on the certifications of two psychiatrists (E. 44, T. 15). In accordance with MD. CODE ANN. HEALTH-GEN. § 10-632, an Administrative Law Judge (ALJ) approved

Mr. Martin's involuntary commitment after finding that he had a mental disorder, that he was in need of inpatient treatment and that he presented a danger in the community. The ALJ's findings were based upon Mr. Martin's brother's testimony that he observed Mr. Martin walking directly into traffic as he left a bus station. (E. 45, T. 17).

On July 3, 1995, after Mr. Martin had been in Crownsville for three weeks, a Clinical Review Panel was convened in accordance with MD. CODE ANN. HEALTH-GEN. § 10-708 to determine whether psychotropic medications could be administered to him over his objections. The Panel approved the medications and Mr. Martin appealed the decision to an ALJ who held a hearing on July 20, 1995.

Evidence at the forced medication hearing established that Mr. Martin never exhibited any violent or dangerous behavior directed towards another individual, either in the community or while in Crownsville. (E.54, T. 54). To the contrary, the evidence showed that during his stay at Crownsville, Mr. Martin was entirely passive and spent most of his time alone, reading the Bible in his room. (E. 55, T. 58). Indeed, the State conceded at the ALJ hearing that Mr. Martin posed no danger to staff, other patients, or himself while in Crownsville. (E. 56, T. 64).

The Crownsville psychiatrist who prescribed Prolixin for Mr. Martin, Dr. Silverine Samaranyake, testified at the ALJ hearing that the benefits of the medication included the amelioration of

his suspiciousness, less obvious delusions, clearing of his thought processes and his return to a normal life. (E. 49-50, T. 35-37). Mr. Martin contended at the hearing that although he may benefit from the medication prescribed, he could not be forcibly administered the medication since he had presented no danger to himself or others while in Crownsville. (E. 55, T. 57-58).

The State argued that Mr. Martin would pose a danger if released from Crownsville:

> The statutory criteria [for forcible administration of medication] is that [Mr. Martin] cannot be released from the hospital because of mental illness symptoms that cause him to be a danger to himself or others, and the implication of that is that a danger to himself outside of the hospital -- outside of the safe confinement of these walls and the supervision provided herein.

(E. 56, T. 64).

Administrative Law Judge Harry Tebbutt approved the decision of the Panel, accepting the State's argument that he must focus upon whether Mr. Martin would be dangerous if released to the community. Judge Tebbutt found that:

> ...we look at dangerousness from the sense of if the individual were to be released today, would that individual constitute a danger to himself or to other persons

(E. 63, T. 89).

On July 21, 1995, Mr. Martin appealed the ALJ's decision to the Anne Arundel County Circuit Court and successfully sought a stay dated July 28, 1995 of the administrative order to forcibly medicate him.

In an October 19, 1995 Memorandum and Order, Judge Bruce C. Williams of the Anne Arundel County Circuit Court upheld the ALJ's decision that Mr. Martin could be forced to take psychotropic medications without requiring the State to prove that without the medications, he is a danger to himself or others in the facility. Judge Williams found that under Maryland law and the United States Constitution, the State's burden is to show that an individual needs treatment for a condition which causes him to be a danger to himself or others while interacting with the community-at-large. The Court also stated, without explanation, that MD. CODE ANN. HEALTH-GEN. § 10-708 required nothing more than what it believed the Supreme Court had required under the Constitution in its forced medication cases. (E. 6).

Mr. Martin filed this appeal on November 14, 1995. He was discharged from Crownsville on January 16, 1996 to a supervised community residential rehabilitation program in Anne Arundel County.[1]

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[1] This case is not moot despite Mr. Martin's discharge because the forced administration of medication clearly concerns an important public issue which is likely to recur and may evade judicial review. Beeman v. Department of Health and Mental Hygiene, 105 Md. App. 147, 157-58, 658 A.2d 1172, 1177 (Md. App. 1995).

ARGUMENT

I. SECTION 10-708 REQUIRES THAT AN INDIVIDUAL BE CURRENTLY DANGEROUS TO HIMSELF OR OTHERS WITHIN THE FACILITY TO WHICH HE IS CONFINED BEFORE HE CAN BE ADMINISTERED PSYCHOTROPIC DRUGS AGAINST HIS WILL.

Maryland CODE ANN. HEALTH-GEN. § 10-708 establishes the right of psychiatric inpatients in Maryland to refuse psychotropic medication. The present statute was enacted in response to a successful challenge to its predecessor statute in Williams v. Wilzack, 319 Md. 485, 573 A.2d 809 (1990). In Williams, the Court of Appeals held that the predecessor statute violated procedural due process. Williams, 319 Md. at 509-510, 573 A.2d at 821.

The General Assembly reenacted Section 10-708 in 1991 correcting the procedural deficiencies identified in Williams. The reenacted statute also includes a new substantive requirement that an individual be a danger to himself or others before forcible medication can be approved.[2] This requirement was not

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[2] The legislative history of § 10-708, then House Bill 588, indicates that the dangerousness requirement was not included in the original bill dated February 1, 1991. In that bill, the corresponding section to § 10-708(g) read:

> (3) Without the medication, the individual is at substantial risk of continued hospitalization because of:
>
> A. Remaining seriously mentally ill with no significant relief of the mental illness.
>
> B. Remaining seriously mentally ill for a significantly longer period of time.

The dangerousness requirement was added in the second version of House Bill 588 dated March 19, 1991. Records from the Committee deliberations do not explain why this language was added.

(continued...)

present in the predecessor statute.

Section 10-708 sets forth limited exceptions to the right to refuse psychotropic medication. The only circumstances under which an involuntary psychiatric inpatient can be forcibly medicated over his objections are in an emergency on the order of a physician or in a non-emergency when the forcible administration of medication is approved by a Clinical Review Panel.

Section 10-708(g) specifies the findings that a Clinical Review Panel must make to overcome an involuntary inpatient's right to refuse medication in a non-emergency situation.[3] The

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[2](...continued)
Clearly, the reenacted § 10-708 requires some finding about dangerousness. See Note 3 for the reenacted statute.

[3] § 10-708(g) in its entirety states:

Approval of medication by panel. - The panel may approve the administration of medication or medications and may recommend and approve alternative medications if the panel determines that:

1. The medication is prescribed by a psychiatrist for the purpose of treating the individual's mental disorder;
2. The administration of medication represents a reasonable exercise of professional judgment; and
3. Without the medication, the individual is at substantial risk of continued hospitalization because of:
   (i) Remaining seriously mentally ill with no significant relief of the mental illness symptoms that cause the individual to be a danger to the individual or to others;
   (ii) Remaining seriously mentally ill for a significantly longer period of time with mental illness symptoms that cause the individual to be a danger to the individual or to others.
   (iii) Relapsing into a condition in which the individual is in danger of serious physical harm resulting from the individual's inability

(continued...)

plain language of § 10-708(g) requires a finding that the patient is currently exhibiting mental illness symptoms that cause him to be a danger to himself or others. However, the statute's dangerousness requirement is only one of three separate and distinct determinations that must be made before forcible medication can be approved. The first two prongs of the subsection require findings that:

> (1) The medication is prescribed by a psychiatrist for the purpose of treating the individual's mental disorder;
>
> (2) The administration of medication represents a reasonable exercise of professional judgment.

§ 10-708(g)(1) & (2). In other words, under these first two prongs, the statute requires that the medications be medically appropriate for the treatment of the individual's mental illness. The third prong of the subsection, which the Circuit Court misconstrued, requires an additional finding that the individual is "at substantial risk of continued hospitalization" with "mental illness symptoms that cause [him] to be a danger to [himself] or to others." § 10-708(g)(3).

The Circuit Court's interpretation of § 10-708(g) overlooks the current dangerousness language within this third prong and is so broad that it would undermine the legislature's explicit intention of giving involuntary psychiatric patients a meaningful right to refuse medications. The practical effect of the Court's

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[3](...continued)
to provide for the individual's essential human needs of health or safety.

decision is to reduce the State's burden to showing that the patient could benefit from the medications and consequently be returned to the community. However, this result looks only at the medical appropriateness of the medications, and not at whether the individual requires the medications because he is dangerous. Where the medication prescribed by the treating physician is a "reasonable exercise of professional judgment" or medically appropriate, the medication is expected to reduce the risk of continued hospitalization and shorten the patient's length of stay in the hospital. Appellee's Memorandum. (E. 28-29) and (E. 49-50, T. 35-37).

The Circuit Court below held that § 10-708 requires a finding that a patient would be a danger to himself or others if released to the community. (E. 6). However, this interpretation undermines the statutory scheme established in the Health General Code's Title 10, Mental Hygiene Law. Analysis of Title 10 provides a context from which we can discern the intended focus of § 10-708's dangerousness requirement. See Kaczorowski v. City of Baltimore, 309 Md. 505, 516, 535 A.2d 628, 633 (1987).

The Circuit Court's holding confuses the forced medication law with Maryland's involuntary commitment statute, MD. CODE ANN. HEALTH-GEN. § 10-632. Under § 10-632, an ALJ is already required at the time of the individual's commitment hearing, to determine whether the individual is a danger to himself or others in the community in order to involuntarily commit him to the psychiatric hospital. § 10-632(e)(2) & (2)(iii). Therefore, under the

Circuit Court's reasoning, an ALJ under § 10-708 would make the same determination about an individual's dangerousness in the community that the ALJ in the commitment hearing has already made in order to confine the individual to the psychiatric hospital under § 10-632.[4] In Mr. Martin's case, another ALJ made such a finding about him on June 15, 1995, just five weeks before the July 20, 1995 forced medication hearing. It was as a consequence of that finding that Mr. Martin was committed to Crownsville Hospital Center.

In State v. Bricker, 321 Md. 86, 93, 581 A.2d 9, 12 (1990), the Court of Appeals stated:

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[4] § 10-632. Notice and time of hearing; hearing officer; decision.

(e) Decision - The hearing officer shall:
(1) Consider all the evidence and testimony of the record; and
(2) Order the release of the individual from the facility unless the record demonstrates by clear and convincing evidence that at the time of the hearing each of the following elements exist as to the individual whose involuntary admission is sought:
(i) The individual has a mental disorder;
(ii) The individual needs in patient care or treatment;
(iii) The individual presents a danger to the life or safety of the individual or of others;
(iv) The individual is unable or unwilling to be voluntarily admitted to the facility.
(v) There is no available less restrictive form of intervention that is consistent with the welfare and safety of the individual; and
(vi) If the individual is 65 years or older and is to be admitted to a State facility, the individual has been evaluated by a geriatric evaluation team and no less restrictive form of care or treatment was determined by the team to be appropriate...

> When several statutes are made in pari materia, any interpretation must be made with full awareness of all the relevant enactments... It is presumed that the General Assembly acted with full knowledge of prior legislation and intended statutes that affect the same subject matter to blend into a consistent and harmonious body of law... Therefore, various consistent and related enactments, although made at different times and without reference to one another, nevertheless should be harmonized as much as possible.

Sections 10-632 and 10-708 must be read in harmony with each other. Each statute has its particular role. Section 10-632 is designed to ensure that mentally ill persons are confined to a psychiatric hospital and are not released to the community if they are a danger to themselves or to others. Section 10-708 is designed to delineate the circumstances under which involuntarily committed patients, who were already determined to be dangerous in the community, can have their right to refuse psychotropic drugs overcome. It is inconceivable that the legislature intended that an ALJ in a § 10-708 forced medication hearing make the very same determination about dangerousness in the community that another ALJ under § 10-632 has already made.[5]

Under the Circuit Court's interpretation of § 10-708, every involuntary psychiatric patient will be subject to the forcible administration of psychotropic drugs so long as the medications prescribed are medically appropriate to treat the patient's

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[5] If the Court finds that § 10-708 requires nothing more than the commitment standard's finding of dangerousness, the statute will be unconstitutional under the Supreme Court decisions in Washington v. Harper, 494 U.S. 210 (1990) and Riggins v. Nevada, 504 U.S. 127 (1992). See Section II, infra at 15-24.

mental illness and thus hasten the patient's return to the community. Pursuant to Maryland's commitment statute, involuntary patients have already been determined to be dangerous in the community and in need of hospitalization. Thus, the Circuit Court's conclusion renders § 10-708(g)(3)'s dangerousness requirement duplicative and unnecessary.

Furthermore, the Circuit Court's interpretation suggests that an ALJ who finds that an individual would not be dangerous in the community under the forced medication law should overrule the previous ALJ's commitment order and find that the patient must be released from the hospital. Yet there is no provision under § 10-708 which authorizes the release of a patient where the ALJ determines that the patient would not be dangerous if released. Any subsequent involuntary confinement of the individual after he is determined not to be a danger in the community in the forced medication context would be illegal under both Maryland law and the United States Constitution. See MD. CODE ANN. HEALTH-GEN. § 10-632(e)(2)(iii); Addington v. Texas, 441 U.S. 418, 426-27 (1979); Youngberg v. Romeo, 457 U.S. 307, 314-315 (1982); and Thomas S. v. Flaherty, 902 F.2d 250, 252 (4th Cir. 1990).

The Circuit Court below summarily dismissed the arguments made by Mr. Martin with regard to the meaning of the dangerousness requirement. The Court reasoned that § 10-708 did not go further than the Constitution without even attempting to reconcile its conclusion with the language of the statute. (E-6).

Furthermore, the Court failed to consider the confusion which its interpretation of § 10-708 will inevitably cause to the statutory scheme of which both the forced medication and commitment laws are a part.

