

Singleton v. Norris: Exploring the Insanity of Forcibly Medicating, then Eliminating, the Insane

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Much madness is divinest sense
To a discerning eye;
Much sense the starkest madness.
'Tis the majority
In this, as all, prevails.
Assent, and you are sane;
Demur, – you're straightway dangerous,
And handled with a chain.

Emily Dickinson

I. INTRODUCTION

On February 10, 2003, the United States Court of Appeals for the Eighth Circuit voted to permit the State of Arkansas to forcibly administer antipsychotic medication to Charles Singleton, a mentally ill death row inmate, in order to render him competent for execution.¹ Eight months later, the United States Supreme Court denied certiorari,² thus allowing the Eighth Circuit decision to stand. This article examines the recent Eighth Circuit Court decision in *Singleton v. Norris* in light of the history of mental health law, explores an inmate's right to refuse medication, questions the propriety of the death penalty as applied to the mentally ill, and addresses significant constitutional and ethical problems that arise from the *Singleton* decision.

Part One of this Note provides a brief history of American perceptions of the "insane," from the seventeenth century onward, and consequent treatments thereof. The section continues with the development of psychotropic drugs, followed by a discussion of particular drugs used in the treatment of psychotic disorders and their diverse side effects. Finally, this part includes a current report of psychotropic drug effectiveness.

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¹ *Singleton v. Norris*, 319 F.3d 1018 (8th Cir. 2003), *cert. denied* 540 U.S. 832 (2003).

² *Singleton v. Norris*, 540 U.S. 832 (2003).

Part Two of the Note reviews the cornerstone cases of mental health law relevant to an inmate's right to refuse unwanted antipsychotic medication, including *Washington v. Harper*,³ *Riggins v. Nevada*,⁴ and *Sell v. United States*.⁵ The cases in this section illustrate the progression of a prisoner's right to refuse antipsychotic medication not only while incarcerated, but also during trial. These precedents set forth the framework necessary for analyzing the critical legal question presented in *Singleton*.

Part Three begins with a summary of the evolution of the Eighth Amendment's prohibition of "cruel and unusual punishments." An historical overview of the execution of the mentally ill is also provided, highlighting significant cases leading up to *Ford v. Wainwright*.⁶ Finally, justifications often cited by advocates of the death penalty are depicted, along with questions as to their validity.

Part Four describes the courts' efforts to address whether a person deemed incompetent may be forcibly medicated in order to restore competency for execution. This section begins with a discussion of the only other cases in the United States that confronted the issue of forcibly medicating a prisoner for execution: *State v. Perry*⁷ and *Singleton v. State*.⁸ Both the Louisiana Supreme Court and the South Carolina Supreme Court concluded that forcible medication to facilitate execution was "cruel and unusual." However, as mentioned above, the Eighth Circuit decided differently, and a discussion of *Singleton v. Norris* follows.

To further explore the issue of competence, the execution of the mentally retarded and juveniles is addressed in Part Five. Close attention is paid to the recent United States Supreme Court decision in *Atkins v. Virginia*,⁹ which excluded the mentally retarded from capital punishment. Furthermore, Part Five considers the execution of juvenile

³ 494 U.S. 210 (1990) (holding that a prisoner has a due process right to refuse unwanted antipsychotic drugs).

⁴ 504 U.S. 127 (1992) (holding that forced antipsychotic medication prevented a full and fair trial).

⁵ 539 U.S. 166 (2003) (holding that antipsychotic medication may not be forced on a defendant to restore competency for trial unless the medication is medically appropriate, the least intrusive means of restoring competence, and does not infringe on trial rights).

⁶ 477 U.S. 399 (1986) (holding that the Eighth Amendment's prohibition of "cruel and unusual punishments" bars the execution of the insane).

⁷ 610 So. 2d 746 (La. 1992).

⁸ 437 S.E.2d 53 (S.C. 1993).

⁹ 536 U.S. 304 (2002).

offenders in United States Supreme Court cases *Thompson v. Oklahoma*¹⁰ and *Stanford v. Kentucky*.¹¹ An examination of these United States Supreme Court categorical exclusions from the death penalty helps clarify the Court's notions of what is humane and is therefore relevant to the issue at hand.

