Justice Albin's dissenting opinion, in which Justice Long joined, stated that the burden of proof should require the state to prove beyond a reasonable doubt that the defendant is not mentally retarded, because shifting the burden to the defendant "increases the likelihood of wrongly executing a mentally retarded person" (*Jimenez*, 908 A.2d, p 182).

Discussion

In 1989, in *Penry v. Lynaugh*, 492 U.S. 302 (1989), the U.S. Supreme Court ruled that, due to lack of national consensus, applying the death sentence to the mentally retarded was not categorically prohibited by the Eighth Amendment; however, the defendant could use mental retardation as a mitigating factor. The Court explained that, although the Eighth Amendment categorically prohibits punishments considered cruel and unusual under evolving societal standards of decency, there was insufficient evidence of a national consensus against the execution of mentally retarded people convicted of capital offenses.

In 2002, the question of whether it is constitutional for the state to execute a mentally retarded defendant who had been found guilty of a capital offense was again before the Court. In *Atkins*, the Court reversed *Penry* and ruled that executing a mentally retarded individual is cruel and unusual punishment. The majority, Justices Stevens, O'Connor, Kennedy, Souter, Ginsburg, and Breyer, based their opinion on the "evolving standards of decency" as reflected by the actions of the lower courts and state legislatures.

Justice Rehnquist filed a dissenting opinion in which Justices Scalia and Thomas joined. He stated that: (1) the execution of offenders who were mildly mentally retarded would not have been considered cruel and unusual punishment when the Eighth Amendment was adopted; and (2) the fact that 18 states, which was less than half the number that permitted capital punishment, had enacted legislation barring the execution of criminals who were mentally retarded was not sufficient to establish a national consensus, especially since only 7 of those states had barred all such executions.

The Court left it to state legislatures and the lower courts to describe the procedures to be followed when resolving an *Atkins* claim, which was what the Supreme Court of New Jersey did when it ruled in *Jimenez III*.

In 2006, the New Jersey Legislature created the New Jersey Death Penalty Study Commission, which was in charge of studying all aspects of the death penalty as it is administered in New Jersey. In January 2007, the commission released its report to the legislature and recommended that:

> [T]he death penalty in New Jersey be abolished and replaced with life imprisonment without parole, to be served in a maximum security facility. The Commission also recommends that any cost savings resulting from the abolition of the death penalty be used for benefits and services for survivors of victims of homicide [New Jersey Death Penalty Study Commission Report, January 2007, page 67].

As a result, the Senate and the General Assembly of New Jersey passed Bill 5171 repealing the death penalty, "An Act to allow for life imprisonment without eligibility for parole when certain aggravators exist and to repeal the death penalty, amending N.J. Stat. Ann. 2C: 11-3 and N.J. Stat. Ann. 2B:23-10, repealing P.L. 1983, c.245, and supplementing Title 2C of the New Jersey Statutes" (2007 N.J. ALS 204; 2007 N.J. Ch.204; 2006 N.J. S.N. 171). On December 17, 2007, Governor Corzine signed the bill, making New Jersey the first state to abolish the death penalty by passing a law (Peters JW: Corzine Signs Bill Ending Executions, Then Commutes Sentences of 8. The New York Times. December 18, 2007, B3).

The issues raised in *Jimenez III* are now moot in New Jersey. However, states that are in the process of determining how to resolve *Atkins* claims may profit from reviewing the reasoning in *Jimenez II* and *Jimenez III*.

Right to Refuse Treatment

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Dangerousness Within the Institution Must Be Proven to Treat an Involuntarily Committed Individual Over His Objection

In *Dep't of Health & Mental Hygiene v. Kelly*, 918 A.2d 470 (Md. 2007), the Court of Appeals of Maryland unanimously upheld the Circuit Court for Baltimore City's ruling that Section 10-708 (g), of the

Health-General Article of the Maryland Code (1982, 2005 Repl. Vol.) requires the state to prove that an involuntarily committed individual is dangerous to himself or others within the institution before it may forcibly administer medication.

