IN THE
COURT OF APPEALS OF MARYLAND

No. 47
September Term, 2006

DEPARTMENT OF HEALTH AND MENTAL HYGIENE,

Appellant,

v.

ANTHONY KELLY,

Appellee.

On Appeal from the Circuit Court for Baltimore City
(Albert J. Matricianni, Jr., Judge)

Brief of Appellee Anthony Kelly

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QUESTION PRESENTED

Whether Md. Code, Health General §10-708(g), requires the State to prove that a competent psychiatric patient is currently dangerous to himself or others within a hospital before it may forcibly administer psychotropic drugs against his will?

STATEMENT OF THE CASE

The Appellee adopts the statement of the case articulated in Appellant's initial brief.

FACTUAL AND PROCEDURAL BACKGROUND

A. The Circuit Court of Montgomery County Found Mr. Kelly Incompetent to Stand Trial and Committed Him to a State Psychiatric Hospital.

Judge Durke Thompson of the Montgomery County Circuit Court found Appellee Anthony Kelly incompetent to stand trial[1] and committed him to a state psychiatric hospital on May 27, 2004. The State placed Mr. Kelly at Clifton T. Perkins Hospital Center ("Perkins"), a Maryland maximum security psychiatric hospital, where he had previously been admitted for

[1] Mr. Kelly has never been adjudicated "medically incompetent." Under Maryland law he is therefore presumed to be competent to make his own medical decisions. *Williams v. Wilzak*, 319 Md. 485 (1990); Brief *Amicus Curiae* of the American Civil Liberties Union of Maryland *et al.* ("ACLU *Amicus* Br.") pp. 5-6. Accordingly he is referred to herein as a "competent involuntary psychiatric patient."

evaluation in preparation for the competency hearing. SE.[2] 59.[3] Mr. Kelly is charged with capital offenses[4] but has steadfastly maintained his innocence.

During the evaluation period at Perkins and thereafter, Perkins psychiatrists diagnosed Mr. Kelly with "delusional disorder," which is a psychotic disorder characterized by "fixed, false, idiosyncratic belief[s]" that are "non-bizarre . . . mean[ing] that the thing that the person believes generally could happen." SE. 61-62. The beliefs that Mr. Kelly holds which Perkins psychiatrists consider delusions include reasonable beliefs such as the charges against him are both "fabricated and inadequate," SE. 69, that there was no adequate search warrant to search his home and car, SE. 90, and that he "expects all of [the evidence against him to be] thrown out of court." SE. 69. His Perkins treating psychiatrist also considers it delusional that Mr. Kelly distrusted his defense counsel, complained about her and sought to replace her, and that Mr. Kelly indicated to the presiding judge that he would rather represent himself than be represented by an attorney he did not trust. *Id.*[5] The Perkins treating psychiatrist, thought this was delusional

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[2] References to the "Joint Record Extract" are indicated herein by "E." Those to the "Supplemental Joint Record Extract" are indicated by "SE." And references to the Appellee's Appendix are indicated by "Apx." In addition, Appellee cites to two government publications that are not readily available and those are attached to this brief for the Court's convenience following the statutes. These are referred to as "Brief Attachments." References to Appellant's Brief in this case are indicated by "DHMH."

[3] Mr. Kelly was admitted for evaluation on October 14, 2003. SE. 59.

[4] Mr. Kelly is charged with two counts of first degree murder, two counts of first degree rape, burglary in the first degree, two counts of robbery with a dangerous and deadly weapon, three counts of use of a handgun in a crime of violence, burglary in the second degree, first degree assault, two counts of use of a handgun in a crime of violence, three counts of theft over $500, one count of theft under $500, and transporting a handgun by vehicle. Apx. 7-8. Mr. Kelly has pled not guilty to all charges against him and maintains his innocence.

[5] The State's sole witness, Dr. Wisner-Carlson, testified that this "may or may not be a delusion." SE. 66. Dr. Wisner-Carlson acknowledged, however, that "it is absolutely reasonable

because Mr. Kelly never graduated high school, had failed many grades, and assertedly had been incarcerated "most of his life."[6] SE. 65-67, 70. Mr. Kelly's diagnosed delusions also include "cuerolous" or "peevish" behavior exhibited by his filing numerous complaints about conditions in the hospital and the performance of his doctors and lawyers. SE. 71-72.[7]

At the competency hearing Mr. Kelly, a self-proclaimed "jail house attorney,"[8] explained that if the Court would not assign him a different attorney, he would rather represent himself in the criminal case because he had lost confidence in his public defender. Apx. 3a. Mr. Kelly preferred to represent himself because, in his own words, "he did not want to plead guilty to something he did not do." *Id*. This request prompted Judge Thompson to refer Mr. Kelly to Perkins for the competency evaluation on October 14, 2003.

Throughout the evaluation period, Mr. Kelly's "stated wish and repeated effort" was to be found competent to stand trial. Apx. 42. In a 63-page-report, Perkins concluded that

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that a client would want to change a lawyer. . .", SE. 90, but when looking at the prosecution's pretrial evidence Dr. Wisner-Carlson asked himself "if I were charged with these crimes, and if this evidence that was listed was evidence that was going to be used to prosecute me, would I want a lawyer, or did I feel that I could represent myself? Was it reasonable? And it wasn't." SE. 94.

[6] The criminal record which the Perkins staff reviewed before testifying to this fact reflected that Mr. Kelly had been sentenced to a combined potential maximum sentence of 14.5 years for two separate convictions. Apx. 4-6. The record did not indicate what portion of those potential maximum sentences Mr. Kelly had actually served. At the time of the competency hearing, Mr. Kelly was 39 years old. Apx. 3.

[7] Another delusion that Dr. Wisner-Carlson testified Kelly held is the belief that he has "millions of dollars" buried somewhere, the proceeds of drug trafficking over the years, and that "he could use that money to start up a company, and that he could be very successful in running such a company." SE. 68. Dr. Wisner-Carlson deemed this aspiration to be a delusion because Kelly "doesn't have the cognitive abilities. He has borderline intelligence on testing . . . so it is not felt that he has a cognitive ability to pursue-to be a CEO of a company and to be a successful businessman in that way." *Id*.

[8] Mr. Kelly, who while incarcerated "had been doing criminal law book[s] since 1985" also "took up paralegal" correspondence courses but did not finish. Apx. 3a.

although Kelly was "cognitively competent" Apx. 23, he was incompetent to stand trial because he lacked "the capacity to [both] understand the object of the proceedings," *id.*, or to cooperate with his attorneys. Apx. 27.

On June 16, 2004, Judge Thompson issued a Memorandum Opinion and Order holding that the State had not proved competency to stand trial beyond a reasonable doubt and Mr. Kelly was therefore incompetent to stand trial. Since Mr. Kelly was charged with a capital crime, Judge Thompson could not set bail or release Mr. Kelly on his own recognizance. *See* Md. Code Crim. Proc. §3-106(a). Judge Thompson opined that "'given the gravity of the charges pending against [Mr. Kelly], it is fair to say that, if proven, the charged actions of the defendant represent a risk to the public of the most dangerous degree." Apx. 44. However, this conclusion of the judge was not supported by any evidence propounded or any factual findings concerning Mr. Kelly's alleged dangerousness.[9] Judge Thompson ordered Mr. Kelly to confinement at a facility chosen by the State, Apx. 44, and the State returned Mr. Kelly to Perkins.

B. Perkins Forcibly Medicates Mr. Kelly

Throughout his hospitalization at Perkins, Mr. Kelly has denied that he has a mental disorder and refused to consent to medication. Although found to be legally incompetent to stand trial, Mr. Kelly was never adjudicated incompetent to make medical decisions. On August 23, 2005, Perkins convened a Clinical Review Panel ("CRP" or "Panel") comprised of hospital

[9] Judge Thompson granted Mr. Kelly's counsel leave to request a hearing to determine the degree of dangerousness the defendant's release would represent to the public," but held that in the absence of such a request he would "treat the issue of dangerousness as having been established." Apx. 44. In any event, as noted earlier, by statute the court could not release Mr. Kelly on bail or on his own recognizance, even had he presented evidence that he would not be dangerous to the community if released. Md. Code, Crim. Proc. § 3-106(a).

medical personnel, in accordance with §10-708, to decide whether psychotropic medications could continue to be administered to him against his will. SE. 56.[10] The Panel approved the medications on the ground that the requirement that Mr. Kelly present a "danger to himself or others" was satisfied by Judge Thompson's May 27, 2004 order which presumed Mr. Kelly dangerous to the community-at-large. *See* E. 3-4; SE. 74; Apx. 44. On that same day, Mr. Kelly appealed to the Office of Administrative Hearings ("OAH"). E. 6. Pending the appeal, Perkins continued to forcibly medicate Mr. Kelly with the potentially harmful psychotropic medication, Risperdal, and with Benztropine to ameliorate the side effects of the Risperdal.. SE. 73.[11]

[10] This was a "repanel" meaning that a prior panel had authorized forced medication, but evidence of that panel is not in the record.

[11] Perkins could not legally force Mr. Kelly to take medication pending the appeal of the August 23, 2005 repanel. CRP orders to medicate are automatically stayed pending their appeal to an ALJ. Md. Code, Health Gen. § 10-708(k)(3). Thus it appears that the forced medication during this time was inflicted pursuant to the previous panel that is not in the record. At the time of the ALJ hearing, Mr. Kelly had been forcibly medicated for approximately six months. The forcible medication was discontinued when the Baltimore City Circuit Court ruled two months later, that Perkins had not established grounds for overcoming Mr. Kelly's refusal of consent. E. 49-50. In all, Mr. Kelly was forcibly medicated for "approximately 8 months." Aff. of Robert Wisner-Carlson, M.D., Appellant's Memo. In Opp. To Appellee's Emergency Mot. for Inj. Pending Appeal, at para. 5, *Dep't Health & Mental Hygiene v. Kelly*, No. 02227 (Court of Special Appeals, June 27, 2006).

At the ALJ hearing Dr. Wisner-Carlson testified that after six months of medication, he believed that Mr. Kelly's delusions has "faded to a certain degree," but were still present. SE. 65. During Mr. Kelly's now almost 3 years of confinement at Perkins, he has never engaged in any dangerous behavior.

While forced to take the medication Mr. Kelly experienced shaking of his entire body, difficulty breathing and profuse sweating on one occasion. SE. 105-06. According to Mr. Kelly's treating physician, Dr. Wisner-Carlson, other potential side effects of the psychotropic medication includes, "sleepiness, tremor, stiffness, . . . tardive dyskinesia, a rare serious side effect called neuropleptic malignant syndrome, [e]ffects on the liver, effects on blood sugar,

C. The Administrative Law Hearing

Evidence at the September 1, 2005, hearing before Administrative Law Judge (ALJ) Georgia Grady established that – apart from refusing medication and filing written complaints – Mr. Kelly had been a model patient and never exhibited any violent or dangerous behavior while at Perkins. Dr. Wisner-Carlson, Kelly's treating psychiatrist of seven months – and the State's sole witness – SE. 58-59, testified that Mr. Kelly had neither

> threatened [n]or assaulted anyone while he's been in the hospital. He's not been in seclusion or restraints. He's not been on any special observation. And he's not had any special intervention in regard to assaultiveness or the like.

SE. at 96. Dr. Wisner-Carlson's testimony to Kelly's model behavior at Perkins was corroborated by evidence that, at the time of the Administrative Hearing, Kelly had been on "Super Three" privilege level, Perkin's highest privilege level, for 15 months, practically the entire duration of his stay at Perkins.[12] SE. 112-13. By the hospital's own definition a patient on "Super Three" is not dangerous within the hospital.

Even though Dr. Wisner-Carlson testified that throughout his stay at Perkins, Mr. Kelly exhibited model patient behavior, he testified that Mr. Kelly was still a danger to himself or

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effects on cholesterol or triglyceride, [and] weight gain. Those are some of the more common or the more serious side effects. And for the benztropine. . . the side effects are dry mouth, constipation, blurred vision, [and] trouble urinating." SE. 77.

[12] Upon admittance to Perkins, all patients begin at Zero level and through good behavior work their way up the privilege ladder. SE. 112. Thus, prior to achieving Super Three status, Mr. Kelly was working his way from zero to Super Three. *See* Perkins, *Privilege Level System Handbook for Staff* (2d ed. Dec. 2000)(Brief Attachment).

others. This conclusion was based solely on Judge Thompson's 2004 commitment decision. SE. 74.[13]

In closing argument, counsel for the Department of Mental Health and Hygiene ("DHMH") argued that, because "the legislature has not decided to clarify its definition or its use of the word 'dangerousness,' courts should construe dangerousness – per the language of §10-708 – to mean 'why the person is here in the hospital to begin with.'" SE. 129. According to DHMH's interpretation of §10-708, Mr. Kelly met the statute's requirement of dangerousness simply because in 2004 a judge presumed him dangerous to the community-at-large and committed him to Perkins. SE 129.[14]

Ruling from the bench at the close of evidence, ALJ Grady concluded that, "as a matter of law[,] [] the hospital has shown by a preponderance of the evidence that Mr. Anthony Kelly should be medicated with psychiatric medication listed above for a period not to exceed 90 days." SE. 141. In deciding whether §10-708 requires a finding that a patient is "currently dangerous" in the hospital context, or whether, as counsel for DHMH contended, a finding that the person was dangerous to the community at large was sufficient, ALJ Grady reasoned that

[13] Dr. Wisner-Carlson also testified that medication would diminish Mr. Kelly's symptoms but not relieve them entirely. Without treatment, Dr. Wisner-Carlson opined, Mr. Kelly's prognosis was poor, whereas with treatment "he has a moderate prognosis." SE. 71. He also acknowledged that even if Mr. Kelly's symptoms were relieved entirely, he could not be discharged to the community because of the court orders and the nature of the charges against him. SE. 80.

[14] Counsel for DHMH also specifically argued that Perkins is not attempting to medicate Mr. Kelly in order to render him competent to stand trial. "[T]hat is not what is happening here today." SE. 131. ALJ Grady was also clear that "medicat[ing] someone against their will so that they would have to stand trial for criminal offenses… is not the issue that's presented in the hearing before me." SE. 140.

> The Court of Special Appeals several years ago . . . issued a decision saying that dangerousness had to be current dangerousness for [§]10-708. . . That decision . . . was vacated. Therefore I cannot rely upon it as any legal authority to determine that in Maryland this statute requires evidence of current dangerousness. . . There is no Maryland case law interpreting Section [§]10-708 with regard to the term of current dangerousness. And I find that in the absence of such case law, that it is reasonable, it is a reasonable interpretation for me to rely on the previous determination by the Circuit Court. . . [committing Mr. Kelly].

SE. 139-41. Accordingly, ALJ Grady held that the 2004 commitment order was sufficient evidence of dangerousness to justify forced medication under §10-708(g), even though such evidence was "not recent," and even though it was questionable whether such evidence established "whether Kelly is dangerous as of this time." SE. 139.

D. Mr. Kelly Appeals the ALJ Decision.

Mr. Kelly appealed to the Circuit Court, E. 42, moving for a stay of forced medication pending the appeal. E. 43. On September 23, 2005, the Circuit Court for Baltimore City denied the stay pending a hearing. E. 44.

On November 9, 2005, the Circuit Court for Baltimore City, acting as an appellate court, reversed the decision of the ALJ. E. 49-50. The Circuit Court, relying upon the persuasive authority of *Martin v. Dept. of Health & Mental Hygiene*, 114 Md. App. 520 (1997), held that, for purposes of the forcible administration of medication, §10-708 requires evidence that "an involuntarily committed individual is a danger to himself or others in the facility to which he has been committed, rather than to society generally upon his release." E. 50. As a result, after eight months of forced medication, Perkins ceased to force Mr. Kelly to ingest psychotropic medication.

E. The State Seeks to Forcibly Medicate Mr. Kelly Pending Its Appeal of the Circuit Court Decision.

Pursuant to the Administrative Procedures Act, Md. Code, State Gov. §10-222, the State appealed the Circuit Court's decision to the Court of Special Appeals. On May 25, 2006, Perkins once again convened a CRP to review whether to forcibly medicate Mr. Kelly based upon the same evidence and the same rationale for forcible medication as the prior panel: that Mr. Kelly was a danger to himself or others as evidenced by the 2004 Montgomery County Circuit Court order committing him.[15] Despite the Circuit Court of Baltimore City's November 2005 decision that §10-708 required proof of dangerousness within the facility, the new CRP concluded that he should be forcibly medicated based on the original commitment order. Mr. Kelly appealed to OAH, and prior to action on his appeal at OAH, Mr. Kelly sought and was granted an injunction from the Court of Special Appeals staying further "administrative or judicial proceedings involving [Mr. Kelly] . . . without prejudice to [the State's] right to request that the stay be lifted upon a full and complete showing that [Mr. Kelly] needs medication because he has become a danger to himself or others in the facility. . . ." Apx. 1. On July 26, 2006, this Court *sua sponte* issued a writ of *certiorari*.

PERTINENT STATUTE

In this statutory interpretation case, the pertinent language of the relevant statute §10-708 is, as follows: "The panel may approve the administration of medication or medications . . . if the panel determines," *inter alia*, that:

[15] The Panel also concluded that it was a reasonable exercise of professional judgment for Perkins to prescribe the medications to forcibly medicate Mr. Kelly.

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

(i) Remaining seriously mentally ill with no significant risk 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, Health Gen. §10-708(g)(3).

SUMMARY OF ARGUMENT

This statutory interpretation case involves the meaning of the dangerousness requirement in Maryland's forcible medication statute. Md. Code, Health Gen. §10-708(g). As the Circuit Court below recognized, the only plausible reading of the statute is that the State must prove dangerousness based on the individual's current condition and present circumstances of involuntary confinement in the hospital context. The State conceded that Mr. Kelly posed no danger within Perkins hospital. The far broader reading of the statute advanced by the State – that §10-708(g) permits evidence that an individual would be a danger to himself or others *in the community-at-large* upon his release – would allow hospitals to forcibly medicate a presently non-dangerous, competent individual, like Mr. Kelly, simply because the State deems the medication prescribed to be medically appropriate to treat his mental illness. Respondent urges affirmance of the Circuit Court's decision because, for the reasons listed below, the State's interpretation of §10-708(g) is fatally flawed.

First, the State's broad interpretation contradicts the plain language of the statute. In this case, it is significant that the plain language of §10-708 is written in the present, rather than the conditional future or past tense. The Legislature's use of the present tense for the dangerousness requirement indicates that it intended that the CRP determine whether the individual currently poses a danger to himself or others within the facility to which he is confined.

Second, the State's broad interpretation of §10-708 would lead to absurd consequences and turn the statute on its head. Section 10-708 – designed to protect the right of a psychiatric patient to refuse unwanted, invasive drug treatment during involuntary hospitalization – would be rendered meaningless because all involuntary or court-ordered[16] patients could be medicated so long as the State deems the medication appropriate. Moreover, the State's interpretation would be inconsistent with the legislative scheme of which §10-708 is a part by suggesting that a second finding of dangerousness in the community is required, even though such a finding must already hold true for each involuntary patient pursuant to the statutes empowering the State to involuntarily commit patients and to continue to keep them confined. *E.g.*, Md. Code, Health Gen. § 10-632, Md. Code, Crim. Proc. §§ 3-106(b)(1) & 3-112. Consequently, the State's broad reading of § 10-708(g) would mean that an ALJ at a forced medication hearing must remake the same determination about dangerousness in the community that an ALJ at an involuntary commitment hearing had already made, and thereby leave §10-708(g)'s dangerousness requirement devoid of independent meaning. Furthermore, requiring present dangerousness

[16] Technically, patients who are committed via civil commitment proceedings are called "involuntary" patients. Whereas patients who are committed via criminal court proceedings are call "court-ordered" patients. This brief refers to both classes of patients as "involuntary" patients.

does not, as the State claims, render §10-708(g) duplicative of hospitals' power under §10-708(b)(1) which authorizes forced medication "in an emergency." The State's interpretation ignores the fact that §10-708 (b)(1) authorizes only temporary forced medication, pursuant to a doctor's order, in response to a crisis. It does not permit a forced regimen of medications to treat symptoms of mental illness that cause the individual to be dangerous within the facility, such as that authorized for up to ninety (90) days under the non-emergency language of §10-708 (b)(2).

Third, the legislative history of §10-708(g) also supports the Circuit Court's conclusion that the intent of the legislature was for dangerousness to mean that a patient is currently dangerous within the hospital walls. Because the Legislature intended to amend §10-708(g) to bring it into compliance with *Harper* and *Williams*[17] – both of which understood the phrase "danger to himself or others" to refer to danger inside the psychiatric hospital – this is further evidence that the Circuit Court's interpretation of §10-708(g) was proper.

Fourth, sound public policy reasons also weigh in favor of requiring a finding of present dangerousness in the hospital before forcible medication is permitted under §10-708(g). Since the State admittedly does not seek to forcibly medicate Mr. Kelly in order to render him competent to stand trial, and without such competence Mr. Kelly cannot be discharged, the State does not have a justification for medicating him against his will. Moreover, despite the State's unfounded assertions to the contrary, the Circuit Court's decision will not result in the indefinite confinement of a significant number of involuntary psychiatric patients. The State's own data show that in fiscal years 2004 and 2005, a total of 195 patients—less than 3% of the close to

[17] *Washington v. Harper*, 494 U.S. 210 (1990); *Williams v. Wilzack*, 319 Md. 485 (1990).

6,000 individuals involuntarily admitted to a state facility during that period—refused medication and were subject to the Clinical Review Panel process. Since at least some of these persons refusing medication were presently dangerous within the hospital, the actual number of competent and non-dangerous individuals refusing medication is even less than 3%. In any event, for that subset of non-dangerous patients who refuse medication, the alternatives of medical guardianship for medically incompetent patients, treatment with non-drug therapies that render patients capable of discharge, or placement in a supervised community program will avoid the State's parade of horrors in most cases.

Fifth, the State's interpretation should be rejected because it will render §10-708(g) subject to constitutional challenges. The premise upon which Mr. Kelly's claim rests – that the individual is "sovereign over his own body and mind," J.S. Mill, On Liberty 11 (Norton ed. 1975) – is one that is implicit in the concept of ordered liberty and in the Supreme Court's constitutional jurisprudence. The fundamental right to control one's own intellect and mental processes is protected by Article 40 of the Maryland Declaration of Rights, and is eviscerated if courts permit the government to forcibly drug citizens. While the government may, of course, use words and other expressions to advocate and persuade with the intent to alter thoughts, Article 40 forbids the government from directly and forcibly manipulating a person's brain with the intent of changing what, or how, the person thinks.[18] Additionally, forcible medication is

[18] To clarify, Appellee does not propose that the State cannot take reasonable steps to regulate *behavior* within the hospital confines through the use of mechanisms such as the privilege level system, for example. Rather, we maintain that the State cannot, consistent with constitutional protections, use psychotropic medication to manipulate the *thought processes* or behavior of competent unconsenting individuals who do not pose a present danger to themselves or others.

itself a substantial infringement on the fundamental right over one's own dignity and bodily integrity, and has been described by Supreme Court decisions as the realms where, as a matter of Due Process, the state cannot enter. This is because psychotropic drugs, such as the ones at issue here, are potent and invasive in their intended operation, and can have severe, disturbing, debilitating, and even lethal effects on one's person.

STANDARD OF REVIEW

Since this case involves a question of law – the statutory interpretation of Md. Code, Health General §10-708(g) – this Court should review ALJ Grady's decision to forcibly medicate Kelly *de novo*. *Bowie v. Prince George's County*, 384 Md. 413, 424 (2004). Under the Administrative Procedure Act, which governs this appeal, "[t]he scope of review . . . is essentially the same as the circuit court's scope of review. [The appellate court] must review the administrative decision itself." *Beeman v. Dep't of Mental Health & Hygiene*, 105 Md.App. 147, 154 (1995); *see* Md. Code, State Gov. § 10-222(h). "When an agency makes 'conclusions of law,'…[the reviewing court] decides the correctness of the agency's conclusions and may substitute the court's judgment for that of the agency's." *Spencer v. Md. State Bd. of Pharmacy*, 380 Md. 515, 528 (2004).

It is undisputed, that in the ALJ decision below, the court's decision turned upon a question of law: whether §10-708(g) requires a finding that a patient is "currently dangerous" in the hospital context, or whether a finding that the person was dangerous to the community-at-large at the time of commitment, is sufficient to override a competent patient's refusal of consent to medication. Accordingly, this Court should review the ALJ's question of law *de novo*.

ARGUMENT

I. Section 10-708(g) Requires That A Competent Individual Pose A Present Danger To Himself Or Others Within The Facility To Which He Is Confined Before His Refusal Of Consent Can Be Overridden To Administer Psychotropic Drugs Against His Will.

The Circuit Court based its decision upon a straightforward analysis of the express language of §10-708(g) and its statutory scheme. Relying on the accepted principles of statutory construction, the Circuit Court held that §10-708(g) permits forcible medication only if, without the medication, the individual is a danger to himself or others within the facility where he is confined. E. 50.

On appeal, the State argues that the original finding at the time of commitment, that the individual was a danger to himself or others in the community, is sufficient to fulfill the statutory requirement of dangerousness in order to override his consent. *See generally* Brief of Appellant ("DHMH"). Specifically, the State contends that the Circuit Court erred because, under §10-708(g), the phrase "cause the individual to be a danger to the individual or to others" requires only a showing that the person would be dangerous to the community-at-large if released from the hospital. *Id*.

The State's position, however, is untenable. As demonstrated below, by applying "the cardinal rule of construction of a statute" that a Court first look to the plain language of the statute, *Mazor v. State Dep't of Correction*, 279 Md. 355, 360 (1977),[19] this Court should affirm

[19] This Court elaborated in *Mazor v. State Department of Correction*

> [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

the Circuit Court's reading of §10-708(g) that the Legislature intended a CRP to show that a patient is currently dangerous to himself or others in the hospital context in order to compel him to ingest medication against his will.

A. The Present Tense Wording of §10-708(g) Plainly and Unambiguously Requires a Showing of Present Dangerousness in the Hospital Context.

It is axiomatic that, in discerning the legislative intent, a court must first look to the plain language of a statute. *See Lagos*, 388 Md. at 728 ("In examining a statute we give words their ordinary and natural meaning."); *Oaks v. Connors*, 339 Md. 24, 35 (1995) (same); *Montgomery County v. Buckman*, 333 Md. 516, 523 (1994) (same). In this case, it is significant that the plain language of §10-708 is written in the present, rather than the conditional future tense. In particular, the Legislature's use of the present tense for the dangerousness requirement indicates that it intended that the CRP determine whether the individual currently poses a danger to himself or others within the facility to which he is confined. *Martin v. Dep't of Health & Mental Hygiene*, 114 Md.App. 520, 527 (1997), *vacated as moot*, 348 Md. 243 (1997); *see also Enis v. Dep't of Health & Social Servs. of Wis.*, 962 F.Supp. 1192, 1199 (W.D. Wis. 1996) (use of present tense language in forced medication policy requires a finding of current dangerousness within the facility).

> 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. 355, 360-61 (1977); *accord Design Kitchen & Baths v. Lagos*, 388 Md. 718, 728 (2005).

The language of the statute specifies that the CRP must find that "without the medication the individual is at substantial risk of continued hospitalization because of . . . remaining seriously mentally ill . . . with symptoms that cause the individual to be a danger to the individual or to others." §10-708(g). If the Legislature meant the CRP to demonstrate the patient's dangerousness to the community-at-large upon release, it would have written, "with symptoms that **would cause** the individual to be a danger. . . ." The use of the future conditional tense, "would cause," would allow for a situation where the patient is not dangerous within the structured confines of the hospital, but he would be dangerous if released to the community.

Likewise, if the Legislature meant the CRP to decide dangerousness based upon the evidence presented at the commitment proceeding, it would have written the phrase in the past tense, "with symptoms that **caused** the individual to be a danger. . . ." In the absence of the words "would cause" or "caused," however, this Court must read the statute to comport with its "common everyday meaning," which is that §10-708 requires a showing of current dangerousness within the hospital where the patient resides at the time of the hearing. *See Lagos*, 388 Md. at 728-29 ("'Where the words of a statute, construed according to their common and everyday meaning, are clear and unambiguous and express a plain meaning,' the Court will give effect to the statute as the language is written.") (*quoting Moore v. Miley*, 372 Md. 663, 677, 566 (2003)).

B. To Accept the State's View Would Render the Statute Meaningless Because, Via Commitment Proceedings, Every Involuntary Patient Has Already Been Found Dangerous to Self or Others in the Community.

As this Court has often stated, principles of statutory construction require that courts read a statute so that "no word, phrase, clause or sentence is rendered surplusage or meaningless."

Lagos, 388 Md. at 728-29 (quoting *Buckman*, 333 Md. at 524, *Condon*, 332 Md. at 491; *Prince George's Co. v. White*, 275 Md. 314, 319 (1975)). For a number of reasons, listed below, the State's interpretation of §10-708 would render that statute "redundant and meaningless."

First, the State's interpretation would render §10-708(g)(3) "redundant and meaningless" because a finding of dangerousness in the community already is required by either Maryland Code Health General §10-632, the involuntary commitment statute, or Maryland Code Criminal Procedure §§3-106(b)(1) & 3-112, the criminal commitment statute. In *Martin*, speaking to the civil commitment statute, the Court of Special Appeals relied on this Court's decision in *State v. Bricker*, 321 Md. 86, 93 (1990), reasoning that:

> [F]or an individual to be involuntarily committed [to a psychiatric hospital], §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 [] as urged by the State, §§10-708(g)(3)(i) and 10-632(d)(2)(iii) would be redundant.

Martin, 114 Md. App. at 528. The *Martin* Court noted that the State's broad reading of §10-708(g)(3) would mean that an ALJ at a forced medication hearing must remake the same determination about dangerousness in the community, which an ALJ at an involuntary commitment hearing had already made. Clearly the same would also be true of the criminal commitment statute's requirement that an individual be determined "to present a danger to the life or safety of the individual or of others." Md. Code, Crim. Proc. §3-106(b)(1). This interpretation would leave §10-708(g)'s dangerousness language devoid of "independent meaning" since the ALJ at the forced medication hearing would merely be re-determining that an individual meets the commitment standards, a threshold finding which is presumed by the individual's continued involuntary retention. *Martin*, 114 Md. App. at 528 (*citing Bricker*, 321

Md. at 93). Accordingly, if this Court accepted the State's assertion[20] then §10-708(g)'s requirement of dangerousness would be rendered meaningless: every person involuntarily committed to a facility would automatically satisfy the dangerousness prong and could thus be subjected to forced medication if State doctors deemed it medically appropriate.

The State seeks to side step this absurd result by arguing that the purpose of §10-708(g) is not to provide additional due process protections for patients whom the hospital wants to involuntarily medicate; rather, the purpose is to provide the hospital the power to medicate unconsenting competent patients in order to hasten their discharge from the hospital. Thus, the State erroneously concludes that, if §10-708(g) required a finding of present dangerousness in the hospital context, this "effectively voids subsection (3) because it does not comprehend the scenario that an unmedicated, mentally ill individual can be at substantial risk of hospitalization, yet not dangerous to self or others in the context of a secure environment." DHMH at 12.

The State's argument is dispelled for several reasons. First, looking to the plain words contained in the statute, Subtitle 7 is entitled "Rights of Mentally Ill Individuals in Facilities." We can assume that the Legislature was not being cruelly ironic by granting the State nearly unfettered power to medicate patients against their will---thereby eviscerating their

[20] The State asserts that the only evidence of dangerousness that is required to justify forcible medication is the initial ruling of the court committing the person. DHMH at 5-19. Nevertheless, the State seemingly acknowledges – in its initial brief – that its argument would render the statute meaningless because every involuntary patient who is eligible to be forcibly medicated pursuant to §10-708(g), -- that is **every** involuntary patient, which includes **all** patients at Perkins and other state facilities -- have already been found to be dangerous to the community at large. *Id.* at 16. These patients could not have been admitted or committed to the hospital without a finding that their mental illness made them dangerous to the community. *Id.* at 17; s*ee* Md. Code, Health Gen. §10-632(e)(2); Md. Code, Crim. Proc. §§3-106(b)(1) & 3-112.

constitutional right to control their own treatment---in the very subtitle that sets forth the rights of those confined in facilities.

Rather, as discussed below, the purpose of the 1991 amendment to §10-708 – which added the dangerousness requirement – was to provide constitutionally required due process protections for patients after the statute had been invalidated as unconstitutional in *Williams v. Wilzack*, 319 Md. 485 (1990). *Infra* at I.C. Even more importantly, the State's argument is barred by the Constitution: courts have made clear that it is constitutionally impermissible to compel a competent patient to take medication to alleviate their symptoms and hasten their discharge. *Infra* at I.E.c.iii. Thus, §10-708 plainly articulates the legislative intent that Maryland comport with the constitutional limits on the State's power *vis-a-vis* the individual's right to autonomy of mind and body, as set forth by this Court and the United States Supreme Court, and provides that: [m]edication may not be administered to an individual who refuses medication," except in narrow circumstances where (1) there is a crisis necessitating the immediate administration of sedating drugs; or (2) where a competent individual is refusing treatment for symptoms of a mental illness that cause him to be a danger to himself or others in the facility.

The State also argues that because the word "danger" is not listed as a "separate and independent requirement" in the statute, but appears as "a dependent clause describing which mental illness symptoms the prescribed medication are intended to treat," the statute's requirement of "danger to self or others" must refer to the danger the patient presented to the community-at-large while free, rather than present danger in the hospital context. DHMH at 11. The State's cramped reading of the statute, however, fails to take account of the fact that

psychotropic medications are not effective for all patients and that patients have the right to choose whether to take them. In the wake of state and federal decisions delineating constitutional protections for involuntary patients to refuse medication, *infra* at I.C., the General Assembly amended §10-708(g) to establish constitutionally adequate procedural and substantive boundaries. These cases required both danger within the facility *and* medical appropriateness for the patient. *Washington v. Harper*, 494 U.S. 210 (1990); *see also Riggins v. Nevada*, 504 U.S. 127, 134 (1992) (subsequent case confirming this standard). The General Assembly must therefore be presumed to have understood the scientific backdrop, reflected in the aforementioned court decisions, that psychotropic medications are ineffective for a significant percentage of individuals. The General Assembly must also be presumed to have understood that, even when effective, such medicines often have serious detrimental side effects that might cause a person to choose to suffer mental illness without taking medication. ACLU *Amicus* Br. at II. Accordingly, the General Assembly determined that, along with the requisite finding of danger within the facility, the hospital has to prove that the medication advances a substantial interest — *i.e.*, that the person's condition will improve enough to be discharged. Thus, the statute is worded to require that

> without the medication, the person is at substantial risk of continued hospitalization because of… remaining seriously mentally ill with no significant relief from symptoms, [or 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.

§10-708(g). Pursuant to this reading of the statute, the proposed medication that the State seeks to force on the patient must treat the symptoms that cause the patient to be dangerous within the

facility. Medication cannot be forced on a patient, even one who is dangerous within the facility, if that medication is not designed to reduce the patient's dangerousness in the facility or has not proven effective at reducing dangerous behavior. Furthermore, such forced medication medication must also serve the patient's interest of improving his mental illness and hastening his discharge.

Nor does interpreting the statute to require dangerousness within the hospital destroy the usefulness of the CRP, as the State asserts. In its theoretical scenario, not remotely similar to the facts present in the instant case, a person with schizophrenia is forcibly medicated based upon objective evidence of dangerous behavior within the hospital. DHMH at 14-15. Over the ninety-day period of forced medication, the person's behavior improves and he is no longer dangerous within the hospital — although, apparently, the medication does not otherwise improve the symptoms of his mental illness because he remains "unsuitable" for release. *Id*. The State then posits that this fictional patient would again refuse medication and would "inevitably decompensate," again becoming dangerous in confinement. *Id*. The State concludes that, because the person is not currently dangerous, it would be forced to petition for a guardian. *Id*.

The above hypothetical fails to support the State's argument that interpreting §10-708 to require present dangerousness renders the CRP useless. First, again, the purpose of the CRP process is to ensure that facilities do not violate the substantive rights of individuals refusing medication. Thus, if a State doctor seeks an order to forcibly medicate a person who is not presently dangerous, the CRP must deny the request.

Second, in the hypothetical presented, the State need not wait until the person assaults someone before seeking a medication order. If, after stopping the medication, the individual does begin to decompensate and exhibit behavior indicative of future violence (*e.g.*, becomes delusional, paranoid and increasingly agitated), the State doctor can present this evidence of recent behavior and mental condition, coupled with evidence of the prior pattern of violence, to the CRP to prove that the person represents a danger to self or others within the facility. Having to carefully weigh the evidence to reach a conclusion as to whether the person represents a credible present risk of harm, rather than rendering the CRP "useless," is an extremely critical function.

Third, the guardianship statute is not, as the State suggests, an alternative to meeting the standards under §10-708. Rather, it is designed to allow for the treatment — be it mental or physical – of persons who lack the capacity to make their own decisions. If a person, such as the one presented in the State's hypothetical, is not presently dangerous, but is competent to make treatment decisions, a petition for guardianship is not appropriate. If, on the other hand, a person is not competent to make treatment decisions, the CRP process is not appropriate and the State *must* petition for a guardian.[21]

Finally, without the dangerousness requirement, the CRP would simply be ensuring that the prescribed medication is a reasonable exercise of professional judgment, a necessary but not

[21] The State also makes the unsupported claim that a petition for guardianship is a "lengthy process that would significantly delay the patient's treatment, as well as significantly lengthen the patient's hospitalization." Petitions for guardianship, however, must be heard on an "expedited basis." Md. Code, Estates & Trusts §13-705(f).

constitutionally sufficient requirement. Thus, the opposite of the State's claim is actually true: ignoring the present dangerousness inquiry renders the CRP substantially "useless."

In addition, requiring present dangerousness does not, as the States claims, render 10-708(g) duplicative of the hospitals' power under §10-708(b)(1) which authorizes forced medication "in an emergency." DHMH at 13. The language of §10-708(b)(1) states: "[m]edication 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 [pursuant to the CRP procedure and the dangerousness standard specified in subsection (g)] . . ." §10-708(b). The State's interpretation ignores the fact that §10-708 (b)(1) authorizes only temporary forced medication, pursuant to a doctor's order, as a response to a crisis. It does not permit a forced regimen of medications, such as that authorized for up to ninety (90) days under the non-emergency language of §10-708 (b)(2).

In short, the (b)(1) emergency provision permits forcible medication as an immediate, short-term response to a bona fide crisis such as an individual who is in the midst of destructive or imminently threatening behavior. Due to the clear and present danger, the denial of notice and hearing is justified. This case, however, involves the (b)(2) **non-emergency** situations when the hospital needs to forcibly medicate someone over time, because that patient's behavior in the hospital presents a danger to themselves or others. Without this non-emergency power to force medication on patients exhibiting dangerous behavior within the facility, Perkins would only be able to respond to emergencies, but could not act to treat the symptoms of mental illness that cause a patient's demonstrated present dangerousness.

Furthermore, requiring present dangerousness for §10-708(g) does not, as the State alternatively claims, cause the statute to "contain two separate and competing provisions for treating an involuntary patient who is dangerous within the facility and is refusing medication," one with due process protections and one without. DHMH at 14. This statutory scheme recognizes the reality that emergencies arise in psychiatric hospitals when a patient becomes unexpectedly violent or self-injurious and must be subdued without time for a due process hearing. Thus, §10-708(b)(1) permits forced medication on the order of a physician in emergency situations where the "individual presents a danger to the life or safety of the individual or others."

These orders are for sedating or tranquilizing medications to immediately subdue or restrain the individual's behavior and are applicable to any patient presenting an imminent threat of harm regardless of whether they otherwise consent to a prescribed daily regimen of medications to treat their mental illness. Section 10-708(b)(2), on the other hand, does not similarly authorize "chemical restraint" in an emergency; rather it authorizes the forced administration of prescribed medications designed to treat the symptoms of mental illness that cause the individual to be dangerous to self or others within the facility. This non-emergency situation, governed by subsection (g), does permit time for due process proceedings and protects staff and patients from individuals whose symptoms cause them to be a continuous threat. Accordingly, the temporary emergency and non-emergency provisions work in tandem to protect the safety of the individual and all others within the facility and are narrowly tailored to serve this compelling state interest.

Lastly, in regard to the plain language of the statute and an interpretation that gives credence to all of its parts, it is important to note that the emergency provision of §10-708(b)(1) clearly requires that the patient present a "danger to the life or safety of the individual or others" **in the hospital context.** After all, it would not be an emergency if a patient, docilely and securely confined in the hospital, presented a danger to life or safety when outside of the hospital. Similar to the wording in §10-708(g), this emergency provision does not specify that the danger must be present in the hospital context, rather that context is understood.

C. The Legislative Intent Behind the 1991 Amendment to §10-708(g) Was to Protect the Due Process Rights of Involuntary Psychiatric Patients To Comply With Recent U.S. Supreme Court and Maryland Court of Appeals Decisions.

When the wording of a statute is ambiguous, courts will resort to examination of the legislative history to discern the true intent of the Legislature. *Moore v. Miley*, 372 Md. 663, 677 (2003) ("When language [of a statute] is ambiguous . . . [i]t is then appropriate to look to the legislative history and other relevant evidence external to the statute that may manifest intent or general purpose.)"… While the plain words of the statute, as explained above, clearly require a showing of present dangerousness to override consent, the legislative history also demonstrates that the Legislature intended this requirement.

Section 10-708(g) was amended in 1991 in order to add due process protections for the significant constitutional liberty interest to be free from the arbitrary administration of anti-psychotic drugs. Fiscal and Policy Note, Dept. of Leg. Serv. SB 163 (1991), p.2, *available at* http://mlis.state.md.us/2005rs/fnotes/bil_0003/sb0163.pdf#search=%22%22resident%20grievance%20system%22%22 ("Fiscal and Policy Note"); *see Williams*, 319 Md. at 508. Prior to the

1991 amendment, this Court struck down the statute's predecessor in *Williams* on the basis that it failed to provide procedural due process protections as required by Article 24 and the newly announced federal constitutional standard in *Washington v. Harper*, 494 U.S. 210 (1990). *Williams*, 319 Md. at 503, 509-510.

In *Williams*, this Court noted that the Legislature intended §10-708's predecessor to protect an inmate's "justifiable expectation that the drugs will not be administered to an inmate unless he is mentally ill and a danger to himself or others." *Id*. at 508. The Legislature nevertheless struck down that version of the law, because it provided inadequate procedural protection for that constitutionally-protected expectation. In the wake of the *Williams* decision, the common law informed consent principles prevailed requiring state psychiatric hospitals to abide by a competent patient's refusal to consent in non-emergency situations. *Williams*, 319 Md. at 510. Until §10-708(g) was amended the following year in 1991, no provision existed for medicating patients against their will when, in non-emergency situations, such patients exhibited dangerous behavior in the hospital due to untreated symptoms of mental illness. The 1991 amendments to §10-708(g) revived this non-emergency mechanism for overriding a patient's refusal of consent by making the requirement of present "danger to self or others" explicit, and by inserting the procedural protections of notice of CRP hearings, right to be present and to present evidence, right to appeal, and to representation on appeal. Md. Code, Health Gen. §10-708.

While primarily addressing the procedural due process questions, it is clear that the *Williams* Court understood the phrase "danger to himself or others" to refer to danger inside the psychiatric hospital. Indeed, the *Williams* court expressly stated that "[t]he extent of [the

inmate's] constitutional right to refuse drugs prescribed for this purpose must be determined **in the context of his confinement**, as stated in *Harper*, [494 US at 223]." *Williams*, 319 Md. at 508-09. That reference to *Harper* concerns "the State's interest in prison safety and security," and "prison administration." *Harper*, 494 US at 223. As the *Harper* Court explained,

> Prison administrators have not only an interest in ensuring the safety of prison staffs and administrative personnel, but also a duty to take reasonable measures for the prisoners' own safety. These concerns have added weight when a penal institution, like [the one at issue in *Harper*] is restricted to inmates with mental illnesses. 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.

Id. at 225 (citations omitted). Because the Legislature intended to amend §10-708(g) to bring it into compliance with *Harper* and *Williams*, this legislative history – in addition to the plain language of the statute – also shows that the Legislature intended the patient's danger to be one current within the hospital walls.

D. Predicating Forced Psychotropic Medication on Proof of Present Danger to Oneself or Others Within the Facility Will Not Deprive State Hospitals of the Ability to Function.

In addition to the statutory construction arguments posited above, sound public policy considerations also militate toward reading a requirement of present dangerousness in §10-708(g). The State advances the policy argument that the statute must be read to allow forced medication based upon an inmate's dangerousness to the community-at-large or else it will be "stripp[ed] . . . of its ability to provide the necessary and required treatment to a vulnerable population." DHMH at 18. Indeed, the State implies that §10-708(g) empowers it to medicate competent involuntary patients – who are not dangerous in the hospital context – in order to relieve the symptoms of their mental illness that assertedly make them dangerous to the

community, and thereby to hasten their discharge. The serious flaws in this argument reveal that policy considerations actually favor restricting §10-708(g)'s application to cases where patients are dangerous within the hospital context.[22]

a. Sound Public Policy Dictates that this Court Reject the State's Argument that it Can Forcibly Medicate Patients to Hasten their Discharge.

i. **Since the State admittedly does not seek to medicate Mr. Kelly in order to render him competent to stand trial, and without such competence Mr. Kelly cannot be discharged, the State's rationale for medicating him is seriously flawed.**

As an initial matter, the State should be estopped from arguing that its specific purpose in seeking to forcibly medicate Mr. Kelly is so that he can be discharged from the hospital. DHMH at 12. The State's alleged purpose is unsupported by law as applied to the facts of this case. Because Mr. Kelly is charged with a capital crime, he is prohibited by statute from being released to the public. Md. Crim. Proc. §3-106(a). Thus, until he becomes competent to stand trial, he will not be discharged from the facility.

However, the State conceded in the hearing below that it is not seeking to forcibly medicate Mr. Kelly in order to render him competent to stand trial. SE. 131. As counsel for DHMH argued on closing in the hearing before ALJ Grady, "*Sell [v. United States*, 539 U.S 166 (2003)] is wholly irrelevant to this case. . . . *Sell* concerns medication of an individual who is

[22] It should be noted that *Harper* involved the right of prisoners to refuse medications and the Court recognized that prisoners have diminished constitutional rights. *Washington v. Harper*, 494 U.S. at 223-24 (1990); *see Riggins v. Nevada*, 504 U.S. at 136 (1992)(pretrial detainees). The Maryland statute, on the other hand, applies to persons committed civilly and to persons who have not yet been adjudicated guilty of any crime. Certainly, the Legislature could not have intended to give less substantive protections to non-prisoners than those found minimally adequate under *Harper* and *Riggins*.

being medicated for the purpose of establishing competency. That is not what is happening here today." SE. 131. ALJ Grady accepted this concession and made clear in the record, that "medicat[ing] someone against their will so that they would have to stand trial for criminal offenses… is not the issue that's presented in the hearing before me." SE. 141. The State therefore cannot argue on appeal for the first time, that it seeks to medicate Mr. Kelly to hasten his discharge, *i.e.*, that he be found competent to stand trial.

b. Recognizing a Patient's Right to Refuse Consent to Treatment Will not Result in the Indefinite Confinement of Large Numbers of Patients Thereby Making Hospital Management Unduly Burdensome.

With respect to individuals who, unlike Mr. Kelly, are not accused of a capital offense, and therefore, may be released when no longer dangerous to the community, sound public policy reasons also weigh in favor of requiring a finding of present dangerousness in the hospital before forcible medication is permitted under §10-708(g). First, the Legislature assuredly has not enacted measures to allow hospitals to forcibly medicate competent patients who do not present a danger in the hospital in part because it is not a widespread problem.[23] The State makes the unsupported claim that "it is not uncommon for mentally ill individuals to refuse administration of antipsychotic medications," and that such unconsenting but nondangerous individuals would languish warehoused indefinitely. DHMH at 18. To the contrary, as shown below, only a small fraction of patients in psychiatric hospitals refuse to take medication.

The number of patients refusing to consent to drug treatment in Maryland state facilities is consistently quite small. In fiscal years 2004 and 2005, only 195 of the 5,993 patients

[23] It would also be unconstitutional to authorize such treatment, *infra* I.E., no minor matter to legislators considering where to direct their attention.

admitted involuntarily to state facilities[24]—less than 3% - refused medication and were subjected to a clinical review panel. In 2004, there were 70 appeals of a CRP decision to forcibly medicate, and in 2005, there were 73 appeals.[25] Of the total number of patients in 2004 and 2005 for whom the CRP approved forcible medication, only **31** individuals ultimately prevailed upon appeal, either to the Office of Administrative Hearings or to a circuit court, and thus remained unmedicated. *Id.* That represents only .005% of the total patients admitted to state facilities. The interpretation of §10-708 has been in dispute since its enactment in 1991, and it is impossible to determine how many of the CRP or OAH decisions were upheld despite no evidence that the individual presented a danger within the confines of the hospital. Even assuming, however, that the numbers of persons prevailing upon appeal increases due to this Court's clarification that §10-708 requires present dangerousness, the small number of patients who refuse medication each year demonstrates that the doomsday scenario suggested by the State is unlikely to materialize.

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[24] Dep't of Health and Mental Hygiene, 2006 Budget Report, pp. II-171 through II-201, *available at* http://www.dbm.maryland.gov/dbm_publishing/public_content/dbm_search/budget/tocfy2007operbudgetdetail/hlthhosp.pdf.

[25] For 2004: Fiscal and Policy Note, p.2; For 2005: DHMH 2005 Annual Report Excerpt (Brief Attachment).

In the *Martin* case, both DHMH and counsel for Mr. Martin presented evidence to this Court that, in fiscal years 1992, 1993 and 1994, CRPs convened in state facilities approved forced medication in 175 cases per year, from which 73 appeals were taken annually to the OAH, on average. *E.g. Dep't of Health & Mental Hygiene v. Martin*, No. 44, (Court of Appeals, Sept. Term 1997), Brief of Respondent, pp. 21-22. Due to the fact that some individuals are repaneled every ninety days if they continue to refuse medication, the number of CRPs exceeded the number of persons refusing medication. *Id.* Evidence was also presented to this Court that, in 1992, there were 6,800 admissions to state facilities. *Id.* Thus, the numbers of persons refusing medication and appealing a CRP decision to forcibly medicate, have remained approximately the same for more than a decade.

Secondly, as the Supreme Court specifically noted in *Sell v. United States*, 539 U.S. 166 (2003), a medically competent, nondangerous defendant who has been found incompetent to stand trial "may [face] lengthy confinement in an institution for the mentally ill," when he refuses to take medication. 539 U.S. at 180; *accord Riggins*, 504 U.S. at 145 (Kennedy, J. concurring). Thus, the Supreme Court specifically foresaw that our constitutional scheme of protection of patients' rights to informed consent would result in some non-consenting patients remaining confined for long periods. Indeed, the Court stated that lengthy confinement of a person who is not dangerous within the facility, and thus not subject to forced medication on *Harper*–type grounds may, in many cases, mitigate *against* forced medication for the purpose of bringing the individual to trial. *Id*.

Thirdly, patients who cannot be forcibly medicated can still be treated and rendered capable of discharge through individual psychotherapy, group therapy, educational and occupational therapy, and through what Perkins refers to as "milieu therapy" — adjusting one's behavior to the confines and privilege level reward system of the hospital. *See also, id*. at 181 (2003) (some patients can be rendered competent to stand trial through non-drug therapies).

Fourthly, for patients who are not competent to make medical decisions, the State can and should file a petition for medical guardianship under Md. Code, Estates and Trusts § 13-704 *et seq*. *See Woodland v. Angus*, 820 F. Supp. 1497, 1514 n.20 (D. Utah 1993) (rejecting a state's argument that a pretrial detainee would be "warehouse[d]" in the state hospital if he could not be forcibly medicated, noting that "[t]he defendants also have available to them the guardianship provisions of Utah law.")

In sum, in the absence of any evidence that the claimed warehousing is a problem, or that the Legislature sought to address that problem in the 1991 amendments to §10-708(g), this Court should not distort the statute on the State's asserted policy grounds.

E. Reading the Statute to Require Present Dangerousness Avoids Substantial Constitutional Issues.

A competent involuntary psychiatric patient has constitutionally protected rights to refuse unwanted psychotropic drugs, and such rights cannot be overridden simply because the State deems the drugs medically appropriate to treat him. *See Sell*, 539 U.S. at 178; *Riggins*, 504 U.S. at 134; *Harper*, 494 U.S. at 227. The State must demonstrate a "compelling" or "overriding" interest to overcome a patient's refusal of consent, and the physician's "duty to treat" an involuntary patient or the desire to help the patient is not a sufficient interest. Medically competent involuntary patients retain their right to refuse treatment, even life-saving treatment. Thus, interpreting §10-708(g) to require the State to prove that the safety of the patient, hospital staff, or other patients is endangered would avoid substantial constitutional issues, as the Legislature assuredly intended.

As this Court and the Supreme Court have acknowledged, the forcible injection of psychotropic drugs into a non-consenting competent person constitutes a "significant interference" with that person's constitutional liberty interests. *Williams*, 319 Md. at 503. This is especially true "since the purpose of the drugs is to alter the chemical balance in a patient's brain, leading to changes, intended to be beneficial [to the individual's] cognitive processes.'" *Id.* (*quoting Harper*, 494 U.S. at 229). Thus, the liberty interests at issue here include the right to bodily integrity and the right to freedom of speech and thought.

a. The Right to Bodily Integrity Includes the Right to Refuse Even Medically Advisable or Appropriate Treatment.

The right to preserve one's bodily integrity by refusing unwanted medical treatment is a paramount right in the hierarchy of constitutional values. Indeed, it has long recognized that "no right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law." *Cruzan v. Director, Mo. Dept. of Health*, 497 U.S. 261, 269 (1990) (*quoting Union Pacific RR. Co. v. Botsford*, 141 U.S. 250, 251 (1891)). In numerous cases over the years, the Supreme Court has repeatedly found that the Constitution protects individuals from government control of decisions affecting bodily integrity. *See Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 849 (1992) ("It is settled now ... that the Constitution places limits on a State's right to interfere with a person's most basic decisions about family and parenthood, as well as bodily integrity.") (citations omitted).

There are two interrelated components of the liberty interest to bodily integrity. The first component of this liberty interest protects the individual's interest in decisional autonomy – the freedom to make decisions concerning his or her life free from significant government interference. *See Walen v. Roe,* 429 U.S. 589 (1977); *Roe v. Wade,* 410 U.S. 113 (1973); *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Loving v. Virginia*, 388 U.S. 1 (1967); *Griswold v. Connecticut*, 381 U.S. 479 (1965); *Prince v. Massachusetts*, 321 U.S. 158 (1944). In *Casey*, the Supreme Court aptly explained that "[a]t the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs

about these matters could not define the attributes of personhood were they formed under compulsion of the State." 505 U.S. at 851.

The second component of the liberty interest to bodily integrity is the right to avoid unwanted medical treatment. In *Cruzan*, this Court reasoned that the right to bodily integrity is embodied in the general requirement of informed consent for medical treatment, and that "[t]he logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is to refuse treatment." 497 U.S. at 269. The *Cruzan* Court found that "a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions." *Id*. at 278. This right includes even the right to refuse life saving treatment, and it is grounded in the notion of liberty that is "inextricably entwined with our idea of physical freedom and self-determination." *Id*. at 287 (O'Connor, J., concurring).

Moreover, in cases arising from the correctional context, the Supreme Court has recognized that "[t]he 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. at 229 (1990) (quoted in *Riggins v. Nevada*, 504 U.S. 127, 133-34 (1992)). Those cases, like the case at issue here, involved involuntary medication by state officials, and the Court found the liberty interest in avoiding injections of anti-psychotic drugs in the Due Process Clause of the Fourteenth Amendment.

Whenever medical treatment is imposed contrary to a person's consent, courts have recognized an interference with the person's liberty interest that must be balanced against the government's interest in seeking to infringe upon the right to bodily integrity. *See, e.g., Vitek v. Jones*, 445 U.S. 480, 494 (1980) (finding that involuntary psychiatric treatment and behavior

modification of an alleged mentally unstable prisoner constitutes "deprivations of liberty that requires procedural protections"); *Parham v. J.R.*, 442 U.S. 584, 600 (1979) ("It is not disputed that a child, in common with adults, has a substantial liberty interest in not being confined unnecessarily for medical treatment. ...") *Riggins*, 504 U.S. at 135-36 (establishing three-part test government must meet before it may override an individual's liberty interest to be free from forced medication).

b. Forcible Medication to Alter a Patient's Thoughts and Speech Also Implicates Article 40 Rights.

The State's intention to force Kelly to ingest antipsychotic drugs with the express aim of controlling his beliefs and his written and oral speech, intrudes on his Article 40 rights. Md. Declaration of Rights, art. 40; *see also* U.S. Const. amend. I. Article 40 of the Maryland Declaration of Rights states in pertinent part "[E]very citizen of the State ought to be allowed to speak, write and publish his sentiments on all subjects. . . ." *See* U.S. Const. amend. I. ("Congress shall make no law ... abridging the freedom of speech. ..."). This Court has held, "[t]he freedom protected by this article have been interpreted to be co-extensive with the freedoms protected by the First Amendment." *Jakanna Woodworks, Inc. v. Montgomery County*, 344 Md. 584, 595 (1997). Thus, federal court guidance concerning First Amendment protections often inform this Court's independent application of Article 40. *Id*.

The Supreme Court has interpreted the First Amendment "freedom of speech" clause to include rights deemed essential to free speech, such as freedom of thought and "freedom of the mind." *See, e.g., Abood v. Detroit Bd. of Educ.*, 431 U.S. 209, 234-235 (1977) ("For at the heart of the First Amendment is the notion that an individual should be free to believe as he will, and

that in a free society one's beliefs should be shaped by his mind and his conscience rather than coerced by the State."); *Wallace v. Jaffree*, 472 U.S. 38, 50 (1985) (an "individual's freedom of conscience [is] the central liberty that unifies the various clauses of the First Amendment."). In *Stanley v. Georgia*, 394 U.S. 557 (1969), the Supreme Court found that individuals were entitled to First Amendment protection from intrusions into their minds:

> The makers of our Constitution ... recognized the significance of man's spiritual nature, of his feelings and of his intellect. [They] sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred, as against the government, the right to be let alone -- the most comprehensive of rights and the right most valued by civilized men.

Stanley, 394 U.S. at 565-566 (*quoting Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting). While *Stanley* addressed a constitutional right to possess obscene material, the *Stanley* Court's decision recognized a broader liberty interest to be free from government interference with the workings of one's mind. The *Stanley* Court observed: "Our whole constitutional heritage rebels at the thought of giving government the power to control men's minds." *Stanley*, 394 U.S. at 565.

Sixty years ago, the Supreme Court opined "[f]reedom to think is absolute of its own nature; the most tyrannical government is powerless to control the inward workings of the mind." *Jones v. Opelika*, 316 U.S. 584, 618 (1942). Since the advent of powerful antipsychotic drugs in the 1950s, the government now *does have* the capability to "control the inward workings of the mind." *Id.* Here, the State seeks to forcibly change the way Kelly *thinks*, by directly manipulating his brain chemistry. Antipsychotic drugs, the Supreme Court has noted, are "mind altering" and "[t]heir effectiveness resides in their capacity to achieve such effects."

Mills v. Rogers, 457 U.S. 291, 293 n.1 (1982). These drugs "alter the chemical balance in a patient's brain leading to changes . . . in his or her cognitive processes." *Harper*, 494 U.S. at 229.

By forcing a person to take a mind-altering drug against his or her will, the government is commandeering that person's mind, and forcibly changing his or her very ability to formulate particular thoughts. *In re guardianship of Roe*, 421 N.E.2d 40, 52-3 (Mass. 1981) ("The impact of the chemicals upon the brain is sufficient to undermine the foundations of personality."). By directly manipulating the manner in which a person's brain processes information and formulates ideas, the government *ipso facto* manipulates and alters both the form and content of that person's subsequent expression and thereby completely undermines the Article 40 free speech guarantees. Moreover, forced medication may permanently distort the thought process of involuntary patients depriving them of their liberty interests including the freedom from intrusion and control of the government into and over their minds.

In short, given that alteration of thinking is both the design and effect of antipsychotic drugs, permitting the government to *force* a citizen to take such drugs outside of the narrow context of *Harper*, cannot be squared with the supremely fundamental nature of the right to freedom of thought.

Several federal Circuit Courts have found First Amendment principles applicable to the forced medication of pre-trial defendants. In *Bee v. Greaves*, 744 F.2d 1387 (10th Cir. 1984), *cert. denied*, 469 U.S. 1214 (1985), a unanimous panel of the Tenth Circuit found that "[t]he First Amendment protects the communication of ideas, which itself implies protection of the capacity to produce ideas." *Id*. at 1393-1394. The court further found that "[a]ntipsychotic

drugs have the capacity to severely and even permanently affect an individual's ability to think and communicate," and thus implicate rights protected by the First Amendment. *Id*. at 1394. Relying in part on the Supreme Court's First Amendment analysis that the government cannot have the power "to control men's minds," *Stanley*, 394 U.S. at 565, the Tenth Circuit in *Greaves* concluded that a pretrial detainee "retains a liberty interest derived from the Constitution in avoiding unwanted medication with [antipsychotic] drugs." 744 F. 2d at 1394.

More recently, a unanimous panel of the Sixth Circuit found that a pretrial detainee "has a First Amendment interest in avoiding forced medication, which may interfere with his ability to communicate ideas." *U.S. v. Brandon*, 158 F.3d 947, 953 (6th Cir. 1998) (citing *Greaves*, 744 F. 2d at 1393). This fundamental interest is not limited to those free of any mental illness. Rather the First Amendment protects the interest of all persons to avoid government interference with their ability to produce and communicate their thoughts.

Although this Court has not directly considered the nature of Article 40 when the government seeks to alter a person's mind with antipsychotic drugs, the General Assembly was certainly aware of this constitutional backdrop when amending §10-708.

The intrusion sought by the State is extensive and reaches far beyond its short-term treatment goals. The forced medication sought by the State could have a life-long impact on Mr. Kelly's ability to think and communicate. It impacts far more than just the symptoms of his alleged mental illness, altering the very essence of his identity. For many people, antipsychotic drugs may provide life-enhancing benefits. For others, the physical and mental side effects of the drugs may be unacceptable, even dangerous. *See*, *e.g.*, *Harper*, 494 U.S. at 229 ("While the

therapeutic benefits of antipsychotic drugs are well documented, it is also true that the drugs can have serious, even fatal, side effects.").

Even in the absence of physical and mental "side effects," the fact remains that the administration of antipsychotic drugs affects thought processes. In this case, Article 40 concerns are implicated because the State's purpose in forcibly medicating Kelly is to diminish his symptoms, SE. 72, 78, which, since his symptoms concern only what he believes and says or writes, would require Kelly to alter his speech and his beliefs. For example, one of the symptoms the State seeks to curtail is Kelly's penchant for filing complaints about Perkins and its medical services. Dr. Wilsner-Carlson noted at the administrative hearing that after enduring approximately six months of forced medication, Kelly's "cuerolousness," that is his complaint filing behavior, "ha[d] seemed to have gotten . . . significantly better with treatment." SE. 72.[26] The other symptoms the State seeks to alleviate are Kelly's **beliefs** about the validity of the charges against him, the legality of the police search of his home, the competence of his defense attorney, and whether he should represent himself rather than risk defense by his current attorney. Perkins' doctors have decided that Kelly's beliefs on these topics are erroneous and they seek to drug him to change these beliefs to ones with which the doctors agree. *E.g.*, SE. 87. Because Kelly has not been tried by a court of law, however, the truth or validity of his beliefs cannot be independently established.

[26] Under state law Mr. Kelly has the right to use judicial process to file complaints concerning the services of his doctors and lawyers and the conditions at the hospital. Thus, much the same as his constitutionally protected beliefs concerning the charges against him, the State cannot forcibly medicate Mr. Kelly in order to prevent him from exercising this right to access judicial process.

Regardless of the truth of the allegations against Mr. Kelly,[27] a government action that directly and intentionally alters the way a person thinks by forcibly modifying that person's brain, directly violates the Article 40 right to freedom of thought. By manipulating the way that Mr. Kelly thinks, through the forcible act of administering mind-altering drugs to him, the State commits a type of cognitive censorship – suppressing Mr. Kelly's own thoughts in favor of state-approved, drug-induced, "normal," or "acceptable" thoughts. Such state action is surely no less disfavored under Article 40 than the censorship of speech.

If, as the Supreme Court has stated, "at the heart of the First Amendment is the notion that . . . in a free society one's beliefs should be shaped by his mind and his conscience rather than coerced by the State" *Abood v. Detroit Bd. of Educ.*, 431 U.S. 209, 234-35 (1977), then there can be no doubt that the government impinges on Article 40 when it acts to alter what, or how, a person thinks by forcibly and directly manipulating a person's brain. A government that is permitted to manipulate a citizen's consciousness at its very roots does not need to censor speech, because it can prevent the ideas from ever occurring in the mind of the speaker. Chemical or technological manipulation of the brain, therefore, has the potential to become the ultimate prior restraint on speech.[28]

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[27] While Perkins' psychiatrists reviewed the prosecution's allegations and asserted evidence against Mr. Kelly and found it to be quite convincing, SE. 69, those allegations have not been subjected to the test of the judicial process. In the face of evidentiary rules and the defense case, these allegations might very well be found lacking. At this time, there is no way to know whether what Mr. Kelly believes is true.

[28] The State's attempt to change Mr. Kelly's beliefs about his criminal case alone implicates free speech rights. However, Mr. Kelly is constitutionally entitled to be presumed innocent until proven guilty at trial. Md. Declaration of Rights, art. 21; U.S. Const. Amend V. Moreover, he is constitutionally entitled to eschew an attorney and represent himself. Md. Declaration of Rights, art. 21; U.S. Const. Amend. VI. Thus, the State not only seeks to drug Mr. Kelly in order to

c. The State's Interest in Providing Medical Care to Mr. Kelly, or in the Efficient Administration of its Hospitals, Is Not Sufficient to Override His Constitutionally Protected Right to Refuse Consent.

While this Court has not had occasion to determine the level of state interest that must be shown to justify interference with an involuntary competent patient's fundamental rights to free speech and bodily integrity,[29] the Supreme Court has made it clear that under the federal constitution, an "overriding justification" or "compelling concern" must be shown, in addition to establishing that the treatment would serve the patient's medical needs. *Riggins,* 504 U.S. at 136. [30] Courts have uniformly recognized only three state interests sufficient to override the person's liberty interest to avoid unwanted, potentially lethal drugs. First, as discussed previously, the state may assert the interest in rendering an accused competent to stand trial, but that interest is not asserted here. Second, the state may assert a *parens patriae* interest on behalf of a person who lacks capacity to make his or her own decisions. And third, the state may assert a police power interest in protecting the safety of staff or patients, including the individual refusing the medication, within the confines of the institution. In the instant case, the State urges that this Court find that the Legislature disregarded well-settled principles and case law and enacted a statute that grants to the State unprecedented, overreaching and unconstitutional powers.

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change his beliefs, it seeks to change beliefs that he is specifically entitled to hold under the state and federal constitutions.

[29] *But see Martin v. Dep't of Health & Mental Hygiene,* 114 Md. App. 520 (1997), *vacated as moot,* 348 Md. 243 (1997)(persuasive authority).

