IN THE
COURT OF SPECIAL APPEALS OF MARYLAND

No. 02227
September Term, 2005

DEPARTMENT OF HEALTH AND MENTAL HYGIENE,

Appellant,

v.

ANTHONY KELLY,

Appellee.

APPEAL FROM THE CIRCUIT COURT FOR BALTIMORE CITY
(Albert J. Matricianni, Jr., Judge)

BRIEF OF THE MARYLAND PSYCHIATRIC SOCIETY, THE JOHNS HOPKINS HEALTH SYSTEM CORPORATION, AND THE JOHNS HOPKINS UNIVERSITY, AMICI CURIAE

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INTEREST OF AMICI CURIAE

The Maryland Psychiatric Society is a Maryland nonprofit scientific corporation constituting the Maryland District Branch of the American Psychiatric Association. Founded in 1950, the Society now has approximately 780 members. The Society's mission and objectives were set forth in its motion for leave to file an amicus curiae brief. Two important objectives are "to promote the best interest of actual or potential patients of psychiatrists" and "to advance the standards of all psychiatric services and facilities."

In the present case, the Society and its members have an interest in ensuring that the legal standards governing involuntary medication of dangerous patients involuntarily committed to mental hospital facilities on account of their mental illness be based on well-grounded facts about antipsychotic medications. The Society, its members, and the other amici also have a strong interest in ensuring judicial appreciation of the adverse consequences – for the patient, for other patients at the facility, for the legal system, and for society generally – if medications are not administered to a patient when the medications are appropriate treatment for psychotic illness and are the only realistic hope of restoring the patient to mental health.

The Johns Hopkins University employs the physicians who provide psychiatric services to mental patients who are treated at mental health facilities operated through The Johns Hopkins Health System Corporation. Both Johns Hopkins amici have a particular interest in reversal of the decision below, because, if the decision were to stand, (1) they would be unable to treat patients with severe mental illness even if treatment is in the patient's best interest;

(2) without treatment, the patients would have to be indefinitely hospitalized; (3) the resources of the Hopkins facilities and psychiatrists would be strained to the point that they may be unable to serve patients who need and want treatment; (4) the quality of psychiatric care for all Johns Hopkins patients would be impaired; and (5) the consequent deprivation of the only promising opportunity for the improvement of the patient's condition would be a grave injustice to all concerned.

STATEMENT OF THE CASE

This is an appeal from an order of the Circuit Court for Baltimore City reversing an administrative law judge's decision holding that Anthony Kelly, a psychiatric patient at the Clifton T. Perkins Hospital Center, may be involuntarily medicated to treat his serious mental illness. On August 23, 2005, after compliance with all procedural requirements, a properly constituted clinical review panel authorized involuntary medication for up to 90 days (E. 1-5). The authorization was renewed, and the medication continued. The authorization was based on the following findings: (1) the proposed medication had been prescribed by a psychiatrist, (2) the medication was needed to treat Mr. Kelly's symptoms, (3) the medication represents a reasonable exercise of professional judgment, (4) alternative treatment and/or medications were rejected "because they have not been effective," (5) All procedures required by statute had been complied with, and (6) without the medication, Mr. Kelly was "at substantial risk of continued hospitalization because of: (i) remaining seriously mentally ill with no significant relief of the mental illness symptoms that cause [him] to be a danger to [him]self

or to others [and] (ii) remaining seriously mentally ill for a significantly longer period of time with mental illness symptoms that cause [him] to be a danger to [him]self or to others." (*Id.*)

Mr. Kelly filed a timely appeal to an administrative law judge, who conducted a *de novo* hearing on September 1, 2005, at which Mr. Kelly was represented by counsel. The only witness called by the Department of Health and Mental Hygiene was Dr. Robert Wisner-Carlson, the psychiatrist who treated Mr. Kelly and was qualified as an expert witness in forensic psychiatry (E. 9). The only other witness was Mr. Kelly himself, who was called by his counsel to testify. At the conclusion of the hearing, the Administrative Law Judge, Hon. Georgia Brady, made her own findings which substantially tracked those of the Clinical Review Panel (E. 36-40, T. 82-85), and affirmed (E. 41). In accordance with those findings, she concluded "as a matter of law that the hospital HAS shown by a preponderance of the evidence that [Mr. Kelly] should be medicated with the [proposed] psychiatric medications. . . ." (E. 41).