Part Six, a critique of the Eighth Circuit's decision in *Singleton v. Norris*, begins with an analysis of the *Singleton* Court's reliance on *Ford v. Wainwright*,¹² *Washington v. Harper*,¹³ *Riggins v. Nevada*,¹⁴ and *United States v. Sell*.¹⁵ In addition, the role of antipsychotic medication in the forced competency of death row inmates for execution is explored. The reasoning in *Singleton* is then compared to the underlying principles of exemptions from execution afforded to other groups such as the mentally retarded and juveniles. Lastly, Part Six describes the various ethical codes guiding the medical field and conveys the reactions of several professionals confronted with the pressures and hardships of being asked to treat a mentally ill patient for the ultimate goal of achieving competency for execution.

Finally, Part Seven suggests alternative solutions to the forced medication of the mentally ill for execution that has been adopted by the Eighth Circuit. In closing, Part Seven also provides a brief summary of the issues discussed throughout the Note and advocates that the United States Supreme Court revisit the issue in order to put an end to the inhumane practice presently occurring in the Eighth Circuit.

II. BACKGROUND: THE EMERGENCE OF ANTIPSYCHOTIC MEDICATION

A. *Brief Overview of American Psychiatry: The Seventeenth Century to the 1950s*

Because of the ancient belief that insanity was caused by a full moon or supernatural and demonic possession, those suffering from mental illnesses were treated by medicine men or other religious figures throughout the 1600's.¹⁶ Throughout the eighteenth century, the insane

¹⁰ 487 U.S. 815 (1988).

¹¹ 492 U.S. 361 (1989).

¹² 477 U.S. 399 (1986).

¹³ 494 U.S. 210 (1990).

¹⁴ 504 U.S. 127 (1992).

¹⁵ 282 F.3d 560 (8th Cir. 2002).

¹⁶ LYNN GAMWELL & NANCY TOMES, *MADNESS IN AMERICA: CULTURAL AND MEDICAL PERCEPTIONS OF MENTAL ILLNESS BEFORE 1914* at 15, 17 (1995); see also *The History of Mental Illness*, <http://www.ohiou.edu/~ridges/history.html> (last visited Mar. 20,

were seen as “little better than animals” and the first hospitals were created to “protect citizens from the threat to social order posed by violent lunatics.”¹⁷ During the 1700’s, treatment of the mentally ill shifted from spiritual to physical, which included procedures such as drowning in an ice bath,¹⁸ forced vomiting,¹⁹ the near-starvation diet,²⁰ and the infamous “bleeding” practice.²¹ It was believed that these remedies were therapeutic because “they inflicted considerable pain, and thus the madman’s mind became focused on this sensation rather than on his usual raving thoughts.”²² These procedures were eventually terminated when more humane treatments such as phrenology, hypnosis, and relaxation were introduced in the 19th century.²³

In the late 1800’s, countless asylums, financially supported by state and federal government, began to spread all over the United States.²⁴ Because of the lack of specific requirements for allowing patients into the asylums, overcrowding became a serious problem and patient care decreased, with asylums once again returning to ice baths, electro-shock therapies, and in the late 1930’s to the mid 1950’s, the lobotomy.²⁵ In the late 1940’s, psychotropic medication was introduced in America.²⁶ Finally, in the mid-1950’s, asylums were able to release patients in mass numbers because of the development of psychotropic

2004); *See also History of Mental Illness*, <http://www.mentalwellness.com/schizophrenia/about/history.jsp> (last visited Mar. 20, 2004).

¹⁷ GAMWELL, *supra* note 16, at 19.

¹⁸ ROBERT WITAKER, *MAD IN AMERICA: BAD SCIENCE, BAD MEDICINE, AND THE ENDURING MISTREATMENT OF THE MENTALLY ILL* 11–12 (Perseus Publishing 2002) (2001).

¹⁹ *Id.* at 7. Some of the purging techniques were described as follows: “Mercury and other chemical agents . . . were used to induce nausea so fierce that the patient could not hope to have the mental strength to rant and rave.” *Id.*

²⁰ *Id.*

²¹ *Id.*; *see also The History of Mental Illness*, *supra* note 16. The bleeding practice “entailed draining the bad blood from the individual, unfortunately this inhumane practice normally resulted in death or the need for lifelong care; at best the odds were one in three that this procedure would actually lead to an improvement in the patient’s health.” *Id.*

²² WITAKER, *supra* note 18, at 7.

²³ *The History of Mental Illness*, <http://www.ohiou.edu/~ridges/history.html> (last visited Mar. 20, 2004).