The Circuit Court also misconstrued Mr. Martin's argument in this case as requiring a finding that the patient is "an immediate threat to himself or others before he can be forced to receive psychiatric medical treatment." (E. 3). Mr. Martin argued that a patient must be found to be dangerous within the hospital, not an immediate threat. There is no question that a patient who presents an "immediate threat" can be forcibly medicated under § 10-708(b)(1):

> (b) Medication authorized. - Medication may not be administered to an individual who refuses the medication, except:
> (1) In an emergency, on the order of a physician where the individual presents a danger to the life or safety of the individual or others.

That section authorizes the forcible medication of a patient who presents an emergency danger and is not at issue in this case. Moreover, Mr. Martin did not challenge the right of the State to force upon him all forms of "psychiatric medical treatment;" he challenged only the intrusive forcible administration of psychotropic drugs where a person is not currently dangerous.

Several Maryland Circuit Court decisions have held that the patient's behavior in the hospital, as opposed to his behavior if released, is the focus of the dangerousness inquiry in a forced medication hearing under § 10-708. In Department of Health and Mental Hygiene v. Fred Greenhill, Case No. 93-CA-22250, (Howard

Cty. Cir. Ct., July 16, 1993), the Howard County Circuit Court upheld an ALJ finding that a Clifton T. Perkins Hospital patient could not be forcibly medicated. The decision squarely addressed the issue of whether the locus of the danger should be the hospital or the community. The ALJ ruled that under the plain language of the statute:

> I've got to find that he's a danger right now, [that he could] cause himself harm or cause harm to others. He's certainly not going to do that in this institution. This is not a release hearing. We're not talking about his release to the community. (sic)

In Re: Fred L. Greenhill, No. 93-DHMH-CTP-09-2526, Transcript at 172 (E. 81). The Circuit Court upheld the ALJ's decision in Greenhill, ruling that there was a substantial basis in the record for the decision, particularly on the issue of dangerousness. Department of Health and Mental Hygiene v. Fred Greenhill, Case No. 93-CA-22250, (Howard Cty. Cir. Ct., July 16, 1993).[6]

Another Howard Circuit Court in Chapman v. Clifton T. Perkins Hospital Center, Case No. 93-CA-23503, (Howard Cty. Cir. Ct., December 2, 1993) (E. 86), also found that an ALJ must make a determination of current dangerousness before approving a forced medication order. In Chapman, the Howard County Circuit Court remanded an ALJ's decision approving a forced medication recommendation because no determination had been made about the petitioner's dangerousness while in the hospital. (E. 87).

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[6] The Howard County Circuit Court in Department of Health and Mental Hygiene v. Fred Greenhill made its decision on the record and provided no Memorandum and Order.

In Nusser v. Clifton T. Perkins Center, Case No. 95-CA-27338, (Howard Cty. Cir. Ct., April 26, 1995), another Howard County Circuit Court approved the forcible administration of medications, assuming arguendo that § 10-708(g)(3)(ii) required a finding of current dangerousness.[7]

In sum, the plain language of § 10-708, the statutory scheme of which it is a part, and the reasoning of other Circuit Court decisions dictate that the statute's dangerousness language be interpreted to require a finding of the patient's current dangerousness within the facility to which he is confined.

II. AN INVOLUNTARY PSYCHIATRIC INPATIENT'S CONSTITUTIONALLY PROTECTED RIGHT TO REFUSE PSYCHOTROPIC DRUGS CANNOT BE OVERCOME SOLELY BECAUSE THE DRUGS ARE MEDICALLY APPROPRIATE TO TREAT HIM.

Applying a reasonable relationship, low scrutiny Due Process test, the Circuit Court below held that, "[u]nder Maryland law and the U.S. Constitution, the State's burden [in a case of psychotropic drug refusal] is to show that an individual needs treatment for a condition which causes him to be a danger to himself or others while interacting with the community-at-large." (E. 5-6). In so finding, however, the Circuit Court

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[7] But see, Fetter v. Clifton T. Perkins Hospital Center, Case No.96-CA-29827 (Howard Cty. Cir. Ct., February 5, 1996), in which a Howard County Court upheld an ALJ decision authorizing the forced administration of medication despite it findings the Mr. Fetter was not currently acting out his symptoms in a violent manner within the hospital. The Court found that because his mental illness symptoms continued to interfere with his ability to be discharged to the community, he could be forced to take the medications.

failed to consider the Supreme Court's most recent case on the issue of the forcible administration of psychotropic medications, Riggins v. Nevada, 504 U.S. 127 (1992). Furthermore, the Circuit Court misinterpreted the Supreme Court's decision in Washington v. Harper, 494 U.S. 210 (1990). The Supreme Court held in both Riggins and Harper that the medical appropriateness of treatment with psychotropic drugs is not sufficient by itself to justify forced medication. Riggins, 504 U.S. at 135 (affirmatively citing Harper, 494 U.S. at 227). In addition, the Court required the State to show "compelling concerns" or "overriding justifications" which outweigh the individual's interest in being free from unwanted psychotropic drugs. Riggins, 504 U.S. at 136.

In Riggins v. Nevada, the Supreme Court addressed the circumstances under which a mentally ill pretrial detainee may be forcibly medicated. The Court held that the forced administration of psychotropic drugs during Mr. Riggins' criminal trial violated his Constitutional rights guaranteed by the Sixth and Fourteenth Amendments. The Court stated that an individual has a fundamental, constitutionally protected right to avoid the involuntary administration of antipsychotic drugs. Riggins, 504 U.S. at 127; See also, Washington v. Harper, 494 U.S. 210 (1990); Mills v. Rogers, 457 U.S. 291, 299 (1982). The Court also pointed to the serious, even fatal side effects of psychotropic drugs, focusing particular attention on tardive dyskinesia.

Riggins, 504 U.S. at 134 (citing Harper, 494 U.S. at 229-230).[8]

Interpreting Washington v. Harper, 494 U.S. 210 (1990), its earlier pivotal case on this issue, the Court in Riggins stated that:

> Under Harper , forcing antipsychotic drugs on a convicted prisoner is impermissible absent a finding of overriding justification **and** a determination of medical appropriateness.

Riggins, 507 U.S. at 135 (emphasis added). The Court went on to find that in Riggins' case, the lower court's order did not "indicate a finding that safety or other compelling concerns outweighed Riggins' interest in freedom from unwanted antipsychotic drugs." Id. at 136.

The Court in Riggins noted the types of "compelling concerns" or "overriding justifications" that would overcome a patient's refusal to take medication. The Court pointed to the State's interest in providing a safe environment for the staff and occupants of the institution. Safety within the institutional setting was precisely the basis of the forced medication order in Washington v. Harper, 494 U.S. 210 (1990), upon which the Circuit Court below relied extensively. The

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[8] In Washington v. Harper, 494 U.S. 210, 229 (1990), the Supreme Court found that Mr. Harper's interest in avoiding the forcible administration of the drugs was protected by the Due Process Clause of the Fourteenth Amendment because "[t]he forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty." The Court went on to explain the many serious side effects of taking psychotropic medications, including tardive dyskinesia, a sometimes irreversible neurological disorder, and neuroleptic malignancy syndrome which can lead to death from cardiac disfunction. Id. at 229-230.

purpose of the forced medication in Harper was to reduce a prison inmate's level of dangerousness and ensure safety in the prison environment. Id., 494 U.S. at 227.

The Court approved Mr. Harper's forcible medication because he had a history of violent conduct **within the institutional setting to which he was confined.** Harper, 494 U.S. at 210. The Supreme Court held that Mr. Harper could be forcibly medicated because to do so would be "reasonably related to the State's legitimate interest in combatting the danger posed by a violent, mentally ill inmate." Harper, 494 U.S. at 211. By contrast, in the instant case, the State conceded that Mr. Martin posed no danger while confined to Crownsville. (E. 56, T. 64). Thus, the Circuit Court's reliance on Harper to medicate Mr. Martin was misplaced.

In the instant case, the Circuit Court did not identify any "compelling concerns" or "overriding justifications" in addition to the provision of medically appropriate treatment, as required by the Supreme Court in Riggins. Nor do such concerns or justifications exist. The State's interest in this case was in treating the symptoms of Mr. Martin's mental illness so that he could be discharged to the community. In its Memorandum of Law, the State conceded that the State's interest in the provision of medically appropriate treatment equates to its interest in reducing the risk of continued hospitalization and shortening hospital stays:

> [The] substantial risk of continued hospitalization directly contravenes a compelling state interest in providing dangerous, involuntarily admitted patients with prompt, appropriate, efficacious treatment, so that they may be safely returned to the community as soon as sound medical practice permits.

Appellee's Memorandum. (E. 31). While this provision of "medically appropriate" psychotropic drug treatment is a legitimate function of the State, it cannot alone amount to a "compelling concern" or "overriding justification" sufficient to overcome Mr. Martin's constitutionally protected right to refuse medication. Riggins, 507 U.S. at 135-36.

If the State's interest in providing treatment and returning patients to the community were a compelling interest by itself, the Constitutional and statutory right of an involuntary psychiatric patient to refuse drugs would be nullified. All involuntarily hospitalized mentally ill individuals for whom psychotropic drugs are "medically appropriate" could be forcibly medicated because such medication is always intended to treat them and shorten their hospital stay. The Supreme Court has never identified the goal of providing medically appropriate treatment to shorten hospital stays as a compelling interest justifying forcible medication. Rather, the Supreme Court has explicitly stated in both Riggins and Harper that providing treatment with psychotropic drugs which are "medically appropriate" is not a sufficient justification alone to overcome an individual's constitutionally protected interest in being free from unwanted psychotropic medications. Riggins, 504 U.S. 135; Harper, 494 U.S. 227.

The Circuit Court below improperly relied on Harper's requirement that the State establish a reasonable relationship to a legitimate penal purpose in finding:

> The Substantive Due Process test to be applied when asked to order involuntar[y] treatment on an individual confined due to mental illness is whether the treatment is 'reasonably related' to legitimate governmental interests.

(E. 4-5). However, the Supreme Court in Harper explained that this standard was appropriate because Mr. Harper was confined to a penal institution and the "proper standard for determining the validity of a prison regulation claimed to infringe on an inmate's constitutional rights" was to determine if the regulation was "reasonably related to a penalogical interest." Harper, 494 U.S. at 223.

In Riggins however, the Court applied a more stringent due process standard for individuals who have not been convicted of a crime, distinguishing Harper.[9] The Court, quoting O'Lone v. Estate of Shabazz, 482 U.S. 342 (1987), explained that:

> [P]rison regulations... are judged under a 'reasonableness' test less restrictive than ordinarily applied to alleged infringements of fundamental constitutional rights.

Riggins, 504 U.S. at 135 (quoting O'Lone, 482 U.S. at 349). In contrast to Harper, the Supreme Court in Youngberg v. Romeo, 457

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[9] Even if this Court finds that the reasonable relationship Due Process test applies in the instant case, under Riggins the State's interest in providing medically appropriate psychotropic drug treatment alone cannot be a sufficient justification for overcoming Mr. Martin's right to refuse psychotropic drugs. Riggins, 504 U.S. at 135-36.

U.S. 307, 322 (1982), held that persons who have been involuntarily committed for treatment are entitled to greater Constitutional protections than criminals whose conditions of confinement are designed to punish.[10]

Although the Riggins Court found that the errors of the court below made it unnecessary to explicitly adopt a strict scrutiny standard, its language and reasoning clearly indicate that the compelling state interest test applied. The Court focused on the lower court's failure to indicate whether "compelling [state] concerns outweighed Riggins' interest in freedom from unwanted antipsychotic drugs." Riggins, 504 U.S. at 136. It went on to hold that Mr. Riggins could not be forcibly medicated because the State had failed to establish that its interests in maintaining Mr. Riggins' competency and ensuring safety within the institution could not be accomplished by "less intrusive means." See Woodland v. Angus, 820 F. Supp. 1497, 1510 (D. Utah 1993) (construing Riggins to require a standard of strict scrutiny); Bruce Winick, "New Directions in the Right to Refuse Mental Health Treatment: The Implications of Riggins v. Nevada", 2 Wm. & Mary B.R.J 206, 219-232 (1993) (discussing the Riggins Court's strict scrutiny standard).

The Supreme Court in Riggins also discussed the concept of current dangerousness. Although Mr. Riggins had been charged

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[10] The Maryland Court of Appeals decision in Williams v. Wilzack, 319 Md. 485, 573 A.2d 809 (1990), which relied on the standards set out in Harper, was decided before Riggins v. Nevada, 504 U.S. 127 (1992).

with murder, the Court concluded that psychotropic medication was not "essential for the sake of Riggins' own safety or the safety of others." Riggins, 504 U.S. at 135. In finding that Mr. Riggins was not dangerous for purposes of forced medication, the Supreme Court clearly did not consider his pre-incarceration murder charge. Nor did the Court evaluate how Mr. Riggins would behave if released to the community without medication. By contrast, in the instant case, the ALJ relied exclusively upon his projections of Mr. Martin's potentially dangerous behavior in the community (E. 63, T. 89). The Circuit Court and the ALJ disregarded the fact that the State conceded that Mr. Martin was not currently dangerous in Crownsville. Speculation about an individual's future dangerousness if released does not amount to a compelling concern sufficient to overcome an individual's right to refuse psychotropic medication in the hospital. See Riggins, 504 U.S. at 135; Harper, 494 U.S. at 226-27; Woodland v. Angus, 820 F.Supp. at 1508-1509. As discussed supra, the State's concerns about Mr. Martin's dangerousness if released are already addressed by MD. CODE ANN. HEALTH-GEN. § 10-632, Maryland's commitment statute.

