IN THE
COURT OF APPEALS OF MARYLAND

September Term, 2015

No. 34

GARY ALLMOND,

Petitioner,

v.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE,

Respondent.

On Appeal from the Circuit Court for Howard County
(Lenore R. Gelfman, Judge)
Pursuant to a Writ of Certiorari to the Court of Special Appeals

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BRIEF OF THE MARYLAND PSYCHIATRIC SOCIETY, THE AMERICAN PSYCHIATRIC ASSOCIATION, THE WASHINGTON PSYCHIATRIC SOCIETY, THE JOHNS HOPKINS HEALTH SYSTEM CORPORATION, THE JOHNS HOPKINS UNIVERSITY, THE SHEPPARD PRATT HEALTH SYSTEM, MEDSTAR HEALTH, THE UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE DEPARTMENT OF PSYCHIATRY, AND NAMI MARYLAND AS AMICI CURIAE IN SUPPORT OF RESPONDENT

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INTEREST OF AMICI CURIAE

The Maryland Psychiatric Society ("MPS") is a Maryland non-profit scientific corporation whose physician members specialize in psychiatry and the diagnosis, treatment, and prevention of mental illnesses. The MPS's mission and objectives are, among others, to improve the evaluation, treatment, rehabilitation, and care of persons treated by psychiatrists, to promote the best interest of actual and potential patients of psychiatrists, and to advance the standards of all psychiatric services and facilities.

The American Psychiatric Association ("APA") is the Nation's leading organization of physicians specializing in psychiatry and has more than 36,000 members. The APA's members are physicians engaged in treatment, research, and forensic activities, and many of them regularly perform roles in the criminal justice system. The Washington Psychiatric Society is the Washington, D.C. metropolitan area district branch of the APA.

The Johns Hopkins University employs physicians through its School of Medicine who provide psychiatric services to patients treated at mental health facilities operated through The Johns Hopkins Health System Corporation. The Sheppard Pratt Health System and MedStar also employ physicians and other professionals who provide mental health services to patients. The University of Maryland School of Medicine Department of Psychiatry trains physicians and provides mental health services, including psychiatric treatment, for children, adults, and geriatric patients.

NAMI Maryland encompasses a statewide network of more than 32,000 families, individuals with mental illness, community-based organizations and service providers, and provides education, support and advocacy services to improve the quality of life for individuals with mental illness and their families.

Amici curiae have substantial knowledge and experience relevant to the issues in this case, and seek to ensure that the legal standards governing the involuntary medication of patients who are committed by court order or involuntarily hospitalized for treatment are based on well-grounded information concerning mental illness and

antipsychotic medications. *Amici* also have an interest in enhancing this Court's appreciation of the adverse consequences for a confined mentally ill patient, other patients and staff at the facility, and health care institutions that result from not administering medications to the patient when those medications are medically appropriate and the only realistic hope of restoring the patient's mental health and securing his or her release from an otherwise significantly longer hospitalization.

The interest of *amici* in this case is limited to the validity of § 10-708(g)(3)(i)(2) and (3) and 10-708(g)(3)(ii)(2) and (3) of the Health-General Article ("HG") of the Maryland Annotated Code (2009 Repl. Vol., 2014 Supp.), which Petitioner, Gary Allmond ("Mr. Allmond"), challenges "on their face." Brief of Petitioner ("Br.") at 12. *Amici* take no position on whether Mr. Allmond should be involuntarily medicated.

STATEMENT OF THE CASE

This is an appeal from an order of the Circuit Court for Howard County (Gelfman, J.) affirming the decision of an Administrative Law Judge ("ALJ") of the Office of Administrative Hearings ("OAH") that Mr. Allmond, an individual who had been committed by court order to Clifton T. Perkins Hospital Center ("Perkins"), may be involuntarily medicated to treat his serious mental illness. Following a hearing held pursuant to HG § 10-708(k), the ALJ found that Mr. Allmond had refused medication prescribed by a psychiatrist for the purpose of treating a mental disorder diagnosed as schizophrenia; that the administration of the medication represented a reasonable exercise of professional judgment; and that without the medication Mr. Allmond was at substantial risk of continued hospitalization because of remaining seriously mentally ill with no significant relief of, and for a significantly longer period of time with, the mental illness symptoms that resulted in his court-ordered commitment. (E. 12.)

Mr. Allmond filed a Petition for Judicial Review challenging the ALJ's decision and the constitutionality of HG § 10-708. (E. 2; 4.) Following a hearing, the Circuit Court concluded that "the statute does not unreasonably abridge [Mr. Allmond's] rights"

and affirmed the ALJ's decision. (E. 90; 93.) This Court subsequently granted Mr. Allmond's Petition for a Writ of Certiorari on May 22, 2015.

QUESTION PRESENTED

Has Mr. Allmond, who challenges the facial validity of HG § 10-708(g) under the Maryland Declaration of Rights, established that there are no circumstances under which the statute would be valid?

STATEMENT OF FACTS

In September of 2011, Mr. Allmond was charged in the Circuit Court for Baltimore City with committing first-degree murder by choking and killing his girlfriend. (E. 26.) After he was charged, questions concerning his mental health status arose and he was admitted to Perkins where, pursuant to § 3-105 of the Criminal Procedure Article ("CP") of the Maryland Annotated Code (2008 Repl. Vol., 2014 Supp.), he was evaluated to determine whether he was incompetent to stand trial. (E. 46.) CP § 3-106(b)(1)(ii) provides that "[i]f, after a hearing, the court finds that the defendant is incompetent to stand trial and, because of ... a mental disorder, is a danger to self or the person or property of another, the court may order the defendant committed ... until the court finds that ... the defendant no longer is, because of ... a mental disorder, a danger...." Following Mr. Allmond's evaluation, he was adjudicated incompetent to stand trial and committed to Perkins. (E. 46.) The commitment order is not part of the record, but the Event History Information portion of the electronic case record on the Maryland Judiciary Case Search website for *State v. Allmond*, Case No. 111266006, Circuit Court for Baltimore City, reflects that the order was entered on January 4, 2012.

CP § 3-106(c)(1) requires the committing court to hold periodic hearings to determine whether the defendant "continues to meet the criteria for commitment set forth in subsection (b) of this section...." The electronic case record in *State v. Allmond* shows that these hearings have been conducted every six months and that Mr. Allmond's commitment status remains unchanged. Mr. Allmond has been hospitalized at Perkins throughout all of the proceedings in this case.

