

Prescription for Death?: Psychotic Capital Defendants and the Need for Medication

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I. Introduction

Derek took a seat at the table, put his hands onto the cold tabletop, and silently stared across at his attorney. Over two years ago, he had been charged with capital murder and now faced a possible sentence of death. But something much more immediate was bothering him today. After he was arrested for the murder of a Chesapeake shop-owner, the court ordered a competency evaluation and hospitalized him after finding him incompetent to stand trial. Following a long process of trial-and-error, during which his treating psychiatrists administered various types and amounts of antipsychotic medication, the doctors finally found an exotic and very expensive drug which seemed to alleviate his psychotic symptoms and Derek was returned to jail. Derek welcomed the clarity of thought and freedom of choice that arrived with this breakthrough.¹

But now he was no longer being given those exotic drugs. For reasons incomprehensible to Derek, he had been moved temporarily to a different jail, where the “good drugs” were not available. So, with sweat dripping down his arms and pooling onto the tabletop, he looked across to his attorney and told him that he needed to go back to the other jail; he was afraid of what he might do if he slipped back into his delusional former self.²

The attorney stared back and contemplated the legal, ethical, and moral issues now before him. If he were to instruct his client to refuse the medication, Derek may stay incompetent to stand trial. But was it ethical to ask his client to

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1. This narrative is based on an account given by attorney Stephen Givando of a meeting which took place during his representation of a capital defendant in early 2004. Telephone Interview with Stephen P. Givando, Givando & Shilling (Jan. 20, 2004).

2. *Id.*

refuse the medication when taking it was truly in his best medical interest? His client had a liberty interest in refusing the administration of medication, but at what cost? Was it worth his client's temporary sanity, and, if so, for how long? If the court ordered him to be medicated regardless, how would he be able to show the jury the mentally ill young man who now sat across the table?³

This article will address several important issues that may arise when a capital defendant is in need of antipsychotics and trial is approaching. Part II will begin by examining the types of mental disorders for which antipsychotic medication is prescribed and the neurological effects of the specific drugs. This Part will also explore potential side-effects that may result from the administration of antipsychotics and compare the advantages and disadvantages of traditional versus new or "atypical" antipsychotics. Part III will address several legal issues that may arise when defending "psychotic" capital defendants and suggest specific strategies to manage those issues during capital proceedings. This Part will also survey recent case law defining a defendant's right to refuse the administration of antipsychotics and the implications of such a refusal for trial strategy. Part IV will address ethical considerations that attorneys may face when representing defendants suffering from psychotic mental illnesses. Finally, Part V will consider jury instructions as a means of safeguarding the due process rights of medicated defendants.

II. *Scientific Analysis*

A. *Uses of Antipsychotics*

The term "psychotic" is commonly used in the modern English language to describe a person who exhibits abnormal or unusually violent behavior.⁴ In the medical profession, however, "psychotic" carries a much more specific meaning. It is used to describe a patient who suffers from a form of psychosis, "a mental disorder characterized by gross impairment in reality testing as evidenced by delusion, hallucinations, markedly incoherent speech, or disorganized and agitated behavior, usually without apparent awareness on the part of the patient of the incomprehensibility of his behavior."⁵ Although various forms of psychoses exist, "[t]he persons most consistently considered

3. *Id.*

4. *See, e.g.*, Desson Thomson, *An Old 'Wives' Tale*, WASH. POST, June 11, 2004, at T41 (describing a disgruntled film character's actions as going into "a psychotic shooting rage"); K.C. Johnson, *Kendall Gill's 'Pizza' Diet*, CHI. TRIB., Oct. 28, 2003, at Sports 10 (quoting Chicago Bulls point guard Kendall Gill as having described his strict adherence to a four thousand calorie-per-day diet as "psychotic").

5. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 1489 (29th ed. 2000); *see* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 273 (4th ed. 2000) [hereinafter DSM IV] (recognizing that while the meaning of the term psychotic is derived from the word "psychosis," various definitions of "psychotic" exist).

psychotic are those suffering from schizophrenia, the severe paranoid disorders . . . the bipolar (manic-depressive) disorder, and the severe depressions.”⁶

An overabundance of dopamine in the brain is a common physiological factor in people suffering from psychosis.⁷ Dopamine is a hormone-like substance that is produced in the human brain and acts as a neurotransmitter.⁸ The dopamine system serves as a mediator of reward-reinforcing mechanisms.⁹ For example, a person who experiences a craving sensation, whether for nicotine, alcohol, caffeine, or even extreme sports, also experiences a reward or satisfaction sensation upon satiation.¹⁰ The dopamine system facilitates this reward sensation by producing dopamine, which interacts with dopamine receptors (which run what one might call the brain’s “pleasure center”), which in turn trigger the reward sensation.¹¹ When dopamine is produced in abnormal levels, however, the risk of developing mental illness increases.¹² For example, schizophrenia is associated with an abnormally high level of dopaminergic stimulation.¹³ In addition, heavy use of cocaine or amphetamines can trigger an abnormally high level of dopamine production.¹⁴ Use of these drugs for a long period of time may lead to a drug-induced psychosis, characterized by many of the symptoms of schizophrenia.¹⁵

6. ROBERT G. MEYER, *ABNORMAL BEHAVIOR AND THE CRIMINAL JUSTICE SYSTEM* 114 (1992). In addition to the scientific resources cited throughout this article, the author relied heavily on the explanations of the uses and effects of antipsychotics given by Barbara G. Haskins, M.D. Interview with Barbara G. Haskins, M.D., Forensic Psychiatrist, Western State Hospital, in Staunton, Va. (Aug. 23, 2004). Psychopharmacologist Kenneth H. Brasfield was also present at the meeting and provided valuable information regarding the various antipsychotic agents available for prescription, as well as the evolution of those drugs. *Id.*

7. *See* ROBERT M. JULIEN, *A PRIMER OF DRUG ACTION: A CONCISE, NONTECHNICAL GUIDE TO THE ACTIONS, USES, AND SIDE EFFECTS OF PSYCHOACTIVE DRUGS* 491 (2001) (explaining the “dopamine theory” of schizophrenia and the effect of antipsychotics on the blockade of dopamine receptors); DANIEL M. PERRINE, *THE CHEMISTRY OF MIND-ALTERING DRUGS: HISTORY, PHARMACOLOGY, AND CULTURAL CONTEXT* 23 (1996) (noting that schizophrenia is thought to be due to “an excess of dopaminergic stimulation”); MEYER, *supra* note 6, at 267 (recognizing the widely-held theory that various forms of psychoses are caused by an excess of dopamine in the brain).

8. PERRINE, *supra* note 7, at 22–23 (explaining the mesotelencephalic dopamine system and its role in the transmission of neurons in the central nervous system).

9. *Id.* *See generally* Roy A. Wise & Pierre P. Rompre, *Brain Dopamine and Reward*, 40 *ANNUAL REV. OF PSYCHOL.* 191, 191–225 (1989) (discussing the role of dopamine in reward-reinforcing mechanisms).

10. PERRINE, *supra* note 7, at 23.

11. *Id.*

12. *Id.*; JULIEN, *supra* note 7, at 491.

13. JULIEN, *supra* note 7, at 491.

14. PERRINE, *supra* note 7, at 23.

15. *Id.* at 219. *See generally* Nora D. Volkow, *Drug Abuse and Mental Illness: Progress in Under-*

The symptoms of psychoses can be separated into two groups: (1) the disorganization of thought content, meaning the substance of thoughts or lack thereof; and (2) the disorganization of thought processes, characterized by a loose association of single thoughts.¹⁶ For example, schizophrenics are often subject to “auditory hallucinations (usually hearing voices, often perceived as hostile) [and] delusions concerning their own identity.”¹⁷ They may often experience “ideas of reference,” a belief that the individual’s thoughts are actually being controlled by others.¹⁸ In addition, schizophrenics experience abnormalities in social and motor behavior as well as speech and mental creativity.¹⁹ While the specific symptoms of the different forms of psychoses may vary, the most serious forms will almost always involve some combination of those symptoms listed above.²⁰ As a result of the debilitating effects of these diseases, capital defendants who suffer from some form of psychosis and have not received treatment, via medication or otherwise, will in many cases be found incompetent to stand trial.²¹

Since the 1950’s, medical professionals have used antipsychotic agents (antipsychotics) to treat the various forms of psychoses and to normalize the form and processes of the patients’ thoughts.²² Antipsychotics, however, do not cure the underlying disease; rather, they treat and reduce the symptoms and effects of the disease.²³ Traditional antipsychotics, such as haloperidol (commonly known as Haldol) and thioridazine (commonly known as Mellaril), simply block the patient’s dopamine receptors and prevent the extremely severe symptoms that psychotic patients often experience.²⁴ The efficacy of this type of antipsychotic can be tied to the simplicity of the targeting mechanism.²⁵ But

standing Comorbidity, 158 AM. J. PSYCHIATRY 1181 (2001) (noting the correlation between heavy drug use, the overproduction of dopamine, and the eventual psychotic symptoms).

16. MEYER, *supra* note 6, at 116; Interview with Barbara G. Haskins, M.D., Forensic Psychiatrist, Western State Hospital, in Staunton, Va. (Aug. 23, 2004).

17. PERRINE, *supra* note 7, at 220.

18. *Id.*

19. JULIEN, *supra* note 7, at 489–90.

20. *See* DSM IV, *supra* note 5, at 287 (noting the wide range of delusions and auditory hallucinations experienced by schizophrenics).

21. *See* VA. CODE ANN. § 19.2–169.1 (Michie Supp. 2003) (providing that a competency evaluation is required if the court finds “that there is probable cause to believe that the defendant . . . lacks substantial capacity to understand the proceedings against him or to assist his attorney in his own defense”).

22. GOODMAN & GILMAN’S THE PHARMACOLOGICAL BASIS OF THERAPEUTICS 485 (Joel G. Hardman & Lee E. Limbird eds., 2001) [hereinafter “GOODMAN & GILMAN”].