Judge Brady specifically found, as the Clinical Review Panel did, that, in the words of the statute, without medication, Mr. Kelly was at substantial risk of continued hospitalization because of remaining seriously mentally ill with no significant relief of the mental illness symptoms that cause him to be a danger to himself or others, and because of remaining seriously mentally ill for a significantly longer period of time with mental illness symptoms that cause him to be a danger to himself or to others (E. 41).

Mr. Kelly appealed to the Circuit Court for Baltimore City and on November 9, 2005,

Judge Albert Matricianni, Jr., reversed in a one and one-half page order (E. 49-50). There was no accompanying memorandum opinion. The reason stated in the order for the reversal was:

> This Court is persuaded on the issue presented by the analysis of the panel of the Court of Special Appeals of Maryland in the case of *Martin v. Dept. of Health and Mental Hygiene*, 114 Md.App. 520 (1997), interpreting Md. Code Ann. [Health-General Article] § 10-708 to require evidence that an involuntarily committed individual is a danger to himself or others in the facility to which he had been involuntarily admitted, rather than to society generally upon his release. This court is persuaded that that is a correct interpretation of Maryland's involuntary medication statute. Although the judgment of the Court of Special Appeals in *Martin* was vacated and ultimately dismissed on the ground of mootness, following a per curiam order of the Court of Appeals, 348 Md. 243 (1997), its reasoning may constitute persuasive authority to this Court in the same sense as other dicta may constitute persuasive authority on any legal issue. *West v. State*, 369 Md. 150, 157 (2002). [E. 50]

The Department of Health and Mental Hygiene filed a timely notice of appeal.

QUESTION PRESENTED

Did the Circuit Court err in construing § 10-708 of Md. Code Ann. Health-General Article (2005 Supp.) to prohibit involuntary medication by a mental health facility for an involuntarily committed patient who would be dangerous upon release, unless the patient also displays dangerousness within the facility?

STATUTES INVOLVED

The statutes involved are printed in the appendix to Appellant's brief.

STATEMENT OF FACTS

Anthony Kelly was 41 years old at the time of his hearing before Administrative Law Judge Brady (T. 75). He had been imprisoned for various crimes for most of his life (E. 16).

His most recent adventure with the law began in 2002, when he was charged with murder, two first-degree rapes and vehicle theft (E. 11,32). On October 14, 2003, he was admitted involuntarily to the Clifton T. Perkins Hospital Center. On May 27, 2004, after a lengthy contested hearing, Judge Durke G. Thompson of the Circuit Court for Montgomery County issued a 39-page opinion finding Mr. Kelly both dangerous and not competent to stand trial (E. 22).[1] Mr. Kelly has remained at Perkins ever since.

The only expert testimony in the ALJ hearing about Mr Kelly's mental illness came from Dr. Robert Wisner-Carlson, who had been Mr. Kelly's treating psychiatrist for the previous seven months (E. 10). Dr. Wisner-Carlson testified that Mr. Kelly is housed in a maximum security residential ward (E. 10). Mr. Kelly was being involuntarily medicated at the time of the hearing and had previously been involuntarily medicated for some time (E. 14, 21, T. 22).[2]

Mr. Kelly's mental illness was diagnosed as Delusional Disorder, Persecutory and Grandiose Type (E. 11), a psychotic disorder (E. 12, T. 36) characterized by beliefs that in context are unreasonable and improbable (E. 14), by querulousness (E. 20),[3] and by a highly exaggerated and unrealistic estimate of the patient's own powers. Mr. Kelly was also

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[1] The transcript incorrectly states the length of the opinion as 38 pages (E. 22). The opinion itself is not in the record but the length is actually 39 pages.

[2] After the panel decision of the Court of Special Appeals in *Martin* was vacated, involuntary medication was continued by psychiatrists on the same basis as before the *Martin* decision.