Dr. Khalid El-Sayed, a board-certified psychiatrist who treated Mr. Allmond at Perkins, was qualified as an expert in psychiatry and testified at the OAH hearing. (E. 24.) Dr. El-Sayed testified that Mr. Allmond suffers from schizophrenia. (E. 25; 27.) Schizophrenia is a mental illness characterized by a constellation of symptoms, including positive symptoms such as delusions, hallucinations, disorganized speech, and disorganized or catatonic behavior, and negative symptoms such as diminished emotional expression and a lack of motivation. *See* American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition: DSM-5* ("DSM-5") at 87-88 (2013). An estimated 1% of the worldwide population has schizophrenia. *See* A. Millier, *et al.*, *Humanistic Burden in Schizophrenia: A Literature Review*, 54 J. Psychiatric Research 85 (2014). Schizophrenia leads to substantial functional and cognitive impairments. *See* S.R. Sponheim, *et al.*, *Cognitive Deficits in Recent-Onset and Chronic Schizophrenia*, 44 J. Psychiatric Research 421 (2010); M. Davidson, *et al.*, *Cognitive Effects of Antipsychotic Drugs in First-Episode Schizophrenia and Schizophreniform Disorder: A Randomized, Open-Label Clinical Trial*, 166 Am. J. Psychiatry 675 (2009). Hostility and aggression are common in persons suffering from the disorder and are more likely to occur among those with a prior history of violence, non-adherence with medication, substance abuse, and impulsivity. *See* DSM-5 at 101.

Dr. El-Sayed testified that Mr. Allmond's symptoms include auditory hallucinations, paranoia, grandiose and bizarre delusional thinking, and significant thought disorganization. (E. 27.) His thought disorganization results in "very fluid rambling, disjointed speech that incorporates lots of nonsensical ideas about religion, philosophy, art, telepathy, psychological warfare, delusions that he's been persecuted by various world religions, and an inability to simply answer a question without rambling on, at times for 10 or 15 minutes." (*Id.*) Dr. El-Sayed testified that "Mr. Allmond has, for years, spent hours a day talking to persons unseen" and "[w]hen you approach him, he would say that he's talking telepathically to people elsewhere in the world." (E. 28.)

Prior to being committed to Perkins, Mr. Allmond briefly took fluphenazine, an antipsychotic medication, but stopped, not because of concerns about side effects, but because he believed "he had cured himself" and "did not need medicine. He equated medication for psychiatric symptoms to addictions to heroin or cocaine." (E. 25.) Antipsychotic medication "has well-demonstrated efficacy against overt psychotic symptoms" and has "been the mainstay of treatment of schizophrenia since the mid-twentieth century." R. Hales, *et al.*, eds., *The American Psychiatric Publishing Textbook of Psychiatry* 423, 436 (5th ed. 2008). The American Psychiatric Association's Practice Guideline for treating patients with schizophrenia recommends that antipsychotic medications "be initiated promptly … because acute psychotic exacerbations are associated with emotional distress, disruption to the patient's life, and a substantial risk of dangerous behaviors to self, others, or property." American Psychiatric Association, *Practice Guideline for the Treatment of Patients with Schizophrenia* at 11 (2nd ed. 2004).

Dr. El-Sayed testified that, following Mr. Allmond's commitment, Mr. Allmond "refused to take any antipsychotic medicine for the better part of this hospitalization" and has "repeatedly, over the last few years, told me he does not believe he has a mental illness." (E. 26; 28.) Dr. El-Sayed testified that Mr. Allmond "was getting a little bit worse" shortly before the events triggering the involuntary medication action at issue in this case occurred, and was heard "yelling in the bathroom" on one occasion when "there was nobody else around" and "cursing really loud at a window" on another occasion when "there was nobody else in the room." (E. 28.) Dr. El-Sayed stated that "pointing all of this out to Mr. Allmond did not affect his ability to consider medication." (*Id.*)

Mr. Allmond is not unique in refusing medication based on his belief that he is not mentally ill. "Anosognosia, the inability to recognize one's illness, is thought to affect nearly 50 percent of patients with schizophrenia. Those whose psychotic symptoms are poorly controlled are more likely to possess limited insight into their illness and the need for antipsychotic treatment." J. Williams, *Adjusting Treatment for an Inmate-Patient Receiving Medication Involuntarily*, 43 J. Am. Acad. Psychiatry & L. 223, 226 (2015).

On September 3, 2014, Mr. Allmond became "severely agitated" and threatened to assault a psychologist with a clenched fist during a treatment team meeting when the topic of medication was raised. (E. 29-30.) Stating that the meeting was abruptly stopped, Dr. El-Sayed testified, "I insisted that Mr. Allmond needed medication to help address his acute symptoms. He refused medicine when staff and security approached him. At that point he attempted to assault a staff member." (E. 30.) Dr. El-Sayed stated that Mr. Allmond was placed in "locked door seclusion" following the incident but his psychiatric state, "especially the paranoia and thought disorganization, was worsening." (*Id.*) Dr. El-Sayed testified that because he believed "that was related to the behavior we'd seen here, I pursued a clinical review panel." (*Id.*)

A clinical review panel ("CRP") is responsible for making the determination whether to approve the administration of medication to an individual who objects to the medication. *See* HG § 10-708(a)(2). After a CRP was convened in September of 2014, Mr. Allmond initially refused the oral medications approved by the CRP but ultimately accepted them and showed "remarkable progress." (E. 8.) Treatment may not be approved for longer than 90 days, but if, prior to the expiration of this period, the patient "continues to refuse medication, a panel may be convened to decide whether renewal is warranted." HG § 10-708(m)(2)(i). Dr. El-Sayed testified that Mr. Allmond told him he intended to stop the medication as soon as the CRP expired because he did not believe he had a mental illness. (E. 29.) Dr. El-Sayed requested the CRP to reconvene because he was concerned that "the clinical improvements ... shown over the last 90 days would go away" and "the paranoia and bizarre, delusional thought content would worsen and affect [Mr. Allmond's] behavior more in the absence of antipsychotic medicine." (E. 33.)