Facts of the Case

From 2002 to 2003, Anthony Kelly was charged with multiple violent crimes including murder, rape, assault, and theft. On September 16, 2003, the Circuit Court of Montgomery County ordered an evaluation of Mr. Kelly's competency to stand trial after he decided to represent himself. He was subsequently ordered to the Clifton T. Perkins Hospital, a maximum-security psychiatric hospital operated by the state of Maryland, for evaluation for competency to stand trial. Two examining psychiatrists opined that Mr. Kelly had a mental disorder that influenced his understanding of the adversarial nature of the legal proceedings and therefore he was not competent to stand trial. In addition, both doctors opined that he was considered dangerous, due to his history of violent behavior and his serious charges. On June 3, 2004, the circuit court determined that Mr. Kelly was not competent to stand trial and presumed that he was dangerous to himself and others because of the "gravity of the charges pending." Therefore, Mr. Kelly was committed to Perkins Hospital until he was no longer incompetent to stand trial or considered dangerous. No separate hearing was held regarding Mr. Kelly's dangerousness.

While hospitalized, Mr. Kelly took antipsychotic medications for a period of six months. He then refused any kind of medication because he believed he was not mentally ill. On August 23, 2005, pursuant to § 10-708 (b)(2) of the Health-General Article of the Maryland Code, a Clinical Review Panel approved the involuntary administration of medication to treat Mr. Kelly's delusional disorder. Using language found in § 10-708, the panel opined that without the medication, Mr. Kelly was at risk of a longer period of hospitalization due to his remaining serious mental illness that caused him to be a danger to himself or others.

Mr. Kelly appealed the decision to the Office of Administrative Hearings. During the hearing before an administrative law judge (ALJ), Mr. Kelly's psychiatrist at Perkins Hospital, Dr. Wisner-Carlson, opined that Mr. Kelly had a delusional disorder and that he was a danger to himself and others because he was adjudicated as dangerous by the circuit court during his competency hearing. However, Wisner-Carlson was unable to identify any threatening or aggressive behavior by Mr. Kelly during his confinement at Perkins. Nonetheless, the ALJ concluded that the hospital proved by a preponderance of the evidence that Mr. Kelly should be medicated to treat his mental illness and that the circuit court's determination that he was a danger to himself and others was "sufficient to permit forcible medications."

The ALJ decision was reversed by the Circuit Court of Baltimore City based on the Maryland Court of Special Appeals' decision in *Martin v. Dep't of Health & Mental Hygiene*, 691 A.2d 252 (Md. Ct. Spec. App. 1997), (a decision that had been overturned and rendered moot by the Maryland Court of Appeals):

> . . . which held that for purposes of forcible administration of medication, § 10-708 (g) of the Health-General Article requires evidence that an involuntarily committed individual is a danger to himself or others in the context of his confinement within the facility in which he has been committed, rather than to society upon release [*Kelly*, 918 A.2d, p 479].

The Department of Health and Mental Hygiene appealed the Circuit Court of Baltimore City's decision to the court of special appeals. Meanwhile, the Court of Appeals of Maryland issued a writ of *certiorari* before any proceedings in the intermediate appellate court could begin.

Ruling and Reasoning

The Court of Appeals of Maryland unanimously upheld the ruling of the Circuit Court of Baltimore City that Mr. Kelly should not be forcibly medicated. The court held that before individuals involuntarily committed to an institution can be forcibly medicated, the state must prove in accordance with § 10-708 (g) that, because of the individual's mental illness, the individual is dangerous to himself or others while inside the institution.