As it did in Riggins, the Court in Harper clearly relied upon the finding that Mr. Harper was dangerous in the prison environment. The Circuit Court in the present case even quoted the Court's holding that required the inmate to pose a threat within the institution:

> Where an inmate's mental disability is the root cause of the threat he poses **to the inmate population**, the State's interest in decreasing the danger to others necessarily encompasses an interest in providing him with medical treatment for his illness.

(E. 5) (quoting Harper 494 U.S. at 225-226) (emphasis added). But the Circuit Court below erroneously equated the State's interest in Harper in treatment to decrease actual danger to other inmates with the State's interest in the instant case in treatment to decrease hypothetical danger to the patient should he be discharged. The Supreme Court has never defined dangerousness this way in a forced medication case.

Maryland CODE ANN. HEALTH-GEN. § 10-708 is an acknowledgement that the State's interest in treating an involuntary patient is not sufficient, by itself, to overcome a patient's right to refuse psychotropic drug treatment. Under Maryland common law:

> [A] physician, treating a mentally competent adult under non-emergency circumstances, cannot properly undertake to perform surgery or administer other therapy without the prior consent of his patient.

Sard v. Hardy, 281 Md. 432, 439, 379 A.2d 1014, 1019 (1977). Every patient involuntarily committed to a psychiatric facility is admitted there for treatment. However, the patient's right to refuse psychotropic drug treatment remains intact within the facility, despite the State's interest in providing treatment to those involuntarily confined. Maryland Section 10-708 codifies that right and lays out specific exceptions. There must be a further overriding justification or compelling state concern

sufficient to overcome this fundamental Constitutional and statutory right to refuse psychotropic drug treatment. Riggins stands for the proposition that the provision of treatment with psychotropic drugs that are "medically appropriate" does not alone meet that threshold. Riggins, 504 U.S. 135-36.

In Chapman v. Clifton T. Perkins Hospital Center, Case No. 93-CA-23503, (Howard Cty. Cir. Ct., December 2, 1993), discussed supra, the Howard County Circuit Court applied the holding of Riggins in a forced medication case under section 10-708. The Chapman Court explained the holding of Riggins to be that "due process required the State to show that the [forced medication] treatment was medically appropriate and, considering less intrusive alternatives, essential for Riggins' own safety and the safety of others." Chapman at 3 (citing Riggins, 504 U.S. at 135). The Circuit Court stated that "the ALJ appears to rely for the dangerousness determination on the nature of the offense with which Chapman is charged", as opposed to making a determination about current dangerousness. Chapman at 3. The Chapman Court remanded the case to the ALJ for more specific findings on whether Mr. Chapman was dangerous in the hospital.

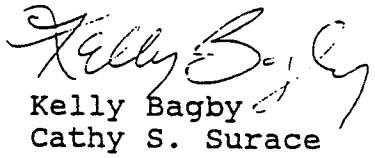
In the instant case, the Circuit Court failed to satisfy the Riggins standards which require a finding that forcibly medicating Mr. Martin was essential to a compelling state concern, in addition to being a medically appropriate means of treating him. Under the reasoning of Riggins and Harper, Mr. Martin's dangerousness in the community, rather than in the

facility, cannot provide the State a compelling reason to overcome his constitutional right to refuse psychotropic drugs.

CONCLUSION

For the reasons stated above, Mr. Martin requests that the decision of the Anne Arundel County Circuit Court be reversed on the ground that MD. CODE ANN. HEALTH-GEN. § 10-708 requires a finding that Mr. Martin was currently dangerous within the facility to which he was confined, or in the alternative, on the ground that § 10-708 violates the Due Process Clause of the United States and Maryland Constitutions.

Respectfully submitted,



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APPENDIX

Editor's note. — Chapter 405, Acts 1983, transferred former § 10-707 of this article to be § 10-710 of this article.

§ 10-708. Refusal of medication; clinical review panel [Section subject to termination].

(a) *Definitions.* — (1) In this section the following words have the meanings indicated.

(2) "Panel" means a clinical review panel that determines, under the provisions of this section, whether to approve that medication be administered to an individual who objects to the medication.

(3) "Medication" means psychiatric medication prescribed for the treatment of a mental disorder.

(4) "Lay advisor" means an individual at a facility, who is knowledgeable about mental health practice and who assists individuals with rights complaints.

(b) *Medication authorized.* — Medication may not be administered to an individual who refuses the medication, except:

(1) In an emergency, on the order of a physician where the individual presents a danger to the life or safety of the individual or others; or

(2) In a nonemergency, when the individual is hospitalized involuntarily or committed for treatment by order of a court and the medication is approved by a panel under the provisions of this section.

(c) *Composition of panel.* — (1) A panel shall consist of the following individuals appointed by the chief executive officer of the facility or the chief executive officer's designee, one of whom shall be appointed chairperson:

(i) The clinical director of the psychiatric unit, if the clinical director is a physician, or a physician designated by the clinical director;

(ii) A psychiatrist; and

(iii) A mental health professional, other than a physician.

(2) If a member of the clinical review panel also is directly responsible for implementing the individualized treatment plan for the individual under review, the chief executive officer of the facility or the chief executive officer's designee shall designate another panel member for that specific review.

(d) *Notice of panel.* — (1) The chief executive officer of the facility or the chief executive officer's designee shall give the individual and the lay advisor written notice at least 24 hours prior to convening a panel.

(2) Except in an emergency under subsection (b) (1) of this section, medication or medications being refused may not be administered to an individual prior to the decision of the panel.

(e) *Composition of notice; rights of an individual at a panel; authority of chairperson.* — (1) The notice under subsection (d) (1) of this section shall include the following information:

(i) The date, time, and location that the panel will convene;

(ii) The purpose of the panel; and

(iii) A complete description of the rights of an individual under paragraph (2) of this subsection.

(2) At a panel, an individual has the following rights:

(i) To attend the meeting of the panel, excluding the discussion conducted to arrive at a decision;

(ii) To present information, including witnesses;

(iii) To ask questions of any person presenting information to the panel;

(iv) To request assistance from a lay advisor; and

(v) To be informed of:

1. The name, address, and telephone number of the lay advisor;

2. The individual's diagnosis; and

3. An explanation of the clinical need for the medication or medications, including potential side effects, and material risks and benefits of taking or refusing the medication.

(3) The chairperson of the panel may:

(i) Postpone or continue the panel for good cause, for a reasonable time; and

(ii) Take appropriate measures necessary to conduct the panel in an orderly manner.

(f) *Duties of the panel.* — Prior to determining whether to approve the administration of medication, the panel shall:

(1) Review the individual's clinical record, as appropriate;

(2) Assist the individual and the treating physician to arrive at a mutually agreeable treatment plan; and

(3) Meet for the purpose of receiving information and clinically assessing the individual's need for medication by:

(i) Consulting with the individual regarding the reason or reasons for refusing the medication or medications and the individual's willingness to accept alternative treatment, including other medication;

(ii) Consulting with facility personnel who are responsible for initiating and implementing the individual's treatment plan, including discussion of the current treatment plan and alternative modes of treatment, including medications that were considered;

(iii) Receiving information presented by the individual and other persons participating in the panel;

(iv) Providing the individual with an opportunity to ask questions of anyone presenting information to the panel; and

(v) Reviewing the potential consequences of requiring the administration of medication and of withholding the medication from the individual.

(g) *Approval of medication by panel.* — The panel may approve the administration of medication or medications and may recommend and approve alternative medications if the panel determines that:

(1) The medication is prescribed by a psychiatrist for the purpose of treating the individual's mental disorder;

(2) The administration of medication represents a reasonable exercise of professional judgment; and

(3) Without the medication, the individual is at substantial risk of continued hospitalization because of:

(i) Remaining seriously mentally ill with no significant relief of the mental illness symptoms that cause the individual to be a danger to the individual or to others;

(ii) Remaining seriously mentally ill for a significantly longer period of time with mental illness symptoms that cause the individual to be a danger to the individual or to others; or

(iii) Relapsing into a condition in which the individual is in danger of serious physical harm resulting from the individual's inability to provide for the individual's essential human needs of health or safety.

(h) *Bases of panel's decision.* — (1) A panel shall base its decision on its clinical assessment of the information contained in the individual's record and information presented to the panel.

(2) A panel may meet privately to reach a decision.

(3) A panel may not approve the administration of medication where alternative treatments are available and are acceptable to both the individual and the facility personnel who are directly responsible for implementing the individual's treatment plan.

(i) *Documentation by panel.* — (1) A panel shall document its consideration of the issues and the basis for its decision on the administration of medication or medications.

(2) A panel shall provide a written decision on the administration of medication or medications, and the decision shall be provided to the individual, the lay advisor, and the individual's treatment team for inclusion in the individual's medical record.

(3) If a panel approves the administration of medication, the decision shall specify:

(i) The medication or medications approved and the dosage and frequency range;

(ii) The duration of the approval, not to exceed the maximum time provided under subsection (m) of this section; and

(iii) The reason that alternative treatments, including the medication, if any, were rejected by the panel.

(4) If a panel approves the administration of medication, the decision shall contain:

(i) Notice of the right to request a hearing under subsection (k) of this section;

(ii) The right to request representation or assistance of a lawyer or other advocate of the individual's choice; and

(iii) The name, address, and telephone number of the designated State protection and advocacy agency and the Lawyer Referral Service.

(j) *Duties of lay advisor.* — If a panel approves the administration of medication, the lay advisor promptly shall:

(1) Inform the individual of the individual's right to appeal the decision under subsection (k) of this section;

(2) Insure that the individual has access to a telephone as provided under § 10-702 (b) of this subtitle;

(3) If the individual requests a hearing, notify the chief executive officer of the facility or the chief executive officer's designee pursuant to subsection (k) (1) of this section and give the individual written notice of the date, time, and location of the hearing;

(4) Advise the individual of the provision for renewal of an approval under subsection (m) of this section.

(k) *Request for an administrative hearing.* — (1) An individual may request an administrative hearing to appeal the panel's decision by filing a request for hearing with the chief executive officer of the facility or the chief executive officer's designee within 48 hours of receipt of the decision of the panel.

(2) Within 24 hours of receipt of a request for hearing, the chief executive officer of the facility or the chief executive officer's designee shall forward the request to the Office of Administrative Hearings.

(3) An initial panel decision authorizing the administration of medication shall be stayed for 48 hours. If a request for hearing is filed, the stay shall remain in effect until the issuance of the administrative decision.

(4) The Office of Administrative Hearings shall conduct a hearing and issue a decision within 7 calendar days of the decision by the panel.

(5) The administrative hearing may be postponed by agreement of the parties or for good cause shown.

(6) The administrative law judge shall conduct a de novo hearing to determine if the standards and procedures in this section are met.

(7) At the hearing, the individual representing the facility:

(i) May introduce the decision of the panel as evidence; and

(ii) Shall prove, by a preponderance of the evidence, that the standards and procedures of this section have been met.

(8) The administrative law judge shall state on the record the findings of fact and conclusions of law.

(9) The determination of the administrative law judge is a final decision for the purpose of judicial review of a final decision under the Administrative Procedure Act.

(l) *Appeal.* — (1) Within 14 calendar days from the decision of the administrative law judge, the individual or the facility may appeal the decision and the appeal shall be to the circuit court on the record from the hearing conducted by the Office of Administrative Hearings.

(2) The scope of review shall be as a contested case under the Administrative Procedure Act.

(3) (i) Review shall be on the audiophonic tape without the necessity of transcription of the tape, unless either party to the appeal requests transcription of the tape.

(ii) A request for transcription of the tape shall be made at the time the appeal is filed.

(iii) The Office of Administrative Hearings shall prepare the transcription prior to the appeal hearing, and the party requesting the transcription shall bear the cost of transcription.

(4) The circuit court shall hear and issue a decision on an appeal within 7 calendar days from the date the appeal was filed.

(m) *Time period of treatment; renewal.* — (1) Treatment pursuant to this section may not be approved for longer than 90 days.

(2) (i) Prior to expiration of an approval period and if the individual continues to refuse medication, a panel may be convened to decide whether renewal is warranted.

(ii) Notwithstanding the provisions of paragraph (1) of this subsection, if a clinical review panel approves the renewal of the administration of medication or medications, the administration of medication or medications need not be interrupted if the individual appeals the renewal of approval.

(n) *Documentation by treating physician.* — When medication is ordered pursuant to the approval of a panel under this section and at a minimum of every 15 days, the treating physician shall document any known benefits and side effects to the individual. (1991, ch. 385.)

Editor's note. — Section 2, ch. 385, Acts 1991, as amended by § 1, ch. 135, Acts 1993, effective July 1, 1993, provides that "this Act shall take effect July 1, 1991. This Act shall remain effective for a period of 4 years and at the end of January 1, 1995, an evaluation report on this Act recommending reestablishment or termination of this Act shall be prepared by the Secretary of Health and Mental Hygiene in consultation with the Maryland Hospital Association, the State designated protection advocacy agency, and other affected parties, and shall be submitted to the Governor and the General Assembly."

Maryland Law Review. — For survey, "Developments in Maryland Law, 1989-90," see 50 Md. L. Rev. 1027 (1991).

Constitutionality. — Provisions governing the forcible administration of antipsychotic medication to involuntarily committed mental patients in nonemergency situations, and specifically this section did not afford the patient the requisite procedural due process protections. Williams v. Wilzack, 319 Md. 485, 573 A.2d 809 (1990).