The CRP met with Mr. Allmond on December 4, 2014, and approved the medications that Dr. El-Sayed had prescribed. (E. 9.) The CRP found that "[n]o alternative treatments are acceptable to both [Mr. Allmond] and [his] treating physician;" that "[g]iving the recommended medication(s) represents a reasonable exercise of professional judgment;" and that the remaining requirements set forth in HG § 10-

708(g)(3)(i) and (ii) were met. (E. 9.) HG § 10-708(g) authorizes the involuntary medication of an individual when:

> (3) Without the medication, the individual is at substantial risk of continued hospitalization because of:
>
> (i) Remaining seriously mentally ill with no significant relief of the mental illness symptoms that:
>
> 1. Cause the individual to be a danger to the individual or others while in the hospital;
>
> 2. Resulted in the individual being committed to a hospital under this title or Title 3 of the Criminal Procedure Article; or
>
> 3. Would cause the individual to be a danger to the individual or others if released from the hospital;
>
> (ii) Remaining seriously mentally ill for a significantly longer period of time with the mental illness symptoms that:
>
> 1. Cause the individual to be a danger to the individual or to others while in the hospital;
>
> 2. Resulted in the individual being committed to a hospital under this title or Title 3 of the Criminal Procedure Article; or
>
> 3. Would cause the individual to be a danger to the individual or others if released from the hospital; or
>
> (iii) Relapsing into a condition in which the individual is unable to provide for the individual's essential human needs of health or safety.

Pursuant to HG § 10-708(k), Mr. Allmond requested an administrative hearing, which was held on December 18, 2014. (E. 11; 13.) Dr. El-Sayed was the only witness who testified at the hearing. In addition to describing Mr. Allmond's mental illness and the events that led up to the CRP, Dr. El-Sayed testified that his treatment plan was in accordance with the standards of care in the field of medicine and psychiatry, and that the benefits of the medications prescribed outweighed their risks. (E. 41-42.)[1] Dr. El-Sayed

[1] Dr. El-Sayed stated that Mr. Allmond was "currently actively symptomatic" and was taking fluphenazine, but that it had not reached a therapeutic level, noting, "even when I'm seeking involuntary meds, I try to balance the patient's needs with the need for treatment.... And so, I've been a little bit more cautious with adjusting the dose." (E. 34; 37.) He stated that Mr. Allmond was also taking Benadryl (diphenhydramine) to counteract the possible side effects of fluphenazine, which can cause restlessness, tremor, sedation, and weight gain. (E. 35-36.)

also testified that without medications, Mr. Allmond is at substantial risk of continued hospitalization by remaining seriously mentally ill with no significant relief of, and for a significantly longer period of time with, mental illness symptoms that met the criteria set forth in HG § 10-708(g)(3)(i) and (ii). (E. 42-44.)

On December 18, 2014, the same day of the hearing, the ALJ issued a decision authorizing Perkins to administer medications involuntarily. (E. 12.) The ALJ found that Mr. Allmond has schizophrenia and suffers from the paranoia, delusional thinking, and other symptoms of schizophrenia described by Dr. El-Sayed when not on medication. (E. 54.) The ALJ also found that "individualized therapy" and other non-medication interventions have been ineffective in treating Mr. Allmond's mental illness and that, without medication, Mr. Allmond was at substantial risk of continued hospitalization because of remaining seriously mentally ill with no significant relief of, and for a significantly longer period of time with, the mental illness symptoms that resulted in Mr. Allmond being committed to Perkins. (E. 55-57.) Stating that the purpose of the medications prescribed for Mr. Allmond "is to help make [him] healthy again and ... able to leave the hospital and become an active member of society," the ALJ found that the medications recommended and ordered by the CRP "are appropriate given [Mr. Allmond's] symptoms and that it's a reasonable exercise of professional judgment, even considering the side effects that may potentially be involved with them, so that [Mr. Allmond] may receive the treatment of [his] very serious mental disorder." (E. 57-58.)

STANDARD OF REVIEW

Under the standard of review governing this appeal, "a party challenging the facial validity of a statute must establish that no set of circumstances exist under which the [statute] would be valid." *Burruss v. Bd. of Cnty. Comm'rs. of Frederick Cnty.*, 427 Md. 231, 263-63 (2012), quoting *Koshko v. Haining*, 398 Md. 404, 426 (2005). As this Court recently observed, "[w]e do not presume that the Legislature intended to enact unconstitutional legislation and, if it did so intend, we would limit a statute to only those situations in which it would pass constitutional muster." *Harrison-Solomon v. State*, 442

Md. 254, 287 (2015). Questions concerning the constitutional validity of an act of the Maryland General Assembly and the interpretation of the Maryland Declaration of Rights are questions of law subject to *de novo* review. *See DRD Pool Serv., Inc. v. Freed*, 416 Md. 46, 62 (2010).

SUMMARY OF ARGUMENT

Mr. Allmond's facial challenge to the constitutionality of HG § 10-708 should be rejected because the State of Maryland has an overriding interest in administering medically appropriate medication in the circumstances set forth in the statute. No person in Maryland afflicted by mental illness may be committed or hospitalized involuntarily for treatment unless the determination is made that the person presents a danger to the safety of the individual or others. All people with mental illness, including a person such as Mr. Allmond found incompetent to stand trial, have a constitutionally-protected interest in avoiding forced bodily intrusions, such as unwanted medication. But that interest is not absolute and unyielding. Mr. Allmond's commitment status has not changed since 2012 because a court has determined repeatedly, most recently as several months ago, that he remains dangerous. Mr. Allmond also remains at substantial risk of continued hospitalization without medication because, as the ALJ found, he continues to suffer from the same mental illness symptoms that resulted in his commitment. The State has a constitutionally justifiable interest in treating him with medically appropriate medication to reduce the danger these symptoms cause, facilitate his release from confinement by restoring his mental health, and avoid the harm that results from leaving him hospitalized without medication.

ARGUMENT

I. THE STATE HAS A CONSTITUTIONALLY SUFFICIENT INTEREST IN ADMINISTERING MEDICALLY APPROPRIATE MEDICATION IN THE CIRCUMSTANCES SET FORTH IN HG § 10-708(G)(3).