²⁴ *Id.*

²⁵ *Id.*; *see also* PETER SCHRAG, *MIND CONTROL* 5 (1978); *History of Mental Illness*, <http://www.mentalwellness.com/schizophrenia/about/history.jsp> (last visited Mar. 20, 2004).

²⁶ RALPH REISNER ET AL., *LAW AND THE MENTAL HEALTH SYSTEM* 22 (4th ed. 2004).

drugs.²⁷ Because of the quick success of the drugs, patients were able to spend less time in mental facilities and more time in outpatient programs, families' homes, nursing homes, and halfway houses.²⁸

In 1949, lithium was the first successful psychotropic, also known as antipsychotic, drug used to treat bipolar affective disorders.²⁹ The success of lithium in treating symptoms in bipolar disorders encouraged the development of other psychiatric medications through the ensuing decades.³⁰ A variety of antidepressant drugs were introduced in the 1950's, followed by antipsychotic medication such as chlorpromazine, commonly known as Thorazine.³¹ Additional drugs, targeting anxiety disorders, were developed throughout the 1970's and the 1980's.³² Since the late 1980's, depression medications have been the main focus of drug developers.³³ In the last decade, a new class of drugs called atypical antipsychotics ("atypicals") has been introduced.³⁴ Although atypicals exhibit reduced side effects in some patients, these drugs are not yet available in injectable form.³⁵ As such, treating physicians continue to rely on conventional drugs given the higher cost of atypicals and their impractical form.³⁶

B. *Psychosis*

1. *The Definition and Treatment of Psychosis*

Although there is not one universally accepted definition of "psychotic," the American Psychiatric Association's *Diagnostic and*

²⁷ WITAKER, *supra* note 18, at 141.

²⁸ *The History of Mental Illness*, *supra* note 16.

²⁹ *Id.* Bipolar disorders are characterized by "episodes of depression and 'highs,' the later corresponding to what is known as the 'manic' phase." *Id.* at 26.

³⁰ *Id.* at 22.

³¹ *Id.* Some of the drugs developed during the 1950's included monoamine oxidase inhibitors and tricyclics/heterocyclics.

³² *Id.*

³³ *Id.* Selective serotonin reuptake inhibitors include medications most commonly known as Prozac, Zoloft, Paxil, Luvox, Celexa, and Lexapro. *Id.* at 25.

³⁴ *Recent Developments in Atypical Antipsychotic Medications*, http://www.healthyplace.com/Communities/Thought_Disorders/schizo/medications (last visited July 15, 2004).

³⁵ Amicus Brief in Support of the Appellees at 18, *Hargrave v. Vermont*, 340 F.3d 27 (2d Cir. 2003) (No. 02-7160). In their brief to the Second Circuit Court of Appeals regarding advanced directives, the Amici Curiae state, "atypicals are not without serious risks and side effects which will continue to justify refusals in particular cases." *Id.* at 19.

³⁶ *Id.*

Statistical Manual of Mental Disorders (Fourth Edition) (DSM-IV) defines the term according to the presence of certain symptoms.³⁷ Psychotic diagnoses vary depending upon specific symptoms in each of the following categories: Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, and Brief Psychotic Disorder.³⁸ Schizophrenia is a “disorder that lasts for at least six months and includes at least one month of active-phase symptoms (*i.e.*, two [or more] of the following: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, negative symptoms).”³⁹ Schizophrenia subtypes include Paranoid, Disorganized, Catatonic, Undifferentiated, and Residual.⁴⁰ Schizophreniform Disorder’s symptoms are “equivalent to Schizophrenia except for its duration (*i.e.*, the disturbance lasts from one to six months) and the absence of a requirement that there be a decline in functioning.”⁴¹ Schizoaffective Disorder is “a disorder in which a mood episode and the active-phase symptoms of Schizophrenia occur together and were preceded or are followed by at least two weeks of delusions or hallucinations without prominent mood symptoms.”⁴² Finally, Brief Psychotic Disorder is “a disorder that lasts more than one day and remits by one month.”⁴³ Within each of the foregoing categories, the term “psychotic” refers to “delusions, any prominent hallucinations, disorganized speech, or disorganized or catatonic behavior.”⁴⁴

Within the two categories of Psychotic Disorder Due to a General Medical Condition and in Substance-Induced Psychotic Disorder, the term “psychotic” refers to “delusions or only those hallucinations that are not accompanied by insight.”⁴⁵ In Psychotic Disorder Due to a General Medical Condition, the psychotic symptoms are “a direct physiological consequence of a general medical condition.”⁴⁶ Substance-Induced Psychotic Disorder symptoms are “a direct physiological consequence of a drug of abuse, a medication, or toxin exposure.”⁴⁷

³⁷ AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 297 (4th ed. 2000) [hereinafter DSM-IV].