Construction with other sections. — Nothing in § 10-704 of this article circumscribed the authority granted by a former version of this section to administer antipsychotic drugs for treatment purposes. Williams v. Wilzack, 319 Md. 485, 573 A.2d 809 (1990).

Finding of incompetency. — Nothing in this section requires that the inmate be adjudged incompetent before drugs may be involuntarily administered to him. The fact that the inmate has been involuntarily institutionalized in a psychiatric facility is not tantamount to a finding that he is mentally incompetent to make treatment decisions. Williams v. Wilzack, 319 Md. 485, 573 A.2d 809 (1990).

§ 10-632. Notice and time of hearing; hearing officer; decision.

(a) *Right to hearing.* — Any individual proposed for involuntary admission under Part III of this subtitle shall be afforded a hearing to determine whether the individual is to be admitted to a facility or a Veterans' Administration hospital as an involuntary patient or released without being admitted.

(b) *Time of hearing.* — The hearing shall be conducted within 10 days of the date of the initial confinement of the individual.

(c) *Same — Postponement.* — (1) The hearing may be postponed for good cause for no more than 7 days, and the reasons for the postponement shall be on the record.

(2) A decision shall be made within the time period provided in paragraph (1) of this subsection.

(d) *Rules and regulations; designation of hearing officer.* — The Secretary shall:

(1) Adopt rules and regulations on hearing procedures; and

(2) Designate an impartial hearing officer to conduct the hearings.

(e) *Decision.* — The hearing officer shall:

(1) Consider all the evidence and testimony of record; and

(2) Order the release of the individual from the facility unless the record demonstrates by clear and convincing evidence that at the time of the hearing each of the following elements exist as to the individual whose involuntary admission is sought:

(i) The individual has a mental disorder;

(ii) The individual needs in-patient care or treatment;

(iii) The individual presents a danger to the life or safety of the individual or of others;

(iv) The individual is unable or unwilling to be voluntarily admitted to the facility;

(v) There is no available less restrictive form of intervention that is consistent with the welfare and safety of the individual; and

(vi) If the individual is 65 years old or older and is to be admitted to a State facility, the individual has been evaluated by a geriatric evaluation team and no less restrictive form of care or treatment was determined by the team to be appropriate.

(f) *Notice of hearing.* — The parent, guardian, or next of kin of an individual involuntarily admitted under this subtitle:

(1) Shall be given notice of the hearing on the admission; and

(2) May testify at the hearing. (An. Code 1957, art. 59, § 18; 1982, ch. 21, § 2; ch. 525, §§ 2, 3; 1983, ch. 90; 1986, ch. 133; 1990, ch. 73.)

Quoted in Newman v. Reilly, 314 Md. 364, 550 A.2d 959 (1988).

Stated in Spratlin v. Montgomery County, 772 F. Supp. 1545 (D. Md. 1990), aff'd, 941 F.2d 1207 (4th Cir. 1991).

Cited in Williams v. Wilzack, 319 Md. 485, 573 A.2d 809 (1990).

AMENDMENT XIV [1868].

SECTION 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

SECTION 2. Representatives shall be apportioned among the several States according to their respective numbers, counting the whole number of persons in each State, excluding Indians not taxed. But when the right to vote at any election for the choice of electors for President and Vice President of the United States, Representatives in Congress, the Executive and Judicial officers of a State, or the members of the Legislature thereof, is denied to any of the male inhabitants of such State, being twenty-one years of age, and citizens of the United States, or in any way abridged, except for participation in rebellion, or other crime, the basis of representation therein shall be reduced in the proportion which the number of such male citizens shall bear to the whole number of male citizens twenty-one years of age in such State.

SECTION 3. No person shall be a Senator or Representative in Congress, or elector of President and Vice President, or hold any office, civil or military, under the United States, or under any State, who, having previously taken an oath, as a member of Congress, or as an officer of the United States, or as a member of any State legislature, or as an executive or judicial officer of any State, to support the Constitution of the United States, shall have engaged in insurrection or rebellion against the same, or given aid or comfort to the enemies thereof. But Congress may by a vote of two-thirds of each House, remove such disability.

SECTION 4. The validity of the public debt of the United States, authorized by law, including debts incurred for payment of pensions and bounties for services in suppressing insurrection or rebellion, shall not be questioned. But neither the United States nor any State shall assume or pay any debt or obligation incurred in aid of insurrection or rebellion against the United States, or any claim for the loss of emancipation of any slave; but all such debts, obligations and claims shall be held illegal and void.

SECTION 5. The Congress shall have power to enforce, by appropriate legislation, the provisions of this article.

AMENDMENT VI [1791].

In all criminal prosecutions, the accused shall enjoy the right to a speedy and public trial, by an impartial jury of the State and district wherein the crime shall have been committed, which district shall have been previously ascertained by law, and to be informed of the nature and cause of the accusation: to be confronted with the witnesses against him: to have compulsory process for obtaining Witnesses in his favor, and to have the Assistance of Counsel for his defence.

DECLARATION OF RIGHTS

Article 24.

That no man ought to be taken or imprisoned or disseized of his freehold, liberties or privileges, or outlawed, or exiled, or, in any manner, destroyed, or deprived of his life, liberty or property, but by the judgment of his peers, or by the Law of the land. (1977, ch. 681, ratified Nov. 7, 1978.)

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 25th day of October, 1996, copies of the foregoing Appellant's Brief and Joint Record Extract were sent by first-class mail postage prepaid to David R. Morgan, Assistant Attorney General, State of Maryland, Department of Health and Mental Hygiene, 300 West Preston Street, Suite 302, Baltimore, Maryland 21201.

KELLY BAGBY

IN THE

COURT OF SPECIAL APPEALS OF MARYLAND

September Term, 1996

No. 851

DAVID MARTIN,

Appellant

v.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE,

Appellee

APPEAL FROM THE CIRCUIT COURT FOR ANNE ARUNDEL COUNTY, MARYLAND

(Honorable Bruce Williams, Judge)

APPELLANT'S REPLY BRIEF

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SUMMARY OF ARGUMENT

The issue in this case is the meaning of the dangerousness requirement in MD. CODE ANN. HEALTH-GEN. § 10-708, Maryland's forced medication statute. The only plausible reading of the statute is that an Administrative Law Judge (ALJ) should assess dangerousness based on the individual's current condition and present circumstances in the hospital. The far broader reading advanced by the State would allow a patient like Mr. Martin, whom the State conceded was not dangerous within the hospital, to be forcibly medicated whenever medically appropriate simply because he s not yet ready for release. The State's interpretation is at dds with the express language of the statute, and the egislature's intent to create a narrow legislative exception to e common law rule prohibiting treatment without consent. It also nores the legislative scheme of which § 10-708 is a part by gesting that a second finding of dangerousness in the community required when such a finding has already been made at a itment hearing. The State's interpretation of dangerousness d lead to the bizarre result that a patient could be found not erous in the community but nonetheless forced to remain ally hospitalized because the statute fails to give an ALJ diction to order a patient's release.

he State has also misconstrued the case law on the tutional right to refuse psychotropic drugs. It ignored the cent decisions of the Supreme Court in both Washington v. 494 U.S. 210 (1990) and Riggins v. Nevada, 504 U.S. 127

723, 738 (1972); McNeil v. Director, Patuxent Institution, 407 U.S. 245, 248-250 (1972).

The State's position conflicts with the well accepted principle of statutory construction that "'if the statute is part of a general statutory scheme or system, the sections must be read together to ascertain the true intention of the Legislature.'" Beeman v. Department of Health and Mental Hygiene, 105 Md. App. 147, 161 (1995) ("Beeman I")). HEALTH-GENERAL § 10-708 is part of a statutory scheme which includes the involuntary commitment law, MD. CODE ANN. HEALTH-GEN. § 10-632. The involuntary commitment law requires that an individual "present[] a danger to the life or safety of the individual or of others." HEALTH-GEN. § 10-632(e)(2)(iii). Therefore, it is not plausible that the legislature intended to require an ALJ in a forced medication hearing to make a duplicative determination that the individual would be dangerous in the community, since this threshold finding is presumed by the individual's confinement.[1]

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[1] The State argues that current dangerousness cannot be required by section 10-708 because our legislature must have intended to adopt the definition of dangerousness in O'Connor v. Donaldson, 422 U.S. 563 (1975). Appellee's Brief at 12-13. The O'Connor Court found that an individual would be dangerous for the purposes of involuntary commitment if he was "helpless to avoid the hazards of freedom." 422 U.S. 563, 574 n.9. However, since O'Connor was an involuntary commitment case, not a forced medication case, Maryland's legislature should only be presumed to have adopted O'Connor when it enacted HEALTH-GEN. § 10-632, the involuntary commitment statute. When the legislature enacted HEALTH-GEN. § 10-708, the legislative history indicates that it did so relying on the forced medication case of Williams v. Wilzack, 319 Md. 485, 573 A.2d 809 (1990) which was based on Washington v. Harper, 494 U.S. 210 (1990). Beeman v. Department of Health and Mental Hygiene (Beeman II), 107 Md. 122, 137-138 (1995). As set (continued...)

In response to Mr. Martin's arguments regarding the interplay of §§ 10-708 and 10-632, the State contends that should an ALJ find a patient to be non-dangerous in the community and thus ready for discharge during a forced medication hearing, the individual's due process right to be free from unnecessary confinement would be protected by the "always readily available" writ of habeas corpus or a semi-annual review retention hearing. Appellee's Brief at 14, n.5. But, the State cannot seriously contend that due process would be satisfied by forcing the patient to find an attorney to file another lawsuit -- a writ of habeas corpus-- or by spending up to six months in confinement waiting for the next semi-annual review hearing.[2] The due process rights of an individual found to be non-dangerous in the community could only be satisfied through immediate release, but this is not an option available to an ALJ under § 10-708. O'Connor v. Donaldson, 422 U.S. 563, 574-75 (1975); Jackson v. Indiana, 406 U.S. 715, 720-723, 738 (1972); McNeil v. Director, Patuxent Institution, 407 U.S. 245, 248-250 (1972).

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[1](...continued)
forth in Mr. Martin's Opening Brief, the Supreme Court's decision in Harper focused on current dangerousness in the institutional setting. Harper 494 U.S. at 225-227. See also, Appellant's Brief at 17-18, 21-23.

[2] The writ of habeas corpus is extraordinary relief and should not be the primary means of securing prompt release from the hospital for a patient who is determined to be no longer dangerous. Furthermore, mentally ill individuals are not necessarily going to be cognizant of the possibility of relief under the habeas corpus writ, and even if cognizant of their rights, may have difficulty finding an attorney who can remedy their rights violations. See, e.g., Robbins v. Budke, 739 F. Supp. 1479, 1489 (D. N.M. 1990).

Thus, the State's interpretation of dangerousness in this case cannot be squared with this Court's ruling that § 10-708 provides a "narrow legislative exception to the common law rule that a physician cannot administer treatment of any kind to a patient without the patient's consent, absent emergency circumstances." Beeman v. Department of Health and Mental Hygiene, 107 Md. App. 122, 146, 666 A.2d 1314 (1995) ("Beeman II") (citing Williams v. Wilzack 319 Md. 485, 494, 573 A.2d 809 (1990)). The expansive reading of dangerousness advanced by the State -- allowing a patient to be medicated whenever it is medically appropriate and he is not yet ready for release from confinement -- would have the effect of allowing virtually every hospitalized patient to be forcibly medicated, an exception that would totally swallow the rule.

B. The Express Language of the Statute Requires that Dangerousness be Based on the Current Circumstances of the Individual.

The State erroneously argues that Mr. Martin is attempting to append a "dangerous-in-confinement" requirement to the language of section 10-708. Appellee's Brief at 10-11. To the contrary, the express language of section 10-708 requires a finding that without the medication, the individual is at substantial risk of continued hospitalization with "mental illness symptoms that cause the individual to be a danger." The statute's use of the word "cause" in the present tense (as opposed to "caused" in the past tense) demonstrates the legislature's intention that an individual cannot be forced to take medication unless he is currently exhibiting

symptoms that cause him to be dangerous. HEALTH-GEN. § 10-708(g)(i) & (ii).

The State incorrectly claims that a requirement of current dangerousness would mean that forced medication could be authorized only when an "individual has caused injury within the structured confines of the facility." Appellee's Brief at 10. To the contrary, requiring a showing of current dangerousness does not mean that a person must cause actual injury within the hospital. If, for example, a patient has a history of making verbal threats of harm which escalate into physical assaultiveness, and the patient has begun to verbally threaten others within the facility, the ALJ need not wait for actual harm to occur before approving forced medication.

Nor does a requirement of present dangerousness mean that an individual's actions in the community are irrelevant to an assessment of dangerousness under section 10-708. Clearly, an individual's dangerous acts in the community may be considered when deciding whether he is a danger to himself or others in the facility. Section 10-708 only prohibits the <u>exclusive</u> reliance on pre-hospitalization events in the absence of evidence of a risk of current dangerousness in the facility.

Where the types of behavior which resulted in the individual's involuntary commitment are not likely to be repeated within the safe confines of a psychiatric facility, those pre-hospitalization behaviors cannot be the sole basis to satisfy the dangerousness requirement. In this case, an ALJ involuntarily committed Mr.

Martin because he had been observed walking into traffic outside of a bus station. E. 45, T. 17. At the forced medication hearing, the State conceded that not only was Mr. Martin not at risk of walking into traffic during his confinement (E. 54, T. 55), he had not been a danger to himself or others while at Crownsville. E. 56, T. 64.