The court reviewed Maryland's history of involuntary medication legislation to define in which temporal context—past, present, and/or future—the authors of § 10-708 (g) intended dangerousness to be viewed. The court presented a comprehensive review of the evolution of treatment over objection in Maryland, to which we refer all interested scholars. Briefly, in 1984, the Maryland House passed the Mentally Ill

Individuals—Refusal of Medication law (House Bill 1372 (1984)), which permitted involuntary medication if a patient was emergently dangerous, court-ordered to take medication, or simply involuntarily hospitalized. In 1990, the Maryland Court of Appeals applied the Supreme Court decision in *Washington v. Harper*, 494 U.S. 210 (1990) to their decision in *Williams v. Wilzack*, 573 A.2d 809 (Md. 1990), and found that the law provided inadequate procedural and substantive due process protection for the individuals treated with medications over objection. In response to this decision, in 1991, the Maryland General Assembly, with input from the Maryland Psychiatric Society and On Our Own, Inc., changed § 10-708 to provide additional procedural and substantive due process safeguards. Section 10-708, in its current form, permits the forcible administration of medication if, without medication, the individual remains seriously mentally ill and dangerous with no significant relief, remains ill for a significantly longer time, or relapses into essentially being unable to provide for basic human needs and personal safety.

The court further asserted that, because the Maryland Legislature built the new § 10-708 on *Williams* and *Harper* and rejected the possibility that medication could be forced based solely on involuntary commitment, then it must have intended for the circumstances in *Harper* to apply, as well—that is, the patient (like the inmate in *Harper*) had to be dangerous in the context of his confinement before involuntary medication can be undertaken. The court pointed to three federal courts of appeals decisions to bolster its argument: *Morgan v. Rabun*, 128 F.3d 694 (8th Cir. 1997), *Jurasek v. Utah State Hosp.*, 158 F.3d 506 (10th Cir. 1998), and *United States v. Weston*, 255 F.3d 873 (D.C. Cir. 2001). In *Morgan v. Rabun*, the Court of Appeals for the Eighth Circuit found that the administration of psychotropic medication did not violate Mr. Morgan's substantive or procedural due process rights, because the physician had determined that Mr. Morgan was displaying imminently dangerous behavior inside the hospital. In *Jurasek v. Utah State Hospital*, the Court of Appeals for the Tenth Circuit agreed with medication over objection for a patient who was "gravely disabled," but noted that if the hospital was to medicate Mr. Jurasek pursuant to the "immediate danger of physical injury to others or himself" component of the Utah State Hospital policy, it was required to determine whether the individual "poses an immediate danger of physical injury to others or himself" within his current confinement. In *U.S. v. Weston*, the Court of Appeals for the District of Columbia ruled that the record was insufficient to support forcible administration of drugs to Mr. Weston based on dangerousness, because Mr. Weston was in seclusion and under constant observation, which "obviated any significant danger he might pose to himself or others" at the institution.

Based on these federal courts of appeals decisions, *Williams*, and *Harper*, and because there was no finding that Mr. Kelly was dangerous at Perkins Hospital, the Court of Appeals of Maryland affirmed the judgment of the Circuit Court for Baltimore City that Mr. Kelly could not be forcibly medicated.

Discussion

Dep't of Health & Mental Hygiene v. Kelly represents a further tilting of the scales of justice toward a police-powers model of involuntary treatment and away from a treatment-driven philosophy. This case codifies judicial sentiment that has been coalescing for years about the dangerousness criterion for involuntary medication in cases such as *Morgan*, *Jurasek*, and *Weston*.

In essence, understanding the ramifications of *Kelly* rests on understanding *Washington v. Harper*, in which the U.S. Supreme Court held that when a state treats an inmate against his will, the state must balance the inmate's liberty interest to refuse treatment against the state's interest to maintain a safe and secure prison environment. The Court found that "the extent of a prisoner's right under the [Due Process] Clause to avoid the unwanted administration of antipsychotic drugs must be defined in the context of the inmate's confinement" (*Harper*, 494 U.S., p 222).

Kelly extends that reasoning from the prison setting into the hospital. The temporal lens through which dangerousness is viewed has been narrowed, as the court indicated that it is not interested in a person's history of violence before hospitalization or potential for violence once released. The danger, by the Maryland Court of Appeals' standard, must now be imminent and immediate and within the walls of confinement. The court even acknowledged that a probable outcome of this ruling is that individuals will be without effective treatment for longer peri-

ods; require longer, perhaps indefinite, periods of hospitalization; and incur a greater financial cost. What appears lost in the balancing of the liberty interests of avoiding unwanted medication is that remaining involuntarily hospitalized and under the yoke of an untreated mental illness is, in and of itself, a great loss of liberty.

This decision further separates the need for confinement of mentally ill and dangerous individuals to protect society from the need for these ill individuals to receive treatment. The opinion assumes that the lesser restrictive alternative to forced medication is confinement, a holding courts have consistently upheld but one that needs further scrutiny. It is possible to identify a cohort of involuntarily hospitalized patients who are dangerous when outside of an institution; are rendered nondangerous by the security, structure, and services provided inside a hospital; and then become ill and dangerous again after they are discharged.

It deserves comment, although it is perhaps not surprising, that the *Sell* test was not applied to the application for involuntary medication, even though Mr. Kelly was involuntarily hospitalized for the dual purpose of decreasing his dangerousness and restoring his competency to stand trial. In *Sell v. United States*, 539 U.S. 166 (2003), the U.S. Supreme Court opined that for a nondangerous individual to be involuntarily treated for the purpose of competency restoration, the testimony must focus on trial-related side effects and risks of the antipsychotic and how it could affect the defendant's right to a fair trial. In *Kelly*, the issue of competency restoration was not taken into consideration when the request for treatment over objection was brought to the Maryland court. The test was probably not applied because of the state's heeding the Supreme Court's warning in *Sell* that:

> . . . the medical experts may find it easier to provide an informed opinion about whether, given the risk of side effects, particular drugs are medically appropriate and necessary to control a patient's potentially dangerous behavior (or to avoid serious harm to the patient himself) than to try to balance harms and benefits related to the more quintessentially legal questions of trial fairness and competence [*Sell*, 539 U.S., p 182].

If rulings such as *Kelly* proliferate, and dangerousness must be shown to exist inside institutions for ill defendants to be treated properly, *Sell* hearings may become more commonplace.

Competence to Stand Trial

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Feigning Mental Illness Is Punishable by Enhancement of Sentence for Obstruction of Justice

In *United States v. Batista*, 483 F.3d 193 (3rd Cir. 2007), Braulio Antonio Batista knowingly feigned mental illness. His fraud was discovered, and he received a sentence enhancement. He appealed on the grounds that the enhancement was unfair because he was "exploring a potential defense." The enhancement was affirmed.

Facts of the Case

Mr. Batista was arrested September 19, 2002, for being involved in the sale of 450 grams of crack cocaine. He acted as the middleman in a sale between a police informant and the seller. He pleaded guilty to "possessing only 150 grams of crack cocaine." After Mr. Batista had pleaded guilty, his lawyer requested that her client be evaluated to determine whether he was competent to stand trial. He was evaluated at least five times over the next two years. Dr. Barber saw Mr. Batista and opined that he was not competent to stand trial. Later, Dr. Ryan evaluated Mr. Batista and agreed with Barber, but commented that the apparent lack of competence might be the result of malingering. Dr. Ryan suspected malingering, because Mr. Batista did so poorly on an administered memory test that even someone with severe brain damage would have scored better.

The court subsequently asked Dr. Simring to evaluate Mr. Batista. He found that Mr. Batista was "simulating mental illness" and concluded that Mr. Batista was "faking or exaggerating . . . to avoid going to trial." Dr. Ryan re-evaluated Mr. Batista and determined that he was "probably malingering." She stated that, during the evaluation, Mr. Batista had said that he was at home and had opened an imaginary refrigerator and offered her a drink. Dr. Morgan was the final clinician to evaluate Mr. Batista. Morgan (a neuropsychologist) concluded, after examining Mr. Batista, that he was malingering and con-