IN THE
COURT OF SPECIAL APPEALS OF MARYLAND

September Term, 2005

No. 02227

DEPARTMENT OF HEALTH AND MENTAL HYGIENE,

Appellant,

v.

ANTHONY KELLY,

Appellee.

On Appeal From the Circuit Court For Baltimore City
(Albert J. Matricciani, Jr., Judge)

BRIEF OF APPELLANT

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BRIEF OF APPELLANT

STATEMENT OF THE CASE

This case arises from a decision by a Clinical Review Panel ("CRP" or the "Panel") to authorize the forced administration of psychiatric medications to the appellee, Anthony Kelly. The Panel approved treatment with the prescribed medications for a period of ninety days. Mr. Kelly appealed the Panel's decision to the Office of Administrative Hearings, and on September 1, 2005, Administrative Law Judge ("ALJ") Georgia Brady affirmed the Panel's decision.

On September 8, 2005, Mr. Kelly appealed the ALJ's decision to the Circuit Court for Baltimore City. On November 9, 2005, the circuit court reversed the ALJ's Decision. The Department of Health and Mental Hygiene ("DHMH" or the "Department") timely noted its appeal from the circuit court's decision.

QUESTION PRESENTED

Did the circuit court err in construing section 10-708 of the Health-General Article to require the Department to show that an involuntary patient is a danger to himself or to others in the facility before the patient may be forcibly medicated when, without medication, the patient will remain hospitalized indefinitely?

STATEMENT OF FACTS

On October 14, 2003, Mr. Kelly was admitted to Clifton T. Perkins Hospital Center ("Perkins"), Maryland's maximum security psychiatric hospital, to undergo a pre-trial psychiatric evaluation to determine his competency to stand trial on charges of rape (two counts), murder, and vehicle theft. (E. 10-11, 32.) This was not Mr. Kelly's first contact with the criminal justice system, as he had been "in an out of the court system for the past 20 years." (E. 34.)

Rosemary Carr-Malone, M.D., a Forensic Psychiatry Fellow at Perkins, conducted the evaluation and concluded that Mr. Kelly has a mental disorder and was not competent to stand trial. (E. 11.) Dr. Carr-Malone's evaluation of Mr. Kelly resulted in the longest pre-trial report that Perkins has ever produced. (E. 26.)

Following a contested hearing, the Circuit Court for Montgomery County issued a 39-page opinion concluding that Mr. Kelly has a mental disorder, is incompetent to stand trial, and is dangerous to himself or the person or property of others as a result of his mental disorder. (E. 11, 22.) The court then committed Mr. Kelly to the Department under section 3-106(b) of the Criminal Procedure Article of the Maryland Annotated Code. Mr. Kelly has been a patient at Perkins since that time.

Throughout his hospitalization at Perkins, Mr. Kelly has denied that he has a mental disorder and has refused to take the medications prescribed for that disorder. Under section 10-708(b) of the Health-General Article of the Maryland Annotated Code, "[m]edication may not be administered to an individual who refuses the medication, except" (1) in an emergency or (2) to an involuntary patient under the provisions of section 10-708. Md. Code Ann., Health-Gen. I § 10-708(b) (Supp. 2005). Pursuant to the second of these provisions, Mr. Kelly was notified on August 18, 2005 that a CRP was scheduled to review his continued eligibility for forced medication.[1] (E. 1-2.) Mr. Kelly refused to acknowledge his receipt of the Notice of Clinical Review Panel. (E. 2.)

A CRP determines "whether to approve that medication be administered to an individual who objects to the medication." Md. Code Ann., Health-Gen. I § 10-708(a)(2). "The panel may approve the administration of medication or medications . . . if the panel determines," *inter alia,* that:

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

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[1] At the time, Mr. Kelly was already under a previous order of forced medication.

> (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.

Id. § 10-708(g)(3).

On August 23, 2005, Perkins convened a CRP to consider whether Mr. Kelly continued to meet the criteria under section 10-708.[2] (E. 3-5.) Mr. Kelly, his treating psychiatrist, Robert Wisner-Carlson, M.D., and Jenny Bishop, Rights Advisor, were present at the CRP. (E. 3-5.) Mr. Kelly's father, Roosevelt Kelly, was interviewed by the Panel via telephone. (E. 3.) The Panel approved treatment with the medications that were prescribed for the treatment of Mr. Kelly's mental disorder and found that the medications were prescribed

> for the treatment of [Mr. King's] mental disorder, which is Delusional Disorder, Persecutory and Grandiose Type, based upon the following symptoms: delusions regarding his criminal case; that the charges were falsely pressed against him; delusions regarding having special abilities, that his attorney and the judge are involved in the case against him.

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[2] As Dr. Wisner-Carlson later testified at the administrative hearing, Mr. Kelly was taking his medication as prescribed, but only because the medications were forced under a previous CRP order. (E. 21.) Dr. Wisner-Carlson further testified that "every time I interview [Mr. Kelly], he says he doesn't believe he has a mental illness, doesn't believe he needs the medications, and that if the medications were not forced he would not take them." (E. 21.)

(E. 4.) The Panel also determined that, without these medications, Mr. Kelly was "at substantial risk of continued hospitalization because" he would remain "seriously mentally ill with no significant relief of the mental illness symptoms that cause you to be a danger to yourself or others" and "seriously mentally ill for a significantly longer period of time with mental illness symptoms that cause you to be a danger to yourself or to others." (E. 4.) The Panel approved the medications for a period of ninety days as set forth in section 10-708(m)(1) of the Health-General Article. (E. 5.)

Mr. Kelly appealed the Panel's decision to the Office of Administrative Hearings pursuant to section 10-708(l)(1) of the Health-General Article. (E. 6.) Mr. Kelly was timely notified that an administrative hearing was scheduled for September 1, 2005, (E. 7), and, on that date, an administrative hearing was held before Georgia Brady, Administrative Law Judge, (E. 8). The only witnesses who testified during the administrative hearing were Dr. Wisner-Carlson, who was admitted as an expert in Forensic Psychiatry, and Mr. Kelly. (E. 9, 31.) Mr. Kelly did not offer any expert testimony.

Dr. Wisner-Carlson testified that Mr. Kelly suffers from delusional disorder, which is a psychotic disorder that is characterized by "fixed, false, idiosyncratic belief[s]" that are "non-bizarre . . . mean[ing that] the thing that the

person believes generally could happen."[3] (E. 11-12.) Individuals with delusional disorder are "out of touch with reality in some way." (E. 12.) According to Dr. Wisner-Carlson, however, in evaluating an individual for delusional disorder, "one must check a lot of collateral information to determine whether this is a normal belief or a pathological belief that falls in the realm of delusion." (E. 12.)

Upon reviewing the case, several psychiatrists, including Dr. Wisner-Carlson, believed that Mr. Kelly "is making erroneous decisions, and that he's holding erroneous beliefs based on a mental illness." (E. 28.) Dr. Wisner-Carlson testified that delusional disorder is a chronic condition that "without treatment tends to go on for years and decades once it starts, although it can wax and wane some." (E. 19.) Further, delusional disorder is fairly treatable, assuming patient compliance with medication. (E. 19.) Without treatment, Mr. Kelly's prognosis is very poor. (E. 19.) Further, he has little, if any, insight into his mental illness.[4] (E. 21).

Dr. Wisner-Carlson testified that Mr. Kelly suffers from persecutory and grandiose delusions. (E. 12-13.) Mr. Kelly's persecutory delusions include the belief that a conspiracy exists involving his defense attorney and the judge presiding over the criminal case, that he was offered a plea bargain that would cap his sentence for all of the charges to six years, that his defense attorney was

[3] Mr. Kelly is also diagnosed with borderline intellectual functioning, a cognitive disorder, a reading disorder, a substance abuse disorder, and an antisocial personality disorder. (E. 30.)
[4] On direct examination, Mr. Kelly testified that "I don't have any mental illness. I don't suffer from delusions." (E. 34.)

involved with the prosecutor in fabricating evidence and trying to convict him of the charges, and that his defense attorney lied to him about a "secret search warrant". (E. 14-15.) Mr. Kelly also has delusions about the evidence against him in his criminal case. (E. 20.) Specifically, Mr. Kelly believes that the evidence was "fabricated and inadequate," despite the fact that there is DNA evidence, eyewitnesses and other physical evidence against him that seemed "fairly substantial," according to Dr. Wisner-Carlson. (E. 18.) Mr. Kelly believes that all of this evidence will be thrown out by the court. (E. 18.)

Dr. Wisner-Carlson also testified about Mr. Kelly's grandiose delusions, which include a belief that he can competently and successfully represent himself in his criminal trial, that he was able to start and run a multi-million dollar company, that he has millions of dollars buried despite the fact that Mr. Kelly has borderline intelligence, has failed many grades, has been incarcerated for most of his life, and has had very few jobs, all of them of low skill.[5] (E. 15-17.)

According to Dr. Wisner-Carlson, another feature of Mr. Kelly's mental illness is querolousness or behavior that is "argumentative, litigious . . . [and] peevish." (E. 20.) Mr. Kelly, exhibits this behavior by repeatedly filing numerous complaints, lawsuits, and grievances, even after the reviewing court or agency dismisses them for lack of merit. (E. 20.) Dr. Wisner-Carlson noted that many of

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[5] Mr. Kelly maintains that he earned his General Education Diploma ("GED") and produced a GED certificate from Ohio. (E. 35.) When a Perkins psychologist attempted to verify the authenticity of the certificate by faxing it to the appropriate authorities in Ohio, she learned that it was a forgery or false certificate. (E. 17.)

Mr. Kelly's delusions, as well as his querulous behavior, have decreased in severity with treatment, indicating that the prescribed treatment is successful. (E. 17.)

Dr. Wisner-Carlson testified that Mr. Kelly is a danger to others "based on the circuit court finding of him as a dangerous person" that resulted in his commitment to Perkins. (E. 22.) Mr. Kelly has not, however, required any "special intervention" with regard to assaultive behavior since his admission to Perkins. (E. 29.) Dr. Wisner-Carlson further testified that without medication, Mr. Kelly was at substantial risk of continued hospitalization because of remaining seriously mentally ill with no significant relief of the symptoms that cause him to be a danger to himself or to others, and because of remaining seriously mentally ill for a significantly longer period of time with symptoms causing him to be a danger to himself or to others. (E. 23-24.) Dr. Wisner-Carlson explained that, without medication, Mr. Kelly "would not be able to be discharged" and "would have to stay in the hospital indefinitely." (E. 25.)

At the conclusion of the testimony, the ALJ found that Dr. Wisner-Carlson's diagnosis of delusional disorder is "a reasonable, supportable diagnosis," based on the fact that Mr. Kelly has been repeatedly confronted with "bold, concrete information that would in any reasonable, non-delusional person allow them to separate from the belief. . . . Ye[t], he maintains his faithfulness to these beliefs." (E. 36-37.) The ALJ further found that the medications were prescribed for the purpose of treating Mr. Kelly's mental disorder, that Mr. Kelly

had refused the medication, and that the administration of the medications represented a reasonable exercise of professional medical judgment. (E. 37-38.) Finally, the ALJ found that without the medication Mr. Kelly was at a substantial risk of continued hospitalization because of remaining seriously mentally ill with no significant relief of the mental illness symptoms that cause him to be a danger to himself or to others and of continued hospitalization because of remaining seriously mentally ill for a significantly longer period of time with mental illness symptoms that cause him to be a danger to himself or to others. (E. 40.)

The ALJ specifically noted that no Maryland case law exists that interprets dangerousness as it relates to Maryland's forced medication statute and, therefore, that it is reasonable for her to rely on the circuit court's finding of dangerousness in Mr. Kelly's criminal case. (E. 40.) The ALJ found that Perkins demonstrated by a preponderance of the evidence that all of the statutory criteria for approving forced medication had been satisfied in this case. (E. 40.) The ALJ affirmed the Panel's decision to authorize treatment with the approved medications for a period of ninety days beginning September 1, 2005. (E. 40.)

On September 8, 2005, Mr. Kelly appealed the ALJ's Decision to the Circuit Court for Baltimore City. (E. 42.) Along with his Petition for Judicial Review, Mr. Kelly filed a Motion for Stay of Forced Medication. (E. 43.) On September 23, 2005, the circuit court denied Mr. Kelly's request to stay the ALJ's Decision pending disposition of the appeal. (E. 44.) On November 9, 2005, the circuit court reversed the ALJ's decision. (E. 49-50.) Judge Matricciani was

persuaded by the interpretation of Maryland's involuntary medication statute in *Martin v. Department of Health and Mental Hygiene*, 114 Md. App. 520, *vacated*, 348 Md. 243 (1997), requiring evidence that the patient is dangerous "in the facility . . . rather than to society generally upon his release." (E. 50.) This appeal followed.

ARGUMENT

THE CIRCUIT COURT ERRED WHEN IT REQUIRED THE DEPARTMENT TO SHOW THAT AN INVOLUNTARY PATIENT IS A DANGER TO HIMSELF OR TO THE PERSON OR PROPERTY OF OTHERS INSIDE THE FACILITY BEFORE HE CAN BE FORCIBLY MEDICATED, WHEN, WITHOUT MEDICATION THE PATIENT WILL REMAIN HOSPITALIZED INDEFINITELY.

A. The Lower Court's Construction Of Section 10-708 Frustrates The Legislative Intent.

The lower court disregarded well-settled principles of statutory construction when it held that an involuntary patient must display dangerousness within the secure confines of a psychiatric hospital before being medicated against his will. That interpretation contradicts the plain language of section 10-708(g)(3) of the Health-General Article and adds a requirement not contemplated by the legislature.

The cardinal rule of statutory construction is to determine the intention of the legislature. *Motor Vehicle Administration v. Weller*, 390 Md. 115, 134 (2005). "First and foremost, a court should thoroughly examine the plain language of the statute when attempting to ascertain the Legislature's intentions." *Id.* The plain

language of the statute does not itself limit the use of forced medication to patients who have exhibited dangerous behavior within the highly structured confines of a psychiatric facility. The statute sets forth unambiguous criteria that must be satisfied before forced medication may be ordered by a panel:

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

Md. Code Ann., Health-Gen. I § 10-708(g). The "dangerousness-in-confinement" requirement added by the trial court is conspicuously absent from the list.

While the word "danger" does appear in the statute, it is not listed as a separate and independent requirement. Rather, it appears as part of a dependent clause describing which mental illness symptoms the prescribed medications are intended to treat.

Adopting the lower court's interpretation would render whole sections of the statute surplusage, in particular, all of subsection (3). *See Office of People's Counsel v. Maryland Public Service Commission*, 355 Md. 1, 22 (1999) (whenever possible, construe statutes to avoid rendering any portion superfluous). Subsection (3) concerns whether, without the medication, the individual is at "substantial risk of continued hospitalization" because of his mental illness. Md. Code Ann., Health-Gen. I § 10-708(g)(3). Requiring that the individual exhibit dangerous behavior within the confines of the hospital effectively voids subsection (3) because it does not comprehend the scenario that an unmedicated, mentally ill individual can be at a substantial risk of continued hospitalization, yet not dangerous to self or others in the context of a secure environment.

That is precisely the scenario before this Court. Applying the lower court's interpretation of section 10-708 to this case, without medication, Mr. Kelly will remain seriously mentally ill and at risk for indefinite hospitalization because he has not displayed dangerous behavior within the hospital. Practically speaking, according to the lower court, an involuntary patient with Mr. Kelly's disorder is condemned to lifelong commitment in a maximum security psychiatric facility. The legislature could not possibly have intended this result. *Office of People's Counsel*, 355 Md. at 23 (a statute must be read to avoid an interpretation that is inconsistent with or ignores common sense or logic.)

Adding a dangerous-in-confinement requirement would also render surplusage the portions of the statute that were drafted specifically to manage

dangerous behavior within the confines of the hospital. First, section 10-701(c)(3)(i) states that individuals in a facility have a right to be free from restraints or seclusions, except when used "only during an emergency where the individual presents a danger to the life or safety of the individual or of others." Second, section 10-708(b)(1) provides that medication may not be administered to a non-consenting patient, except that a physician may order that a non-consenting patient be medicated against his will in an emergency, "where the individual presents a danger to the life or safety of the individual or others."

Here, the legislature has provided various procedures for managing patients who exhibit dangerous behaviors within the facility—the use of restraints, seclusion, and emergency forced medication. To require dangerousness within the facility in order to obtain an order of forced medication from a CRP would be duplicative. This is especially so because section 10-708 was not intended to be an emergency tool but, rather, a treatment tool. Giving an involuntary patient medication only when he is dangerous only mitigates the dangerous behavior; it does nothing to treat the mental illness itself. Further, had the legislature intended a dangerous-in-confinement requirement in section 10-708(g), it would have included the relevant language that appears in sections 10-701(b)(3)(i) and 10-708(b)(1)—"where the individual presents a danger to the life or safety of the individual or others." That language is absent from section 10-708(g), which begs the logical conclusion that the legislature meant what it said, and said what it meant.

If the lower court's interpretation is correct, the statute now contains two separate and competing provisions for treating an involuntary patient who is dangerous within the facility and is refusing medication. One section allows medication to be administered solely on the order of the physician (section 10-708(b)(1)), while the other section requires that the hospital comply with various due process protections (section 10-708(g)). Such an interpretation gives short shrift to the legislature's 1991 revision of section 10-708, which corrected the constitutional deficiencies of the original statute in response to the Court of Appeals' decision in *Williams v. Wilzack*, 319 Md. 485 (1990). This is yet another illogical consequence of the lower court's interpretation of the statute.

The lower court's interpretation would "effectively destroy[] the usefulness of the CRP." *Cf. Beeman v. Department of Health and Mental Hygiene*, 105 Md. App. 147, 162 (1995) (construing statute to prohibit forced administration of medication for side effects would destroy statute's utility). Limiting the use of a CRP by adding a current dangerousness requirement has the illogical result of prohibiting the use of this effective treatment tool once the patient begins to respond positively to panel-approved treatment. For instance, a CRP authorizes the forced medication of a schizophrenic patient who frequently assaults peers and staff in response to internal stimuli, delusions, and severe paranoia. Over a period of ninety days, the patient improves and is no longer dangerous in confinement, yet remains unsuitable for release for clinical reasons and continues to refuse to take medication voluntarily. Under the interpretation espoused by the lower court,

this patient would not be eligible for a re-panel, and the Panel's order would expire. As a result, this patient would resume medication refusal and, lacking the necessary treatment, would inevitably decompensate and again become dangerous in confinement.

In the above scenario, psychiatric facilities would then confront an additional challenge—petitioning Maryland courts to appoint a guardian for those patients who do not meet the CRP criteria. This is a lengthy process that would significantly delay the patient's treatment, as well as significantly lengthen the patient's hospitalization. When the legislature revised section 10-708 in response to the Court of Appeal's decision in *Williams v. Wilzack*, 319 Md. 485 (1990), it contemplated the use of guardianships in lieu of having a forced medication statute. H.B. 588 Floor Report, Senate Judicial Proceedings Committee (1991). The legislature determined that a CRP statute was preferable to guardianship proceedings because of the time involved in seeking a guardian and because there are certain involuntary patients who are not appropriate for guardianship. *Id.* Surely the legislature did not intend an interpretation of the statute that renders the CRP useless and undermines its own decision to revise section 10-708, rather than rely on guardianship proceedings.

B. The Lower Court's Interpretation Frustrates The Purpose Of The Statutory Scheme For The Treatment Of Mentally Ill Persons.

Maryland's forced medication statute is just one component of a larger statutory scheme concerning the admission, treatment, and release of involuntary

patients. *See* Md. Code Ann., Crim. Proc. §§ 3-101 *et seq.* (incompetency and criminal responsibility in criminal cases); Health-Gen. I § 10-632 (involuntary admissions); *id.* § 10-805 (judicial release). These statutes must be read together to ascertain the true intention of the legislature. *See Office of People's Counsel*, 355 Md. at 22 ("where the statute to be construed is part of a statutory scheme, the legislative intent is . . . to be discerned by considering it in light of the statutory scheme.")

The lower court's interpretation of section 10-708(g) confounds the statutory scheme and frustrates its purpose. There are three different categories of patients who are eligible to receive forced medication under section 10-708, involuntary patients who are not court involved ("IVA"), incompetent to stand trial patients ("IST"), and not criminally responsible ("NCR") patients. *See* Md. Code Ann., Health-Gen. I § 10-708(b)(2). In each case, an individual is admitted or committed to a psychiatric facility for care and treatment because a mental disorder makes that person dangerous. *See* Md. Code Ann., § 10-632(e)(2); Crim. Proc. §§ 3-106(b)(1), 3-112. And, in each case, a patient may be released from the psychiatric facility when that person would no longer be dangerous because of a mental disorder. *See* Md. Code Ann., Health-Gen. I § 10-806; Crim. Proc. §§ 3-106, 3-114. The statutory scheme also permits patients to be released if they prove to a factfinder that they no longer are dangerous because of a mental disorder. *See* Md. Code Ann., Health-Gen. I § 10-805; Crim. Proc. § 3-119.

Under each of these involuntary commitment statutes, the facility, through the individual's commitment to the Department, is charged with the duty to provide the necessary medical care and/or treatment for involuntarily committed individuals so that they maybe discharged from the hospital. *Williams*, 319 Md. at 506-08. The lower court's interpretation of section 10-708(g)(3) frustrates both the Department's efforts to discharge that duty and the overall purpose of the involuntary commitment statutes. A patient may be committed to a psychiatric hospital for care and treatment because the patient has a mental disorder that makes him or her dangerous; that same patient may not be released as long as the patient would be dangerous upon release. Yet, under the lower court's interpretation of section 10-708, the Department may not treat the patient unless the patient also displays dangerous behavior in the hospital.

Several similarities exist among the three statutes that mandate involuntary admission to a psychiatric facility. Most notably, each statute requires that the individual is dangerous, by reason of mental illness, to self or others and instructs that that the individual be admitted to a psychiatric facility for inpatient care and/or treatment. Implicit in this statutory scheme is the recognition that the facility will provide the necessary care and treatment with the goal of discharging these individuals. This not only involves medication and therapy, but the provision of a structured and secure environment designed to minimize dangerous behavior among the population. In short, individuals are admitted to psychiatric facilities, whether by emergency petition or by court order, primarily to receive

treatment for their mental illness, and the facility is charged with providing treatment until such time as the individual can be safely released from the hospital.

As it is not uncommon for mentally ill individuals to refuse the administration of antipsychotic medications, the lower court's interpretation of Maryland's forced medication statute has the unfortunate consequence of stripping the facility of its ability to provide the necessary and required treatment to a vulnerable population. If an involuntary patient refuses medication, yet does not demonstrate dangerous behaviors within the confines of the facility, the treatment team is rendered incapable of fulfilling its duty. An individual who has already been adjudicated dangerous *outside* the facility, and who cannot be released until he is no longer dangerous outside the facility, is essentially condemned to indefinite hospitalization if not medicated. Under these circumstances, the individual suffers because he is warehoused in a psychiatric hospital, without the benefit of treatment to which he is entitled and that mental health professionals have determined is most effective. Further, the facility's limited resources are used for patients who are not receiving treatment and who, therefore, will never be well enough for discharge.

Further, it is inconceivable that the committing authority would determine that an involuntary patient is appropriate for discharge from the hospital when the hospital has not had the opportunity to treat the condition for which the individual was initially committed. To release an involuntary patient under these circumstances would invite grievous consequences, as the individual has already

been determined incapable of living safely outside the hospital while his mental illness remains untreated.

The ability to administer antipsychotic medication over the objection of an involuntary patient, in the absence of exhibited dangerous behavior, is an essential component of the aforementioned statutory scheme. The lower court's interpretation of section 10-708(g) of the Health-General Article frustrates the basic tenets of the statutory scheme—to protect, treat, and release mentally ill individuals.

C. The Lower Court Improperly Relied On *Martin* Because The Reasoning In *Martin* Is Unpersuasive.

In determining that section 10-708(g) requires current dangerousness, the lower court considered the reasoning in *Martin v. Department of Health and Mental Hygiene*, 114 Md. App. 520, *vacated*, 348 Md. 243 (1997) to be persuasive *dicta*. The lower court's reliance on *Martin* was misplaced because the analysis in *Martin* is not persuasive.

First, the opinion concluded that evidence of current dangerousness is required because the legislature used the present tense in section 10-708. *Martin*, 114 Md. App. at 527. According to the opinion, any other interpretation would result in requiring the hospital to prove only that "forcible medication would improve an involuntarily committed individual's condition." *Id.* That analysis overlooks the fact that the hospital must prove, by a preponderance of the evidence

that all of the criteria in section 10-708 have been met. *See* Md. Code Ann., Health-Gen. I § 10-708(g).

Next, the opinion attempted to harmonize section 10-708 with section 10-632, which governs involuntary admissions. *Martin*, 114 Md. App. at 527-28. According to the opinion, if section 10-708(g)(3)(i) did *not* require evidence of dangerousness in the facility, then sections 10-708(g)(3)(i) and 10-632(d)(2)(iii) would be redundant. *Id.* at 528. In fact, the opposite is true. Although sections 10-708 and 10-632 are part of the same statutory scheme, each serves a completely separate purpose. Section 10-632 provides a mechanism for involuntarily removing mentally ill dangerous individuals from the community for the purpose of providing psychiatric treatment. Section 10-708 enables the facility to provide essential psychiatric treatment to involuntary patients who are unwilling to accept antipsychotic medication as part of their therapy, if certain criteria are met.

To require evidence of dangerous behavior in the facility under section 10-708 would not create redundancy within the statutory scheme. Rather, it would thwart the fundamental objective of section 10-708, and ultimately of the statutory scheme, because involuntary patients who refuse medication, yet do not display dangerous behavior within the facility would not receive treatment and would not be released, thus defeating the ultimate goals of one's admission to a psychiatric hospital.

Finally, the opinion reasoned that the legislature intended to ensure that involuntary patients were forcibly medicated as a last resort, and that evidence of

dangerous behavior in the facility is essential to ensure that involuntary patients' are accorded "substantial protections." *Id.* The opinion fails to consider the legislature's 1991 revision of section 10-708 in response to *Williams*, 319 Md. 485 (1990), and *Washington v. Harper*, 494 U.S. 210 (1990). That revision added the provisions that the legislature deemed necessary to bring the statute into compliance with due process requirements. As a result, section 10-708 already contains ample safeguards to ensure that involuntary patients are accorded the procedural and substantive due process protections to which they are entitled. Requiring only that an involuntary patient be dangerous *outside* the confines of a secure psychiatric facility before he can be administered antipsychotic medication over his objection does not, as *Martin* suggests, invalidate those protections.

CONCLUSION

For the reasons stated, this Court should reverse the decision of the circuit court.

Respectfully submitted,

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TITLE 3.

INCOMPETENCY AND CRIMINAL RESPONSIBILITY IN CRIMINAL CASES.

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§ 3-101. Defined terms.

(a) *In general.* — In this title the following words have the meanings indicated.

REVISOR'S NOTE

This subsection formerly was HG § 12-101(a).

No changes are made.

(b) *Committed person.* — "Committed person" means a person committed to the Health Department as not criminally responsible under the test for criminal responsibility.

REVISOR'S NOTE

This subsection formerly was HG § 12-101(b).

In this subsection, the defined term "person" is substituted for the former reference to an "individual" to conform to the terminology used throughout this article.

There are no other changes.

Defined term:
"Person" § 1-101

(c) *Court.* — "Court" means a court that has criminal jurisdiction.

REVISOR'S NOTE

This subsection formerly was HG § 12-101(c).

No changes are made.

(d) *Health Department.* — "Health Department" means the Department of Health and Mental Hygiene.

Sangster v. State, 312 Md. 560, 541 A.2d 637 (1988).

Descriptive terms permissible. — Rather than be required to express his opinion on the competency issue in conclusory statutory language, a psychiatrist should be permitted to do so in descriptive terms compatible with his medical training and experience. Raithel v. State, 280 Md. 291, 372 A.2d 1069 (1977).

Agency conducting examination. — The Department of Health and Mental Hygiene, in its discretion, may conduct a competency examination by a community forensic screening program or other agency that the Department finds appropriate. Lewis v. State, 79 Md. App. 1, 555 A.2d 509, cert. denied, 316 Md. 549, 560 A.2d 1118 (1989).

Ability to assist in defense not dependent upon remembering crime. — Although there are no definitive judicial explanations of what constitutes the ability to assist in one's own defense, it is clear that the cases without exception reject the notion that an accused possesses that ability only if he is able to remember the circumstances of the crime with which he is charged. Morrow v. State, 47 Md. App. 296, 423 A.2d 251 (1980), aff'd, 293 Md. 247, 443 A.2d 108 (1982).

Amnesia did not render defendant incompetent. — Where defendant was admittedly normal except for his amnesia and expert witness agreed that defendant was able to communicate in a normal manner with his attorney, except that he was unable to state from personal knowledge how the alleged crime occurred, defendant's claimed disability did not render him unable to assist in his defense and he was not, therefore, incompetent to stand trial. Morrow v. State, 47 Md. App. 296, 423 A.2d 251 (1980), aff'd, 293 Md. 247, 443 A.2d 108 (1982).

Amnesia does not prevent an accused from rationally discussing his defense with counsel, nor from making rational decisions with respect to his defense. Morrow v. State, 47 Md. App. 296, 423 A.2d 251 (1980), aff'd, 293 Md. 247, 443 A.2d 108 (1982).

§ 3-106. Finding of incompetency.

(a) *Release.* — Except in a capital case, if, after a hearing, the court finds that the defendant is incompetent to stand trial but is not dangerous, as a result of a mental disorder or mental retardation, to self or the person or property of others, the court may set bail for the defendant or authorize release of the defendant on recognizance.

(b) *Commitment.* — (1) If, after a hearing, the court finds that the defendant is incompetent to stand trial and, because of mental retardation or a mental disorder, is a danger to self or the person or property of another, the court may order the defendant committed to the facility that the Health Department designates until the court is satisfied that the defendant no longer is incompetent to stand trial or no longer is, because of mental retardation or a mental disorder, a danger to self or the person or property of others.

(2) If a court commits the defendant because of mental retardation, the Health Department shall require the Developmental Disabilities Administration to provide the care or treatment that the defendant needs.

(c) *Reconsideration.* — (1) On suggestion of the defendant or on its initiative and subject to the limitations on frequency in § 7-507 or § 10-805 of the Health-General Article, as the case may be, the court may reconsider whether the defendant is incompetent to stand trial.

(2) If the court orders commitment under subsection (b) of this section, the defendant may apply for release under § 7-507 or § 10-805 of the Health-General Article. In computing the availability of review under those sections, as the case may be, the date of the commitment order shall be treated as a hearing.

(d) *Other legal questions.* — If the defendant is found incompetent to stand trial, defense counsel may make any legal objection to the prosecution that

may be determined fairly before trial and without the personal participation of the defendant.

(e) *Inclusion in Central Repository.* — The court shall notify the Criminal Justice Information System Central Repository of any commitment ordered or release authorized under this section and of any determination that a defendant is no longer incompetent to stand trial. (HG § 12-105(a), (b)(1), (2), (c), (d), (e); 2001, ch. 10, § 2.)

REVISOR'S NOTE

This section is new language derived without substantive change from former HG § 12-105.

In subsection (e) of this section, the reference to the "Criminal Justice Information System Central Repository" is substituted for the former reference to the "central repository of the criminal justice information system" to conform to the terminology used in Title 10, Subtitle 2 of this article.

Defined terms:

"Court"	§ 3-101
"Health Department"	§ 3-101
"Incompetent to stand trial"	§ 3-101
"Mental disorder"	§ 3-101
"Person"	§ 1-101

Maryland Law Review. — For discussion concerning whether a defendant found guilty but insane may appeal his conviction, see 39 Md. L. Rev. 538 (1980).

University of Baltimore Law Review. — For note, "Amnesia as to Events of Crime Charged Does Not by Itself Justify Finding of Incompetence to Stand Trial," see 12 U. Balt. L. Rev. 351 (1983).

This section and former § 12-110 et seq. of the Health-General Article distinguished. — Although the standard for release under former § 12-110 et seq. of the Health-General Article (now § 3-111 et seq. of this article) is identical to the inquiry under subsection (a) of this section, it serves a different function. Where subsection (a) of this section is for pretrial release, former § 12-110 et seq. of the Health-General Article is designed for post-trial commitment and release if warranted. Johnson v. Clifton T. Perkins State Hosp., 257 Md. 100, 262 A.2d 527 (1970).

Danger to self or others as grounds for commitment. — A person may be committed as insane under the civil procedures established by law if he is a danger to himself or to the safety and property of others even if he is able to distinguish between right and wrong and understands the nature and consequences of his acts as applied to himself. Dubs v. State, 2 Md. App. 524, 235 A.2d 764 (1967), cert. denied, 249 Md. 732 (1968).

Incompetent defendant, ordered committed, may not be interviewed by media or prosecutor if his counsel objects. — A defendant in a capital murder case, who had been judicially determined to be incompetent to stand trial because of mental illness and ordered committed cannot be interviewed, even with his permission, by the media and the prosecution as long as defense counsel objects to the interviews. Mann v. State's Att'y, 298 Md. 160, 468 A.2d 124 (1983).

§ 3-107. Dismissal of charges.

(a) *In general.* — Whether or not the defendant is confined, if the court considers that resuming the criminal proceeding would be unjust because so much time has passed since the defendant was found incompetent to stand trial, the court may dismiss the charge. However, the court may not dismiss a charge:

(1) without providing the State's Attorney and a victim or victim's representative who has filed a notification request form under § 11-104 of this article advance notice and an opportunity to be heard; and

dant found guilty but insane may appeal his conviction, see 39 Md. L. Rev. 538 (1980).

University of Baltimore Law Review. — For note discussing the attorney-client privilege, see 9 U. Balt. L. Rev. 99 (1979).

For note, "Rule of Conspiratorial Consistency Not Applicable to Verdicts Rendered in Separate Trials," see 10 U. Balt. L. Rev. 176 (1980).

Section authorizes order requesting examination by Department of Health and Mental Hygiene. — The court is authorized by this section to order that the Department of Health and Mental Hygiene conduct a mental examination of the accused to determine her sanity or insanity at the present time and at the time of the commission of the crime. State v. Pratt, 284 Md. 516, 398 A.2d 421 (1979).

Defendant raising insanity defense under legal obligation to submit to examination. — The clear intent of the statute is that upon order of the court a defendant raising the defense of insanity is under a legal obligation to submit to an examination. Bremer v. State, 18 Md. App. 291, 307 A.2d 503, cert. denied, 269 Md. 755 (1973), cert. denied, 415 U.S. 930, 94 S. Ct. 1440, 39 L. Ed. 2d 488 (1974); State v. Statchuk, 38 Md. App. 175, 380 A.2d 225 (1977), cert. denied, 282 Md. 739 (1978).

And mental examination does not violate right against self-incrimination. — A defendant's right against self-incrimination is not violated per se by requiring him to submit to a mental examination. Bremer v. State, 18 Md. App. 291, 307 A.2d 503, cert. denied, 269 Md. 755 (1973), cert. denied, 415 U.S. 930, 94 S. Ct. 1440, 39 L. Ed. 2d 488 (1974).

Provision allowing the State access to the underlying factual basis of the accused's mental affliction for use by its psychiatrists has been upheld against attacks that it amounts to a per se violation of the accused's right against self-incrimination. Pratt v. State, 39 Md. App. 442, 387 A.2d 779 (1978), aff'd, 284 Md. 516, 398 A.2d 421 (1979).

Request for order for examination. — There is no requirement that order for examination be requested by defendant. Monge v. State, 55 Md. App. 72, 461 A.2d 21 (1983).

Testimony of psychiatrist. — There is no statutory requirement of the testimony of a psychiatrist for the court to determine competency. Lewis v. State, 79 Md. App. 1, 555 A.2d 509, cert. denied, 316 Md. 549, 560 A.2d 1118 (1989).

Delays caused by examinations charged to defendant. — Delays in the proceedings caused by examinations to determine defendant's competence are charged against the defendant because such evaluations are solely for his benefit, and even if time limits for such reports are violated, dismissal of the case is not the appropriate sanction. Lewis v. State, 79 Md. App. 1, 555 A.2d 509, cert. denied, 316 Md. 549, 560 A.2d 1118 (1989).

Request for extension held in compliance with statutory requirements for postponing cases. — Where the trial court regarded a hospital's request for an extension to file its report under this section, as a request by the State to postpone the trial date and the trial court also viewed the administrative judge's order extending the time for filing the report as an order postponing the trial date for extraordinary cause, the trial court properly held that there was compliance with the requirements of former Art. 27, § 591 (now § 6-103 of this article) and the applicable provisions of the Maryland Rules for postponing cases. Goins v. State, 293 Md. 97, 442 A.2d 550 (1982).

Indigent defendant pleading insanity entitled to psychiatrist at State expense. — When defendant has pleaded insanity as a defense and is indigent the State is required to provide him with an impartial and competent psychiatrist at the State's expense. Bremer v. State, 18 Md. App. 291, 307 A.2d 503, cert. denied, 269 Md. 755 (1973), cert. denied, 415 U.S. 930, 94 S. Ct. 1440, 39 L. Ed. 2d 488 (1974).

Failure to obtain evidence supporting plea. — When defendant escaped from place he had been sent for sole purpose of obtaining evidence that might have supported his plea of insanity, he could not later complain that he had been denied the right to obtain such evidence if it is shown that because of the escape no examination could be conducted. Riggleman v. State, 33 Md. App. 344, 364 A.2d 1159 (1976), overruled on other grounds, Treece v. State, 313 Md. 665, 547 A.2d 1054 (1988).

Testimony of physician. — Testimony of physician is generally admissible on a question of mental condition or capacity, including sanity or insanity, at least where it appears that he is competent to give his opinion in the sense that he has either a general knowledge as a practicing physician or specialized training upon the subject. Millard v. State, 8 Md. App. 419, 261 A.2d 227, cert. denied, 257 Md. 735 (1970).

Clinical psychologist. — Clinical psychologist cannot express his expert opinion on the ultimate issue of sanity. Millard v. State, 8 Md. App. 419, 261 A.2d 227, cert. denied, 257 Md. 735 (1970).

§ 3-112. Same — Commitment.

(a) *In general.* — Except as provided in subsection (c) of this section, after a

verdict of not criminally responsible, the court immediately shall commit the defendant to the Health Department for institutional inpatient care or treatment.

(b) *Retarded defendant.* — If the court commits a defendant who was found not criminally responsible primarily because of mental retardation, the Health Department shall designate a facility for mentally retarded persons for care and treatment of the committed person.

(c) *Release.* — After a verdict of not criminally responsible, a court may order that a person be released, with or without conditions, instead of committed to the Health Department, but only if:

(1) the court has available an evaluation report within 90 days preceding the verdict made by an evaluating facility designated by the Health Department;

(2) the report indicates that the person would not be a danger, as a result of mental retardation or mental disorder, to self or to the person or property of others if released, with or without condition; and

(3) the person and the State's Attorney agree to the release and to any conditions for release that the court imposes.

(d) *Notification of Central Repository.* — The court shall notify the Criminal Justice Information System Central Repository of each person it orders committed under this section. (HG § 12-111; 2001, ch. 10, § 2.)

REVISOR'S NOTE

This section formerly was HG § 12-111.

In subsection (d) of this section, the reference to the "Criminal Justice Information System Central Repository" is substituted for the former reference to the "central repository of the criminal justice information system" to conform to the terminology used in Title 10, Subtitle 2 of this article.

The only other changes are in style.

Defined terms:

"Committed person"	§ 3-101
"Court"	§ 3-101
"Health Department"	§ 3-101
"Mental disorder"	§ 3-101

Maryland Law Review. — For discussion concerning whether a defendant found guilty but insane may appeal his conviction, see 39 Md. L. Rev. 538 (1980).

For note discussing rejection of diminished capacity as a criminal defense, see 42 Md. L. Rev. 522 (1983).

For comment, "Bifurcation in Insanity Trials: A Change in Maryland's Criminal Procedure," see 48 Md. L. Rev. 1045 (1989).

"Not guilty by reason of insanity". — "Not guilty by reason of insanity" is holdover from common law concepts and prior statutory provisions regarding insanity and the commission of crimes. Pouncey v. State, 297 Md. 264, 465 A.2d 475 (1983).

When provisions governing release apply. — In using the language it did in the 1984 act, the legislature clearly manifested an intent to have those provisions affecting the trial apply only to cases filed on or after July 1, 1984, to have those provisions affecting initial commitment apply only to commitments made on or after that date, and to have those provisions governing release from confinement apply to all persons who were in fact "under commitment" on that day. Anderson v. Department of Health & Mental Hygiene, 64 Md. App. 674, 498 A.2d 679 (1985), rev'd in part, 310 Md. 217, 528 A.2d 904 (1987), cert. denied, 485 U.S. 913, 108 S. Ct. 1088, 99 L. Ed. 2d 247 (1988).

Former section 12-113(d) of the Health-General Article (now § 3-114(d) of this article), imposing the burden of proof upon the person seeking administrative release, relates only to those who have been found guilty of committing the criminal act charged but insane. Where an individual, because of an alleged mental disorder, has come into the custody of the Department of Health and Mental Hygiene through a different route than a judgment in a criminal case, the burden of proof at his administrative

verdict of "not guilty by reason of insanity." Langworthy v. State, 284 Md. 588, 399 A.2d 578 (1979), cert. denied, 450 U.S. 960, 101 S. Ct. 1419, 67 L. Ed. 2d 384 (1981).

Bifurcated proceedings for guilt and criminal responsibility. — Major changes in the law, shifting the burden of proof on the issue of criminal responsibility from the State to the defendant, and increasing the chances of lengthy indefinite confinement for a defendant found not criminally responsible, emphasize the desirability of a bifurcated proceeding in appropriate circumstances, where, when criminal responsibility is an issue the decision on guilt or innocence should be made first, and then, if the verdict is guilty, the decision on criminal responsibility should follow. Treece v. State, 313 Md. 665, 547 A.2d 1054 (1988).

Jury instructions. — Upon the defendant's request, the court should instruct the jury as to the dispositional consequences of a verdict of not guilty by reason of criminal nonresponsibility. Erdman v. State, 315 Md. 46, 553 A.2d 244 (1989).

§ 3-113. Report on committed persons.

(a) *In general.* — (1) Within 10 days after commitment of a person under § 3-112 of this title, the facility that receives the committed person shall send to the Health Department an admission report on the committed person.

(2) The report shall contain the information and be on the form that the Health Department requires.

(b) *Notification of movement.* — (1) The facility of the Health Department that has charge of the committed person shall notify the State's Attorney any time a committed person:

(i) is transferred;

(ii) is approved for temporary leaves of more than 24 hours; or

(iii) is absent without authorization.

(2) For information purposes, a copy of this notice shall be sent for inclusion in the court file and to counsel for the committed person.

(c) *Notification of Central Repository.* — The facility of the Health Department that has charge of a committed person shall notify the Criminal Justice Information System Central Repository if the committed person escapes. (HG § 12-112; 2001, ch. 10, § 2.)

REVISOR'S NOTE

This section formerly was HG § 12-112.

In subsection (c) of this section, the reference to the "Criminal Justice Information System Central Repository" is substituted for the former reference to the "central repository of the criminal justice information system" to conform to the terminology used in Title 10, Subtitle 2 of this article.

The only other changes are in style.

Defined terms:

"Committed person"	§ 3-101
"Court"	§ 3-101
"Health Department"	§ 3-101

§ 3-114. Eligibility for release.

(a) *In general.* — A committed person may be released under the provisions of this section and §§ 3-115 through 3-122 of this title.

(b) *Discharge.* — A committed person is eligible for discharge from commitment only if that person would not be a danger, as a result of mental disorder or mental retardation, to self or to the person or property of others if discharged.

(c) *Conditional release.* — A committed person is eligible for conditional release from commitment only if that person would not be a danger, as a result of mental disorder or mental retardation, to self or to the person or property of others if released from confinement with conditions imposed by the court.

(d) *Burden of proof.* — To be released, a committed person has the burden to establish by a preponderance of the evidence eligibility for discharge or eligibility for conditional release. (HG § 12-113; 2001, ch. 10, § 2.)

REVISOR'S NOTE

This section formerly was HG § 12-113.
The only changes are in style.

Defined terms:

"Committed person"	§ 3-101
"Court"	§ 3-101
"Mental disorder"	§ 3-101

Maryland Law Review. — For article, "Survey of Developments in Maryland Law, 1987-88," see 48 Md. L. Rev. 551 (1989).

For comment, "Bifurcation in Insanity Trials: A Change in Maryland's Criminal Procedure," see 48 Md. L. Rev. 1045 (1989).

Release provisions violate ex post facto prohibition. — The 1984 amendment to this section, which changed the burden of proof from the State to the defendant at administrative release hearings, violates the ex post facto prohibition when applied to persons committed prior to July 1, 1984. Anderson v. Department of Health & Mental Hygiene, 310 Md. 217, 528 A.2d 904 (1987), cert. denied, 485 U.S. 913, 108 S. Ct. 1088, 99 L. Ed. 2d 247 (1988).

When provisions governing release apply. — In using the language it did in the 1984 act, the legislature clearly manifested an intent to have those provisions affecting the trial apply only to cases filed on or after July 1, 1984, to have those provisions affecting initial commitment apply only to commitments made on or after that date, and to have those provisions governing release from confinement apply to all persons who were in fact "under commitment" on that day. Anderson v. Department of Health & Mental Hygiene, 64 Md. App. 674, 498 A.2d 679 (1985), rev'd in part, 310 Md. 217, 528 A.2d 904 (1987), cert. denied, 485 U.S. 913, 108 S. Ct. 1088, 99 L. Ed. 2d 247 (1988).

Subsection (d) of this section, imposing the burden of proof upon the person seeking administrative release, relates only to those who have been found guilty of committing the criminal act charged but insane. Where an individual, because of an alleged mental disorder, has come into the custody of the Department of Health and Mental Hygiene through a different route than a judgment in a criminal case, the burden of proof at his administrative release hearing is upon the Department. Anderson v. Department of Health & Mental Hygiene, 310 Md. 217, 528 A.2d 904 (1987), cert. denied, 485 U.S. 913, 108 S. Ct. 1088, 99 L. Ed. 2d 247 (1988).

Release of persons "under confinement" on July 1, 1984. — State bears the burden of proof by clear and convincing evidence at the administrative release hearing of persons "under confinement" on July 1, 1984. Anderson v. Department of Health & Mental Hygiene, 310 Md. 217, 528 A.2d 904 (1987), cert. denied, 485 U.S. 913, 108 S. Ct. 1088, 99 L. Ed. 2d 247 (1988).

Conditional release. — Conditional release is not a tool of the penal system but a therapeutic release of a mentally ill individual from a psychiatric hospital as part of a continuing course of treatment. Bergstein v. State, 322 Md. 506, 588 A.2d 779 (1991).

Evidence of violation of conditional release. — If hearsay is used to establish a violation of conditional release, the violation is a threshold finding. Bergstein v. State, 322 Md. 506, 588 A.2d 779 (1991).

Jury instructions. — Upon the defendant's request, the court should instruct the jury as to the dispositional consequences of a verdict of not guilty by reason of criminal nonresponsibility. Erdman v. State, 315 Md. 46, 553 A.2d 244 (1989).

§ 3-115. Release hearing.

(a) *When required.* — Within 50 days after commitment to the Health Department under § 3-112 of this title, a hearing officer of the Health

§ 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).

§ 10-633. Review of decision.

(a) *Board of Review without jurisdiction.* — The Board of Review does not have jurisdiction to review the determination of a hearing officer on an involuntary admission under this subtitle.

(b) *Final decision.* — The determination of the hearing officer is a final decision of the Department for the purpose of judicial review of a final decision under the Administrative Procedure Act. (An. Code 1957, art. 41, § 206A; 1982, ch. 21, § 2.)

Subtitle 7. Rights of Mentally Ill Individuals in Facilities.

§ 10-701. Enumerated.

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

(2) "Facility" does not include an acute general care hospital that does not have a separately identified inpatient psychiatric service.

(3) (i) "Mental abuse" means any persistent course of conduct resulting in or maliciously intended to produce emotional harm.

(ii) "Mental abuse" does not include the performance of an accepted clinical procedure.

(b) *State policy.* — It is the policy of this State that each mentally ill individual who receives any service in a facility has, in addition to any other rights, the rights provided in this subtitle.

(c) *Rights enumerated.* — Each individual in a facility shall:

(1) Receive appropriate humane treatment and services in a manner that restricts the individual's personal liberty within a facility only to the extent necessary and consistent with the individual's treatment needs and applicable legal requirements;

(2) Receive treatment in accordance with the applicable individualized plan of rehabilitation or the individualized treatment plan provided for in § 10-706 of this subtitle;

(3) Be free from restraints or locked door seclusions except for restraints or locked door seclusions that are:

(i) 1. Used only during an emergency where the individual presents a danger to the life or safety of the individual or of others; or

2. Used only to prevent serious disruption to the therapeutic environment; and

(ii) 1. Ordered by a physician in writing; or

2. Directed by a registered nurse if a physician's order is obtained within 2 hours of the action;

(4) Be free from mental abuse; and

(5) Be protected from harm or abuse as provided in this subtitle.

(d) *Confidentiality of records.* — Subject to the provisions of §§ 4-301 through 4-309 of this article, the records of each individual in a facility are confidential.

(e) *State designated protection and advocacy agency for persons with developmental disabilities.* — (1) Notwithstanding any other provision of law, when

the State designated protection and advocacy agency for persons with developmental disabilities has received and documented a request for an investigation of a possible violation of the rights of an individual in a facility that is owned and operated by the Department or under contract to the Department to provide mental health services in the community under this subtitle, the executive director of the protection and advocacy agency or the executive director's designee:

(i) Before pursuing any investigation:

1. Shall interview the individual whose rights have been allegedly violated; and

2. Shall attempt to obtain written consent from the individual; and

(ii) If the individual is unable to give written consent but does not object to the investigation:

1. Shall document this fact; and

2. Shall request, in writing, access to the individual's records from the Director of the Mental Hygiene Administration.

(2) On receipt of the request for access to the individual's records, the Director of the Mental Hygiene Administration shall authorize access to the individual's records.

(3) After satisfying the provisions of paragraphs (1) and (2) of this subsection, the executive director of the protection and advocacy agency, or the executive director's designee, may pursue an investigation and as part of that investigation, shall continue to have access to the records of the individual whose rights have been allegedly violated.

(f) *Informing individuals of rights upon admission to facility.* — (1) On admission to a facility, an individual shall be informed of the rights provided in this subtitle in language and terms that are appropriate to the individual's condition and ability to understand.

(2) A facility shall post notices in locations accessible to the individual and to visitors describing the rights provided in this subtitle in language and terms that may be readily understood.

(g) *Complaint procedure.* — A facility shall implement an impartial, timely complaint procedure that affords an individual the ability to exercise the rights provided in this subtitle. (1983, ch. 405, § 2; 1984, chs. 255, 429, 481; 1985, ch. 10, § 3; ch. 695; 1986, ch. 232; 1990, ch. 480, § 2.)

Maryland Law Review. — For article, "Maryland's Exchangeable Children: A Critique of Maryland's System of Providing Services to Mentally Handicapped Children," see 42 Md. L. Rev. 823 (1983).

For article, "Survey of Developments in Maryland Law, 1983-84," see 44 Md. L. Rev. 591 (1985).

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 former § 10-708 of this title, did not afford patients the requisite procedural due process protections. Williams v. Wilzack, 319 Md. 485, 573 A.2d 809 (1990).

Right to individualized treatment plan not extended to correctional inmates. — Although an individualized treatment or rehabilitation plan must be created for mentally ill patients who are institutionalized, there is no comparable statutory provision that applies to inmates in State correctional facilities. State v. Johnson, 108 Md. App. 54, 670 A.2d 1012 (1996).

§ 10-409. Laundry contracts of Eastern Shore Hospital Center.

Effect of amendments.
Section 1, ch. 25, Acts 2005, approved April 12, 2005, and effective from the date of enactment, ratified a previously made technical correction in the first undesignated paragraph.

Subtitle 7. Rights of Mentally Ill Individuals in Facilities.

§ 10-708. Refusal of medication; clinical review panel.

(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 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.

individual may apply at any time to a court of competent jurisdiction for a writ of habeas corpus to determine the cause and the legality of the detention.

(b) *Right of Administration.* — The Director, in the name of the Administration, may make an application for a writ of habeas corpus to determine whether a facility properly admitted or properly holds an individual. The State's Attorney for the county where the facility is located or the individual is a resident, on behalf of the Administration, shall file the application. (An. Code 1957, art. 59, § 14; 1982, ch. 21, § 2.)

Sufficiency under due process. — The alternate statutory methods for post-commitment release of insanity acquittees are sufficient under the due process clause. Dorsey v. Solomon, 435 F. Supp. 725 (D. Md. 1977), modified on other grounds, 604 F.2d 271 (4th Cir. 1979).

Cited in Anderson v. Department of Health & Mental Hygiene, 310 Md. 217, 528 A.2d 904 (1987), cert. denied, 485 U.S. 913, 108 S. Ct. 1088, 99 L. Ed. 2d 247 (1988).

§ 10-805. Judicial release.

(a) *Petition authorized.* — Subject to the limitations in this section, a petition for the release of an individual who is held under this title from the facility or a Veterans' Administration hospital may be filed, at any time by:

(1) The individual; or

(2) Any person who has a legitimate interest in the welfare of the individual.

(b) *Jurisdiction and venue.* — The petition shall be filed in an equity court in the county where the individual resides or resided at the time of the admission or where the facility is located.

(c) *Respondents.* — (1) If the individual is in a public facility, the Administration shall be the respondent.

(2) If the individual is in a private facility or a Veterans' Administration hospital, it shall be the respondent.

(d) *Form and contents of petition.* — The petition shall be in the form and contain the information the Maryland Rules require.

(e) *Trial by jury.* — If the petitioner requests trial by jury, the trial shall be held with a jury as in a civil action at law.

(f) *Issues to be determined.* — The trier of fact shall determine:

(1) Whether the individual has a mental disorder; and

(2) If so, whether the individual needs inpatient medical care or treatment for the protection of the individual or another.

(g) *Action by court.* — (1) If the trier of fact finds that the individual has a mental disorder and needs inpatient medical care or treatment, the court shall remand the individual to the custody of the facility or Veterans' Administration hospital.

(2) If the trier of fact finds that the individual does not have a mental disorder or has a mental disorder, but does not need inpatient medical care or treatment, the individual shall be released from the facility or Veterans' Administration hospital.

(h) *Appeals.* — Any party may appeal from a decision on the petition as in any other civil case.

(i) *Records of proceedings.* — Appropriate records of the proceeding under this section shall be made a permanent part of the individual's record.

(j) *Later review.* — (1) After a determination on the merits of a petition filed under this section, a court may not hear a later petition for the individual within 1 year after that determination, unless the petition is accompanied by a valid affidavit that the court, after review of the petition and affidavit, determines to show an improvement in the mental condition of the individual after the determination.

(2) An affidavit is not valid if executed by an individual under care or treatment in a facility or Veterans' Administration hospital.

(3) If the matter is reopened, the petition shall be heard as provided in this section.

(4) If the affidavit does not show improvement in the individual's mental condition, the petition shall be dismissed. (An. Code 1957, art. 59, § 15; 1982, ch. 21, § 2.)

Maryland Law Review. — For note concerning varying tests for insanity, see 15 Md. L. Rev. 255 (1955).

For article, "Constitutional Limits on the Decisional Powers of Courts and Administrative Agencies in Maryland," see 35 Md. L. Rev. 414 (1976).

For article, "The Law/Equity Dichotomy in Maryland," see 39 Md. L. Rev. 427 (1980).

Release provisions constitutional. — Release provisions of section satisfy requirements of due process of law for a post-commitment release procedure. Dorsey v. Solomon, 435 F. Supp. 725 (D. Md. 1977), modified on other grounds, 604 F.2d 271 (4th Cir. 1979).

And equal protection. — Once the jury has found an individual insane, it is entirely consistent with the equal protection clause for Maryland to require that a judge be the one to determine his dangerousness and once he has been confined indefinitely, to grant him the right to have a jury rule on his right to be released. Dorsey v. Solomon, 435 F. Supp. 725 (D. Md. 1977), modified on other grounds, 604 F.2d 271 (4th Cir. 1979).

Unique procedures for hearing petition. — This section sets forth unique procedure for hearing petition, attempting to provide abundant safeguards against wrongful commitment. The result is a bastard proceeding, for the petition is heard in equity but the patient has the right to a jury, and the trial procedure is as a civil action at law. Apparently, the legislature sought to provide a petitioner with the procedural safeguards of proceedings at law, the conscience of an equity court and the availability of a jury trial. Daniels v. Superintendent, Clifton T. Perkins State Hosp., 34 Md. App. 173, 366 A.2d 1064 (1976).

Statutory procedures for redetermination must be followed. — Redetermination of mental condition should be made according to statutory procedure and not by habeas corpus. Robertson v. Superintendent of Spring Grove State Hosp., 198 Md. 666, 80 A.2d 900 (1951).

Civil rules apply to proceeding. — The legislature intended that in any judicial proceeding arising out of this section the courts employ the civil case rules in conducting such a proceeding, be it jury or nonjury. Bush v. Director, Patuxent Inst., 22 Md. App. 353, 324 A.2d 162, cert. denied, 272 Md. 745 (1974).

It is unmistakable that the legislature meant that in any judicial proceeding arising out of this section the courts employ the civil case rules in conducting such a hearing, be it jury or nonjury. Dower v. Director, Patuxent, 396 F. Supp. 1070 (D. Md. 1975), modified on other grounds, 539 F.2d 969 (4th Cir. 1976).

Burden of proof. — It is proper to place burden of proving fitness for release on inmates committed in accordance with constitutionally adequate procedures. Dorsey v. Solomon, 604 F.2d 271 (4th Cir. 1979).

Burden of proving sanity. — See Daniels v. Superintendent, Clifton T. Perkins State Hosp., 34 Md. App. 173, 366 A.2d 1064 (1976).

Assistance of counsel. — Inmate can obtain the assistance of appointed counsel under this section. Dorsey v. Solomon, 604 F.2d 271 (4th Cir. 1979).

Secretary not authorized to set standard of proof in judicial proceedings. — It was not the legislative intent, in authorizing the Secretary of Health and Mental Hygiene to make rules and regulations for the administration and enforcement of this article and for the operation and administration of the Department of Health and Mental Hygiene, that the Secretary, in exercise of such authority, could set the standard of proof in judicial proceedings, including those related to matters completely independent of his responsibilities, duties, and jurisdiction. Davis v. Director,

(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, and by ch. 266, Acts 1995, effective July 1, 1995, and by § 1, ch. 14, Acts 1997, approved Apr. 8, 1997, and effective from date of enactment, and by § 2, ch. 21, Acts 1998, approved Apr. 14, 1998, and effective from date of enactment, and by ch. 203, Acts 1999, effective June 1, 1999, by § 1, ch. 15, Acts 2001, effective June 1, 2001, and by ch. 13, Acts 2005, effective June 1, 2005, provides that "this Act shall take effect July 1, 1991."

Subtitle 8. Release and Transfers.

§ 10-806. Administrative release.

(a) *"Responsible official" defined.* — In this section, "responsible official" means:

(1) If the individual is held in a Veterans' Administration hospital, the chief officer of the Veterans' Administration hospital; or

(2) If the individual is held in any other facility, the Director or the administrative head of the facility.

(b) *Full release.* — At the direction of the responsible official, an individual who has been admitted under this title shall be released from a facility or a Veterans' Administration hospital if the individual:

(1) Does not have a mental disorder; or

(2) Has a mental disorder but:

(i) Does not need inpatient medical care or treatment to protect the individual or another;

(ii) Would not endanger the individual or the person or property of another; and

(iii) Would be cared for properly by the individual or by a responsible person who is able and willing to care for the individual.

(c) *Conditional release.* — (1) At the direction of the responsible official, any individual who has been admitted under this title shall be released conditionally from a State facility within 2 weeks after the responsible official, with the written consent of the individual:

(i) Certifies that the individual:

1. Would not endanger the individual or the person or property of another; and

2. Could live in the community with appropriate assistance under the protective services program provided for in § 14-201 of the Family Law Article; and

(ii) Notifies the provider of the protective services and the local department of social services in the county where the individual would live.

(2) At the direction of the responsible official, any individual who has been admitted under this title may be released conditionally from a facility other than a State facility or from a Veterans' Administration hospital, if, in the judgment of the responsible official, the individual:

(i) Would be cared for properly by the individual or by a responsible person who is able and willing to care for the individual; and

(ii) Would not endanger the individual or the person or property of another.

(3) The responsible official may set the conditions for release that the responsible official considers reasonable. The conditions may relate to:

(i) The duration of the release; or

(ii) Care or treatment during release.

(4) As resources allow, services shall be provided to individuals released from a State facility in accordance with the aftercare plan required by § 10-809 of this subtitle, as follows:

(i) The Mental Hygiene Administration shall provide community mental health services that are suitable to the needs of the individual;

(ii) The Division of Rehabilitation Services shall provide, to individuals determined to be eligible, vocational rehabilitation services and occupational placement opportunities consistent with the assessed needs and abilities of the individual; and

(iii) The Department of Human Resources shall provide needed case management services and shall make arrangements for housing suitable to the needs of the individual.

(5) For purposes of annual examination and execution of new admission documents, an individual released conditionally is considered to be held by the facility or Veterans' Administration hospital from which the individual was released.

(d) *Other releases.* — A facility shall release an individual who has been admitted to the facility within 1 year after the admission if, before the expiration of that 1-year period:

(1) The individual, whether admitted on a formal, written application or on informal request, does not execute a new application for the voluntary admission;

(2) The parent or guardian does not execute a new request for the voluntary admission of the minor individual; or

(3) The physician and psychologist or 2 physicians do not execute the new certificates required for involuntary admission of the individual.

(e) *Record of determinations.* — Each determination on any release of an individual, whether full or conditional, including a summary of the reasons for the determination, shall be made a permanent part of the individual's record. (An. Code 1957, art. 59, §§ 11, 12, 18; 1982, ch. 21, § 2; ch. 348; 1986, ch. 5, § 1; 1991, ch. 55, § 1; 2005, ch. 25, § 7.)