In a similar vein, if the dangerous act which led to commitment is so remote in time that it is no longer a fair indicator of the individual's current dangerousness, it would be inappropriate to rely exclusively on that act without some indication that the individual is currently at risk of repeating that behavior. Citing this reasoning, the Circuit Court in Chapman v. Clifton T. Perkins Hospital Center, Case No. 93-CA-23503, (Howard Cty. Cir. Ct., December 2, 1993), held that reliance on an offense outside of the facility, alone, without "any other specific finding on the issue of current dangerousness" is insufficient to forcibly medicate a person under § 10-708. E. at 86.

C. The Current Dangerousness Requirement Will Not Result in the Indefinite Confinement of Psychiatric Patients.

The State contends that Mr. Martin's interpretation of § 10-708 will result in Maryland's psychiatric facilities having an "obligation to retain indefinitely -- and without effective treatment -- individuals such as Mr. Martin." Appellee's Brief at 15. To the contrary, studies have shown that forced medication "[does] not reduce [the] length of hospitalization" because the

patient does not become invested in the therapy and therefore stops taking the medications once released. Rodenhauser, Schwenknerm and Khamis, Factors Related to Drug Treatment Refusal in a Forensic Hospital, 38 Hospital and Community Psychiatry 631, 635 (1987). See also, Hassenfeld and Grumet, A Study of the Right to Refuse Treatment, 12 Bulletin of the Academy of Psychiatry and Law 65, 72 (1984).[3]

The State's argument also assumes that medications are the only treatments available in psychiatric hospitals. Psychiatric hospitals have professional and support staff who provide numerous other types of treatment for mentally ill persons. Such methods include psychotherapy,[4] behavioral management techniques,[5] music and art therapy, cognitive therapy, activity therapy, and work therapy. Finally, the guardianship process is always available to the State in those instances where a patient refusing medication is

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[3] The State has presented no evidence to support its assertion that Mr. Martin's condition improved as a consequence of taking psychotropic medication, permitting him to be discharged to the community. Appellee's Brief at 8. Any facts concerning the reasons for Mr. Martin's discharge are not part of the record of this case. Mr. Martin contests the assertion that the forcible administration of the medication was the catalyst for his discharge.

[4]. See, e.g., Dennis C. Madden, "Psychotherapeutic Approaches in the Treatment of Violent Persons," in Clinical Treatment of the Violent Person (Loren H. Roth ed., 1987).

[5]. See, e.g., Robert Liberman and Stephen E. Wong, "Behavior Analysis and Therapy Procedures Related to Seclusion and Restraint," in Psychiatric Uses of Seclusion and Restraint, at 35 (Kenneth Tardiff ed., 1984); Stephen E. Wong et al., "Behavioral Analysis and Therapy for Aggressive Psychiatric and Developmentally Disabled Patients", in Clinical Treatment of the Violent Person, supra note 2, at 20.

not currently dangerous but cannot be treated effectively and released without the medication. The State acknowledges this in its brief. Appellee's Brief at 16. Under those circumstances, the State can file a petition for medical guardianship under MD. CODE ANN. ESTATES & TRUSTS §§ 13-704 et seq. because the patient has evidenced a lack of capacity to make responsible decisions about his health care. Although the State contends that appointment of medical guardians would result in "significant delays" (Appellee's Brief at 16), ESTATES & TRUSTS § 13-705(f) requires courts to hear petitions seeking medical guardians on an expedited basis.

The State also erroneously contends that a current dangerousness requirement:

> 'would... effectively destroy[] the usefulness of the [clinical review panel]'... because, once a patient begins to respond to the panel-approved treatment so as to no longer be dangerous in confinement -- but yet remains unsafe to release -- the panel's authorization would terminate.

Appellee's Brief at 16.[6] The State wrongly suggests that the

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[6] The State takes the "effectively destroy the usefulness of the [clinical review panel]" language from Beeman v. Department of Health and Mental Hygiene, (Beeman I), 105 Md. App. 147, 162, 658 A.2d 1172 (1995). The Court in Beeman was discussing the efficacy of not permitting a clinical review panel to approve forcible administration of side effects medications. Such medications are routinely prescribed for patients taking psychotropic medications. The Court reasoned that excluding the side effects medication would mandate the hospital pursuing guardianship proceedings in every case. This process would render the clinical review panel's authority superfluous because the medical guardian could approve the forcible administration of both the psychotropic medication and the side effects medication.

Beeman I is inapplicable here because, as explained above, a current dangerousness requirement would not render the clinical review panel's authority superfluous. The guardianship process (continued...)

Clinical Review Panel could not continue to forcibly treat a patient under an appropriate § 10-708 order once he begins to respond to the medication if he is no longer dangerous in the facility. Once the hospital has proven that an individual is dangerous within the hospital when not on the medications, those findings must continue for the duration of the 90 day ALJ order authorizing forced medication. Moreover, those findings would be relevant at any subsequent clinical review panel, at which the panel would consider whether the patient would be dangerous in the hospital, based on his history as well as his current circumstances, if he were not to continue on the medication. In Chapman v. Clifton T. Perkins Hospital Center, Case No. 93-CA-23503, (Howard Cty. Cir. Ct., December 2, 1993), the Court disapproved the fifth forcible medication order of the Appellant because there were no findings as to whether he would be currently dangerousness within the hospital "if the medications were to cease." E. at 86. Thus, even if a patient is no longer dangerous within the facility, he could be forcibly medicated if he would be dangerous in the facility without the medication.

In conclusion, a finding of dangerousness should focus on the individual's current condition and present circumstances in the hospital and not rely solely on pre-hospitalization behavior. This

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[6](...continued)
would be appropriate only if the patient was refusing psychotropic medication and did not present a risk of danger in his present circumstances, but still could not be effectively treated and released to the community.

interpretation is the only plausible reading of § 10-708. It is consistent with the express language of the statute and the legislative intent to allow forced medication for psychiatric patients only under limited circumstances. This reading will prevent the bizarre situation where an individual could be found to be no longer dangerous if released to the community, yet an ALJ would lack jurisdiction to release him.

II. THE STATE MISCONSTRUES THE CASE LAW ON THE CONSTITUTIONAL RIGHT TO REFUSE PSYCHOTROPIC DRUGS.

The State completely distorts the holding of the Court of Appeals in Williams v. Wilzack, 319 Md. 485, 573 A.2d 809 (1990). The Williams Court did not resolve the substantive due process question now before this Court, but ruled solely on the procedural due process issue and did so relying on Washington v. Harper, 494 U.S. 210 (1990), a prisoner case. The Court in Williams held that:

> In light of Harper, we conclude that § 10-708, on its face and as applied in this case, did not afford the requisite procedural due process protections to which Williams was entitled. Consequently, on this ground alone, without consideration of Williams's other claims, it was error for the trial court to enter summary judgment against Williams.

Williams, 319 Md. at 509-510.

The State now claims that the Supreme Court decisions in Washington v. Harper and Riggins v. Nevada, 504 U.S. 127 (1992), are irrelevant in determining the rights of involuntary psychiatric patients, in part, because they are prisoner cases. Appellee's Brief at 17-20. The State is wrong. Washington v. Harper and

Riggins v. Nevada are the Supreme Court's most recent statements about the substantive right to refuse psychotropic medications. Riggins, decided after Williams, is particularly salient because Mr. Riggins was a pretrial detainee, not a convicted prisoner as in Harper. In Youngberg v. Romeo, 457 U.S. 307, 322 (1982), the Supreme Court held that the constitutional rights of an institutionalized person are at least as great as those of a convicted inmate. Thus, the State's contention that Harper and Riggins are inapposite to the case at bar is simply wrong. Appellee's Brief at 18-19.

In his opening brief, Mr. Martin, relying on Riggins v. Nevada and Washington v. Harper, argued that current dangerousness in the facility, not dangerousness in the community, could be a sufficiently compelling state interest to overcome a patient's constitutional right to refuse medication. Appellant's Brief at 17-18, 21-23. The State, citing Washington v. Silber, 805 F. Supp. 379 (W.D. Va. 1992), aff'd, 993 F.2d 1541 (4th Cir. 1993), claims that Mr. Martin's position is incorrect. Silber, however, supports Mr. Martin's position that under the Fourteenth Amendment's Due Process Clause, an ALJ must consider a patient's current risk of danger in the facility before approving forcible medication. The Court in Silber, in contrast to the Circuit Court in the instant case, did not rely exclusively on the individual's danger outside of the hospital in approving forced medication but, instead, made

a specific finding of current dangerousness in the hospital, as well:

> It is clear that Washington's condition fell well within those parameters [of dangerousness] both at the time he was committed and at the time he was actually medicated.

Silber, 805 F. Supp. at 384.

In addition to considering his dangerousness outside the facility, the Silber Court reasoned that Washington had begun to act "bizarrely" again in the hospital by "wrapping his penis in plastic, and tying his scrotum with a shoestring." 805 F. Supp. at 384 n.5, 381. Thus the quotation in the State's brief is misleading; Silber is consistent with Mr. Martin's position that findings about current dangerousness in the facility are constitutionally required.

Even if this Court were to find under the reasoning of Silber that dangerousness in the community is constitutionally sufficient to overcome an involuntary psychiatric patient's right to refuse medication, Silber is not relevant to Mr. Martin's statutory argument. The Virginia law at issue in Silber, unlike that in Maryland, required a judge to authorize forcible medication at the time of the commitment hearing. Silber, 805 F. Supp. 384-85 n.6. Moreover, for the reasons set out in section I, supra pages 2-11, Maryland's distinctive forced medication statute and legislative scheme require a finding of current dangerousness at the forced medication hearing.

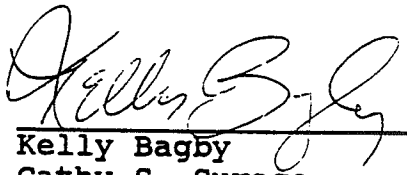
The State has failed to respond to Mr. Martin's argument that under both Harper, 494 U.S. 210 (1990) and Riggins, 504 U.S. 127 (1992) the medical appropriateness of psychotropic drugs alone is not enough to overcome an individual's constitutionally protected right to refuse psychotropic drugs. The State asserts only that nothing in Riggins impinges its legitimate state interest in providing treatment to an individual in its facility in order to allow for his return to the community. Appellee's Brief at 19. However, as the State suggests in its brief, the provision of pharmacological treatment to hasten a patient's return to the community is tantamount to providing "medically appropriate" treatment. Appellee's Brief at 19. This interest, though a legitimate one, cannot alone amount to a "compelling concern" or "overriding justification" as required in Harper and Riggins. Riggins, 504 U.S. at 135. See Appellant's Opening Brief at 18-19.

Misconstruing the case law on the constitutional right to refuse psychotropic drugs, the State argues that Harper and Riggins do not support Mr. Martin's case. To the contrary, under the Supreme Court's reasoning, neither an individual's dangerousness in the community nor the fact that psychotropic drugs are medically appropriate and thus may shorten his hospitalization, are compelling reasons to overcome an individual's constitutionally protected right to refuse psychotropic drugs. Otherwise, involuntary psychiatric patients would have no constitutional right to refuse medically appropriate psychotropic drugs.

CONCLUSION

For the reasons stated above and in Appellant's Opening Brief, David Martin requests that this Court reverse the Circuit Court's decision.

Respectfully Submitted,



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APPENDIX

§ 13-705. Appointment of guardian of disabled person.

(a) *Petition and notice.* — On petition and after any notice or hearing prescribed by law or the Maryland Rules, a court may appoint a guardian of the person of a disabled person.

(b) *Grounds.* — A guardian of the person shall be appointed if the court determines from clear and convincing evidence that a person lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his person, including provisions for health care, food, clothing, or shelter, because of any mental disability, disease, habitual drunkenness, or addiction to drugs, and that no less restrictive form of intervention is available which is consistent with the person's welfare and safety.

(c) *Procedures and venue.* — Procedures and venue in these cases shall be as described by Chapter 1100, Subtitle R of the Maryland Rules.

(d) *Counsel.* — (1) Subject to paragraph (2) of this subsection, unless the alleged disabled person has counsel of his own choice, the court shall appoint an attorney to represent him in the proceeding. If the person is indigent, the State shall pay a reasonable attorney's fee.

(2) In any action in which payment for the services of a court-appointed attorney for the alleged disabled person is the responsibility of the local Department of Social Services, unless the court finds that it would not be in the best interests of the alleged disabled person, the court shall:

(i) Appoint an attorney who has contracted with the Department of Human Resources to provide those services, in accordance with the terms of the contract; and

(ii) In an action in which an attorney has previously been appointed, strike the appearance of the attorney previously appointed and appoint the attorney who is currently under contract with the Department of Human Resources, in accordance with the terms of the contract.

(e) *Presence at hearing; presentation of evidence; closed hearing; sealing.* — The person alleged to be disabled is entitled to be present at the hearing unless he has knowingly and voluntarily waived the right to be present or cannot be present because of physical or mental incapacity. Waiver or incapacity may not be presumed from nonappearance but shall be determined on the basis of factual information supplied to the court by counsel or a representative appointed by the court. The person alleged to be disabled is also entitled to present evidence and to cross-examine witnesses. The issue may be determined at a closed hearing without a jury if the person alleged to be disabled or his counsel so requests and all hearings herein shall be confidential and sealed unless otherwise ordered by a court of competent jurisdiction for good cause shown.