³⁸ *Id.*

³⁹ *Id.* at 298.

⁴⁰ *Id.*

⁴¹ *Id.*

⁴² *Id.*

⁴³ *Id.*

⁴⁴ *Id.* at 297.

⁴⁵ *Id.* at 297–98.

⁴⁶ *Id.* at 298.

⁴⁷ *Id.*

Lastly, in the remaining two categories of Delusional Disorder and Shared Psychotic Disorder, “psychotic” is “equivalent to delusional.”⁴⁸ Delusional Disorder is characterized “by at least one month of nonbizarre delusions without other active-phase symptoms of Schizophrenia.”⁴⁹ In Shared Psychotic Disorder, the symptoms are characterized by “the presence of a delusion in an individual who is influenced by someone else who has a longer-standing delusion with similar content.”⁵⁰ As demonstrated by the DSM-IV, the term “psychotic” usually includes a delusional state.

Antipsychotic drugs, also called neuroleptics, are primarily used in the treatment of schizophrenic disorders.⁵¹ Thorazine (chlorpromazine), Prolixin (fluphenazine), Clozaril (clozapine), and Haldol (haloperidol) are typically used for the treatment of schizophrenia.⁵² A specific neuroleptic for a particular patient is determined to a “considerable degree” by trial and error.⁵³ A patient’s dosage will also vary depending on a variety of factors, including illness severity, negative side effects, and metabolic rate.⁵⁴

About 75% of schizophrenics respond to traditional neuroleptics that work by blocking receptor sites for dopamine.⁵⁵ On the other hand, one-quarter of all schizophrenics have no response.⁵⁶ Moreover, between 15-20% of schizophrenic patients experience a relapse in any given year while on medication.⁵⁷ While antipsychotic medication is often effective in reducing and alleviating psychotic symptoms while directly interacting with the body, the drugs are not a cure for the underlying mental illness.⁵⁸

2. *Side Effects*

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ REISNER ET AL., *supra* note 26, at 27.

⁵² *Id.*

⁵³ *Id.* at 27–28.

⁵⁴ *Id.* at 28.

⁵⁵ *Id.* at 38.

⁵⁶ *Id.*

⁵⁷ *Id.*; see also Margie Patlak, *Schizophrenia: Real Lives, Imaginary Terror*, 31 FDA CONSUMER 23 (Sept.–Oct. 1997).

⁵⁸ REISNER ET AL., *supra* note 26, at 27; see also Michelle K. Bachand, Note, *Antipsychotic Drugs and the Incompetent Defendant: A Perspective on the Treatment and Prosecution of Incompetent Defendants*, 47 WASH. & LEE L. REV. 1059, 1060–61 (1990) (“health practitioners agree that antipsychotic drugs do not cure mental illness, but instead provide only temporary relief”).

Usual side effects of antipsychotic medication include ataraxia (zombielike feeling), sedation, blurry vision, akathisia (restlessness, such as continuous leg movement), low blood pressure (light-headedness, dizziness), dry mouth, and constipation.⁵⁹ Other common side effects include dystonia (involuntary contractions or muscle spasms), tremors and slowed or stiff movements resembling Parkinson's disease, and tardive dyskinesia, a potentially irreversible disorder of abnormal, rhythmical, involuntary muscle movements.⁶⁰ Other possible side effects of antipsychotic medications include cholestatic jaundice, skin rashes, sun sensitivity, and a lowering of the white blood cell count.⁶¹ Furthermore, all antipsychotics can cause neuroleptic malignant syndrome, a rare but severely toxic reaction that is potentially fatal.⁶²

Numerous recipients of antipsychotic medication are described as “zombies” or as having had a “chemical lobotomy” because of the common side effect of extreme sedation.⁶³ A patient's psychotic symptoms are chemically altered with medication, resulting in diminished thinking and reduced emotional responses.⁶⁴ These “synthetically sane” patients appear “bored, lethargic and indifferent to what is going on around them ... being drowsy, confused and unable to stay awake or think clearly.”⁶⁵ Since the drugs' efficiency varies from person to person depending on the exact situation, length of treatment and symptoms, the effects of antipsychotic medication cannot be predicted.⁶⁶

⁵⁹ EDWARD DRUMMOND, *THE COMPLETE GUIDE TO PSYCHIATRIC DRUGS* 170, 179, 193, 199 (2000).