23. PERRINE, *supra* note 7, at 222.

24. GOODMAN & GILMAN, *supra* note 22, at 485.

25. JULIEN, *supra* note 7, at 495.

as discussed further below, these medications can have debilitating side effects.²⁶ Administration of traditional antipsychotics can also be troublesome due to the trial-and-error fashion in which dosage decisions are often made.²⁷

The newer “atypical” antipsychotics, such as olanzapine (commonly known as Zyprexa), risperidone (commonly known as Risperdal), and clozapine (commonly known as Clozaril), were first introduced in the 1990’s and also block the dopamine receptors.²⁸ Their dopamine-blocking mechanism, however, is balanced by blocking effects on serotonin, glutamate, and other neurons as well.²⁹ This newer, balanced approach appears to produce similar beneficial results with fewer side effects.³⁰

B. Potential Side Effects of Antipsychotics

Almost all antipsychotics, although effective in counteracting the symptoms of psychosis, have the potential to produce serious neurological side effects.³¹ Some of these side effects are most likely to appear just after treatment has begun, but others may surface only after several months or years of treatment.³² Dystonia, for example, which is characterized by “abnormal, long-sustained posturing and grimacing of the neck, jaw, and eyes . . . with spasms of the neck or back and protrusion of the tongue,” can occur within one to five days after the initial administration of a drug.³³

Akathisia, parkinsonism, and tardive dyskinesia constitute what are known as “extrapyramidal” side effects and occur more often with the administration of traditional antipsychotics.³⁴ Akathisia is a syndrome that subjects the patient to a “feeling of anxiety, accompanied by restlessness, pacing, constant rocking back and forth, and other repetitive, purposeless actions.”³⁵ Parkinsonism, which resembles the symptoms of Parkinson’s disease, “is characterized by

26. See *infra* Part II.B. (discussing the side effects of both traditional and atypical antipsychotics).

27. JULIEN, *supra* note 7, at 502, 504.

28. See *id.* at 512–22 (describing in detail the history, effects, and side effects of various atypical antipsychotics).

29. PERRINE, *supra* note 7, at 219.

30. See *infra* Part II.B. (examining the side effects associated with various types of antipsychotics and comparing the potential side effects caused by both traditional and newer atypical antipsychotics). For a more complete comparison, see JULIEN, *supra* note 7, at 509–22 and PERRINE, *supra* note 7, at 227–28.

31. GOODMAN & GILMAN, *supra* note 22, at 500.

32. See *id.* at 500–01 (noting that the “acute dystonia,” “akathisia,” and “parkinsonism” side effects usually appear just after the commencement of treatment, but “tardive dyskinesia” and “perioral tremor” are more likely to appear after treatment has been ongoing).

33. GOODMAN & GILMAN, *supra* note 22, at 501; PERRINE, *supra* note 7, at 222.

34. JULIEN, *supra* note 7, at 504.

35. *Id.*

tremor at rest, rigidity of the limbs, and slowing of movement with a reduction in spontaneous activity.”³⁶ Perhaps the most serious of these side effects is tardive dyskinesia, a condition with which the patient exhibits repetitive, involuntary, tic-like movements of the face, jaw, tongue, and trunk.³⁷ This condition is often irreversible and may continue even after administration of the drug is discontinued.³⁸ The new “atypical” antipsychotics, which rarely cause this condition, can at times be used to counter this effect, but the condition may still continue after cessation of the administration.³⁹

In addition to these visible side effects, antipsychotics can also prompt other side effects that may not be noticeable without closer scrutiny.⁴⁰ For instance, some antipsychotics can induce sedation, drowsiness, blurred vision, and, important in the case of a criminal defendant, memory dysfunction.⁴¹ When experienced by a defendant during trial, these conditions may affect his ability to communicate his thoughts and memories effectively and can impair his ability to concentrate on the proceedings.⁴² To the lay observer, however, the defendant’s thought processes may appear to be functioning normally. This can prove to be devastating to the defendant’s fair trial rights as well as to his defense.⁴³

While the new “atypical” drugs may produce less of the extrapyramidal side effects, they do not come without a price. Administration of these antipsychotics is much more expensive than the traditional drugs.⁴⁴ Some of the “atypical” drugs, specifically clozapine, create a risk of developing severe, life-threatening blood diseases.⁴⁵ Because of this risk, weekly to bi-weekly blood cell monitoring is required.⁴⁶ Mental health agencies faced with budget constraints, therefore, might administer the cheaper, traditional antipsychotics before turning to newer drugs that require this added medical attention.⁴⁷ So, while psychopharmaceutical advances have decreased the prevalence of serious side effects resulting from the administration of antipsychotics, the cost and greater complexity of administering the newer drugs may prevent the benefits of those advances from being fully realized.

36. *Id.* at 505.

37. GOODMAN & GILMAN, *supra* note 22, at 502; PERRINE, *supra* note 7, at 223.

38. GOODMAN & GILMAN, *supra* note 22, at 503.

39. JULIEN, *supra* note 7, at 501–02.

40. *Id.* at 506–07.

41. *Id.* at 497.

42. *Id.*

43. *See infra* Part III (discussing a defendant’s right to refuse medication and the preservation of his fair trial rights while under the influence of antipsychotic medication).

44. JULIEN, *supra* note 7, at 515.

45. *Id.*

46. *Id.*

47. *Id.* at 516.

III. Legal Application

A. Refusing the Administration of Antipsychotics During Capital Proceedings

1. *Sell v. United States and its Progeny*

In *Sell v. United States*,⁴⁸ the United States Supreme Court addressed the legality of a state's administration of antipsychotic medication to a non-dangerous pretrial detainee against his will for the sole purpose of rendering him competent to stand trial.⁴⁹ The Court used a four-factor analysis to balance the detainee's constitutionally guaranteed interests in a fair trial against the State's interest in bringing a competent defendant to trial.⁵⁰ To understand the specific legal issues present in *Sell*, however, it is important to analyze the Supreme Court cases that influenced that decision.⁵¹

In *Washington v. Harper*,⁵² the United States Supreme Court scrutinized a Washington Department of Corrections policy that allowed the State to administer antipsychotic drugs to a convicted inmate against his will.⁵³ The policy in question allowed for such administration only after a psychiatrist determined that: (1) the inmate suffered from a mental disorder; and (2) the inmate was either "gravely disabled" or posed a threat of serious harm "to himself, others, or their property."⁵⁴ In addition, the inmate was provided certain procedural safeguards such as an administrative hearing before a qualified committee and a periodic review of the effectiveness and necessity of the administration.⁵⁵

The defendant, Walter Harper, had been paroled in 1980 after serving four years on a robbery charge.⁵⁶ A year later, his parole was revoked after he assaulted two nurses at a Seattle hospital.⁵⁷ Harper was sent to the Special Offender Center, a Washington Department of Corrections facility established "to diagnose and treat convicted felons with serious mental disorders."⁵⁸ Harper was diagnosed as suffering from manic-depressive disorder and voluntarily began

48. 539 U.S. 166 (2003).

49. *Sell v. United States*, 539 U.S. 166, 175 (2003).

50. *Id.* at 180–81.

51. *See id.* at 177–180 (relying primarily on *Washington v. Harper*, 494 U.S. 210 (1990) and *Riggins v. Nevada*, 504 U.S. 127 (1992)).

52. 494 U.S. 210 (1990).

53. *Harper*, 494 U.S. at 213.

54. *Id.* at 215, 215 n.3.

55. *Id.* at 215–16. The Court also noted that an inmate was afforded certain procedural rights before, during, and after the administrative hearing. *Id.* at 216. These included the right to notice, the right to attend and present evidence, and the right to the assistance of a lay adviser who understood the psychiatric issues involved. *Id.*

56. *Id.* at 213–14.

57. *Id.* at 214.

58. *Id.*

a treatment involving the administration of antipsychotics.⁵⁹ In November 1982, however, he refused to continue taking the medication.⁶⁰ His treating physician then sought to administer the drugs against his will in accordance with the above policy.⁶¹ Harper subsequently filed suit and claimed the prison procedure, among other things, violated the Due Process Clauses of both the federal and state constitutions.⁶²

The Supreme Court first acknowledged that an inmate “possesses a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment.”⁶³ The extent of this right, however, is flexible and “must be defined in the context of the inmate’s confinement.”⁶⁴ The Court weighed Harper’s interest in freedom from unwanted medication against the State’s interest in decreasing the danger he posed to others in the prison environment.⁶⁵ The Court found the State’s interest overwhelming in light of Harper’s history of violence and upheld the policy.⁶⁶ “[T]he 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.”⁶⁷

Two years later the Court again addressed the involuntary administration of medication in *Riggins v. Nevada*.⁶⁸ Unlike Harper, Riggins had not yet been convicted when he refused to consent to the administration of antipsychotics.⁶⁹ Riggins, who faced charges of murder and robbery, told the jail psychiatrist a few days after his arrest that he heard “voices in his head.”⁷⁰ He was subsequently placed on a regimen of Mellaril that started at 100 milligrams per day and was eventually increased to 800 milligrams per day.⁷¹ Riggins was evaluated by three court-appointed psychiatrists over the following months while he was taking 450

59. *Harper*, 494 U.S. at 214. At the time this case was decided, Harper had also been diagnosed with schizophrenia. *Id.* at 214 n.2.

60. *Id.* at 214.

61. *Id.*

62. *Id.* at 217.

63. *Id.* at 221–22; *see* U.S. CONST. amend. XIV, § 1 (guaranteeing that no state shall “deprive any person of life, liberty, or property, without due process of law”).

64. *Harper*, 494 U.S. at 222.

65. *Id.* at 224–25.

66. *Id.* at 227.

67. *Id.*

68. *Riggins*, 504 U.S. at 129.

69. *Id.* at 130–31.

70. *Id.* at 129.