(f) *Expedited ruling.* — The court shall hear and rule on a petition seeking appointment of a guardian of the person of a disabled person in connection with medical treatment on an expedited basis. (1977, ch. 768, § 5; 1984, ch. 709; 1991, ch. 30; 1995, ch. 188.)

Effect of amendments. — The 1991 amendment, effective July 1, 1991, deleted "senility, other mental weakness" following "mental disability" in (b).

The 1995 amendment, approved May 9, 1995, and effective from date of enactment, added "Subject to paragraph (2) of this subsection" to the beginning of present (d) (1); and added (d) (2).

Maryland Law Review. — For comment, "The Right to Refuse Life-Sustaining Medical Treatment: National Trends and Recent Changes in Maryland Law," see 53 Md. L. Rev. 1306 (1994).

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 24th day of January, 1997, a copy of the foregoing Appellant's Reply Brief was sent, via Federal Express, to David R. Morgan, Assistant Attorney General, State of Maryland, Department of Health and Mental Hygiene, 300 West Preston Street, Suite 302, Baltimore, Maryland 21201.

KELLY BAGBY

REPORTED

IN THE COURT OF SPECIAL APPEALS

OF MARYLAND

No. 851

September Term, 1996

DAVID MARTIN

v.

DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Wenner,
Davis,
Hollander,
JJ.

Opinion by Wenner, J.

Filed: March 27, 1997

#C95-22510

EXHIBIT A

We are here called upon to consider the extent to which an individual involuntarily committed to a State psychiatric facility may be involuntarily medicated. Appellant is David Martin (Martin), and appellee is the Department of Health & Mental Hygiene (DHMH). On appeal, we are asked to consider the following questions:

> (1) whether Md. Code Ann., Health-Gen. Art. ("HG") § 10-708 (1994 Repl. Volume & 1996 Supp.) requires that an individual be currently dangerous to himself or others within the facility to which he is confined before he can be administered psychotropic drugs against his will; and
>
> (2) whether an involuntary psychiatric patient's constitutionally protected right to refuse psychotropic drugs can be overcome solely because the drugs are medically appropriate to treat him.

We shall respond to the first question in the affirmative, and reverse the judgment of the circuit court. Consequently, we need not address the second question.

Facts

On 11 June 1995, Martin was involuntarily committed to the Crownsville Hospital Center (Crownsville), a State psychiatric facility. The individual was found by an Administrative Law Judge (ALJ) to present a danger to his life or safety or of others. Md. Code (1994 Repl. Vol. & 1996 Supp.), § 10-632 of the Health-Gen. Article ("HG"). While in Crownsville, Martin refused to be administered the prescribed medications.

After Martin for three weeks refused to ingest the psychotropic drugs prescribed for him, a Clinical Review Panel

(CRP) was convened, pursuant to HG § 10-708, to determine whether he should be forcibly medicated. Following a hearing at which it reviewed his treatment plan and prescribed medications, the CRP approved of Martin being forcibly medicated for a period of ninety days. Martin noted an appeal to the Office of Administrative Hearings (OAH).

At a hearing before an ALJ, Dr. Silverine Samaranyake, Martin's attending physician, testified that, while at Crownsville, Martin had neither been a danger to his life or safety, nor to Crownsville's staff or other residents. Moreover, Martin had not required acute behavioral interventions, such as seclusion, restraints, suicidal or homicidal precautions, or emergency medications. In fact, Martin had been passive while at Crownsville, spending a good deal of time alone in his room reading his Bible. While Dr. Samaranyake was of the opinion that the prescribed medication would enable Martin to be discharged from Crownsville, he believed that, without being medicated, Martin would remain mentally ill and hospitalized "for a long, long time."

After considering all of the evidence presented, the ALJ affirmed the decision of the CRP that Martin should be forcibly medicated for a period of ninety days, believing that unless forcibly medicated Martin presented a danger to his life or safety or others upon being discharged from Crownsville.

Martin then noted an appeal to the Circuit Court for Anne Arundel County, which affirmed the ALJ's decision. This appeal followed. In the meantime, after having been forcibly medicated,

Martin was discharged from Crownsville to a community residential program.

Mootness

As we have noted, we must here determine whether, in order to be forcibly medicated, an involuntarily committed individual must present a danger to his life or safety, or others, in the facility to which he has been confined, or present a danger to his life or safety or others upon being discharged from the facility.

We begin by noting that "[g]enerally, appellate courts do not decide moot questions. A question is moot if, at the time it is before the court, there is no longer an existing controversy between the parties, so that there is no longer any effective remedy which the court can provide." *Att'y Gen. v. Anne Arundel Co. Bus Contractors Ass'n*, 286 Md. 324, 327, 407 A.2d 749 (1979) (citations omitted). As Martin has been forcibly medicated and discharged to a community residential program, the matter before us is moot.

Although there may no longer be any controversy between the parties and no effective remedy which we can provide, *Beeman v. Dep't of Health*, 107 Md. App. 122, 133, 666 A.2d 1314 (1995) (hereinafter referred to as "*Beeman II*"), there are "instances in which courts will depart 'from the general rule and practice of not deciding academic questions.'" *Id., quoting Lloyd v. Bd. of Supervisors of Elections*, 206 Md. 36, 43, 111 A.2d 379 (1954). In *Lloyd*, the Court of Appeals articulated the appropriate standard for determining whether an issue otherwise moot may be considered:

> "[O]nly where the urgency of establishing a rule of future conduct in matters of important public concern is imperative and manifest, will there be justified a departure from the general rule and practice of not deciding academic questions. . . . [I]f the public interest clearly will be hurt if the question is not immediately decided, if recurrence will involve a relationship between government and its citizens, or a duty of government, and upon any recurrence, the same difficulty which prevented the appeal at hand from being heard in time is likely to prevent a decision then the Court may find justification for deciding the issues raised by a question which has become moot, particularly if all these factors concur with sufficient weight."

317 Md. at 496.

Applying the *Lloyd* standard, we conclude that we are justified in addressing the issues before us, because "the forced administration of medication clearly concerns 'a relationship between the government and its citizens.'" *Beeman v. Dep't of Health*, 105 Md. App. 147, 158, 658 A.2d 1172 (1995) (hereinafter referred to as "*Beeman I*"). "We are also satisfied that it is a matter of important public concern to ensure that forced medication of hospitalized patients is conducted in a manner that is neither arbitrary nor capricious." *Id.*

Further, such issues will likely recur, requiring judicial review. Thus, we believe it to be of public importance for us to determine under what circumstances an involuntarily committed individual may be forcibly medicated, particularly because such individuals may suffer from a mental illness not only resistant to treatment, but which is likely to recur.

As forcibly medicating such individuals is generally for a fixed and relatively short period of time, "if this issue were to recur, it may again evade judicial review." *Beeman I*, 105 Md. App. at 159.

Standard of Review

"The scope of review on appeal to this Court is essentially the same as the circuit court's scope of review. We must review the administrative decision itself." *Beeman I*, 105 Md. App. at 154 (citations omitted). Judicial review of an ALJ's decision is governed by the provisions of the Administrative Procedure Act (APA), Md. Code (1995 Repl. Volume & 1996 Supp.) § 10-222, State Gov. Art. (SG). According to § 10-222(h), "in a proceeding under this section, the Court may:

(1) remand the case for further proceedings;

(2) affirm the final decision; or

(3) reverse or modify the decision if any substantial right of the petitioner may have been prejudiced because a finding, conclusion, or decision:

i. is unconstitutional;

ii. exceeds the statutory authority or jurisdiction of the final decision maker;

iii. results from an unlawful procedure;

iv. is affected by any other error of law;

v. is unsupported by competent, material, and substantial evidence in light of the entire record as submitted; or

vi. is arbitrary or capricious."

"Where the question on appeal is the sufficiency of the evidence to support a decision, we must determine 'whether a reasoning mind could have reached the factual conclusion reached by the agency.'" *Beeman I*, 105 Md. App. at 155, quoting *Supervisor of Assessments of Montgomery Co. v. Asbury Methodist Home, Inc.*, 313 Md. 614, 625, 547 A.2d 190 (1988). "When the issues concern interpretation of federal and Maryland statutes, however, we afford the agency no such deference." *Id.* This is precisely what is now before us.

Statutory Background

In resolving the issues before us, we must interpret the provisions of HG § 10-708. Martin challenges the application of § 10-708, not its constitutionality. Accordingly, we must consider § 10-708(g)(3)(i)'s requirement that a CRP may:

> "approve the administration of medication or medications . . . if the panel determines that . . . without the medication, the individual is at substantial risk of continued hospitalization because of . . . remaining seriously mentally ill with no significant relief of the mental illness symptoms that cause the individual to be a danger to the individual or to others; . . . ."

Put another way, we must resolve the meaning of the phrase "cause the individual to be a danger to the individual or to others," to which we now turn.

The Dangerousness Requirement

According to Martin, the circuit court erred in interpreting the phrase in question as permitting an individual to be forcibly medicated on determining the individual to be a danger to the individual or to others upon being discharged from Crownsville. As

Martin sees it, an involuntarily committed individual may be forcibly medicated only upon it being determined that without medication the individual is a danger to the individual or to others in Crownsville. We agree.

As the Court of Appeals pointed out in *Mazor v. State Dep't of Corrections*, 279 Md. 355, 369 A.2d 82 (1977):

> [T]he cardinal rule of construction of a statute is to ascertain and carry out the real intention of the Legislature. The primary source from which we glean this intention is the language of the statute itself. And in construing a statute we accord the words their ordinary and natural signification. If reasonably possible, a statute is to be read so that no word, phrase, clause or sentence is rendered surplusage or meaningless. Similarly, wherever possible an interpretation should be given to statutory language which will not lead to absurd consequences. Moreover, if the statute is part of a general statutory scheme or system, the sections must be read together to ascertain the true intention of the Legislature.

279 Md. at 360-61.

Upon applying these principles, we agree with Martin that § 10-708(g)(3)(i) permits forcible medication of an individual only if, without medication, the individual is a danger to himself or to others in Crownsville.

We believe that the requirement of § 10-708(g)(3)(ii) that an individual remain "seriously mentally ill for a significantly longer period of time . . . [causing] the individual to be a danger to the individual or to others in order to be forcibly medicated" is significant. When considering its language, we believe § 10-708(g)(3)(i) was enacted in the present tense to require a CRP to determine that, without medication, an individual is a danger to

the individual or to others in the facility to which he has been involuntarily confined. Otherwise, we believe the General Assembly would have employed the future tense. Under such circumstances, it would be necessary for a CRP only to determine that forcible medication would improve an involuntarily committed individual's condition.

Moreover, "[w]hen several statutes are made in pari materia, any interpretation must be made with full awareness of all the relevant enactments. It is presumed that the General Assembly acted with full knowledge of prior legislation and intended statutes that affect the same subject matter to blend into a consistent and harmonious body of law. Therefore, various consistent and related enactments, although made at different times and without reference to one another, nevertheless should be harmonized as much as possible." *State v. Bricker*, 321 Md. 86, 93, 581 A.2d 9 (1990) (citations omitted).

Consequently, we shall harmonize §§ 10-708(g)(3)(i) and 10-632(e)(2)(iii) as much as possible. Section 10-632(e)(2)(iii) permits an individual to be involuntarily admitted only if "[t]he individual presents a danger to the life or safety of the individual or of others."

In harmonizing §§ 10-708 and 10-632 as much as possible, we conclude that § 10-708 permits forcible medication of an individual only upon a CRP determining that the individual is a danger to the individual or to others in the facility to which he has been involuntarily confined. This is so because for an individual to be

involuntarily committed, § 10-632(d)(2)(iii) requires it to be determined that "[t]he individual presents a danger to the life or safety of the individual or of others." Consequently, if we were to interpret § 10-708(g)(3)(i) as urged by appellee, §§ 10-708(g)(3)(i) and 10-632(d)(2)(iii) would be redundant.

In other words, harmonizing these sections as much as possible ensures that a mentally ill individual may only be involuntarily committed to a psychiatric facility if it is determined that the individual presents a danger to the life or safety of the individual or to the community. Such an individual may only be forcibly medicated, however, upon it being determined that the individual presents a danger to the individual or to others in the facility to which he has been involuntarily confined. We do not believe this was the intent of the General Assembly. Otherwise, § 10-708(g)(3)(i) would be both redundant and meaningless. Such an interpretation would be contrary to the cardinal rule of statutory construction. *See Mazor*, 279 Md. at 360.

In any event, we believe it obvious that it was the intent of the General Assembly to ensure that involuntarily admitted mentally ill individuals be forcibly medicated only when all else fails. As "the forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty," *Washington v. Harper*, 494 U.S. 210, 229, 110 S.Ct. 1028, 108 L.Ed.2d 178 (1990); *Riggins v. Nevada*, 504 U.S. 127, 134, 112 S.Ct. 1810, 118 L.Ed.2d 479 (1992), such individuals must be afforded substantial protections. It was no doubt with this in mind that

§ 10-708(g)(3)(i) was enacted. As we presume the General Assembly intended that § 10-708(g)(3)(i) have independent meaning, *Bricker*, 321 Md. at 93, we conclude that an individual must be determined "to be a danger to the individual or others" in the facility to which the individual has been involuntarily committed before being forcibly medicated.

We point out that § 10-708(g)(3)(i) is used only when seeking forcibly to medicate an involuntarily committed individual; that is, an individual already determined, pursuant to § 10-632, to be a danger to himself or to others. In other words, in considering § 10-708(g)(3)(i), we must bear in mind that such an individual has been involuntarily committed after being determined, pursuant to § 10-632, to be a danger to himself or to others in the community from which the individual has been involuntarily removed.