[3] The transcript has "cuerolousness" (E. 25), but there is no such word.

diagnosed as having borderline intellectual functioning, cognitive disorder, substance abuse disorder, and antisocial personality disorder (E. 30). In Dr. Wisner-Carlson's opinion, Mr. Kelly is "a dangerous person," who constitutes a danger to others (E. 22). He lacks insight into his illness (E. 21), and lack of insight is a dominant feature of delusional disorder and is associated with heightened risk of suicide and violence. X.F. Amador and J.M. Gorman, *Psychopathologic Domains and Insight in Schizophrenia,* 21 PSYCHIATRIC CLINICS OF NORTH AMERICA, 27-42 (1998); P.S., Applebaum, Robbins, P.C., and J. Monahan, *Violence and Delusions: Data From the MacArthur Violence Risk Assessment Study*, 157 AMERICAN JOURNAL OF PSYCHIATRY, 566-572 (2000) (general association but no causal relationship found between delusions and violence); P.J. Taylor, *Delusional Disorder and Delusions: Is There A Risk of Violence in Social Interactions About the Core Symptom?* 24 BEHAVIOR SCIENCES AND THE LAW, 313-331 (2006) (link between delusions and violence); J.W. Swanson, R. Borum and M.S. Swartz, *et al, Psychotic Symptoms and Disorders and Risk of Violent Behavior in the Community*, 6 CRIMINAL BEHAVIOR AND MENTAL HEALTH, 317-338 (1996). Although Mr. Kelly failed many grades (E. 16), he insists that he is capable of representing himself in court on the pending charges (E. 15), which involve the possibility of a death sentence (E. 20), and that he could run a multimillion dollar business which he could capitalize with millions of dollars from his drug business that he has stashed away and buried (E. 17). He filed multiple suits against the Public Defender, the State's Attorney, attorneys in the Attorney-General's Office, and doctors and staff at Perkins; all were dismissed (E. 20,

T. 66). He believes his previous attorney betrayed him and violated confidences (T. 65), and he has written to the judge and filed a grievance against his counsel, complaining that she was in a conspiracy against him with the State's Attorney to have him prosecuted and to fabricate evidence so he could be found guilty (E. 14-15).

Mr. Kelly's mental illness is chronic; without medication, it can go on for years or even decades (E. 19), but the disease is fairly treatable with medication (E. 19, T. 47-48). At the time of the ALJ hearing, he was being involuntarily medicated with Risperidone (one of the newer antipsychotic medications) and with Benztropine to mitigate possible side effects (E. 21, T. 22). His mental condition is closely monitored in the institutional setting (E. 23, T. 27).

Mr. Kelly's condition and behavior have significantly improved under treatment (T. 22). He has not assaulted or threatened anyone in the hospital; he is not in seclusion or under special observation and he has not had any special intervention in regard to assaultiveness or the like (E. 29). Dr. Wisner-Carlson anticipates continued improvement if medication is continued (E. 23). The ultimate anticipated benefit from the treatment is that Mr. Kelly's condition would no longer require hospitalization (E. 23).

Dr. Wisner-Carlson's opinion as to Mr. Kelly's treatability is in full accord with the psychiatric literature and mainstream psychiatric opinion and practice. Medications for delusional disorder include haloperidol (brand name: Haldol),risperidone (brand name: Risperdal), olanzapine (brand name: Zyprexa), and quatiapine (brand name: Seroquel),

prescribed in the present case. *See U.S. v. Gomes*, 289 F.3d 71 (2d Cir. 2002); *U.S. v. Weston*, 255 F.3d 873, 886 n. 7 (D.C. Cir. 2001); P.J. Weiden, et al., *Breakthroughs in Antipsychotic Medications: A Guide for Consumers, Families and Clinicians* (National Alliance For The Mentally Ill), 94-95 (1999); S. Marder, *Antipsychotic Medications*, in A. Schatzberg and C. Nemeroff, THE AMERICAN PSYCHIATRIC PRESS TEXTBOOK OF PSYCHOPHARMACOLOGY, 305 (2d ed. 1998) ("[T]hese drugs have become standard treatments in psychiatry and medicine"). Alistair Munro, one of the leading researchers in the field, concludes in his book *Delusional Disorder: Paranoia and Related Illnesses* (1999) at p. 237:

> If no other conclusion can be reached from the literature to date, the one which must be emphasized again and again is that delusional disorder, properly diagnosed and adequately treated, has an optimistic outlook. Whatever the neuroleptic employed, the overall rate of response, total or partial, is approximately 80 percent, an outcome that compares well with any other in psychiatry. It is clearly desirable to identify and, if possible, treat cases.

There is strong evidence that risk of violence is reduced when psychotic symptoms are appropriately and effectively treated. K. Tardiff, P.M. Marzuk, A.C. Leon, and L. Portera, *A Prospective Study of Violence by Psychiatric Patients After Hospital Discharge,* 48 PSYCHIATRIC SERVICES, 678-681 (1997); Steven K. Hoge, M.D., *et al., A Prospective, Multicenter Study of Patients' Refusal of Antipsychotic Medication,* 47 ARCHIVES OF GENERAL PSYCHIATRY, 949, 954 (1990).

Requiring involuntary medication is therefore a reasonable exercise of professional medical judgment (T. 26). The benefits outweigh the risks; the side effects have been minimal

(E. 28). The downside of failure to medicate is steep: substantial risk of indefinite continued hospitalization (E. 23-25) and inability to be placed in a less restrictive setting (E. 24).[4]

Mr. Kelly's own testimony corroborated the psychiatric diagnosis: He says his lawyer told him he would be sentenced to only six years on the murder charge (E. 33). He insisted "I don't have any mental illness. I don't suffer from delusions. I've been in and out of the court system for the past 20 years and have had no doctor ever say that anything was wrong with me" (E. 34). Asked if he was ever treated otherwise than through the court system, he answered: "You have to see a doctor when you are locked up [E. 34] . . . , so I did see doctors and everything was okay with me" (T. 55). At another point, he said he had never been treated by any psychiatrist (T. 55), and he would stop taking medication if not compelled to take it (T. 66). He insisted that the police told him they knew he was innocent (T. 66).

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[4] Empirical study confirms that patients who reject medication and are not treated remain hospitalized significantly longer and necessarily generate more expense (restraint, seclusion, etc.) and have an adverse effect on themselves and the ward milieu. Steven K. Hoge, M.D., *et al.*, *supra,* 949, 954. On the other hand, the majority of patients in an extensive study who were treated over objection with antipsychotic drugs in state-operated mental health facilities in Massachusetts ultimately accepted medication as a result of the involuntary treatment, or reached the point where they could be discharged or where the psychiatrist and the patient agree that the treatment is no longer medically necessary. *Id.*

Both Martin's and Beeman's cases became moot because the involuntary medication worked and before the litigation was concluded, the plaintiffs could be, and were, released from the hospital as no longer dangerous outside the hospital.

ARGUMENT

I. THE COURT BELOW ERRED IN FOLLOWING THE RATIONALE OF THE VACATED PANEL DECISION IN *MARTIN V. DEPT. OF HEALTH AND MENTAL HYGIENE* BECAUSE THAT RATIONALE IS DEMONSTRABLY FLAWED.

A. The Vacated *Martin* Rationale Is Inconsistent with Other Cases in Both the Court of Appeals and the Court of Special Appeals.

The vacated panel decision in *Martin* failed to take account of the teaching of *Williams v. Wilzack,* 319 Md. 485, 573 A.2d 809 (1990), and *Beeman v. Dept. of Health and Mental Hygiene*, 107 Md.App. 122, 666 A.2d 1314 (1995) (Harrell, J.).

The facts in *Williams v. Wilzack* are similar to those in the present case. Williams had been involuntarily committed to the Clifton T. Perkins Hospital Center after being found not criminally responsible on charges of attempted rape and battery. *Wilzack* found the predecessor statute of § 10-708 unconstitutional for failure to afford procedural due process. (The General Assembly amended § 10-708 in 1991 to correct the deficiencies in the statute declared unconstitutional in *Wilzack.*) In discussing substantive due process, which *Wilzack* indicated was not violated, the Court said: "Manifestly, the institution is charged with a statutory duty to treat Williams for his mental disorder to permit him to rejoin society." 319 Md. at 507, 573 A.2d at 820. This duty requires consideration of the danger posed by a patient upon release from the institution.

Manifestly also, this duty necessarily implies the power to compel medication to improve the mental condition of the patient to the point that the patient is not dangerous to

himself or others if released from the institution. This reading of *Wilzack* is strengthened by *Wilzack*'s reliance on *U.S. v. Charters*, 863 F.2d 302 (4th Cir. 1989), which permitted involuntary medication. Charters, like Mr. Kelly, had been declared incompetent to stand trial and also dangerous to himself and others. He was committed for care and treatment to a federal psychiatric facility. Involuntary medication was upheld because, in the words of the *Wilzack* court, "[I]n his untreated condition the patient would likely require indefinite confinement in an institutional setting, but that with proper medication his dangerousness could be decreased to a level that could permit his return to the community." *Wilzack*, 319 Md. at 504-05, 573 A.2d at 818 (emphasis supplied).[5]

The vacated *Martin* opinion makes the additional argument that an interpretation of § 10-708 contra to the panel's would deny the patient due process. *Beeman*, 107 Md.App. 122, 145, 666 A.2d 1314, 1325, makes clear, however, that notwithstanding *Martin*'s questioning of the constitutionality of the present statute if interpreted otherwise than in *Martin*, the present statute satisfies both substantive and procedural due process.

B. The Vacated *Martin* Panel's Analysis of the Statutory Language is Flawed.

The *Martin* panel focused on Health-General Art. § 10-708(g)(3)(i), which sets forth as one of the conditions for involuntary medication a determination that "Without the

[5] As *Wilzack* noted, the Supreme Court stayed its ruling on Charters's petition for certiorari pending decision of *Washington v. Harper*, 494 U.S. 210, 110 S.Ct. 1029 (1990), a seminal case on involuntary medication; and a week after the decision in *Washington v. Harper*, the Supreme Court lifted the stay and denied certiorari in *Charters*.

medication, the individual is at substantial risk of continued hospitalization because of: (i) Remaining seriously mentally ill with no significant relief of the mental illness symptoms that cause the individual to be a danger to the individual or to others."

There is nothing in the statutory language that would confine involuntary medication to cases where the patient is dangerous inside the facility, where Mr. Kelly is confined in a maximum security ward organized to prevent such dangerousness. Indeed, the danger contemplated by the statute is the danger that produces a substantial risk of continued hospitalization, namely dangerousness if released. The entire thrust of the statute is to provide a fair and reasonable procedure with a view to releasing the patient from the hospital as promptly as possible. This is the "compelling interest" of the state to which the individual's liberty interest in rejecting arbitrary medication must yield. *Dautremont v. Broadlawns Hosp.*, 827 F.2d 291, 300 (5th Cir. 1987) (individual's liberty interest must yield to "the government's legitimate objective to return [the patient's] behavior to that which is acceptable to society, and . . . the professionals' reasonable judgment here that that objective can best be accomplished by the administration of certain types and levels of psychotherapeutic drugs"); *Jurasek v. Payne*, 959 F.Supp. 1441, 1458 (D.Utah 1997) (state's objective of enabling the patient to return to a status of mental health such that he may be discharged constitutes an "essential and compelling state" interest that "overbalance[s]" patient's constitutional liberty interest).

The vacated *Martin* opinion states that its interpretation of § 10-708 is required to

harmonize § 10-708 with § 10-632(e)(2)(iii). The *Martin* opinion was wrong. Section 10-632(e)(2)(iii) provides that a person may be involuntarily admitted to a facility only if, *inter alia*, "the record demonstrates by clear and convincing evidence that at the time of the hearing . . . the individual presents a danger to the life or safety of the individual or of others." It is difficult to follow the *Martin* opinion's reasoning on this point. Section 10-632(e)(2)(iii) relates to criteria for involuntary admission, whereas § 10-708 relates to involuntary medication after admission of a patient who has been demonstrated by clear and convincing evidence to be a danger to self or others outside the facility. The object of the medication is to bring the patient to the point that the patient no longer poses the danger that triggered the involuntary admission, namely, the danger the patient poses if not institutionalized.

The vacated *Martin* opinion argues that § 10-708(g)(3)(i) and § 10-632(e)(2)(iii) would be redundant if "dangerous" in § 10-708 is interpreted to mean "dangerous if released." *Martin*'s stated reason for its claim of redundance is that "Section 10-632(e)(2)(iii) permits an individual to be involuntarily admitted only if '[t]he individual presents a danger to the life or safety of the individual or of others.'" 114 Md.App. at 527, 691 A.2d at 256. The sections, however, are not redundant but complementary. § 10-632 deals with involuntary admission because of dangerousness outside the hospital. Section 10-708 deals with involuntary medication after an admission so that the patient can be released without having to be recommitted for the same reason that caused the patient to be committed in the first place.

It is the vacated *Martin* decision that would make § 10-708 largely superfluous. If

dangerousness in the institution were the test, § 10-708 would hardly be necessary, because the common law has always permitted the hospital to medicate without consent in an emergency; a prime objective of the statute was to substitute a procedure administered by medical professionals in place of the expensive and cumbersome judicial guardianship which had previously been the only avenue to involuntary nonemergency medication. *Beeman v. Dept. of Health and Mental Hygiene*, 107 Md.App. 122, 137, 666 A.2d 1316, 1321 (1995) (Harrell, J.). *Beeman* thus makes clear that involuntary medication may be administered to persons involuntarily committed because of dangerousness outside of the hospital, if adequate protections against arbitrariness are afforded; these protections are procedural due process and appropriate professional medical judgment. *See also* the earlier *Beeman* case, *Beeman v. Dept. of Health and Mental Hygiene,* 105 Md.App. 147, 167, 658 A.2d 1172, 1179 (1995).

Where the mental illness is one that causes dangerousness, it is not a necessary condition for treatment that the patient be manifesting the dangerousness at the time of treatment. The whole point of treatment is to improve the mental condition to the point that it no longer causes the danger that triggered the involuntary admission.[6]

The vacated *Martin* opinion says that its interpretation of § 10-708(g)(3)(i) is supported by § 10-708(g)(3)(ii), which, the panel says, is "significant." It is difficult to follow the opinion's argument. The opinion does not say how § 10-708(g)(3)(ii) is significant or why

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[6] It is significant that the decision of the Court of Special Appeals in *Martin* was vacated for mootness because the system worked. Martin's involuntary medication caused him to be discharged while his appeal was pending.

it supports the position that dangerousness inside the institution is the criterion for involuntary medication. Section 10-708(g)(3)(ii) requires a determination that without the medication, the individual is at substantial risk of continued hospitalization because of "Remaining severely 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" (emphasis supplied). Section 10-708(g)(3)(ii) does not say what period of time the period referred to in that section must be longer than. In any event, however, the complete answer to whatever point the *Martin* opinion was trying to make is that the record in the present case demonstrates that there has been a well-founded determination that the facts satisfy both subsections (i) and (ii) of § 10-708(g)(3).

The *Martin* opinion argues that § 10-708(g)(3) is in the present tense ("the mental illness symptoms that cause the individual to be a danger to the individual or to others" 114 Md.App. at 526, 691 A.2d at 255 (emphasis supplied)) whereas if the section contemplated dangerousness upon discharge, it would have used the future tense.

The section as written, however, will bear the construction here urged as easily as it would if the future tense had been used. The section is speaking generically of a kind of mental illness symptoms, namely those that cause the individual to be dangerous. The section does not limit its application to dangerousness in the institution. The psychotic delusions that are the symptoms of Mr. Kelly's serious mental illness are such as "cause" patients like him to be dangerous whether in or out of the facility if not professionally treated or otherwise

controlled.