[30] While our State Constitution might provide greater protection for these rights than the federal constitution, at a minimum, it grants equal protection. *Williams,* 319 Md. at 498 ("State law may recognize liberty interests more extensive than those independently protected by the Federal Constitution. If so the broader state protections would define the actual substantive rights possessed by a person living within that State.").

i. Medical appropriateness alone is not sufficient to override a person's right to refuse psychotropic medication.

Medical appropriateness alone is not a sufficient state interest to override a competent involuntary patient's right to refuse consent. In *Harper*, for example, the Supreme Court held that "given the requirements of the prison environment, the Due Process Clause permits the State to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if the inmate is dangerous to himself or others **and** the treatment is in the inmate's medical interest." *Harper*, 494 U.S. at 227 (emphasis added). In *Riggins* the Supreme Court, interpreting Harper, stated that forcing drugs on an inmate is "impermissible absent a finding of overriding justification **and** a determination of medical appropriateness. *Riggins,* 504 U.S. at 135 (emphasis added). Thus, both *Riggins* and *Harper* explicitly held that medical appropriateness of treatment by itself is not sufficient to forcibly drug individuals. As the *Riggins* Court further explained, if the medication were "essential for the sake of the [prisoner's] own safety or the safety of the [staff and occupants of the institution]" that would constitute a sufficient state interest to overcome the refusal of consent of a prisoner in pretrial detention. *Id.*

While the protections offered to involuntary patients in Maryland-- some of whom are convicted or charged with crimes, but some of whom are civilly committed with no criminal allegations –might be greater than those afforded a prisoner or pretrial detainee in jail, they most certainly should not be accorded any less protection.

ii. The State's *parens patriae* interest in forcibly treating patients for their benefit and to hasten their discharge does not apply to individuals who are competent to make their own treatment decisions.

The State's arguments to support its interpretation of §10-708 — that it has a duty to treat

patients with a mental illness in order to improve their condition and hasten their discharge – sound in a *parens patriae* power. The State does, of course, have an interest in "providing care to its citizens who are unable because of emotional disorders to care for themselves. *Addington v. Texas*, 441 U.S. 418, 426 (1979). However, by definition, this power can only be invoked where the person lacks capacity to make his own treatment decisions. Courts have thus uniformly held that, when the State acts pursuant to its *parens patriae* power, there must be an adjudication or finding of incompetence to make medical decisions before a patient can be medicated against his will. *Bee v. Greaves*, 744 F.2d at 1395; *Winters v. Miller*, 446 F.2d 65, 68-71 (2d Cir. 1971), *cert. denied*, 404 U.S. 985 (1971); *In re Qawi*, 81 P.3d 224, 237 (Cal. 2004); *Davis v. Hubbard*, 506 F. Supp. 915, 935-36 (N.D. Ohio 1980); *Rogers v. Commissioner*, 458 N.E. 2d 308, 322 (Mass. 1983); *Opinion of the Justices*, 465 A.2d 484, 489-90 (N.H. 1983); *River v. Katz*, 495 N.E.2d 337, 340 (N.Y. 1986); *In re K.K.B.*, 609 P.2d 747, 750-52 (Okla. 1980).

The fact that Mr. Kelly has been found "not competent to stand trial" does not establish that the government may deny his right to make medical decisions for himself. Moreover, as this Court recognized in *Williams*, commitment to a psychiatric facility is "not tantamount to a finding that he is mentally incompetent to make treatment decision." 319 Md. at 508 n.8. Because Mr. Kelly has not been adjudicated incompetent to make medical decisions on his own behalf, the State cannot assert its *parens patriae* power and he retains his constitutionally protected right to refuse consent to medication absent dangerousness within the facility. *See Harper*, 494 U.S. at 221-222, 229 (1990); *Williams*, 319 Md. at 502-03.

iii. Courts have rejected that a State's interest in hastening discharge is sufficient to overcome a competent individual's right to refuse unwanted treatment.

Courts have uniformly rejected a claim that a State may forcibly medicate a competent individual simply to hasten his discharge from involuntary confinement. For example, in *Cochran v. Dysart*, 965 F.2d 649, 651 (8th Cir. 1992), the State of Missouri sought to justify forced medication for:

> Treatment . . . to '[c]ontrol symptoms of mental illness allowing for transfer to less restrictive quarters and participation in more programs.'

The State also argued that the:

> Psychotropics will eventually help [Cochran] to improve his reality testing,' his delusions of grandeur, 'respond to treatment,' and he is 'less agitated when on medication.'

Id. at 651. The Eighth Circuit rejected this argument and held that, "[u]nder *Harper*, none of these reasons justifies forcibly medicating Cochran with potentially fatal psychotropic drugs." *Id*. The Court refused to override the liberty right of an involuntarily committed individual to refuse these potentially dangerous medications merely because the medications were an appropriate means of treating his mental illness and could have hastened his discharge.

Similarly, in *Woodland v. Angus*, 820 F. Supp. at 1508-1509, 1518, the Court rejected the argument that the State's interest in treating and discharging a patient outweighed the individual's right to refuse psychotropic medication. Although the Court found no factual basis in the record suggesting medication would permit release, it also pointed to the absence of any case law to support the State's legal argument. *Id*. at 1518; *accord Myers v. Alaska Psychiatric Institute*, 138 P.3d 238, 249-251(Alaska 2006).

Moreover, courts have rejected claims that a state's "limited resources" override the individual's right to refuse unwanted treatment. *See* DHMH at 18. In *Davis v. Hubbard*, for example, the court rejected involuntary treatment on the basis of the state's interest in maintaining the institution in "the cheapest and most efficient manner possible." 506 F.Supp. 915, 937 (D. Ohio 1980). Citing to the Supreme Court, the *Davis* Court noted that:

> [t]he Constitution recognizes higher values than speed and efficiency. Indeed, one might say of the Bill of Rights in general . . . that they were designed to protect the fragile values of a vulnerable citizenry from the overbearing concern for efficiency and efficacy that may characterize praiseworthy government officials no less, and perhaps more, than mediocre ones.

Id. (citing Watson v. City of Memphis, 373 U.S. 526 (1963)).

Finally, the State suggests an interest in protecting the right to liberty of involuntary patients by arguing that a requirement of dangerousness within the hospital before the State can override a competent individual's right to refuse treatment condemns the individual to "lifelong commitment." DHMH at 12. The State's argument overlooks the fact that the liberty interest in freedom from confinement belongs to the individual to assert, not to the State. The State must find an interest of its own to justify overriding a person' constitutional right to refuse medication. Constitutional jurisprudence would be turned on its head if the State could usurp a competent individual's right to freedom from confinement and use it to quash his choice to exercise another of his constitutionally protected rights.

> *iv.* The compelling interest in forcibly medicating an individual pursuant to the State's police power is implicated only where the individual is dangerous within the facility.

The State urges that the dangerousness requirement under §10-708 is satisfied solely based upon the individual's continuing commitment as dangerous to the community. However, no court has ever found that a State's police power to commit a person who is dangerous in the community extends to forcibly medicating him. The State's interest in keeping citizens in the community safe is satisfied once the person is committed. *See, e.g., Bee v. Greaves,* 744 F.2d at 1395; *Davis v. Hubbard,* 506 F. Supp. at 936. Thus, as courts have uniformly recognized, to justify overriding a competent individual's right to refuse medication, the State must show that he is dangerous to self or others within the facility. *Harper*, 494 U.S. at 226-27; *Riggins*, 504 U.S. at 135; *Woodland v. Angus*, 820 F.Supp. at 1508, 1509; *Enis v. Dep't of Health*, 962 F.Supp. at 1197, 1199; *Rennie v. Klein*, 720 F.2d 266 (3rd Cir. 1983); *Davis*, 506 F.Supp. at 938; *Steele v. Hamilton County Cmty. Mental Health Bd*. 736 N.E. 2d 10 (Ohio 2000).

The General Assembly, in amending §10-708 in the wake of *Harper* and this Court's decision in *Williams*, was clearly cognizant that the individuals confined to psychiatric facilities retain their significant constitutional interests in bodily integrity and freedom of thought. Thus, balancing these rights with the recognized State interests, it properly prohibited the forcible drugging of competent persons absent a finding of present dangerousness within the facility.

Conclusion

For the foregoing reasons, Respondent respectfully requests that, to honor the plain language of the statute and to further the legislative intent and avoid constitutional problems, this Court should hold that §10-708(g) requires a finding of current dangerousness within the hospital context in order to authorize forcible medication. Accordingly, the Court should affirm the decision below. Alternatively, assuming that this Court adopts the reading of the statute

urged by the State, Respondent urges that this Court remand for further proceedings before the Circuit Court.[31]

Respectfully submitted,

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[31] Further proceedings would be necessary for a multitude of reasons. First, the State's argument that the ALJ's finding of a delusional disorder relied, in part, on Mr. Kelly's beliefs about aspects of his criminal case that could not be shown to be untrue. Second, Mr. Kelly was constitutionally entitled to believe in his innocence and to assert that fact, as well as to question the unlawfulness of the police search of his home, and to profess a desire to discharge his attorney and/or represent himself. Third, Mr. Kelly should also be afforded the opportunity to question the ALJ's finding that forcible drug treatment was an appropriate "exercise of professional judgment" rendered solely to benefit the patient because she uncritically accepted the treating psychiatrist's conclusions about the efficacy of drug treatment for delusional disorder, in spite of judicially-noticeable evidence that drugs are not effective for relieving this disorder. *See* ACLU *Amicus* Br.

RULE 8-112 (c) STATEMENT

This Brief was prepared using 13 point Times New Roman with double spacing in the text and one line spacing in footnotes. Md. Rules 8-112(c) and 8-504(a)(8).

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CERTIFICATE OF SERVICE

I hereby certify that on this First day of September, 2006, I mailed first class, postage prepaid, two copies of the foregoing Brief of Appellee Anthony Kelly, and Appellee's Appendix to the following:

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