Moreover, permitting such an individual to be forcibly medicated simply because the individual may be a danger to himself or to others if ultimately released from the facility, would obviate the intent of the General Assembly. We believe the General Assembly intended to enact a comprehensive scheme to ensure that such individuals be forcibly medicated only if determined to be a danger to the individual or to others in the facility to which the individual has been involuntarily admitted, and provided no less intrusive means are available. Otherwise, the General Assembly's scheme for the protection of such individuals could be easily avoided.

We also believe it noteworthy that § 10-708(g)(3)(i) was enacted in 1991, following *Williams v. Wilzack*, 319 Md. 485, 509-10, 573 A.2d 809 (1990). According to the *Wilzack* Court, "§ 10-708 violated procedural due process protections guaranteed by both the State and Federal Constitutions." Although the legislative history of § 10-708(g)(3)(i) fails to reveal the rationale behind adding the disputed clause, we believe it was to afford such individuals additional procedural due process. Thus, to adopt appellee's interpretation of § 10-708(g)(3)(i) would be to nullify its enactment.

In sum, we hold that in order to be forcibly medicated, § 10-708(g)(3)(i) requires that a CRP determine that an involuntarily committed individual is a danger to the individual or others in the facility to which he has been involuntarily admitted. Consequently, we shall reverse the judgment of the circuit court.

JUDGMENT REVERSED.

COSTS TO BE PAID BY APPELLEE.

IN THE
COURT OF APPEALS OF MARYLAND

September Term, 1997

No. 44

DEPARTMENT OF HEALTH AND MENTAL HYGIENE,

Petitioner,

v.

DAVID MARTIN,

Respondent.

On Appeal from the Circuit Court for Anne Arundel County
(Bruce C. Williams, Judge)
Pursuant to a Writ of Certiorari to the Court of Special Appeals

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BRIEF OF THE MARYLAND PSYCHIATRIC SOCIETY, INC., SINAI HOSPITAL OF BALTIMORE, INC., TAYLOR MANOR HOSPITAL, AND SHEPPARD PRATT HEALTH SYSTEM, INC. AS AMICI CURIAE IN SUPPORT OF THE POSITION OF PETITIONER

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September 30, 1997

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INTEREST OF AMICI

Amici incorporate herein by reference the interest stated in their Motions for leave to file this brief as amici curiae.

STATEMENT OF THE CASE

To avoid unnecessary duplication, Amici hereby adopt the Statement of the Case set forth in the Brief of Petitioner.

QUESTION PRESENTED

In enacting Maryland Health-General Code Annotated, §10-708,

was it the intention of the General Assembly that for an individual who has been involuntarily committed to be forcibly medicated, that individual must be determined to be a danger to the individual or to others in the event the individual is released from the facility to which the individual has been involuntarily committed, without having received the necessary medication?

STATEMENT OF FACTS

To avoid unnecessary duplication, Amici hereby adopt the Statement of Facts set forth in the Brief of Petitioner.

PRELIMINARY STATEMENT

Though Amici disagree with the holding of the Court of Special Appeals, that an individual must be a danger in the institution in order to be forcibly medicated, the Amici concur with the holding that this is a matter of important public concern, which will likely recur, and which in the event of recurrence might evade judicial review.

Mental health professionals, mental hospitals and patients across the State need to know now whether an involuntarily admitted patient who needs medication to recover but refuses to take medication may be involuntarily medicated only if a patient is a danger to himself or to others in the institution, or may be medicated if the patient constitutes a danger to himself or to others if released. That issue is a question of law which will be common to all cases in which an involuntarily admitted patient

refuses to take medication which is required for the patient's recovery. The Amici urge this Court to agree with the decision of the Court of Special Appeals to consider the case on its merits but to conclude, contrary to the opinion of the Court of Special Appeals, and hold that an involuntarily admitted patient who refuses to take medication which the patient needs to recover, may be involuntarily medicated upon showing that the patient constitutes a danger to the patient or to others if released without receiving the required medication. Otherwise, mental health professionals and mental hospitals are placed in the untenable position of being required to hold indefinitely an unmedicated individual, who would only have the opportunity to recover if medicated, to the detriment of the individual and all others in the hospital.

Such an untenable position is detrimental not only to those patients who are involuntarily committed and need medication in order to recover, but who refuse to accept that medication, but also to other patients in the institution who need medication in order to recover and agree to accept that medication. Having unmedicated patients who need medication in a hospital interferes not only with the psychiatrists' ability to treat those individuals but also with the psychiatrists' ability to treat other patients in the hospital. Having such unmedicated patients, who need medication in order to recover, causes disruptions in the hospital which affect those individuals, all treatment personnel, and the other patients of the hospital.

ARGUMENT

IN ENACTING MARYLAND HEALTH-GENERAL CODE ANNOTATED, §10-708, IT WAS THE INTENTION OF THE GENERAL ASSEMBLY THAT IN ORDER FOR AN INDIVIDUAL WHO HAS BEEN INVOLUNTARILY COMMITTED TO BE FORCIBLY MEDICATED, THAT INDIVIDUAL MUST BE DETERMINED TO BE A DANGER TO THE INDIVIDUAL OR TO OTHERS IN THE EVENT THE INDIVIDUAL IS RELEASED FROM THE FACILITY TO WHICH THE INDIVIDUAL HAS BEEN INVOLUNTARILY COMMITTED, WITHOUT HAVING RECEIVED THE NECESSARY MEDICATION.

This Court in Williams v. Wilzack, 319 Md. 485, 510 (1990), held that the prior version of Health-General, §10-708 "violated procedural due process protections guaranteed by both the State and Federal Constitutions." Shortly thereafter, House Bill 588 (1991) was introduced and eventually enacted as Chapter 385, Laws of Maryland, 1991, and became the new Health-General §10-708 considered by the Court of Special Appeals in this case.

To determine the intention of the General Assembly, it is important to examine the entire statutory framework dealing with involuntarily committed patients, including standards for commitment, treatment of the involuntarily committed, and standards for release of the involuntarily committed. It is necessary to determine why the General Assembly was acting and what the General Assembly knew at the time it was considering and eventually enacting the legislation. The General Assembly was acting to remedy the procedural deficiencies found in Williams v. Wilzack, supra. The deficiencies were remedied. Beeman v. Department of Health and Mental Hygiene, 107 Md. App. 122, 145 (1995).

It is important to note as recognized in Beeman, supra at 138, "a Mental Hygiene Administration task force, consisting of mental

health consumers, advocates, attorneys, doctors, and state officials was assembled to draft. . ." HB 588 (1991). The Maryland Disability Law Center, Inc., in a letter to the Legislative Committee, supported HB 588 and commented on the months of negotiations by the task force which resulted in "a fair accommodation of the needs of hospitals, doctors, and mental health consumers." (Emphasis supplied). (App. 15-16.) The task force must have reviewed all pertinent case law, statutes, and medical literature in preparing the draft legislation. At the time, HB 588 (1991) was enacted, HG §10-632 set the standards for involuntary admissions. HG §10-706 required and still requires that "promptly after admission of an individual, a facility shall make and periodically update a written plan of treatment for the individual in the facility. . .". HG §10-805 set forth the procedure for judicial release and HG §10-806 set forth the procedure for administrative release.

In Alexander v. Superintendent, 246 Md. 334, 337 (1967), this Court set forth the standards for release in a proceeding under HG §10-805 and held that, "the test for the release of a person committed to a mental institution is whether the patient, if released, would be a danger to the welfare of himself or society as a whole." (Emphasis supplied). See also, Keiner v. Superintendent, 240 Md. 608 (1965) and Salinger v. Superintendent, 206 Md. 623 (1955). In Alexander, supra, 246 Md. at 338, this Court further

stated:

> We recognized in Keiner, supra, that even though there might be a remission of symptoms, if there is testimony as to the likelihood of their recurrence upon release, then the order of the lower court to recommit the patient to the hospital will not be disturbed. (Emphasis supplied).

The task force knew that for an individual to be released that individual must not be a danger to himself or to others if released, whether or not that individual is a danger to himself or to others in the institution to which he is committed. The fact that an individual could only be released if no longer a danger to himself or to others if released to the community would be a compelling reason for the General Assembly to provide that an individual who refused medication could be involuntarily medicated if that medication was necessary for the individual to recover sufficiently to be eligible for release under the standard set forth in Alexander v. Superintendent, supra. Otherwise, if a patient could only recover by utilizing antipsychotic drug treatment but refused such treatment, the patient would not be eligible for release under Alexander, supra, and would have to be warehoused without effective treatment. The whole purpose of the statutory framework was that an involuntarily committed patient would have a treatment plan which would be best suited to return the patient to the community as quickly as possible.

But this isn't the standard the state is advocating ("last resort anything" vs. "most effective treatment" vs. "speed"? Anything preventing recurrence

The Alexander, Keiner, and Salinger cases were not cited in any of the Briefs in the Court of Special Appeals and were not considered by the Court of Special Appeals in its determination of

legislative intent. However, those cases must have weighed heavily in the deliberations of the task force and the legislators.

In Washington v. Harper, 494 U.S. 210 (1990), the Supreme Court held that a written state administrative policy which governed the forcible administration of drugs to a committed inmate against his will and which contained both substantive and procedural components was permissible under the Constitution both procedurally and substantively. The Supreme Court reviewed the medical literature dealing with the efficacy of the use of antipsychotic medication in treating individuals who as a result of their illness represent a significant danger to themselves or others. The Supreme Court found that there was little dispute in the psychiatric profession as to their efficacy. Id., 494 U.S. at 226. In Williams v. Wilzack, supra, 319 Md. at 499-504, this Court extensively considered and quoted from Washington v. Harper, supra, including the Supreme Court's consideration of the medical literature and its conclusions from review of the medical literature.

The beneficial effects of antipsychotic medication for mentally ill who are psychotic was widely recognized in 1990 and is still recognized today. A comprehensive review of the treatment of schizophrenia published by the National Institute of Mental Health concluded flatly that "antipsychotic drugs generally have a dramatic effect on the symptoms of schizophrenia (e.g., delusions, hallucinations, and thought disorder) within 4-6 weeks, although improvement may continue well after that interval." (Emphasis

supplied). Kane, Treatment of Schizophrenia, 13 Schizophrenia Bull. 133, 142 (1987). "Antipsychotic (neuroleptic) drugs remain the primary modality in the treatment of an acute episode or an acute exacerbation of a schizophrenic illness. The efficacy of medication in this context has been established in numerous double-blind, placebo-controlled trials." (Emphasis supplied). Id. at 134. According to one recent review, 85 percent of acute schizophrenic patients treated with antipsychotics show improvement within six to eight weeks. (Emphasis supplied). Kessler & Waletzky, Clinical Use of the Antipsychotic, 138 Am. J. Psychiat. 202, 203 (1981).[1]

Moreover, antipsychotic medication is not an unconventional or controversial treatment for a condition that can be successfully addressed through a variety of other so-called "less intrusive" means. To the contrary, as the NIMH review indicated: "The available data do not support the feasibility of substituting any psychotherapeutic strategy for drug treatment on an indefinite basis." (Emphasis supplied). Kane, supra, 13 Schizophrenia Bull. at 142. Another study concluded that "[T]here is still no single substitute for neuroleptics for control of symptoms and prevention of relapse in the majority of chronic schizophrenic patients.

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[1]To the same effect is the conclusion of an APA Task Force that reviewed the available data on antipsychotic medication: "[T]he evidence that [antipsychotic drugs] are effective in acute psychoses of various kinds is excellent. . . ."; a similar conclusion is warranted with respect to the treatment of chronic schizophrenia. American Psychiatric Association, Task Force Report 18: Tardive Dyskinesia, 123 (1980) ("APA, Task Force Report 18").

Denying these patients the benefit of the neuroleptic action without offering any suitable alternative may be considered clinical error."[2] (Emphasis supplied). Jeste & Wyatt, Changing Epidemiology of Tardive Dyskinesia: An Overview, 138 Am. J. Psychiat. 297, 306 (1981).[3] Since there is no suitable substitute failure to utilize the proper medication, as needed, may cause great harm to the patient.

Therefore, when the legislature enacted House Bill 588 (1991), the legislature knew that an individual who was involuntarily committed could not be released unless he no longer presented a danger to himself or to others in the event that he was released to the community. Alexander, supra. The legislature knew from the medical literature that some mentally ill patients who were

---

[2]If the Court of Special Appeals decision is not reversed, some attorneys, relying on this language, may sue institutions who are unable to medicate patients who need medication to recover but refuse medication, and are, therefore, required to be held indefinitely. Damages will be claimed for lost time in the community. The claim may ultimately fail in court. However, institutions will be faced with the choice of expending valuable time and money to defend the litigation or settling in order to avoid the cost of litigation.

[3]Recent medical literature, published since Washington v. Harper, supra, continues to recognize the efficacy of antipsychotic medication in the treatment of schizophrenia and other mental illnesses. Lehman, Thompson, Dixon, and Scott, Schizophrenia: Treatment Outcomes Research - Editors' Introduction, 21 Schizophrenia Bull. 561 (1995). Another recent study concluded that: "Almost four decades of research has provided strong evidence that the use of conventional antipsychotic medications, which is routine in the treatment of schizophrenia is helpful in controlling the positive symptoms of the syndrome, has immeasurably reduced its morbidity and mortality and thus should be continued. Generally speaking, this research has very much penetrated clinical practice." (Emphasis supplied). Dixon, Lehman, and Levine, Conventional Antipsychotic Medications for Schizophrenia, 21 Schizophrenia Bull., 567, 574-575 (1995).

involuntarily committed could not be successfully treated through other means. If these patients were not given the proper medication they might be required to be held in the institution for unreasonably long periods of time or perhaps even for life. Further, there is the danger that if a patient who needs medication remains unmedicated, the patient's condition not only will not improve, but may worsen. May eventually meet std.