Mr. Allmond contends that he has abandoned his claim under the U.S. Constitution and now seeks relief based solely on the Maryland Declaration of Rights, Br. at 4 n.2, but the cornerstone of his constitutional challenge consists of three cases

representing "[t]he Supreme Court's jurisprudence on involuntary medication." *Id.* at 17. This Court has observed that Article 24 of the Maryland Declaration of Rights and the Fourteenth Amendment to the United States Constitution "are independent and capable of divergent effect," but it has also "noted consistently that, as a general rule, we interpret Article 24 *in pari materia* with the Fourteenth Amendment..., such that pertinent decisions of the Supreme Court are highly persuasive authorities." *Tyler v. City of Coll. Park*, 415 Md. 475, 499-500 (2010). *See also Pack Shack, Inc. v. Howard Cnty.*, 377 Md. 55, 64 n.3 (2003) ("This Court has often 'treated Art. 40 [of the Maryland Declaration of Rights] as being *in pari materia* with the First Amendment' and has stated that the 'legal effect of' both provisions 'is substantially the same.'") (brackets in original), quoting *Sigma Delta Chi v. Speaker*, 270 Md. 1, 4 (1973). The Supreme Court cases discussed in Mr. Allmond's brief demonstrate that, under the standard governing Mr. Allmond's facial challenge and the "strong presumption of constitutionality enjoyed by State statutes," *Burruss v. Bd. of Cnty. Comm'rs. of Frederick Cnty.*, 427 Md. at 263, HG § 10-708 is constitutional.

A. The Right To Refuse Medication Is Not Absolute.

Although an individual has "a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs," *Washington v. Harper*, 494 U.S. 210, 221 (1990), Mr. Allmond acknowledges that "[t]he right to refuse medication is not absolute." Br. at 14. As this Court has stated, "the cases uniformly recognize" that the common law right of a competent adult to refuse medical treatment under non-emergency circumstances "is not absolute" and "is subject to 'at least four countervailing State interests: (1) the preservation of life; (2) the protection of interests of innocent third parties; (3) the prevention of suicide; and (4) the maintenance of the ethical integrity of the medical profession.'" *Mack v. Mack*, 329 Md. 188, 210 n.7 (1993), quoting *Brophy v. New England Sinai Hosp., Inc.*, 497 N.E.2d 626, 634 (Mass. 1986). Similarly, as this Court has observed, although "a competent person has a constitutional right to refuse unwanted medical treatment," the Supreme Court qualified such a right in *Harper*. *Stouffer v. Reid*,

413 Md. 491, 510 (2010). *See also id.* at 512-13 ("the State's interest in maintaining security and order in prison and due deference given to prison officials 'should be considered in addition to the four established compelling state interests' implicated by refusal of medical treatment, as adopted by this Court in *Mack*"), quoting *McNabb v. Dept. of Corr.*, 180 P.3d 1257, 1265 (Wash. 2008).[2]

In *Harper*, the Supreme Court rejected a convicted prisoner's argument that the State "may not override his choice to refuse antipsychotic drugs unless he has been found to be incompetent, and then only if the factfinder makes a substituted judgment that he, if competent, would consent to drug treatment." 494 U.S. at 222. Stating that the prisoner's "suggested rule takes no account of the legitimate governmental interest in treating him where medically appropriate for the purpose of reducing the danger he poses," the Court held that "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." *Id.* at 227-28.

In *Riggins v. Nevada*, 504 U.S. 127 (1992), the Supreme Court concluded that

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[2] As stated previously, Mr. Allmond refused medication because he did not believe he was mentally ill, which the ALJ found that he was, but *amici* assume that Mr. Allmond's refusal of medication was a competent decision. Incompetence to stand trial, involving the inability to understand proceedings or assist in one's defense, *see Godinez v. Moran*, 509 U.S. 389 (1993), is conceptually and practically distinct from competence to make a rational choice about medication. *See* J.W. Berg, *et al.*, *Constructing Competence: Formulating Standards of Legal Competence to Make Medical Decisions*, 48 Rutgers L. Rev. 345 (1996); R.J. Bonnie, *The Competence of Criminal Defendants: Beyond Dusky and Drope*, 47 Miami L. Rev. 539 (1993); *see also Indiana v. Edwards*, 554 U.S. 164 (2008) (holding that a defendant may be competent to stand trial but not competent to represent himself). Empirical data also confirm the distinction between competence to stand trial and competence to consent to treatment, suggesting that "impairment with respect to one legal issue is likely to be a poor proxy for impairment in another." N.G. Poythress, *et al.*, *Adjudicative Competence: The MacArthur Studies* 108 (2002). *See also Williams v. Wilzack*, 319 Md. 485, 509 n.8 (1990) ("The fact that the inmate has been involuntarily institutionalized in a psychiatric facility is not tantamount to a finding that he is mentally incompetent to make treatment decisions."). *But see United States v. Charters*, 863 F.2d 302, 310 (4th Cir.1988) (en banc) ("While in theory there may be a difference between the two mental states, it must certainly be one of such subtlety and complexity as to tax perception by the most skilled medical or psychiatric professionals."), *cert. denied*, 494 U.S. 210 (1990).

"[t]he Fourteenth Amendment affords at least as much protection to persons the State detains for trial," and reversed the conviction of a criminal defendant who claimed he was unconstitutionally administered an antipsychotic drug over his objection during his trial. *Id.* at 135. The Court observed that the State "certainly would have satisfied due process if the prosecution had demonstrated, and the District Court had found, that treatment with antipsychotic medication was medically appropriate and, considering less intrusive alternatives, essential for Riggins' own safety or the safety of others." *Id.* "Similarly, the State might have been able to justify medically appropriate, involuntary treatment with the drug by establishing that it could not obtain an adjudication of Riggins' guilt or innocence by using less intrusive means." *Id.* But reversal was required because the trial court made no determination that "safety considerations or other compelling concerns outweighed Riggins' interest in freedom from unwanted psychotic drugs," nor did the record contain any "finding that might support a conclusion that administration of antipsychotic medication was necessary to accomplish an essential state policy." *Id.* at 136, 138.

In its most recent decision involving the involuntary administration of medication, *Sell v. United States*, 539 U.S. 166 (2003), the Supreme Court reiterated that the right to refuse unwanted medication is not absolute. Stating that forced medication is appropriate for "the purposes set out in *Harper* related to the individual's dangerousness, or purposes related to the individual's own interests where refusal to take drugs puts his health gravely at risk," the Court in *Sell* held that the Constitution also permits the involuntary administration of antipsychotic medication to a criminal defendant "solely for trial competence purposes in certain instances." *Id.* at 180, 182. The Court vacated the judgment in that case upon concluding that the standard it announced for permitting forced medication for trial competence purposes had not been satisfied. But it stated that on remand "[t]he Government may pursue its request for forced medication on the grounds discussed in this opinion, including grounds related to the danger Sell poses to himself or others." *Id.* at 186.

B. The Safety Concerns Justifying Involuntary Medication Are Not Limited To An Individual's Dangerousness Within The Institution.

Citing this Court's discussion of *Harper* in *Dept. of Health and Mental Hygiene v. Kelly*, 397 Md. 399 (2007), Mr. Allmond contends that "the inquiry under *Harper* concerns an individual's *current* behavior." Br. at 22 (emphasis in original). *Kelly* interpreted an earlier version of HG § 10-708 in a manner which limited the administration of involuntary medication to individuals who are dangerous "in the context of the institution." 397 Md. at 436. Stating in his concurring opinion in *Kelly* that such an interpretation "is not Constitutionally required," Judge Wilner observed that *Harper* involved a mentally ill prison inmate "who would remain incarcerated to serve his term with or without the medication. Naturally, the State's focus and that of the Supreme Court was on dangerousness within the institution; no other focus would be relevant." *Kelly*, 397 Md. at 437, 447 (Wilner, J., concurring).

The safety concerns that *Harper* and its progeny recognize as justifying medically appropriate medication are not limited to the danger which a mentally ill person presents in the facility where the individual receives treatment. The Supreme Court in *Harper* noted that the institution where the prisoner in that case was treated was "a facility whose purpose is not to warehouse the mentally ill, but to diagnose and treat convicted felons, with the desired goal being that they will recover to the point where they can function in a normal prison environment." 494 U.S. at 222 n.8. Observing that the medication at issue in *Harper* "may be administered for no purpose other than treatment, and only under the direction of a licensed psychiatrist," the Court stated that "there is little dispute in the psychiatric profession that proper use of the drugs is one of the most effective means of treating and controlling a mental illness likely to cause violent behavior." *Id.* at 226.

As was the facility in *Harper*, Perkins is an institution designed "to provide treatment or other services for individuals who have mental disorders." HG § 10-101(e)(1). Individuals such as Mr. Allmond are not sent to Perkins to be warehoused. They are hospitalized there for treatment, which the Health-General Article defines as

"any professional care or attention given ... to improve or to prevent the worsening of a mental disorder." *Id.*, § 10-101(i). Some individuals are committed to Perkins, as Mr. Allmond was, by court order pursuant to CP § 3-106 upon being found dangerous and incompetent to stand trial. Others are sent there after a verdict of not criminally responsible, *see* CP § 3-112, or following the determination that the conditions of involuntary hospitalization set forth in HG § 10-632 have been met. As this Court has observed, "dangerousness is 'the norm for defendants institutionalized at Perkins.'" *State v. Ray*, 429 Md. 566, 573 n.5 (2012), quoting *Ray v. State*, 410 Md. 384, 419 (2009). The treatment provided at Perkins and similar facilities is intended to eliminate the danger these individuals present and facilitate their release from hospitalization. *See Williams v. Wilzack*, 319 Md. 485, 508 (1990) ("Manifestly, the institution is charged with a statutory duty to treat Williams for his mental disorder to permit him to rejoin society.").

No person who is committed or involuntarily hospitalized for treatment can be released unless the determination is made that the person is not dangerous. *See* CP §§ 3-106(b) and (c), 3-112(c)(2), and 3-114(b); HG § 10-632(e). The only danger-related restriction that the Supreme Court has imposed on the involuntary administration of medically appropriate medication to an individual who has been confined in these circumstances is that the decision be based on the individual's current mental health status. Noting that the defendant in *Sell* had been confined for a lengthy period and that his "medical condition may have changed over time," the Supreme Court directed that on remand the Government base its request for involuntary medication on "current circumstances." 539 U.S. at 186. *See also United States v. Charters*, 863 F.2d 302, 314 (4th Cir.1988) (en banc) (instructing that on remand, because "[c]onsiderable time has elapsed" since the involuntary medication decision at issue had been made, "before medication is administered the appropriate medical professionals reevaluate the situation in light of present conditions and make a new decision before proceeding"), *cert. denied*, 494 U.S. 210 (1990). As one court stated, "[a] commitment court's determination is temporal," and "a hospital may not rely on a commitment court's determination unless

such an assessment was made close in time to the hospital's decision to medicate." *Jurasek v. Utah State Hospital*, 158 F.3d 506, 512 (10th Cir.1998).

In this case, nothing has changed since the time Mr. Allmond was committed to Perkins based on the determination by the Circuit Court for Baltimore City that he was dangerous and otherwise met the criteria for commitment. As recently as July 8, 2015, the Circuit Court found that Mr. Allmond continues to meet these criteria and that he should not be released from Perkins. *See State v. Allmond*, Case No. 111266006, Circuit Court for Baltimore City (Maryland Judiciary Case Search). Mr. Allmond also continues to suffer from the same mental illness symptoms that, as the ALJ in this case found, resulted in his commitment and, without medication, place him at substantial risk of continued hospitalization.

Addressing the prior version of HG § 10-708, which a majority of this Court held authorized involuntary medication only when the patient is dangerous during the hospitalization, Judge Wilner stated in his separate concurrence that "[w]hen the patient is under court commitment pursuant to CP § 3-106, the issue of dangerousness for purposes of HG § 10-708... must be viewed from the perspective of the community, because that is what will control the patient's release." *Dept. of Health and Mental Hygiene v. Kelly*, 397 Md. at 447 (Wilner, J., concurring) (emphasis omitted). Section 10-708 has since been amended and now makes explicit that the involuntary administration of medically appropriate medication is authorized when the patient's release without medication would be a danger to the community.

Section 10-708 constitutionally permits involuntary medication in these and the other circumstances set forth in subsection (g)(3). Although the ALJ failed to find that Mr. Allmond's mental illness symptoms would cause him to be a danger if released, the lack of such a finding makes no difference in Mr. Allmond's facial challenge to § 10-708's validity.[3] *Harper* and its progeny make clear that the State has an overriding

[3] The ALJ concluded that the evidence did not support a finding that Mr. Allmond was a danger to himself or others while at the hospital, stating that "there's been one incident back in September [2014] that was pretty significant," but that "I do see that as an

interest in treating a mentally ill person with medically appropriate medication when the individual's dangerousness resulted in court-ordered commitment or involuntary hospitalization, and is the sole reason why the person remains hospitalized and is not released.[4] These "safety considerations" lay at the heart of the legislature's determination that the administration of medically appropriate medication in the circumstances enumerated in HG § 10-708(g)(3) is "an essential state policy." *Riggins v. Nevada*, 504 U.S. at 136, 138.

C. The State's Interests In Treating Confined Mentally Ill Individuals Are Important And Outweigh The Individuals' Right To Refuse Medication.

Citing *Sell*, Mr. Allmond acknowledges "the possibility that some individuals" who are not a danger while in the hospital "will face longer commitment" absent medication, but he contends that the right of these individuals to make their own treatment decisions outweighs the State's interest here. Br. at 29. In holding in *Sell* that the government could forcibly medicate an individual to render him competent to stand trial, the Supreme Court recognized that "[t]he Government's interest in bringing to trial an individual accused of a serious crime is important." 539 U.S. at 180. But the Court noted that "[s]pecial circumstances may lessen the importance of that interest. The defendant's failure to take drugs voluntarily, for example, may mean lengthy

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isolated incident, though I don't believe that by a preponderance of the evidence it's been proven that without these medications he will continue to be a danger to himself or others while in the hospital." (E. 55-56.) The ALJ stated that for "similar reasons" she did not find that without medication Mr. Allmond would be a danger to himself or others if released from Perkins, noting that "it has been some period of time" since he was committed to Perkins and that the evidence presented at the hearing did not cause the ALJ to believe that Mr. Allmond was a danger to anyone, "at least at this time." (E. 56.)

[4] *See also State v. Wood*, 780 N.W.2d 63, 76 (Wis. 2010) (stating that an institution's interest "in treating the underlying mental illness in order to prevent more criminal behavior and prepare the individual for conditional release and for eventual release from the commitment" is an "overriding interest," and that "we do not believe that a finding of present dangerousness is required when considering whether to issue an order to forcibly medicate such an individual"); *Hightower by Dahler v. Olmstead*, 959 F.Supp. 1549, 1560 (N.D.Ga.1996) ("The effective treatment of mentally ill patients who have been committed to CSH is an important governmental interest. The state's power to act in *parens patriae* to insure such treatment is appropriately invoked to accomplish the goal of returning patients to the community at large.") (internal citation omitted).

confinement in an institution for the mentally ill – and that would diminish the risks that ordinarily attach to freeing without punishment one who has committed a serious crime." *Id.* Stating that "it may be difficult or impossible to try a defendant who regains competence after years of commitment during which memories may fade and evidence may be lost," the Court observed that, in such circumstances, "[t]he potential for future confinement affects, but does not totally undermine, the strength of the need for prosecution." *Id.*

Here, in contrast, the continued confinement of committed and involuntarily hospitalized individuals who suffer from mental illness does not lessen the governmental interest embodied in HG § 10-708(g) but rather underscores the importance of treating these individuals with medically appropriate medication. "[C]onfinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 601 (1999). A ruling which would allow a person with mental illness to remain confined without medically appropriate medication when the individual needs such treatment would exacerbate these harms and have other significant adverse consequences.

Languishing without treatment leaves in place the suffering and impairment of functioning that psychoses cause – the core reasons for medication qualifying as medically appropriate. *See* R. Hales, *et al.*, eds., *The American Psychiatric Publishing Textbook of Psychiatry* 436. An estimated 20% of individuals with schizophrenia will attempt suicide and 5-6% of these individuals will succeed. *See* M. Nordentoft, *et al.*, *Suicidal Behavior and Mortality in First-Episode Psychosis*, 203 J. Nervous & Mental Disease 387 (2015); DSM-5 at 104. Studies have also shown that the longer the duration of untreated psychosis, the worse the individual's long-term prognosis. *See* S. Farooq, *et al.*, *The Relationship between the Duration of Untreated Psychosis and Outcome in Low-and-Middle Income Countries: A Systematic Review and Meta-Analysis*, 109 Schizophrenia Research 15 (2009); B.G. Schimmelmann, *et al.*, *Impact of Duration of*

Untreated Psychosis on Pre-Treatment, Baseline, and Outcome Characteristics in an Epidemiological First-Episode Psychosis Cohort, 42 J. Psychiatric Research 982 (2008); M. Marshall, *et al.*, *Association between Duration of Untreated Psychosis and Outcome in Cohorts of First-Episode Patients: A Systematic Review*, 62 Archives Gen. Psychiatry 975 (2005).

Patients who take antipsychotics to treat schizophrenia are also likely to experience relapse if treatment is discontinued. Relapse rates of more than 90% have been reported, even for a single-psychotic episode, two years after medication discontinuation. *See* R. Emsley, *et al.*, *Symptom Recurrence Following Intermittent Treatment in First-Episode Schizophrenia Successfully Treated for 2 Years: A 3-Year Open Label Clinical Study*, 73 J. Clin. Psychiatry 541 (2012); M. Gitlin, *et al.*, *Clinical Outcome Following Neuroleptic Discontinuation in Patients with Remitted Recent-Onset Schizophrenia*, 158 Am. J. Psychiatry 1858 (2001). *See also* M. Swartz, *et al.*, *Violence and Severe Mental Illness: The Effects of Substance Abuse and Nonadherence to Medication*, 155 Am. J. Psychiatry 226 (1998) (noting that "[a] number of studies have linked medication noncompliance to decompensation and hospital readmission").

"[R]elapse can have devastating repercussions such as worsening of symptoms, progressive cognitive deterioration, impaired functioning and reduced quality of life." J.M. Olivares, *et al.*, *Definitions and Drivers of Relapse in Patients with Schizophrenia: A Systematic Literature Review*, 12 Annals of General Psychiatry 32 (2013). *See also* J.F. Gleeson, *et al.*, *A Randomized Controlled Trial of Relapse Prevention Therapy for First-Episode Psychosis Patients: Outcome at 30-Month Follow-Up*, 39 Schizophrenia Bulletin 436 (2013); J.M. Kane, *Treatment Strategies to Prevent Relapse and Encourage Remission*, 68 J. Clinical Psychiatry 27 (2007). The proven risks of discontinuing medication are so significant that some clinical researchers refuse to conduct placebo-based medication studies and consider them unethical. *See* R. Emsley, W.W. Fleishhacker, *Is the Ongoing Use of Placebo in Relapse-Prevention Clinical Trials in Schizophrenia Justified?*, 150 Schizophrenia Research 427 (2013).

Even when a mentally ill person is not physically dangerous in the facility, other people are adversely affected by leaving the individual untreated. The emphasis over the past few decades on the improvement of institutions and their de-institutionalization illustrates the growing importance of the treatment environment. That environment is harmed by exposure to the agitation, disruption, senseless communication, and languishing associated with a mentally ill individual's untreated psychoses. *See* S. Hoge, *et al.*, *A Prospective, Multicenter Study of Patients' Refusal of Antipsychotic Medication*, 47 Archives of Gen. Psychiatry 949 (1990). A recent study also found that individuals with schizophrenia who remained untreated during and after imprisonment were more likely to be violent following release than those who received treatment. *See* R. Keers, *et al.*, *Association of Violence with Emergency of Persecutory Delusions in Untreated Schizophrenia*, 171 Am. J. Psychiatry 332 (2014).

Warehousing afflicted individuals without medication worsens the harm that they and others suffer, including other people with mental illness who cannot receive the treatment they need because of a shrinking supply of available bed-space. *See* Justice Policy Institute, *When Treatment is Punishment: The Effects of Maryland's Incompetency to Stand Trial Policies and Practices* 23 (Oct.2011) (noting the actions of the Maryland Department of Health and Mental Hygiene in "keeping more people in hospitals for longer, resulting in fewer available beds for people who may need ongoing treatment"). Similarly, limiting the administration of involuntary medication only to those individuals who are a danger while in the institution creates an unacceptable risk of injury to hospital staff and others by requiring a patient to deteriorate to the point of dangerousness within a facility before medically appropriate medication may be given.

The General Assembly struck the proper balance in weighing the interest of confined mentally ill patients in refusing unwanted medication and the State's countervailing interest in treating these individuals to reduce the danger they present without medication and the harm associated with a prolonged, untreated commitment. Section 10-708(g) does not unconstitutionally infringe these patients' rights when, as

discussed *infra*, the administration of antipsychotic medications is medically appropriate.

Finally, the State's interest in treating criminal defendants confined under CP § 3-106 to restore their competence to stand trial provides additional support for the facial validity of HG § 10-708(g)(3). As this Court has stated, "[w]hen a defendant is confined under CP § 3-106(b), the purpose of the confinement is to make the defendant competent to stand trial." *State v. Ray*, 429 Md. at 569 n.1. HG § 10-708(g)(3) was amended for the purpose of facilitating the release of committed and involuntarily hospitalized patients, not just pre-trial detainees, by expanding the criteria governing the administration of medically appropriate medication. *See* Revised Fiscal and Policy Note HB 502, Dept. of Legis. Serv., 2014 Session. Nevertheless, the express terms of HG § 10-708(g)(3)(i)(2) and 10-708(g)(3)(ii)(2) extend to individuals who have been committed under "Title 3 of the Criminal Procedure Article," including individuals who have been found incompetent to stand trial. The Supreme Court has made clear that it is constitutionally permissible to administer medication to restore the competence of such individuals when the requirements set forth in *Sell v. United States* are met. *Sell* provides an additional basis for upholding the constitutionality of HG § 10-708(g)(3).

II. THE STATE'S INTEREST IN TREATMENT JUSTIFIES THE INVOLUNTARY ADMINISTRATION OF MEDICATION WHEN IT IS MEDICALLY APPROPRIATE.

Mr. Allmond contends that the 2014 amendments to HG § 10-708(g) "effectively authorize the forcible medication of all individuals who are involuntarily committed," Br. at 24, but the statute's plain language states that medication may not be administered involuntarily unless "[t]he medication is prescribed by a psychiatrist for the purpose of treating the individual's mental disorder" and "[t]he administration of medication represents a reasonable exercise of professional judgment." § 10-708(g)(1), (2). The statute recognizes, therefore, that medication is not the approved treatment in all cases. Rather, involuntary medication is authorized in the circumstances listed in § 10-708(g)(3)

only when the treatment is medically appropriate. *See Harper*, 494 U.S. at 227.[5]

Virtually all medications, whether psychiatric or non-psychiatric, involve side effect risks to be considered in determining whether a particular drug is medically appropriate. *See, e.g.*, A. Komaroff, ed., *Harvard Medical School Family Health Guide* 1152 (2004) ("Every medication, including nonprescription drugs, has the potential to cause side effects or adverse reactions."). This fact is recognized, for example, in the longstanding law governing drug approval under which "safety" is determined by balancing risks and benefits. *See FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 142 (2000) ("[V]irtually every drug or device poses dangers under certain conditions."); *id.* at 140 ("safety" under the Food, Drug, and Cosmetic Act means that a drug's or device's "probable therapeutic benefits must outweigh its risk of harm"). Medical decisions always involve balancing such risks against the benefits of the medication in relieving suffering and improving functioning. *See United States v. Weston*, 255 F.3d 873, 876-77 (D.C. Cir.2001) (medical appropriateness, as judged by professionals, is measured "by examining the capacity of antipsychotic drugs to alleviate [the individual's] schizophrenia (the medical benefits) against their capacity to produce harm (the medical costs, or side effects)"). That balance is part of the medical appropriateness determination itself, whether the subject is medication for a mental or non-mental illness.

Antipsychotic medications have long been an accepted and often irreplaceable treatment for many psychotic illnesses, particularly schizophrenia, because the benefits of antipsychotic medications, compared to any other available means of treatment, outweigh their acknowledged side effect risks. These benefits were present for the antipsychotic medications prevalent in 1990 when *Harper* was decided, *e.g.*, haloperidol (Haldol),

[5] The CRP's determination of medical appropriateness is entitled to substantial deference. *See Youngberg v. Romeo*, 457 U.S. 307, 322-23 (1982) (holding that "courts must show deference to the judgment exercised by a qualified professional" and that "liability may be imposed only when the decision by the professional is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment").

thiothixene (Navane), chlorpromazine (Thorazine), thioridazine (Mellaril), fluphenazine (Prolixin), and trifluoperazine (Stelazine). *See* B.J. Sadock, *et al.*, *Kaplan & Sadock's Comprehensive Textbook of Psychiatry*, ch. 31.17, at 3105-26 (9th ed. 2009) ("first-generation antipsychotics"). They are also present for the post-*Riggins* generation of antipsychotic medications, such as risperidone (Risperdal), olanzapine (Zyprexa), quetiapine (Seroquel), aripiprazole (Abilify), and ziprasidone (Geodon). *See id.*, ch. 31.28, at 3206-40 ("second-generation antipsychotics").[6]

Many complementary therapies, including family therapy, cognitive behavioral therapy, and skills training, are used in the treatment of schizophrenia when the symptoms have been stabilized with antipsychotic medications. Although these strategies usually carry little risk of adverse events, none has been shown to be effective without concurrent antipsychotic medications. The American Psychiatric Association recommends many of these adjunctive treatments as appropriate during the stable phase of the illness. *See* American Psychiatric Association, *Practice Guideline for the Treatment of Patients with Schizophrenia* at 104-14.

The accepted standard of care governing the administration of antipsychotic medications fully accounts for side effect risks, reflecting the devastating character of the illnesses being treated.[7] The Supreme Court reviewed some of the side effect risks of the older antipsychotic medications in *Harper* and *Riggins*. *See Harper*, 494 U.S. at 229-30 (describing acute dystonia; akathesia; neuroleptic malignant syndrome; and tardive

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[6] *See also* American Psychiatric Association, *Practice Guideline for the Treatment of Patients with Schizophrenia* at 26 ("Treatment with antipsychotic medication is indicated for nearly all episodes of acute psychosis in patients with schizophrenia....These include the first-generation antipsychotic medications and the second-generation (sometimes referred to as 'atypical') agents clozapine, risperidone, olanzapine, quetiapine, ziprasidone, and aripiprazole."); *id.* at 66-95 (listing benefits and side effects).

[7] *See* J.M. Gorman, *The Essential Guide to Psychiatric Drugs* 197-98 (revised and updated ed. 2007) ("[T]here is no debate that schizophrenia is a horrible illness. It strikes people in late adolescence to early adulthood and often never goes away....[Most] endure many hospitalizations, are unable to work, and have little social interaction. Schizophrenia devastates the early adult years of most patients....The patient lives in his or her own world, entertaining bizarre ideas and listening to voices. He may talk without making sense, pace the floors all night, and occasionally become violent or threatening.").

dyskinesia); *Riggins*, 504 U.S. at 134; *id.* at 141-43 (Kennedy, J., concurring). As one court observed, "[a]ntipsychotic drugs have progressed since Justice Kennedy discussed their side effects in *Riggins*." *United States v. Weston*, 255 F.3d at 886 n.7. Side effects also can be monitored and typically controlled by lowering dosages or adding counteracting medication. *See, e.g.,* P.M. Haddad, *et al.*, *Nonadherence with Antipsychotic Medication in Schizophrenia: Challenges and Management Strategies*, 5 Patient Related Outcome Measures 43, 45 (2014). The medication determination for a particular individual with a specific diagnosis is subject to the normal balancing of benefits and risks that applies when any kind of drug, psychiatric or otherwise, is considered, *i.e.*, on a case-by-case basis, as occurred in this case.[8]

Mr. Allmond contends that the medications "manipulate his thoughts and his ability to communicate," Br. at 32, but medications, when used properly to treat the severely mentally ill, positively affect free speech interests by enhancing abilities to concentrate, read, learn, and communicate. Medically appropriate medications aim to clear the hallucinations and delusions produced by psychosis and to allow the patient to

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[8] Two observations are worth noting with respect to one of the more serious potential side effects, tardive dyskinesia ("TD"). First, "[a]lthough the risk of TD is frightening and serious, so is the risk of allowing acute psychosis to remain uncorrected." J.M. Gorman, *The Essential Guide to Psychiatric Drugs* 219. Second, "TD virtually never develops after only a few weeks or months of taking the antipsychotic drugs." *Id.* "The incidence of tardive dyskinesia is about 5% per year of drug exposure for patients taking first generation antipsychotic drugs . . . . In about 2% of cases, tardive dyskinesia is severely disfiguring." C.A. Tamminga, *et al.*, "Clinical Psychopharmacology and Cognitive Remediation in Schizophrenia," *in* G.O. Gabbard, ed., *Gabbard's Treatments of Psychiatric Disorders* 327, 332-33 (4th ed. 2007). Although tardive dyskinesia has been reported with the newer generation of antipsychotic medications, the incidence appears to be substantially reduced. *See* C.U. Correll & E.M. Schenk, *Tardive Dyskinesia and New Antipsychotics*, 21 Current Opinion in Psychiatry 151 (2008).

Mr. Allmond's certiorari petition discussed the possibility of "fatal" side effects, an apparent reference to neuroleptic malignant syndrome ("NMS"). That syndrome is rare: "Although estimates of the incidence of NMS once ran as high as 3% of patients treated with antipsychotics, more recent data suggest an incidence of 0.01%-0.02%." J.R. Strawn, *et al.*, *Neuroleptic Malignant Syndrome*, 164 Am. J. Psychiatry 870 (2007). The declining incidence of the syndrome is the result of increased awareness and efforts at prevention, as is the declining incidence of mortality, which is now estimated at 5-10% of those few patients who develop the syndrome.

recognize and control their dominating influence, thereby alleviating the mental suffering and functional impairments that characterize severe mental illness.[9]

Just as significantly, Mr. Allmond does not dispute that the State may administer medication that is medically appropriate. Rather, he argues only that "the State has not proffered a sufficient interest to warrant hindering Mr. Allmond's ability to think and communicate as he sees fit." Br. at 32. For the reasons stated previously, the State has a constitutionally sufficient interest in treating individuals with medication in the circumstances set forth in HG § 10-708(g)(3). This Court should uphold the statute.

CONCLUSION

For the reasons stated, this Court should affirm the judgment of the Circuit Court for Howard County.

Respectfully submitted,

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[9] *See* J.D. Preston, *et al.*, *Consumer's Guide to Psychiatric Drugs* 17 (2008) ("These days, when people are treated with modern psychiatric medications, one of the most common remarks therapists hear once the drugs begin to take effect is this: 'I am beginning to feel like myself again.' This is a very important point to emphasize. Although some medications do have unpleasant side effects, and some misuse of these drugs certainly continues, the goal of appropriate psychiatric treatment is twofold: to reduce human suffering and to promote the development and expression of autonomy. This a far cry from the chemical straitjackets of the mental hospitals' back wards in the 1950s."); T.G. Gutheil & P.S. Appelbaum, *"Mind Control," "Synthetic Sanity," "Artificial Competence," and Genuine Confusion: Legally Relevant Effects of Antipsychotic Medication*, 12 Hofstra L. Rev. 77, 119 (1983) (antipsychotic medications "reinforce the most important aspects of mental functioning").

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I HEREBY CERTIFY that on this 21st day of October, 2015, two copies of the foregoing Brief were mailed, postage prepaid, to:

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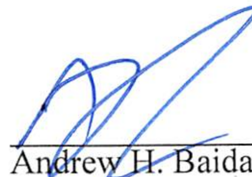

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