The General Assembly understood that the likelihood of dangerousness was greater in the community than in the hospital. Health-General Art. (2005 Supp.), § 10-806(b)(2)(i) permits conditional release from the hospital if the patient, *inter alia*, "Does not need inpatient medical care or treatment to protect the individual or another." Hospitalization itself is thus recognized as being protective against dangerousness. In addition, § 10-806(b)(2)(i) is clear that the dangerousness that is the concern of the statutory scheme is dangerousness outside and not merely inside the hospital.

C. The Vacated *Martin* Interpretation of § 10-708 Is So Contrary to Experience and Sound Public Policy That the Legislature Could Not Have Intended It.

Even if the language of § 10-708 could arguably be read as Appellee would read it, the construction proposed by Appellant is the one that accords with experience and sound public policy. Unless the statutory language leaves absolutely no choice, an intent to ignore experience and violate sound public policy should not be attributed to the legislature. In the present case, the decision below did just that.

Alexander v. Superintendent, Spring Grove Hospital, 246 Md. 334, 228 A.2d 236 (1967), *Keiner v. Superintendent, Spring Grove Hospital*, 240 Md. 608, 214 A.2d 788 (1965), and *Salinger v. Superintendent, Spring Grove Hospital*, 206 Md. 623, 112 A.2d 907 (1955), hold that involuntarily committed mental patients may not be released from the hospital unless after release they are not dangerous to themselves or others. In light of these holdings, which

the *Martin* opinion did not cite, the *Martin* interpretation would make the hospital a custodial warehouse for nonconsenting patients instead of a provider of the treatment that is the objective of the commitment in the first place.

The *Martin* opinion does not protect but rather subverts the very liberty interest the constitution protects. As previously demonstrated (*supra*, pp.7-9), the record, as well as psychiatric literature and experience, demonstrates that properly administered treatment of mental patients with psychotic delusions is effective and often produces complete relief of the patient's symptoms. Treatment offers the prospect of release from the hospital with the ability to function adequately free from the constraints of hospitalization. The *Martin* opinion ultimately impairs rather than protects patients' liberty interest.

Finally, if the vacated *Martin* decision were correct, the administrative machinery of the statute, which was designed to obviate the necessity for expensive and dilatory judicial guardianships, could be frustrated. Except in an emergency, the patient would not be medicated because dangerousness within the facility could generally be otherwise prevented; and without medication, the patient would continue to have the mental illness – likely aggravated by the lack of treatment – that occasioned the involuntary commitment. The risk of continued hospitalization is highest if lack of medication causes continued ineligibility for release. The risk of continued hospitalization is precisely what § 10-708 was intended to reduce. The *Martin* interpretation would produce the very result that § 10-708 was enacted to prevent.

CONCLUSION

If the decision below stands, a compelling state interest would be severely compromised, physicians would be prohibited from healing mental illness in involuntarily committed patients who reject medication, and such patients who could be cured would be condemned to permanent confinement in mental hospitals because lack of treatment would make them dangerous to themselves and others if they are released.

The decision below should be reversed.

Respectfully submitted,

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June 30, 2006

Pursuant to Maryland Rule 8-504(a)(8), this brief has been prepared with proportionally spaced type: Times New Roman 13 point.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 29th day of June, 2006, two copies of the Brief of The Maryland Psychiatric Society, The Johns Hopkins Health System Corporation, and The Johns Hopkins University, Amici Curiae, were mailed first class, postage prepaid, to: Terri D. Mason, Esquire, Law Offices of Terri D. Mason, 1825 Woodlawn Drive, Suite 106, Baltimore, Maryland, 21207, Irene Smith, Esquire, and Laura Cain, Esquire, Maryland Disability Law Center, 1800 N. Charles Street, Suite 400, Baltimore, Maryland, 21201, and Suzanne Sangree, Esquire, and Roscoe Jones, Jr., Esquire, Public Justice Center, 500 E. Lexington Street, Baltimore, Maryland, 21201, Attorneys for Appellee; and Kathleen A. Ellis, Esquire, Deputy Counsel, and Tracee Orlove Fruman, Esquire, Staff Attorney, Offices of the Attorney General, 301 W. Preston Street, Suite 302, Baltimore, Maryland, 21202, Attorneys for Appellant.

Melvin J. Sykes