71. *Id.* Mellaril is the trade name for thioridazine. *See* GOODMAN & GILMAN, *supra* note 21, at 485–514 (listing drugs commonly used to treat antipsychotic disorders and their common trade names).

milligrams of Mellaril per day.⁷² Two of the psychiatrists found him competent to stand trial, and the trial court agreed.⁷³

Prior to trial, Riggins moved the court for an order to cease the administration of the antipsychotic medication until the end of his trial.⁷⁴ Riggins argued that the drugs would affect “his demeanor and mental state during trial,” thus denying him due process, and that his insanity defense entitled him to “show the jurors his true mental state.”⁷⁵ After an evidentiary hearing at which several psychiatrists made various predictions as to Riggins’s possible mental state if taken off the medication, the court denied his motion and Riggins was continuously subjected to a dosage of 800 milligrams per day of Mellaril throughout his trial.⁷⁶ The jury convicted him of capital murder and sentenced him to death.⁷⁷ On appeal to the Supreme Court of Nevada, Riggins argued that “forced administration of Mellaril denied him the ability to assist in his own defense and prejudicially affected his attitude, appearance, and demeanor at trial.”⁷⁸ The Nevada court affirmed his convictions and sentence, and the United States Supreme Court granted certiorari to decide “whether forced administration of antipsychotic medication during trial violated rights guaranteed by the Sixth and Fourteenth Amendments.”⁷⁹ The Court noted, however, that “[t]he question whether a competent criminal defendant may refuse antipsychotic medication if cessation of medication would render him incompetent at trial is not before us.”⁸⁰

Reversing the lower court, the Court acknowledged that the Fourteenth Amendment requires “at least as much protection” for pretrial detainees faced with the involuntary administration of medication as the *Harper* requirement of “a finding of overriding justification and a determination of medical appropriateness.”⁸¹ The Court also recognized that the trial court, during the evidentiary hearing on Riggins’s motion, failed completely to acknowledge the “liberty interest in freedom from unwanted antipsychotics drugs” recognized in *Harper*.⁸² In addition, the Court criticized the trial court’s failure to investigate

72. *Riggins*, 504 U.S. at 129–30.

73. *Id.* at 130.

74. *Id.*

75. *Id.*

76. *Id.* at 130–31.

77. *Id.* at 131.

78. *Riggins*, 504 U.S. at 131.

79. *Id.* at 132–33.

80. *Id.* at 136.

81. *Id.* at 129, 135. The Court first refused to address Riggins’s Eighth Amendment argument that “administration of Mellaril denied him an opportunity to show jurors his true mental condition at the sentencing hearing” due to his failure to raise the issue on appeal in state court. *Id.* at 133.

82. *Id.* at 137.

the concerns Riggins and several of the psychiatrists had voiced regarding possible side effects from taking 800 milligrams of Mellaril per day.⁸³ Riggins was not, however, required to show that he was *actually* prejudiced at trial.⁸⁴ Instead, the Court found that even if Riggins had presented expert testimony to the jury regarding the effect of Mellaril on his demeanor, a “strong possibility” and “unacceptable risk of prejudice remained.”⁸⁵ Justice Kennedy wrote separately to state his view that “absent an extraordinary showing by the State,” the Due Process Clause *prohibits* states from administering antipsychotics against a person’s will for the purpose of rendering that person competent to stand trial.⁸⁶

Both the majority and Justice Kennedy’s concurrence set forth a number of potentially prejudicial side effects of antipsychotics that may impact a defendant’s trial.⁸⁷ For example, the majority noted that “[i]t is clearly possible that [the] side effects [of the Mellaril] had an impact upon not just Riggins’ outward appearance, but also the content of his testimony on direct or cross examination, his ability to follow the proceedings, or the substance of his communication with counsel.”⁸⁸ In a more extensive discussion of possible side effects, Justice Kennedy noted two principal ways in which the drugs may prejudice a defendant: “(1) by altering his demeanor in a manner that will prejudice his reactions and presentation in the courtroom, and (2) by rendering him unable or unwilling to assist counsel.”⁸⁹

As to the first, Justice Kennedy recognized that the common side effects of antipsychotics, such as tremors, restlessness, diminished range of facial functions, and slowed speech and thought processes, could result in serious prejudice to the defendant.⁹⁰ “As any trial attorney will attest, serious prejudice could result if medication inhibits the defendant’s capacity to react and respond to the proceedings and to demonstrate remorse or compassion.”⁹¹ In particular, Justice Kennedy placed great emphasis on the impact the side effects may have on the sentencing process:

The prejudice can be acute during the sentencing phase of the proceedings, when the sentencer must attempt to know the heart and mind of the offender and judge his character, his contrition or its absence, and his future dangerousness. In a capital sentencing

83. *Id.*

84. *See Riggins*, 504 U.S. at 137 (“Efforts to prove or disprove actual prejudice from the record before us would be futile We accordingly reject the dissent’s suggestion that Riggins should be required to demonstrate how the trial would have proceeded differently if he had not been given Mellaril.”).

85. *Id.* at 137–38.

86. *Id.* at 138–39 (Kennedy, J., concurring).

87. *Id.* at 137–38; *Id.* at 142–45 (Kennedy, J., concurring).

88. *Id.* at 137.

89. *Id.* at 142 (Kennedy, J., concurring).

90. *Riggins*, 504 U.S. at 142–43 (Kennedy, J., concurring).

91. *Id.* at 143–44.

proceeding, assessments of character and remorse may carry great weight and, perhaps, be determinative of whether the offender lives or dies.⁹²

As for the second category of potential prejudice, Justice Kennedy found that “[t]he side effects of antipsychotic drugs can hamper the attorney-client relation, preventing effective communication and rendering the defendant less able or willing to take part in his defense.”⁹³ An impairment of the attorney-defendant relationship would, thus, jeopardize the defendant’s Sixth Amendment right to the effective assistance of counsel.⁹⁴ Justice Kennedy opined that a defendant must be able to provide information to his counsel in a timely manner and must have the cognitive capacity to participate in the decision-making process.⁹⁵

Justice Kennedy’s concurrence calls for a more strict standard for determining the constitutionality of forced medication to non-dangerous pretrial detainees, as in *Riggins*, as compared with the “dangerous” prisoner in *Harper*.⁹⁶ After all, those in the pretrial stage have essential fair trial interests at stake.⁹⁷ Interestingly, both the *Riggins* majority and concurrence distinguish between mere competency to stand trial and a defendant’s ability to effectively appear, give testimony, and communicate with counsel.⁹⁸ After *Riggins*, then, a court may not simply shrug off a defendant’s claim of possible prejudice to his fair trial rights merely because he has been found competent to stand trial.

92. *Id.* at 144.

93. *Id.*

94. *Id.*; see also *Massiah v. United States*, 377 U.S. 201, 205–06 (1964) (holding that a defendant’s Sixth Amendment right to the effective assistance of counsel is jeopardized when he cannot assist his counsel).

95. *Riggins*, 504 U.S. at 144 (Kennedy, J., concurring).

96. *Id.* at 140–41 (Kennedy, J., concurring). Justice Kennedy distinguished *Harper* as a case involving an “objective and manageable” inquiry, namely whether the defendant was dangerous. *Id.* at 140 (Kennedy, J., concurring). Justice Kennedy viewed the inquiry into whether *Riggins* was competent as requiring much more care:

The avowed purpose of the medication is not functional competence, but competence to stand trial. In my view elementary protections against state intrusion require the State in every case to make a showing that there is no significant risk that the medication will impair or alter in any material way the defendant’s capacity or willingness to react to the testimony at trial or to assist his counsel . . . I have substantial reservations that the State can make that showing . . .

Id. at 141 (Kennedy, J., concurring).

97. See *Bell v. Wolfish*, 441 U.S. 520, 545 (1979) (“[P]retrial detainees, who have not been convicted of any crimes, retain at least those constitutional rights that we have held are enjoyed by convicted prisoners.”).

98. See *Riggins*, 504 U.S. at 136–37 (finding that the lower court erred in not considering whether the side effects of the drugs would impair his fair trial rights, even though cessation might have rendered him incompetent); *id.* at 142 (Kennedy, J., concurring) (concluding that although the antipsychotics may have rendered a defendant competent to stand trial, the drugs may prejudice him during trial).

Justice Kennedy's concurrence respecting involuntary medication solely to render a criminal defendant competent for trial set the tone for the Court's recent decision in *Sell*.⁹⁹ In 1997 Charles Sell, a practicing dentist, was accused of submitting fraudulent insurance claims in violation of federal law.¹⁰⁰ Sell was charged with mail and Medicaid fraud, money laundering, and later with the attempted murders of the FBI agent who had arrested him and of a potential witness against him.¹⁰¹

In early 1999 a federal magistrate found that Sell was incompetent to stand trial and ordered him hospitalized to determine whether his competence could be restored.¹⁰² After diagnosing him with a delusional disorder, the treating psychiatrist sought to administer antipsychotics to Sell.¹⁰³ When Sell refused, however, a reviewing psychiatrist authorized the administration of the drugs against his will "because Sell was mentally ill and dangerous, . . . medication is necessary to treat the mental illness, and . . . so that Sell would become competent for trial."¹⁰⁴ The magistrate who had ordered Sell's original hospitalization affirmed the psychiatrist's finding of dangerousness and noted that Sell had since been moved to a locked cell after making inappropriate remarks to a nurse.¹⁰⁵ The magistrate then issued an order authorizing the involuntary administration of antipsychotic medication because, among other things, Sell was dangerous and there was a "substantial probability" the drugs would return him to competency.¹⁰⁶

The United States District Court for the Eastern District of Missouri disagreed with the classification of Sell as being "dangerous" but affirmed the magistrate's order because administration of the antipsychotic drugs was "medically appropriate" and "necessary to serve the government's compelling interest in obtaining an adjudication of [Sell's] guilt or innocence of numerous and serious charges."¹⁰⁷ The United States Court of Appeals for the Eighth Circuit affirmed.¹⁰⁸ The Eighth Circuit held that the Government's interest in

99. See *Sell*, 539 U.S. at 179 (pronouncing the standard for the involuntary administration of antipsychotics to a defendant solely for the purpose of rendering him competent to stand trial). For a complete discussion of *Sell* and its application to Virginia capital murder cases, see generally Meghan H. Morgan, Case Note, 16 CAP. DEF. J. 295 (analyzing *Sell v. United States*, 539 U.S. 166 (2003)).

100. *Sell*, 539 U.S. at 170.

101. *Id.*

102. *Id.* at 170–71.

103. *Id.* at 171.

104. *Id.* at 171–72. The reviewing psychiatrist found Sell to be dangerous based on "threats and delusions if outside, but not necessarily inside prison." *Id.* at 172. In fact, the psychiatrist found "that Sell was able to function in prison in the open population." *Id.*

105. *Id.* at 172–73.

106. *Sell*, 539 U.S. at 173.

107. *Id.* at 173–74.

108. *Id.* at 174–75. The Eighth Circuit also affirmed the district court's finding that Sell was

bringing Sell to trial was essential and that the administration of the drugs was medically appropriate and the least intrusive means of rendering him competent.¹⁰⁹

The United States Supreme Court, however, vacated the Eighth Circuit's decision.¹¹⁰ Relying on its decisions in *Harper* and *Riggins*, the Court held that a state may administer antipsychotic drugs to a mentally ill defendant against his will solely for the purpose of rendering him competent to stand trial *only* if the treatment: (1) "is medically appropriate"; (2) "is substantially unlikely to have side effects that may undermine the fairness of the trial"; and (3) "taking account of less intrusive alternatives, is necessary significantly to further important governmental trial-related interests."¹¹¹ The Court cautioned that these instances may be rare because a court must also find that four additional circumstances are present.¹¹²

First, an *important* governmental interest must be at stake.¹¹³ The Court acknowledged that the governmental interest in bringing to trial a defendant charged with serious crimes is "important."¹¹⁴ Certainly in the case of an individual accused of capital murder, the interest in bringing him to court is most compelling.¹¹⁵ That importance, however, is countered by the government's "concomitant, constitutionally essential interest in assuring that the defendant's trial is a fair one."¹¹⁶ The Court also recognized that the importance of prosecution in a given case may be lessened by "special circumstances," such as the possibility that the defendant's refusal to take the drugs would lead to confinement in a mental institution.¹¹⁷

Second, the involuntary administration of the drugs must significantly further the state's concomitant interests.¹¹⁸ In other words, a court must find that the administration is "substantially likely" to render the defendant competent and, at the same time, is "substantially unlikely" to induce side effects that "will interfere significantly with the defendant's ability to assist counsel in

not dangerous. *Id.* at 174.

109. *Id.*

110. *Id.* at 186.

111. *Id.* at 179.

112. *Sell*, 539 U.S. at 180.

113. *Id.*

114. *Id.*; see also *Kansas v. Hendricks*, 521 U.S. 346, 361–62 (1997) (recognizing that the "two primary objectives of criminal punishment" are "retribution and deterrence"); *Moran v. Burbine*, 475 U.S. 412, 426 (1986) (providing that society has a "compelling interest in finding, convicting, and punishing those who violate the law").

115. *Sell*, 539 U.S. at 180.

116. *Id.*

117. *Id.*

118. *Id.* at 181.

conducting a trial defense.”¹¹⁹ As discussed below, this requirement may afford the greatest protection to mentally ill capital defendants.¹²⁰

Third, the medication must be *necessary* to further the state’s concomitant interests.¹²¹ For example, there may exist non-drug therapies that could restore the defendant to competence.¹²² The court must find, then, that any less intrusive means are “unlikely to achieve substantially the same results” as the involuntary administration of drugs.¹²³

Finally, the administration of the drugs must be “medically appropriate.”¹²⁴ The Court defined “medically appropriate” as being “in the patient’s best medical interest in light of his medical condition.”¹²⁵ Therefore, a court may consider different kinds of antipsychotics that produce similar beneficial results without triggering similar side effects.¹²⁶

Before applying this standard to the case before it, the Court cautioned that these four conditions need not be considered by a court if a defendant is found to be “dangerous.”¹²⁷ In such a case, the standard enunciated in *Harper* would control a court’s decision, and the state could medicate the defendant against his will if it was “medically appropriate.”¹²⁸ In fact, the *Sell* Court recommended that “a court, asked to approve forced administration of drugs for purposes of rendering a defendant competent to stand trial, should ordinarily determine whether the Government seeks, or has first sought, permission for forced administration of drugs on these other *Harper*-type grounds; and, if not, why not.”¹²⁹ This makes clear that a court will consider the defendant’s dangerousness first before reaching the considerations set forth in *Sell*.¹³⁰

In accordance with the findings of the district court and Eighth Circuit, the Court first assumed that *Sell* was not dangerous and thereby bypassed a review of the decision to medicate under *Harper*.¹³¹ Applying the four considerations governing the involuntary medication of non-dangerous defendants, the Court

119. *Id.*

120. *See infra* text accompanying notes 175–209 (discussing potential substantive arguments regarding the impairment of a capital defendant’s fair trial rights).

121. *Sell*, 539 U.S. at 181.

122. *Id.*

123. *Id.*

124. *Id.*

125. *Id.*

126. *Id.*

127. *Sell*, 539 U.S. at 181–82.

128. *Id.*

129. *Id.* at 183.

130. *Id.*

131. *Id.* at 183–84. The Court suggested that the record did contain evidence of *Sell*’s dangerousness but noted that neither party had raised the issue of dangerousness on appeal. *Id.*; *see also infra* note 141.

then held that the lower courts had erred in affirming the magistrate's order.¹³² Because the magistrate had approved forced medication based on Sell's dangerousness *and* the drugs' probability of rendering him competent to stand trial, the Court found that the focus of the hearing before the magistrate had, in fact, been on Sell's dangerousness.¹³³ As such, the experts who had testified did not address the possible trial-related side effects of the antipsychotic treatment.¹³⁴ In fact, the hospital's experts had conceded that the proposed treatment had "significant side effects and there has to be a cost benefit analysis."¹³⁵ The Court concluded that the experts, in performing their cost benefit analysis, "primarily took into account Sell's dangerousness, not the need to bring him to trial."¹³⁶

Analyzing this failure under the Court's second consideration, that the administration is "substantially unlikely" to induce side effects that "will interfere significantly with the defendant's ability to assist counsel," the *Sell* Court concluded that "[t]he failure to focus upon trial competence could well have mattered."¹³⁷ Citing Justice Kennedy's concurrence in *Riggins*, the Court set forth several concerns that may not necessarily be relevant when dangerousness is at issue but are relevant to the permissibility of treatment solely for rendering a defendant competent.¹³⁸ For instance, the magistrate should have determined whether the treatment would interfere with Sell's ability to communicate effectively with counsel, whether the treatment would prevent Sell from reacting to trial developments in a rapid fashion, and whether the treatment would impair Sell's ability to express emotion.¹³⁹ Based on the magistrate's failure to consider these circumstances and their potential to undermine the fairness of Sell's trial, the Court reversed the order to administer the antipsychotics.¹⁴⁰

2. *Dangerousness After Sell*

It is important to first recognize that while the *Sell* standard offers heightened protection of a pretrial capital defendant's fair trial interests, the prosecution will presumably seek to have the defendant medicated on the basis that he is dangerous to himself or others. The *Sell* Court, however, failed to enunciate a standard for determining when a pretrial detainee is "dangerous"

132. *Sell*, 539 U.S. at 185.

133. *Id.*

134. *Id.*

135. *Id.* (internal citations omitted).

136. *Id.*

137. *Id.* at 181, 185.

138. *Sell*, 539 U.S. at 185–86 (citing *Riggins*, 504 U.S. at 142–45 (Kennedy, J., concurring)).

139. *Id.*

140. *Id.*

and, thus, subject to the less-restrictive *Harper* standard for forced medication.¹⁴¹ The district court had overturned the magistrate's finding of dangerousness, which had been based primarily on Sell's inappropriate behavior with the medical center nurses and his accompanying mental illness.¹⁴² The question remains: When, and by whom, can a pretrial capital defendant be deemed dangerous?

The *Harper* Court held that the Washington Bureau of Prisons, through an administrative process and with the recommendation of medical professionals, could rightfully make the determination whether the inmate was "dangerous" and, thus, in need of forced medication.¹⁴³ In cases such as this, an administrative finding of dangerousness can be appealed to determine whether that finding was arbitrary or capricious.¹⁴⁴ The *Sell* Court, on the other hand, implied that a judicial hearing was required before forcibly medicating a non-dangerous pretrial detainee to restore competency.¹⁴⁵ In *Sell*, the Court repeatedly referred to the "court" when describing the four factors that must be addressed in applying the standard for pretrial detainees.¹⁴⁶ It can be inferred, then, that because a non-dangerous pretrial detainee retains a constitutionally-protected interest in a fair trial, the decision to forcibly medicate demands a more stringent analysis, and by implication, a judicial analysis.¹⁴⁷ But the *Sell* Court did not decide whether a pretrial detainee can be deemed "dangerous" outside of the judicial process.¹⁴⁸

The standard for determining dangerousness is also still undefined. A pretrial capital defendant who has been deemed incompetent to stand trial will most likely be sent to a state mental hospital for restoration.¹⁴⁹ But must the

141. *Id.* at 184. The *Sell* Court, in dicta, did opine that the record supported the magistrate's finding of dangerousness. *Id.* But because neither of the parties raised the issue, the Court stated that it was forced to accept the district court and Eighth Circuit's reversals of that finding and assume Sell was non-dangerous. *See id.* (stating that the Court assumed that Sell was not dangerous "only because the Government did not contest, and the parties have not argued, that particular matter"). The Court, thus, seemed to imply that Sell's inappropriate conduct with the nurses, even though it did not involve overt acts or threats, might have been enough to support a finding of dangerousness. *Id.*

142. *Id.*

143. *Harper*, 494 U.S. at 228 (holding that the administrative hearing procedures set by the policy in question "do comport with procedural due process").

144. *See* Administrative Procedure Act of 1946, 5 U.S.C. § 706 (2000) (stating that a court may review agency action and set aside that action if it finds the agency's conclusions to be "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law").

145. *Sell*, 539 U.S. at 180–83.

146. *Id.*

147. *Id.*

148. *See supra* note 141 and accompanying text (explaining the Court's reliance on the lower courts' finding of non-dangerousness).

149. *See* 18 U.S.C. § 4241(d) (2000) (providing that upon a finding "by a preponderance of the evidence" that the defendant is incompetent to stand trial, "the court shall commit the defendant to the custody of the Attorney General," who "shall hospitalize the defendant for treatment"); VA. CODE ANN. § 19.2-169.1 (Michie Supp. 2003) (providing that upon finding a defendant is incompe-

setting be taken into account in evaluating a defendant's dangerousness? A defendant may pose a danger to others while awaiting trial in the general jail population; that risk, however, may be diminished when he is moved to the hospital for restoration of competency.¹⁵⁰ In *Sell*, for example, the district court found that he was not dangerous based on his "dangerousness *at this time* to himself and to those around him *in his institutional context*."¹⁵¹ While this issue was not challenged on appeal, and accordingly not addressed by the Supreme Court, the standard used by the district court still does not describe the type of conduct that gives rise to a finding of dangerousness.¹⁵²

Following the Supreme Court's decision in *Riggins*, but before *Sell*, the United States Court of Appeals for the District of Columbia addressed the question of when a defendant is considered dangerous.¹⁵³ Russell Weston was charged with entering the United States Capitol building, opening fire, and killing two United States Capitol Police officers.¹⁵⁴ After being found incompetent and hospitalized for restoration, Weston refused the administration of antipsychotic medication.¹⁵⁵ The Bureau of Prisons, after an administrative hearing, decided to medicate Weston against his will based on his dangerousness to himself and others.¹⁵⁶ The district court affirmed the agency's decision and found that the medication was "essential for the defendant's own safety or the safety of others."¹⁵⁷

The Court of Appeals, however, reversed the district court's finding of Weston's dangerousness based, in part, on insufficient evidence.¹⁵⁸ The court, relying primarily on testimony given at the administrative hearing by Weston's treating psychiatrist, found that the evidence presented indicated that "in his current circumstances Weston poses no significant danger to himself or to others."¹⁵⁹ The psychiatrist, although testifying as an expert for the Government, had stated that given Weston's "immediate containment situation," she was "confident the [prison] staff can prevent him from harming himself or others under his immediate parameters of incarceration where he is in an individual room with limited access to anything that he could harm himself with or anyone

tent to stand trial, the court *shall* order treatment to restore his competency and may order that treatment on an inpatient basis at a state hospital).

150. See *supra* note 149 (setting forth the federal and Virginia statutes governing the restoration of competency for criminal defendants).

151. *Sell*, 539 U.S. at 174 (internal quotations omitted).

152. *Id.* at 184.

153. *United States v. Weston*, 206 F.3d 9 (D.C. Cir. 2000).

154. *Id.* at 11.

155. *Id.* at 11–12.

156. *Id.* at 12.

157. *United States v. Weston*, 69 F. Supp. 2d 99, 118 (D.D.C. 1999).

158. *Weston*, 206 F.3d at 13.

159. *Id.*

else with, and he remains under constant observation.”¹⁶⁰ The court found this testimony, in light of the little evidence presented on the issue of safety, was sufficient to overturn the finding of dangerousness.¹⁶¹

The *Weston* decision, although not binding outside the D.C. Circuit, offers valuable insight into the procedure and standard for determining dangerousness. For one, Weston was a pretrial detainee who was found to be dangerous by way of an administrative hearing; thus he was left with only an appeal to the judicial process for relief.¹⁶² The district court had reviewed the agency’s finding of dangerousness substantively under a “reasonableness” standard and procedurally under the Administrative Procedure Act’s “arbitrary and capricious” standard.¹⁶³ It is important to note, however, that this issue has still not reached the United States Supreme Court.

Also of importance, the *Weston* court’s determination of the sufficiency of the evidence focused on the defendant’s dangerousness in the institutional context at the time of the hearing.¹⁶⁴ Specifically, the treating psychiatrist’s assurance that the prison staff could ensure safety while Weston was in isolation seemed crucial to the court’s determination.¹⁶⁵ Under this standard, then, defense counsel should strive to have the defendant isolated from the general population during the pretrial stages so as to diminish the possibility that he will pose a danger to himself or others. In any event, isolation will certainly diminish the chances the defendant will pose a threat to persons other than himself. So, while the *Weston* court’s determination that the record did not support a finding of dangerousness did little more than provide interesting insight into other courts’ possible interpretation of the *Harper* dangerousness standard, that standard and the process for determining when and by whom a pretrial capital defendant may be deemed “dangerous” are still largely undefined and require further clarification by the courts.

3. Strategy after Sell

As is evident from recent case law, the capital defendant’s right to refuse the administration of antipsychotics is far from guaranteed.¹⁶⁶ In fact, with the uncertainty surrounding the classification of a defendant as “dangerous,” the chance a court will even weigh the *Sell* factors may be slim. In the event, however, the prosecution fails to, or cannot, compel the administration of antipsychotic medication based on the defendant’s dangerousness, and is thus

160. *Id.*

161. *Id.*

162. *Id.* at 11.

163. *Id.* at 12.

164. *Weston*, 206 F.3d at 13.

165. *Id.*

166. *See supra* notes 148–65 and accompanying text (discussing the evolution of a defendant’s right to refuse medication through recent case law).

forced to rely on the rationale of restoration of competence, it is critical that defense counsel preserve the right to refuse the treatment before trial. Therefore, as soon as that defendant refuses to take the antipsychotic medication, whether of his own volition or on the advice of his attorney, any further administration of the drugs is involuntary and counsel should file a motion to prevent or cease the involuntary administration of those drugs.¹⁶⁷ The basis for a non-dangerous defendant's argument is twofold: first, the side effects of the drugs will deprive the defendant of his right to due process under the Fourteenth Amendment; and second, if found guilty, the continued administration of the drugs during the sentencing phase will deprive him of his rights under the Eighth Amendment to a reliable determination of whether the death penalty should be imposed and to have the sentencer consider all relevant mitigating evidence.¹⁶⁸

The *Harper* Court recognized that an individual “possesses a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment.”¹⁶⁹ That interest, according to the first *Sell* factor, may be countered by the prosecution's interest in rendering the defendant competent and bringing him to stand trial.¹⁷⁰ In fact, the more serious the crime, the more compelling the prosecution's interest in seeking justice through the judicial system.¹⁷¹ But the *Sell* Court also recognized that the prosecution has an equally compelling “concomitant” interest in ensuring each defendant is afforded a fair trial.¹⁷² Furthermore, courts have long recognized that in capital cases, “the finality of the sentence imposed warrants protections that . . . may not be required in other cases.”¹⁷³ The heightened importance of bringing a capital defendant to stand trial, then, appears to be equally diminished by the heightened importance of assuring that both the trial and sentencing proceedings are fair.¹⁷⁴

The *Sell* Court's second factor opens the door for a defendant's substantive arguments regarding the impairment of his fair trial rights.¹⁷⁵ In both *Sell* and *Riggins*, the Court placed great emphasis on the effects of antipsychotics on a

167. Please contact the Virginia Capital Case Clearinghouse at (540) 458-8557 for a sample motion for the cessation of the involuntary administration of antipsychotics prior to trial.

168. See U.S. CONST. amend. VIII (“Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.”); U.S. CONST. amend. XIV, § 1 (preventing the states from “depriv[ing] any person of life, liberty, or property, without due process of law”).

169. *Harper*, 494 U.S. at 221–22.

170. *Sell*, 539 U.S. at 179–80.

171. *Id.* at 180.

172. *Id.*

173. *Ake v. Oklahoma*, 470 U.S. 68, 87 (1985) (Burger, C.J., concurring).

174. *Sell*, 539 U.S. at 180.

175. See *supra*, notes 118–20 (outlining the second factor considered by the *Sell* Court).

defendant's ability to assist counsel.¹⁷⁶ Both opinions recognized that although a defendant has been deemed competent to stand trial, antipsychotics may have an effect on a defendant's ability to interact with counsel.¹⁷⁷

In Virginia, the competency standard reflects the constitutional necessity of the defendant's capacity to assist counsel.¹⁷⁸ Virginia Code section 19.2-169.1 provides:

A. If, at any time after the attorney for the defendant has been retained or appointed and before the end of trial, the court finds, upon hearing evidence or representations of counsel for the defendant or the attorney for the Commonwealth, that there is probable cause to believe that the defendant . . . lacks substantial capacity to understand the proceedings against him or to assist his attorney in his own defense, the court shall order that a competency evaluation be performed by at least one psychiatrist, clinical psychologist or master's level psychologist who is qualified by training and experience in forensic evaluation.

E. . . . The fact that the defendant claims to be unable to remember the time period surrounding the alleged offense shall not, by itself, bar a finding of competency if the defendant otherwise understands the charges against him and can assist in his defense. Nor shall the fact that the defendant is under the influence of medication bar a finding of competency if the defendant is able to understand the charges against him and assist in his defense while medicated.¹⁷⁹

This statute, however, addresses the importance of assuring a defendant's ability to assist counsel *in advance* of trial, or, in other words, in preparing his defense.¹⁸⁰ Such assistance varies greatly from the assistance required of a defendant at trial in order to be effective.¹⁸¹ During the pretrial period, a defendant can effectively

176. *Sell*, 539 U.S. at 185; *Riggins*, 504 U.S. at 137, 144 (Kennedy, J., concurring).

177. *See Sell*, 539 U.S. at 181 (requiring that a court find that the administration of antipsychotics to render the defendant competent is "substantially unlikely to have side effects that will interfere significantly with the defendant's ability to assist counsel in conducting a trial defense, thereby rendering the trial unfair"); *Riggins*, 504 U.S. at 137 (finding that even though the administration of the Mellaril may have rendered *Riggins* competent to stand trial, the district court did not acknowledge the drugs' possible impact upon "the substance of his communication with counsel").

178. The Virginia statute, of course, merely codifies the constitutional standard for incompetency. *See Dusky v. United States*, 362 U.S. 402, 402 (1960) (*per curiam*) (establishing the test of a defendant's competency to stand trial as "whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he has a rational as well as factual understanding of the proceedings against him"). The Supreme Court has recently confirmed the validity of the *Dusky* standard. *See Cooper v. Oklahoma*, 517 U.S. 348, 354 (1996) (citing the *Dusky* standard as a "well settled" test for determining competency).

179. VA. CODE ANN. § 19.2-169.1 (Michie Supp. 2003).

180. *Id.*

181. *See Riggins*, 504 U.S. at 144 (Kennedy, J., concurring) (noting that a defendant's right to the effective assistance of counsel is impaired when the defendant is not "able to provide needed information to a lawyer and to participate in the making of decisions on his own behalf").

assist counsel by recounting the events surrounding the time of the alleged offense and recalling names of persons who may testify in his defense. Attorneys are given an adequate pretrial period to extract this information from a defendant and to incorporate it into his defense.¹⁸²

During trial, however, a defendant's awareness and responsiveness are essential.¹⁸³ Both *Sell* and Justice Kennedy's concurrence in *Riggins* recognize that the effective assistance of a defendant's counsel during trial requires a "rapid" response and reaction to the proceedings.¹⁸⁴ For instance, an alert defendant may, upon hearing or viewing the trial testimony of a witness against him, provide his counsel with useful information that counsel may be pursue on cross-examination or use to impeach the witness.¹⁸⁵ A defendant under the influence of traditional antipsychotics, which have been shown to impair concentration and memory, may be prevented from relaying this information to his counsel in a timely manner.¹⁸⁶

Another important due process right that the administration of antipsychotics during trial may compromise is the defendant's right to present himself in the most favorable light.¹⁸⁷ In *Estelle v. Williams*,¹⁸⁸ the defendant's request to appear at his murder trial in civilian clothes was denied, and he was forced to appear in clothes that "were distinctly marked as prison issue."¹⁸⁹ The United States Supreme Court, granting Williams's petition for habeas relief, held that because defendants have a compelling interest in the presumption of innocence, any state action which threatens that protection must be justified by a countervailing government interest.¹⁹⁰ In other words, the right to present one's self in the most favorable light corresponds with the defendant's interest in being accorded the presumption of innocence. In addition, while the

182. *See* *DeToro v. Peppersack*, 332 F.2d 341, 342–43 (4th Cir. 1964) (finding a defendant "has the right to have counsel appointed sufficiently in advance of trial to make adequate preparation").

183. *See Sell*, 539 U.S. at 185 (recognizing the danger in administering antipsychotics which may "prevent rapid reaction to trial developments").

184. *Id.*; *Riggins*, 504 U.S. at 144 (Kennedy, J., concurring) (observing that "[t]he side effects of antipsychotics drugs can hamper the attorney-client relation, preventing effective communication").

185. *See Riggins*, 504 U.S. at 144 (Kennedy, J., concurring) (noting the importance of a defendant's ability to react to the proceedings).

186. *See supra* text accompanying notes 40–43 (discussing the less-visible side effects of antipsychotic medication, including sedation, drowsiness, or memory dysfunction).

187. *See Estelle v. Williams*, 425 U.S. 501, 503 (1976) (holding that "[t]he right to a fair trial is a fundamental liberty secured by the Fourteenth Amendment" and that the presumption of innocence is a "basic component" of that fair trial); *Johnson v. Commonwealth*, 449 S.E.2d 819, 821 (Va. 1994) (stating that "[i]t is inappropriate for a trial court to deny a courtroom participant the right to present himself in his best posture").

188. 425 U.S. 501 (1976).

189. *Estelle*, 425 U.S. at 502.

190. *Id.* at 504–05, 513.

prosecution can claim it has an interest in bringing a capital defendant to trial, it also has a “duty to see that the accused is accorded a fair trial,” and that conviction “rest[s] upon reason alone, and not upon appeals to emotion, sympathy, passion, or prejudice.”¹⁹¹

A defendant who is forced to appear before the jury under the influence of antipsychotics may suffer prejudice to the presumption of innocence similar to the potential prejudice inherent in appearing before the jury in prison garb.¹⁹² For instance, a defendant suffering visible side effects, such as tardive dyskinesia or akathisia, may be perceived as being nervous or restless, and this in turn may lead the jury to misread his level of comfort as to the testimony being given or, if testifying, his credibility.¹⁹³ Furthermore, the often numbing effects of the antipsychotics could make the defendant appear remorseless and apathetic.¹⁹⁴ In every criminal case, the defendant’s demeanor is under the constant scrutiny of the jury.¹⁹⁵ For this reason, a defendant must remain cognizant of, and in control of, his demeanor.

In a capital sentencing proceeding, the ability to control one’s demeanor is even more important and may make a difference as to whether the defendant receives a sentence of death or life in prison.¹⁹⁶ Jurors often place considerable weight on the remorsefulness of the defendant, or lack thereof, for the crime of which he has been convicted.¹⁹⁷ A defendant must therefore be able to express his true emotional state through his demeanor. In addition, a defendant who is unable to control his bodily movements due to side effects may be viewed by the jury as being unable to control himself generally. This may lead the jury to believe that the defendant’s lack of control makes him prospectively dangerous

191. *Harrison v. Commonwealth*, 32 S.E.2d 136, 140 (Va. 1944).

192. *See generally Estelle*, 425 U.S. at 501.

193. *See supra* notes 34–39 and accompanying text (discussing the more severe extrapyramidal side effects of antipsychotics).

194. *See supra* text accompanying notes 40–43 (discussing the effects of antipsychotic medication on brain function).

195. *See Riggins*, 504 U.S. at 142 (Kennedy, J., concurring) (noting that “[i]t is a fundamental assumption of the adversary system that the trier of fact observes the accused throughout the trial” and that “the defendant’s behavior, manner, facial expressions, and emotional responses, or their absence, combine to make an overall impression on the trier of fact . . . that can have a powerful influence on the outcome of the trial”).

196. *See id.* at 144 (Kennedy, J., concurring) (recognizing that in capital cases, “assessments of character and remorse may carry great weight and, perhaps, be determinative of whether the [defendant] lives or dies”).

197. *See id.* (Kennedy, J., concurring) (stating that the ability to show remorsefulness is critical in the sentencing phase of a capital case as “the sentencer must attempt to know the heart and mind of the offender and judge his character, his contrition or its absence, and his future dangerousness”); Scott Sundby, *The Capital Jury and Absolution: The Intersection of Trial Strategy, Remorse, and the Death Penalty*, 83 CORNELL L. REV. 1557, 1565 (1998) (noting that studies have shown that “defendants who are sentenced to death are highly likely to have been seen by the jurors as remorseless”).

to others.¹⁹⁸ The likelihood of such prejudice, as well as its severe effect on the fate of the defendant, appears to outweigh any possible interest the prosecution may have in bringing the defendant to trial.

A capital defendant may also have a strong argument, under the Eighth Amendment, that the forced administration of antipsychotics during the sentencing phase will unfairly prejudice his efforts to present mitigating evidence which may persuade the jury to impose a sentence less than death.¹⁹⁹ The United States Supreme Court has recognized that in a capital case, the sentencer *must* be permitted to consider “as a mitigating factor, any aspect of a defendant’s character or record and any of the circumstances of the offense.”²⁰⁰ A mental disorder so severe that it has induced the state to administer antipsychotic drugs against his will appears necessarily to be mitigating evidence.²⁰¹ A juror considering this mental condition might find the defendant to be less culpable and, thus, less deserving of a death sentence.²⁰² However, a defendant’s argument that he was mentally ill at the time of the offense would probably carry less weight if the jury sees before it a calm and impassive defendant.²⁰³

In addition, as mentioned above, a defendant under the influence of antipsychotics may not have the ability to show his true emotions.²⁰⁴ The defendant’s remorse for the crime is certainly a mitigating factor and, if present, can sway a juror’s recommendation from death to life.²⁰⁵ It follows, then, that any action by the Government that prevents this type of mitigating evidence from being introduced and considered during the sentencing phase violates clear

198. See VA. CODE ANN. § 19.2-264.2 (Michie Supp. 2003) (prohibiting a jury from imposing a sentence of death in a capital murder case unless it finds “there is a probability that the defendant would commit criminal acts of violence that would constitute a continuing serious threat to society or that his conduct in committing the offense for which he stands charged was outrageously or wantonly vile, horrible or inhuman”).

199. See U.S. CONST. amend. VIII (“Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.”).

200. Lockett v. Ohio, 438 U.S. 586, 604 (1978) (plurality opinion).

201. See Zant v. Stephens, 462 U.S. 862, 885 (1983) (noting that a defendant’s mental illness may mitigate the penalty); VA. CODE ANN. § 19.2-264.4(B) (“Facts in mitigation may include . . . (ii) the capital felony was committed while the defendant was under the influence of extreme mental or emotional disturbance . . . (iv) at the time of the commission of the capital felony, the capacity of the defendant to appreciate the criminality of his conduct . . . was significantly impaired.”).

202. While evidence of mental illness introduced during the sentencing phase is not offered as an excuse for the defendant’s actions, it does open the door for jurors’ compassion. *C.f.* Atkins v. Virginia, 536 U.S. 304, 319–20 (observing that because the mentally retarded are less culpable the deterrence theory supporting the death penalty does not apply).

203. See *supra* text accompanying notes 140–43 (noting the possible sedative side effects of antipsychotic medication).

204. See *supra* Part II.B. (discussing the potential side effects of antipsychotic medication).

205. See generally Sundby, *supra* note 197 (explaining the role of remorse in a juror’s decision-making process).

Supreme Court precedent.²⁰⁶

These arguments must be advanced prior to the start of capital proceedings and with enough time to allow the prejudicial side effects of the medication to subside.²⁰⁷ Of course, as each case calls for a different trial strategy, the cessation of medication may not be in the defendant's legal interest.²⁰⁸ For example, counsel may utilize the visible side effects of the drugs to suggest that the defendant was so mentally ill that he was unable to control his actions at the time of the offense.²⁰⁹ On the other hand, the defendant may simply refuse to stop taking the antipsychotics. Whatever the case, it appears best to advance the arguments and preserve the right to refuse at the time of trial.

B. Monitoring the Defendant's Treatment Before and During Capital Proceedings

Regardless of whether a court orders the involuntary administration of antipsychotics, defense counsel should pay particular attention to the specific treatments to which their client is subjected. An open line of communication between counsel and the treating psychiatrist is essential to keep the attorney apprised of any developments in the mental condition of the defendant, as well as changes made in the type or amount of antipsychotics being administered. This line of communication should be established at the time treatment is recommended or the appointment of counsel, whichever occurs first.

As the trial approaches, it is particularly important to keep aware of the defendant's treatment regimen. The treating psychiatrist may want to make changes in the type or amount of medication due to side effects the defendant may be experiencing or the ineffectiveness of the drugs.²¹⁰ These changes pose a risk of new side effects, including some that may render the defendant unable to assist counsel, unable to meaningfully participate in the proceedings, or even wholly incompetent to stand trial.²¹¹ Defense counsel should bring to the court's

206. See *Eddings v. Oklahoma*, 455 U.S. 104, 113–15 (1982) (holding that the Eighth Amendment requires that a defendant not be precluded, as a matter of law, from presenting to the sentencer any relevant mitigating evidence); *Lockett*, 438 U.S. at 604 (plurality opinion) (holding that in a capital case, a sentencer must be permitted to consider the defendant's character and record as a mitigating factor). See generally *Penry v. Lynaugh*, 492 U.S. 302 (1989) (holding the Texas capital sentencing scheme did not adequately provide for the jury's consideration of mental retardation as a mitigating factor); *Hitchcock v. Dugger*, 481 U.S. 393 (1987) (providing that non-statutory mitigating factors must be considered); *Skipper v. South Carolina*, 476 U.S. 1 (1986) (holding that a capital defendant's positive adjustment to life in prison prior to trial is relevant mitigating evidence admissible during the sentencing phase).

207. JULIEN, *supra* note 7, at 501–02 (noting that side effects may still continue even after ceasing the administration of antipsychotics).

208. See *infra* notes 235–38 and accompanying text (discussing the conflict between a client's legal, ethical, and medical interests).

209. See *supra* notes 199–203 and accompanying text (discussing the use of a capital defendant's mental illness as mitigating evidence).

210. See *supra* Part II.B. (discussing the potential side effects of antipsychotic medication).

211. See *supra* notes 175–95 and accompanying text (describing a number of ways in which a

attention any changes in the medication regimen which may threaten to impinge on the defendant's fair trial rights. In any case, those changes should be fully documented on a daily basis to ensure a full record for appellate review.

As mentioned earlier, the cost of "atypical" antipsychotics, which cause fewer side effects, by far exceeds the cost of the traditional antipsychotics.²¹² As a result, a pretrial capital detainee may be subjected to the administration of a form of antipsychotic that increases the risk of exhibiting side effects during trial. Defense counsel might discuss with the treating psychiatrist a possible change in medication to prevent this from occurring. While the treating psychiatrist will undoubtedly be aware of the existence of the newer antipsychotics, communication between counsel and the psychiatrist concerning the reasons why the defendant is being administered one form of drug as opposed to another can only benefit the defendant.

During the trial phase, it is critical that defense counsel keep a daily record of the defendant's treatment. A capital defendant who experiences side effects due to the involuntary administration of antipsychotics may suffer actual prejudice to his defense during both the guilt phase and, more importantly, sentencing. For example, the defense team may argue that the defendant, while mentally ill and exhibiting violent tendencies before receiving the proper treatment, no longer poses a danger to others as long as he is taking antipsychotic medication. This defense strategy, however, could be impaired if the defendant is outwardly exhibiting some of the more severe side effects of antipsychotics, such as akathisia or tardive dyskinesia.²¹³ A jury witnessing these noticeable involuntary movements may question the defendant's ability to control his other actions.²¹⁴ At the least, a daily record of treatment may show changes in the type or amount of antipsychotics that were administered during trial.

In a recent unpublished habeas decision by the United States Court of Appeals for the Fourth Circuit, *Bailey v. True*,²¹⁵ the defendant claimed that his counsel were ineffective in failing to inform the jury that his "emotionless" appearance during trial and sentencing was due to the 900 milligrams of lithium that were being administered to him each day.²¹⁶ The defendant argued that his counsel's failure "caused the jury to be misled into believing that he lacked

defendant's fair trial rights may be compromised by the side effects of antipsychotic medication).

212. See *supra* Part II.B. (discussing the potential side effects and cost of antipsychotic medication).

213. See *supra* notes 34–39 and accompanying text (discussing the extrapyramidal side effects of traditional antipsychotic drugs).

214. See VA. CODE ANN. § 19.2-264.2 (Michie Supp. 2003) (stating that one of the two statutory aggravating factors under Virginia law is a finding that "there is a probability that the defendant would commit criminal acts of violence that would constitute a continuing serious threat to society").

215. 100 Fed. Appx. 128 (4th Cir. 2004).

216. *Bailey v. True*, 100 Fed. Appx. 128, 132 (4th Cir. 2004).

remorse for the murders he had committed.”²¹⁷ The court rejected this reasoning based on the Supreme Court of Virginia’s factual finding that the trial record “does not show that such dosage was administered on the days of trial or that the medication caused the demeanor about which he complains.”²¹⁸ It can be inferred from *Bailey*, however, that if the record *had* shown the drugs had been administered and that the side effects about which he complained were a result of the administration, the defendant may have had a valid ineffective assistance of counsel claim based on his attorney’s failure to inform the jury of the treatment.²¹⁹ It is essential, then, that defense counsel ensure that the jury is informed as to the defendant’s drug regimen during trial and the possible side effects therefrom if the defendant is experiencing any changes in his demeanor due to such administration.

It is also important for defense counsel to attempt to record the defendant’s actual appearance during trial. Counsel should monitor the defendant’s behavior during the proceedings and request that any behavior by the defendant that may be prejudicial is entered into the trial record. The ideal method of preserving this type of behavior for the record, of course, would be the court’s permission to videotape the defendant during trial. While it is not clear how this may be practically accomplished, defense counsel should seek the advice of the court prior to trial and agree on a specific method.

Monitoring is important not only during the trial stages, but during the pretrial stages as well. During the pretrial stages, even immediately after the defendant has been hospitalized for restoration, the treating psychiatrist will attempt to diagnose the defendant’s illness and will prescribe the administration of a type of antipsychotic, if necessary.²²⁰ This prescription, however, may not have the intended immediate effect of restoration, and a higher dosage or new type of drug may be prescribed.²²¹ The “trial-and-error” process that follows may lead the psychiatrist to conclude that a specific type of drug is most effective in alleviating the defendant’s psychotic symptoms. It is important to remember, however, that the side effects of antipsychotic medication can be prompted by excessive dosages.²²² So, while the prescription may have alleviated the symptoms of the defendant’s psychosis, it may have also caused the defendant

217. *Id.*

218. *Id.*

219. *But see* *Albrecht v. Horn*, 314 F. Supp. 2d 451, 477–79 (E.D. Pa. 2004) (rejecting an ineffective assistance of counsel claim based on defense counsel’s failure to inform the jury of the defendant’s medicated state). In *Albrecht*, the defendant was *voluntarily* taking anti-depressants (not antipsychotics) and was unable, in the court’s opinion, to show that “the medications actually had a significant, perceptible negative effect on his testimony.” *Id.*

220. *See supra* note 149 (setting forth the federal and Virginia standards for ordering the restoration of competency through hospitalization).

221. JULIEN, *supra* note 7, at 502, 504.

222. Interview with Barbara G. Haskins, M.D., Forensic Psychiatrist, Western State Hospital, in Staunton, Va. (Aug. 23, 2004).

to experience prejudicial side effects.²²³

During this process, defense counsel should independently educate themselves as to the normal dosages of the specific medications prescribed for their client. Armed with this knowledge, counsel will be able to recognize prescribed dosages above the norm and can inquire as to the psychiatrist's reasoning. Once again, open communication between counsel and the psychiatrist can be beneficial. A simple conversation regarding the reasons for a specific dosage may lead to a decision to reduce the dosage, possibly alleviating some of the more prejudicial effects of the drugs. If nothing more, such a dialogue may apprise the psychiatrist of some of the side effects the defendant may be experiencing but failing to report.

C. Using Documented Treatment During Capital Proceedings

Defense counsel may wish to present documented evidence of the defendant's treatment for a number of reasons. First, evidence that the defendant is under the influence of antipsychotics during the voir dire, guilt, and sentencing phases can be instrumental in explaining to the jury why the defendant may appear nervous, unconcerned, or even remorseless.²²⁴ A defendant's reactions to the proceedings may be an important factor in a given juror's decision on both guilt and sentence.²²⁵ As mentioned above, a defendant under the influence of antipsychotics may experience side effects such as tremors or other involuntary movements during his own or others' testimony.²²⁶ This may appear to an unknowing juror as a sign of nervousness, thus putting the credibility of the defendant into question.²²⁷ The presentation of evidence concerning the defendant's treatment, and the potential side effects he may experience during trial, may soften any prejudicial effect. Clearly, this provides additional incentive for counsel to keep detailed records of the defendant's treatment.

To give practical effect to this strategy, defense counsel should consult with the court as to the method with which she can ensure the defendant's treatment becomes part of the record. For example, counsel may ask whether the

223. See *supra* Part II.B. (discussing the various potential side effects of antipsychotic medication).

224. See *supra* note 197 (discussing the role and importance of remorse in capital proceedings).

225. See *Riggins*, 504 U.S. at 144 (Kennedy, J., concurring) (noting that in capital cases "assessments of character and remorse may carry great weight and, perhaps, be determinative of whether the offender lives or dies").

226. See *supra* text accompanying notes 32–37 (discussing the potentially debilitating side effects of antipsychotic medication).

227. See *Riggins*, 504 U.S. at 142 (Kennedy, J., concurring) (noting that "the defendant's behavior, manner, facial expressions, and emotional responses, or their absence, combine to make an overall impression on the trier of fact . . . that can have a powerful influence on the outcome of the trial").

administrator of the medication must appear in court at the start of the proceedings each morning to testify that the defendant has in fact received the medication. If not, it may suffice simply to read the defendant's daily treatment into the record each morning. At the least, the custodian of the jail records may be called to testify as to that morning's administration. In any event, a procedure should be agreed upon prior to the start of trial to ensure efficiency, expediency, and a clear and accurate record.

In addition to the preservation of the capital defendant's constitutionally guaranteed trial rights, documentation of treatment can be instrumental in the presentation of mitigating evidence.²²⁸ As stated earlier, the United States Supreme Court has long recognized that a capital defendant is entitled to present any relevant mitigating factor during the sentencing phase.²²⁹ A defendant's mental condition is necessarily a relevant mitigating factor.²³⁰ It follows that evidence of a capital defendant's mental illness and the effects of treatment on that defendant should be presented to the jury during the sentencing phase.

In Virginia, as in other capital sentencing jurisdictions, a medical expert can be called upon to present evidence of the mental illness for which the defendant is being treated.²³¹ That expert may also be used to explain the symptoms of psychosis and the defendant's inability to control his thought processes.²³² Testimony should also be presented as to the medication's effects on the defendant's ability to express emotions during the sentencing phase. Finally, the expert should be utilized to explain the effects of the treatment upon the defendant's thought processes and the predictability of his behavior.²³³ Evidence

228. See Stephen P. Garvey, *Aggravation and Mitigation in Capital Cases: What Do Jurors Think?*, 98 COLUM. L. REV. 1538, 1564 (1998) (noting that "circumstances over which the defendant had no control and that diminish his individual responsibility at the time of the offense are highly mitigating"); John H. Blume & Pamela Blume Leonard, *Capital Cases: Principles of Developing and Presenting Mental Health Evidence in Criminal Cases*, THE CHAMPION, Nov. 2000, at 64 (recommending that defense counsel gather and document all information pertaining to the defendant's mental condition as mitigating evidence to be used at trial); John Blume, *Mental Health Issues in Criminal Cases: The Elements of a Competent and Reliable Mental Health Examination*, THE ADVOCATE, Aug. 1995, at 4–12 (describing processes for gathering and presenting evidence of a defendant's mental illness at trial, including in mitigation).

229. *Eddings*, 455 U.S. at 113–15.

230. *Lockett*, 438 U.S. at 604 (plurality opinion) (including in the definition of a mitigating factor "any aspect of a defendant's character or record and any of the circumstances of the offense").

231. See VA. CODE ANN. § 19.2-264.3:1(A) (Michie Supp. 2003) (providing that a defendant in a capital case is entitled to a qualified mental health expert "to assist the defense in the preparation and presentation of information concerning the defendant's history, character, or mental condition, including . . . whether there are any . . . factors in mitigation relating to the history or character of the defendant or the defendant's mental condition at the time of the offense").

232. See *supra* text accompanying notes 16–21 (explaining the effects of psychosis on the patient's thought content and processes).

233. See E. FULLER TORREY, SURVIVING SCHIZOPHRENIA: A MANUAL FOR FAMILIES, CONSUMERS AND PROVIDERS 175, 192 (3d ed. 1995) (noting that nearly seventy percent of

of the capital defendant's treatment and results is directly relevant to, and can be used to rebut, a charge of future dangerousness.²³⁴

It might also be helpful for the expert to draw a comparison between the defendant's erratic behavior *before* undergoing treatment and the defendant's calmer demeanor once the treating psychiatrists discovered the optimal combination of antipsychotics. To further this endeavor, counsel may consider videotaping interviews with the defendant. A videotaped session during counsel's early visits with the defendant may provide the jury with a vivid contrast to the more composed individual before them in court. In any event, it is evident that the more detailed the record of defendant's psychological progression, whether on video or on paper, the more beneficial it will be for the defendant during capital proceedings.

IV. Ethical Considerations

In both the civil and criminal arenas, it is the attorney's duty to do everything within the law to obtain a resolution that she feels is in her client's best interest.²³⁵ In a criminal case, a defense attorney's primary goal is to secure a verdict or plea that exposes the client to the smallest punishment.²³⁶ In practice, however, a client may have other interests that compete with this "legal interest." For example, a client may accept a plea bargain rather than put his family through the turmoil of a lengthy and publicized trial. Although the attorney may feel there exists a strong possibility the client would receive a more favorable verdict at trial, the client's "best" interests may be served by accepting the plea offer.

A defense attorney who represents a capital defendant suffering from a mental disease may find her client has competing medical interests of which the client may not even be aware. For instance, the client may not acknowledge or understand that the suicidal thoughts he experiences are due to a mental illness. It is obviously in his best medical interest, however, to address his condition with the proper medical treatment, via antipsychotics or otherwise. But, what should his attorney do if that *medical* interest conflicts with the client's best *legal* interest?

In light of the Supreme Court's decision in *Sell*, it may often be in the best *legal* interest of a non-dangerous defendant to refuse the administration of antipsychotics and thus force the state to find alternate means of rendering him

schizophrenic patients realize a clear improvement from the use of antipsychotic drugs).

234. See *supra* note 198 (explaining that "future dangerousness" is one of two aggravating factors in Virginia, one of which must be found before a jury can sentence a defendant to death).

235. See VIRGINIA RULES OF PROF'L CONDUCT R. 1.2 (2000) ("A lawyer shall abide by a client's decisions concerning the objectives of representation . . . and shall consult with the client as to the means by which they are to be pursued.").

236. *Id.* In many capital murder cases, of course, the primary goal is to secure a sentence for life in prison without the possibility of parole.

competent to stand trial.²³⁷ The best course of legal action, then, would be for defense counsel to instruct the defendant to refuse the antipsychotics, thus protecting his fair trial rights. The defendant, however, may not want to refuse the medication. He may understand that he has an illness and appreciate the fact that there exists medication that will help alleviate his symptoms.²³⁸ If the defendant decides he wants to continue the administration of antipsychotics, defense counsel should advise him of the possible repercussions of that decision, including a recommendation that he speak with his psychiatrist concerning the possible side effects of the drugs. Counsel should also advise the defendant of his right to refuse the medication and the possible benefits of such a refusal during trial.

V. Jury Instructions

Whether a capital defendant volunteers for or is ordered to undergo treatment via antipsychotic medication during trial, it is imperative that the jury is apprised of the possible side effects the defendant may be experiencing. Because the jurors' impressions of the defendant, as formed through his reactions to the proceedings, play a significant part in determining whether to recommend life or death, it is important that they are reminded of his treatment at all times.

Naturally, the first time the potential jurors will see the defendant is at voir dire.²³⁹ The judge will, after they are seated but before voir dire has begun, address the venirepersons with a set of preliminary instructions regarding their purpose for being present in the courtroom, the presumption of innocence, and the burden of proof.²⁴⁰ A defense attorney should move the court, *in limine*, to

237. See Matthew Easley, *Lawyers Letting Client's Mental Illness Flourish*, NEWS & OBSERVER (Raleigh, NC), Feb. 14, 2001, at A1 (discussing Russell Weston's attorneys' legal and ethical decision to refuse to let doctors treat him so long as the prosecution refused to waive the death penalty).

238. During his interview with Barbara G. Haskins, M.D. at Western State Hospital, the author had the opportunity to meet with an accused who had just begun treatment with antipsychotics. Interview with Barbara G. Haskins, M.D., Forensic Psychiatrist, Western State Hospital, in Staunton, Va. (Aug. 23, 2004). The patient, who had upon being relocated to the hospital refused to take the medication, now expressed his desire to "get better" and to take the medication. *Id.* Dr. Haskins explained that this was a common progression among patients experiencing delusional episodes, and that it often takes time to convince the patient that the delusions are not real and that the medication can assist them. *Id.*

239. See *Faretta v. California*, 422 U.S. 806, 819 (1975) (holding that the Confrontation Clause of the Sixth Amendment guarantees the right of a criminal defendant to be present at all critical stages of the trial); *United States v. Rolle*, 204 F.3d 133, 137 (4th Cir. 2000) (noting that the "defendant's presence at voir dire is of utmost importance").

240. See VA. SUP. CT. R. 1:21 (Michie 2003) ("At the outset of jury selection in any civil or criminal case, the court shall deliver preliminary instructions that: (1) explain the purpose of the voir dire examination, (2) explain the difference between peremptory challenges and removals for cause, (3) summarize the nature of the case, (4) estimate how long the trial may last, and (5) indicate

include at this point an instruction regarding the defendant's medicated state.²⁴¹

While the court will most likely decline to give an instruction regarding specific side effects the defendant may be experiencing, it is important that the venire and eventual jury be apprised of the fact that the defendant is under the influence of medications that have the potential to induce visible side effects. The instruction should remind the prospective jurors that any perception they formulate of the defendant through the course of the proceedings should allow for the fact that he is undergoing medical treatment. A sample pre-voir dire instruction might read as follows:

I have been informed by the parties that the defendant, Mr./Ms. _____, is currently, and will probably be through the remainder of the trial, under the influence of medication for an illness from which he/she is currently suffering. I have also been informed that these medications have been known to cause certain side effects. Some of these medications can affect a person's ability to express emotion or even cause that person to make involuntary movements. Throughout the course of this trial you may form an opinion of Mr./Ms. _____ based on his/her conduct, expression, statements, and reaction to testimony. I advise you, however, to keep in mind that Mr./Ms. _____ is under the influence of these medications and may or may not be experiencing some of the side effects I have mentioned. I have no personal feeling as to whether the defendant is necessarily experiencing any of these side effects, but it is important to keep in mind that he/she may at some point during the trial.

In a perfect world, of course, counsel would prefer to have this or a similar instruction given multiple times during capital proceedings: during the preliminary instructions to the venire; during preliminary instructions to the empaneled jury; during pre-deliberation instructions of the guilt/innocence phase; before opening statements of the sentencing phase; and during pre-deliberation instructions of the sentencing phase. Counsel should move the court to instruct the venire/jury at each of these times, but should emphasize the importance of instructing the jury during both sets of pre-deliberation instructions.

VI. Conclusion

With the recent advances in antipsychotic pharmacology, the risk of

whether it is anticipated that the jury will be sequestered.”).

241. Counsel may also request the court to include the instruction by way of pretrial motion. *See* VA. SUP. CT. R. 3A:16(b) (Michie 2003) (“If directed by the court the parties shall submit proposed instructions to the court at such reasonable time before or during the trial as the court may specify and, whether or not proposed instructions have been submitted earlier, the parties may submit proposed instructions at the conclusion of all the evidence.”).

potentially debilitating side effects is now less severe.²⁴² A risk still exists, however, that a capital defendant will experience *some* side effects while under the influence of antipsychotic medication.²⁴³ For this reason, an attorney representing a capital defendant in need of this form of medical treatment may be faced with a number of legal and ethical issues. The right to refuse the administration of antipsychotics has continued to evolve through United States Supreme Court decisions, and mentally ill defendants' fair trial rights are garnering greater protection.²⁴⁴ With this changing legal landscape comes an opportunity for defense counsel to more adequately ensure a capital defendant's constitutionally guaranteed right to a fair trial. The more knowledge a defense attorney obtains regarding her client's specific condition and the methods being used to treat him, the more effectively she can protect his interests, both legally and medically. Therefore, it is increasingly important for an attorney to monitor closely the medical decision-making process, even if only to maintain a level of awareness as to her client's specific treatment.

In addition, the presentation of evidence concerning the defendant's treatment during the various trial phases will protect the defendant against the potentially prejudicial effects that the administration of antipsychotics may have on the jury's perception of the defendant. It is equally critical that the jurors are at all times aware of the defendant's treatment so as to ensure that their impression of the defendant's culpability and potential for future dangerousness is not distorted by the drugs' effects on his demeanor. The more a jury knows about the capital defendant's current medical situation, the more fairly it can assess his true culpability, character, and capacity for remorse. Even more importantly, the more an attorney knows about the current treatment being administered to her client, the more effectively she can prepare her client and his defense.

242. See *supra* Part II.B. (discussing the potential side effects of antipsychotic medication).

243. *Id.*

244. See *supra* Part III.A. (discussing *Sell* and its effect on a pretrial detainee's right to refuse medication).