That is why the legislature in HG §10-708(g) provided that "[t]he panel may approve the administration of medication or medications . . . if the panel determines that:

> (3) without the medication the individual is at substantial risk of continued hospitalization because of:
>
> (i) Remaining seriously mentally ill with no significant relief of the mental illness symptoms that cause the individual to be a danger to the individual or to others;
>
> (ii) Remaining seriously mentally ill for a significantly longer period of time with mental illness symptoms that cause the individual to be a danger to the individual or to others; . . ."

The Court of Special Appeals paid little or no attention to the "[r]emaining seriously mentally ill with no significant relief of mental illness symptoms" or the "[r]emaining seriously mentally ill for a significantly longer period of time with mental illness symptoms" language of HG §10-708(g)(3)(i) and (ii). That language, more than anything else, shows the legislative intent was to tie forcible medication to what is necessary in order to enable a patient to recover sufficiently to be eligible for release - the

patient would no longer be a danger to himself or others if released.

The Court of Special Appeals appeared to base its decision with regard to the legislative intent solely on its contention that if §10-708(g)(3)(i) and §10-632(e)(2)(iii) both have the same standard that the individual presents a danger to the life or safety of the individual or of others in the community, the sections are redundant. Martin v. Department of Health and Mental Hygiene, 114 Md. App. 520, 527-528 (1997). The Court of Special Appeals failed to take into account the fact that the Panel provided for in §10-708 considers appropriate treatment of a committed patient, not whether or not to commit. It will always meet at some time after the decision of the designated hearing officer to commit the patient to the institution. In some instances, this may be substantially after the decision of the designated hearing officer. Further, §10-708(m) provides that treatment may not be approved for longer than 90 days. In order to utilize the medication after the 90 days, a new Panel must be convened to decide whether or not renewal is warranted. This new Panel will act substantially after the hearing officer's decision on commitment and would have to determine at the time of the Panel's review whether the individual remains a danger to himself or others if released to the community. The Panel could not base its approval of medication on the hearing officer's decision for the commitment of the individual since that decision determined dangerousness only at the time of that decision. Further, under §10-632(e)(2)(iii),

Isn't this the function of a Panel determining release? Is there precedence re: an order for release? If so, could these findings be summarized upon?

the hearing officer decides only whether or not to commit, and has no authority to determine what treatment is appropriate after commitment. Therefore, §§10-708(g)(3)(i) and 10-632(e)(2)(iii) are not redundant.

The history of the Respondent in this case proves the validity of the prevailing medical literature and establishes that the intent of the General Assembly must have been to require that an involuntarily committed patient can be forcibly medicated if without the medication the individual will remain hospitalized indefinitely as constituting a danger to himself or to others if released to the community. The Respondent's expert psychiatric witness, Dr. Ellen McDaniel, agreed with the State that the Respondent would be a danger to himself if he was discharged to the community. (E. 59, T.75). She stated that his dangerousness to himself could be controlled in the hospital "if he remains on a closed unit." (E. 59, T. 75). Dr. McDaniel also agreed that the medications prescribed for the Respondent represented "an exercise of reasonable professional judgment." (E. 59, T. 74).

Both the expert psychiatrist for the State and the expert psychiatric witness for the Respondent agreed that without the medication the Respondent remained a danger to himself if released to the community and, therefore, could not be released. While his appeal was pending in the Court of Special Appeals, the Respondent was medicated following a subsequent Clinical Review Panel determination that was made pending his appeal and following medication was discharged from Crownville Hospital to a community

residential program because his condition had improved. Martin v. Department of Health, supra, 114 Md. App. at 523. The Respondent's history is evidence that with the proper use of medication a patient, who remains a danger to himself or to others if released to the community prior to receiving medication, is able to recover to the point that he can be released to the community as no longer a danger to himself or to others in the community. If the Respondent had not been medicated pending appeal, he might still be institutionalized today.

SUMMARY

It is important to be sensitive to the liberty interests of committed patients and to permit the exercise of such interests to the fullest extent possible. However, the decision of the Court of Special Appeals in this case would ultimately constrain even further the liberty interests of persons so profoundly disturbed that they must be hospitalized against their will, to protect themselves or others. This is particularly true because the practical consequence of conferring upon them the right to reject the treatment of choice unless they are a danger in the institution is to condemn many involuntarily committed patients to close and indefinite confinement. We strongly question whether any balanced view of individual rights could support, much less compel, the conclusion that even if an individual remains a danger to himself or others if released prior to receiving the beneficial effects of medication, he cannot be forcibly medicated, if in close and strict confinement he is not a danger in the institution. Such a

conclusion results in the warehousing of these individuals and that would be unacceptable and unfair to the patient.

CONCLUSION

For the reasons stated, this Court should reverse the decision of the Court of Special Appeals and hold that a patient who refuses medication may be forcibly medicated if such medication is necessary for the patient to recover and the patient would be a danger to himself or to others in the community if released.

Respectfully submitted,

Franklin Goldstein

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November 10, 1997

Mr. Ira Burnim
The Judge David L. Bazelon Center
for Mental Health Law
1101 15th Street, NW
Washington, DC 20005-5002

Dear Ira:

I have enclosed three copies of the Brief of the American Civil Liberties Union of Maryland, The American Orthopsychiatric Association, and the Judge David L. Bazelon Center for Mental Health Law as Amici Curiae in Support of Respondent that we filed in the Maryland Court of Appeals today. We have plenty of copies, so please let me know if you would like additional ones.

I have also enclosed, for your information, a copy of an amicus brief filed in the case by Ron Thompson, an individual who was extremely displeased with our brief. We do not know Mr. Thompson. We were curious whether you do, and if you think his letter merits a response.

Thanks again for your assistance.

Sincerely,

Jodi L. Short

Enclosures

November 8, 1997

Dwight Sullivan
ACLU of Maryland
2219 St Paul St
Baltimore, MD 21218

John Townsend Rich, Jodi L. Short
Shea & Gardner
1800 Massachusetts Ave
Washington, DC 20036

Dear Sirs,

Please find enclosed an amicus brief submitted, on my personal initiative alone, in the David Martin case.

I have just read your amicus in this case. I must say that I regard it, for the following reasons, with complete dismay:

A) After citing numerous studies, using graphic quotes of the damage neuroleptic drugs do to the bodies and personalities of psychiatric patients, and to the very possibility of a 'therepeutic alliance' between doctor and patient, you nevertheless repeatedly say that of course these drugs are fine for those patients - i.e. found incompetent - who are legally denied the right to refuse them. In other words, those with no protection are most certain to suffer the cruel effects of these drugs - and you in no way oppose that.

As a sub-point to this strange logic, almost all the many studies you cite are over 10 years old, and often over 20 yrs old, from the 1970's and '80's. Could it be the reason there are no more recent studies is that with the increasing public and media acceptance of biopsychiatry the mental health professions have grown progressivly more callous, and now find no reason to even notice or talk factually about what these drugs do to patients?

B) The key conclusion that these drugs, especially when used on involuntary patients, are for the purpose of social control is nowhere mentioned despite many sentences and cites that seem to cry out for just this conclusion - indeed to admit of no other possible conclusion. But of course to recognize the obvious would be to admit that "administration" of these drugs is not a medical procedure, which is only the cover story for what is actually going on.

C) An equally obvious omission is to keep listing all the iatrogenic damage to patients' bodies and psyches while failing to mention that, unlike real medical procedures, there is no practical possibility of redress, in the form of suits for malpractice.

There is, I believe, a thoroughly paradoxical result of all these blatant and pervasive but unaddressed inconsistencies in your brief. It is to increase the degree and amount of disrespect, contempt, and indifference felt toward mental patients. To say, sub silentio: "Even though we use phrases like the 'right to refuse drugs', OF COURSE these people do not actually have rights we are bound to respect, or that we expect the Court to respect. Even though we are ostensibly arguing for their legal interests, OF COURSE everything we're saying is just ceremonial prattle. We do not seriously mean any of it. If we did, we would be too embarassed to dare show our faces in public with such 'reasoning' as is in our brief".

If this should be true, what does it say about the integrity of the legal profession toward people caught in the embrace of the courts, the police, and mental prisons?

Sincerely,

Ron Thompson
9807 Broad St
Bethesda, MD 20814
301-897-8779

enc

IN THE
COURT OF APPEALS OF MARYLAND

September Term, 1997
No 44

Department of Health and Mental Hygiene, Petitioner
v.
David Martin, Respondent

AMICUS CURIAE Brief in behalf of Respondent

May it please the Court:

Our legal system is in the midst of an unprecedented and historic push by many interests to expand involuntary mental health treatment. To expand its legal techniques, the range of populations subject to forced treatment, the conditions and diagnoses which may trigger it, and the time - i.e. increasingly permanent, lifelong - that forced treatment may be imposed. It appears this court granted a writ of certiorari in the Martin case in order to overturn a ruling by the Circuit Court for Anne Arundel County which recognized a small area where an individual incarcerated ("hospitalized") in the mental health system may refuse psychiatric drugs.

If this is not a proper case to consider the larger legal and social issues involved (see below), I urge you to not close the small and precarious window of freedom in the lower court's holding that a person not found to be presently dangerous while held involuntarily in a mental hospital may refuse powerful, toxic drugs he does not want. I urge that it is wrongful, unwise, and even absurd to argue, as does the State in its brief, that a person's freedom is increased by assaulting him - especially when the reason given is his own good rather than to ease social fears about his condition.

If the larger issue could be addressed of all forms of violent 'help' administered by the psychiatric profession - with full social approval - to persons not found guilty of a crime, I would briefly suggest the following thoughts:

1) Forced treatment is arguably a violation of SUBSTANTIVE due process of law and not merely a debate about procedural due process. That is, rather than deciding how to do it, perhaps - like slavery, or torture for national security reasons - there may be no "right" way to assault people in the name of helping and caring for them. That this argument may instead be peculiarly dishonest and of pernicious import for the prospects of freedom for all citizens.

2) The recent Kansas v. Hendrick decision by the Supreme Court has now extended involuntary incarceration to sexual predators described as having a "mental abnormality", i.e people whom even psychiatrists don't diagnose as mentally ill. How much farther along this path as a society do we want to travel?

3) Just last week the police in the small town of Roby, Il ended with rubber bullets, at a cost approaching $800,000 a 39-day siege of a woman in her own home who was not charged with any crime and did not want to be psychiatrically "evaluated". This incident was

the result of our laws for assaulting, locking up, and "evaluating" people first, and only later wondering whether attacks on their person and dignity were justified. If more of such routine police and medical assaults and deprivations of liberty last this long, become so public, and cost this much, perhaps we will finally decide it is the policy itself which should be (re)"evaluated".

3) Psychiatry is the branch of medicine which has by far the most power over its patients, and at the same time is the least accountable for physical or mental injury to those patients via malpractice suits. This is true because the profession lacks a positive standard of care against which to measure malfeasance or misfeasance. Is this fundamentally fair to individuals subjected to forced treatment, or wise for society as a whole?

4) Psychiatry is the only branch of medicine which can create disease, as opposed to recognize or discover disease which is objectively and scientifically provable, the domain to which the rest of medicine is limited. If anyone doubts this, just look at the out-of-control DSM-IV, psychiatry's official diagnosis manual.

For these reasons and more, I respectfully suggest we need a national debate on the elements that make up our rapidly expanding mental health system, a debate which should start in the courts and among lawyers, concerning the role of the Law in establishing, supporting, and now rapidly extending those involuntary and forced aspects of psychiatry which are at the core of its practice, and give the profession its distinctive identity.

In Support of these comments, I add:

Exhibit A - an attempted diagram of the psychiatric system and

Exhibit B - a chapter by Anne Bradon Johnson from her 1990 book, Out of Bedlam, the Truth about DeInstitutionalization, which seems to trenchantly describe the origin and rise of psychiatric drugs since the mid-1950's and the remarkable self-delusion by many individuals and groups that has accompanied their use.

Perhaps it is true that society can only live with elements of support and comfort from certain core, shared Myths. But what if some of those myths - such as the competence of psychiatric forced treatment - turn out, on critical examination, to be outright Lies?

Respectfully submitted,

Novemebr 4, 1997

Ron Thompson
Member (inactive status), D.C. Bar
Member, Board of Directors,
Maryland Disability Law Center
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301-89-8779

EXHIBIT A

The Psychiatric Merry-Go-Round

The three ideas that make up the modern practice of mental health mutually reinforce each other. But what if all three are wrong? I.e.,

1) What if it's not true that mental illness is biologically caused, as opposed to being correlated or associated with biology? No scientific study that purports to show the biological causation of mental illness has ever been replicated.

2) What if forced treatment - violent, assaultive 'help' - is a dangerous, oxymoronic, orwellian idea that is a product of fear, dislike, and the need for the control of disordered behavior rather than the humanitarian or medical motives claimed for it?

3) What if the doctrine that mentally ill people, instead of being at most temporarily disabled, are permanently not responsible for themselves, has created the self-fulfilling nightmare of an ever-expanding class of people chronically disabled by their 'treatment' rather than the true nature of their problems?

A possible visualization: