example, Prisoners' Resources of Massachusetts sends attorneys to meet with and guide incarcerated people. NYU's National Jailhouse Lawyer's Initiative aims to make general guidance and paralegal training available to incarcerated people. These initiatives are laudable, but the circumstances that cause indigent incarcerees to rely on jailhouse lawyers are unfortunate.

Administration of Involuntary Medication to Restore Competence to Stand Trial

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Defendant's Rights Are Not Violated When Administrative Agencies Rather than Criminal Courts Authorize Involuntary Medication to Restore Competence to Stand Trial

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Key words: psychotropic medication; involuntary treatment; competence to stand trial; competency restoration; Maryland

In *Johnson v. Md. Dep't of Health*, 236 A.3d 574 (Md. 2020), the Court of Appeals of Maryland considered whether involuntary medication for competency restoration could be authorized using an administrative procedure rather than a hearing before the criminal court. The court held that Maryland's separation of powers and a defendant's due process rights are not violated when an administrative law judge authorizes such medication.

Facts of the Case

In 2010, Gregory Johnson began believing that people were harassing and tracking him, causing him to move his place of residence frequently. In 2018 and 2019, Mr. Johnson became suspicious that one of his neighbors was breaking into his apartment to have sexual relations and steal his belongings. Mr. Johnson confronted his neighbor on May 15, 2019, allegedly stabbing the neighbor with a knife in his stomach and torso, causing serious injury. Mr. Johnson was subsequently charged with attempted first-degree murder and several related offenses.

In July 2019, after the court found Mr. Johnson not competent to stand trial, he was committed to Clifton T. Perkins Hospital Center (Perkins) for treatment and restoration to competence. At Perkins, Mr. Johnson was diagnosed with unspecified schizophrenia spectrum and other psychotic disorder, and he was prescribed antipsychotic medications. He was nonadherent with the medications and continued to exhibit psychotic symptoms, which led Perkins to convene a clinical review panel (CRP) to authorize involuntary medication.

Under Maryland law at the time, involuntary medication could be authorized by a CRP if a patient would, without the medication, continue to experience symptoms of the disorder that led to the hospital commitment, pose a danger within the hospital, or pose a danger if released from the hospital (Md. Code Ann., Health-Gen. § 10-708 (2019)). On August 15, 2019, the CRP heard Mr. Johnson's case and approved the administration of involuntary medications. The CRP concluded the proposed medication regimen was appropriate to treat Mr. Johnson's illness and that all three justifications for involuntary medication were applicable in his case.

Soon afterward, Mr. Johnson appealed the CRP's decision, requesting a *de novo* hearing before an administrative law judge (ALJ) from the Office of Administrative Hearings. After hearing testimony from Mr. Johnson and his treatment providers, the ALJ concluded that Perkins had met all requirements to administer involuntary medication under Md. Code Ann., Health-Gen. §10-708. The ALJ found that Mr. Johnson required medication because, without it, he would continue to experience the symptoms that resulted in his hospitalization and would pose a danger if released from the hospital. The ALJ also noted that the state had satisfied the four criteria set forth in *Sell v. United States*, 539 U.S. 166 (2003) to administer involuntary medication for the purpose of competency restoration.

Mr. Johnson appealed the decision to the circuit court, which upheld the ALJ's order. He then appealed to the Maryland Court of Appeals, arguing that the ALJ had exceeded the authority of that position by ordering involuntary medication to restore competence to stand trial. The court granted *certiorari* to consider this question.

Ruling and Reasoning

In challenging the involuntary medication order, Mr. Johnson argued that the ALJ's authority was exceeded for two reasons. First, he stated that Md. Code Ann., Health-Gen. § 10-708 does not allow involuntary medication to be administered solely for the purpose of competency restoration. Second, he argued that the ALJ lacks jurisdiction to make a determination of competency and should have deferred the decision about involuntary medication to the criminal trial court.

To support his first argument, Mr. Johnson asserted that Md. Code Ann., Health-Gen. § 10-708 allows for involuntary medication only when an individual is both incompetent to stand trial and dangerous within the hospital. The court of appeals disagreed. The court noted that the legislative intent of Md. Code Ann., Health-Gen. § 10-708 was to include three different justifications for involuntary medication, not just dangerousness within the hospital. The court also noted that many defendants could never be restored to competence if Perkins were allowed to administer medication only to address dangerousness within the hospital, which would result in unsatisfactory outcomes for the state, defendants, and victims in criminal cases.

Second, Mr. Johnson argued that the ALJ lacks jurisdiction to decide whether incompetent defendants can be administered involuntary medication. He argued that the separation of powers mandated by Article 8 of the Maryland Declaration of Rights (2018) is violated when such determinations are made by an administrative agency like the Department of Mental Health or the Office of Administrative Hearings, rather than the criminal court judge. The court of appeals rejected this argument. The court concluded that the ALJ had not made a finding about competency during the involuntary medication hearing, so the ALJ did not usurp the criminal court's power to decide those matters.

Mr. Johnson also argued that his procedural due process rights were violated by the administrative process for involuntary medication set forth in Md. Code Ann., Health-Gen. § 10-708. In considering this question, the court applied a balancing test, weighing three factors: the private interest affected by the state's action, the state's interest, and the risk of erroneous deprivation of that interest through the current involuntary medication procedures. The court first acknowledged that both Mr. Johnson and the state had compelling interests related to involuntary medication. In considering the risk of erroneous deprivation of those interests, the court examined the specific parts of the involuntary medication procedure with which Mr. Johnson found fault.

Mr. Johnson stated that the involuntary medication process in Md. Code Ann., Health-Gen. § 10-708 was flawed because he should have been able to raise the affirmative defense that he was already competent, because an ALJ is more likely to misapply the *Sell* criteria than the criminal trial court, and because he was deprived of access to his criminal defense attorney during the administrative hearing. The court of appeals disagreed with all three claims. The court noted that Mr. Johnson could have filed a motion with the criminal court to have his competency reexamined if he believed he was already competent, which he did not do. Similarly, Mr. Johnson could have asked his criminal defense attorney to assist with the involuntary medication hearing, and he did not do so. Finally, the court rejected the idea that the *Sell* criteria are too complex for an ALJ to handle, noting that both an ALJ and a trial judge would rely primarily on testimony from medical experts to inform their decisions. Furthermore, the court noted that the ALJ in Mr. Johnson's case had properly applied the *Sell* criteria, including requiring clear and convincing evidence that the criteria had been met before authorizing involuntary medication.

The court of appeals held that the ALJ's order authorizing involuntary medication did not violate Maryland's separation of powers and complied with Mr. Johnson's rights to procedural due process.

Discussion

Although the holding in *Sell* empowered criminal courts to make decisions about involuntary medication to restore competence to stand trial under certain circumstances, the *dicta* in *Sell* suggested that alternative pathways can and should be utilized. As the majority opinion noted, "A court need not consider whether to allow forced medication for [competency restoration] if forced medication is warranted for a different purpose, such as the purposes set out in *Washington v. Harper*, 494 U.S. 210 (1990), 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" (*Sell*, p 181–182). *Johnson v. Md. Dep't of*

Health makes clear that Maryland's administrative process for authorizing involuntary medication is not only compatible with the *Sell* decision but actually encouraged by it.

The outcome in this case will likely be appreciated by psychiatrists who treat patients in competency restoration programs. As Norko *et al.* noted (Norko MA, Cotterell MS, Hollis T. The Connecticut experience with *Sell* legislation. J Am Acad Psychiatry Law. 2020; 48:473–483), alternative pathways to involuntary medication such as probate court proceedings are much less cumbersome than *Sell* hearings in criminal court. In a study comparing Connecticut's two pathways to involuntary medication, the probate court pathway was found to be more efficient because of its weekly hearings and the judges' familiarity with mental illness and psychiatric medication (*Norko*, p 482). It took significantly longer to schedule an involuntary medication hearing in the criminal court, where such matters are rarely heard and judges have less experience making decisions about medical care.

Given those facts, most psychiatrists would prefer to have the option of pursuing involuntary medication in a civil setting. Limiting the options for involuntary medication to the criminal court would leave patients suffering with their psychiatric symptoms and without beneficial treatment for a longer period. This is concerning from a provider's perspective because, for many serious mental illnesses, any lag in initiating treatment can significantly worsen the patient's long-term prognosis. Although the decision in *Johnson* was not based primarily on the court's desire to restore the defendant's health quickly, the end result will likely have a positive impact on the physical well-being of patients in Maryland's competency restoration programs.

Court-Ordered Disclosure of Mental Health Records Without a Patient's Consent

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Circuit Court Did Not Apply the Correct Legal Standard When Considering Whether to Order the Release of Confidential Mental Health Records

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Key words: disclosure; confidentiality; mental health records; balancing test; *in camera* review

In *St. Luke Inst., Inc. v. Jones,* 241 A.3d 886 (Md. 2020), the Maryland Court of Appeals considered the judgment of the Maryland Court of Special Appeals that reversed the order of the Circuit Court for Prince George's County. This order directed St. Luke Institute to produce a deceased patient's mental health records under seal.

Facts of the Case

The plaintiffs in a civil case in Massachusetts alleged they were sexually abused by Brother Edward Anthony Holmes while residing in a children's group home that employed Brother Holmes. Their claims alleged negligent hiring and supervision against the Roman Catholic Archbishop of Boston and the Congregation of Sacred Hearts, entities associated with the group home.

Andre Jones, the lead plaintiff, asserted that documents in discovery in the Massachusetts civil case noted Brother Holmes underwent psychotherapy at St. Luke Institute (SLI), a Catholic mental health treatment center located in Maryland, in the early 1990s, and there were two psychiatric evaluation reports resulting from that care. The documents that were obtained in discovery highlighted and summarized a "caution" from the 1993 SLI evaluation report stating, "[T]here are no reported signs that [Brother Holmes] has been sexually inappropriate. However, we would caution Brother Holmes and his order: there are many signs of risk that should not lightly be dismissed" (*St. Luke Inst.,* p 890). The report also noted Brother Holmes had "not worked through his experience of being molested as a child" (*St. Luke Inst.,* p 890). After Mr. Jones learned of these evaluations, he requested that the reports and associated records be produced by the defendants in the Massachusetts case, as he contended that "what was known about Holmes' propensity to sexually abuse