⁶⁰ *Id.* Tardive dyskinesia is a disorder that most commonly affects the muscles in the mouth and the tongue, but can also affect the trunk, hands and feet. *Id.* at 288. The movements, ranging from mild to grossly incapacitating, generally occur only after one year of neuroleptic use. *Id.* Those who take standard antipsychotics develop tardive dyskinesia at the rate of 10 to 20 percent a year. *Id.* Symptoms, once developed, usually remain at a constant level of severity, although other areas of the body may be gradually affected. *Id.* There is no cure for tardive dyskinesia. *Id.*

⁶¹ REISNER ET AL., *supra* note 26, at 29.

⁶² DRUMMOND, *supra* note 59, at 286. Symptoms of neuroleptic malignant syndrome include a high fever, muscle rigidity, mental status changes, irregular pulse and blood pressure, and sweating. *Id.* Muscle damage and renal failure can occur and lead to death. *Id.*

⁶³ *Riggins v. State*, 808 P.2d 535, 540 (Nev. 1991); see DRUMMOND, *supra* note 59, at 170; see also Vickie L. Feeman, Note, *Reassessing Forced Medication of Criminal Defendants in Light of Riggins v. Nevada*, 35 B.C.L. REV. 681, 699 (1994).

⁶⁴ Feeman, *supra* note 63, at 699.

⁶⁵ *Id.*

⁶⁶ *Id.* at 698.

II. THE USE OF PSYCHOTROPIC MEDICATION IN PRISONS AND DURING TRIAL: DOES AN INMATE HAVE A RIGHT TO REFUSE UNWANTED ANTIPSYCHOTIC MEDICATION?

A. *When Drugs are Forces on an Inmate in Prison: Washington v. Harper*

In 1990, the United States Supreme Court held in *Washington v. Harper*⁶⁷ that a prisoner may only be involuntarily medicated if the treatment is justified by legitimate and sufficient state interest.⁶⁸ *Harper* involved a convicted prison inmate who claimed that the State of Washington violated his due process rights by forcibly administering antipsychotic drugs without his consent while he was incarcerated.⁶⁹

Walter Harper was convicted of robbery in 1976.⁷⁰ He spent the majority of his sentence in the mental health unit, where he consented to antipsychotic drug treatment.⁷¹ In 1980, Harper was granted parole upon the condition that he agreed to continue psychiatric treatment.⁷² The following year, Harper was returned to prison after assaulting two hospital nurses.⁷³ This time he was placed in the Special Offender Center (SOC), where he was diagnosed with manic-depressive disorder and was voluntarily treated with antipsychotic medication.⁷⁴ However, a year later, when Harper revoked his consent and refused to take his prescribed medications, the treating physician attempted to force the drugs on Harper while following SOC policy.⁷⁵

The policy stipulated that if an inmate does not consent to diagnosed treatment, medication may be forced only if he (1) suffers from a “mental disorder” and (2) is “gravely disabled” or poses a “likelihood of serious harm” to himself or others.⁷⁶ Under this policy, an inmate was entitled to a hearing to determine whether the inmate satisfied the two-prong test.⁷⁷

⁶⁷ 494 U.S. 210 (1990).

⁶⁸ *Id.* at 236.

⁶⁹ *Id.* at 217.

⁷⁰ *Id.* at 213.

⁷¹ *Id.*

⁷² *Id.* at 214.

⁷³ *Id.*

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ *Id.* at 216.

⁷⁷ *Id.*

Considered a danger to others because of his mental illness, Harper continued to receive antipsychotic medication against his will.⁷⁸ In 1985, he filed suit under 42 U.S.C. § 1983 against the State of Washington claiming that federal and state Due Process, Equal Protection, and Free Speech Clauses had been violated by his forced medication without a proper judicial hearing.⁷⁹

The state trial court concluded that since the SOC policy procedures met due process requirements, Harper could be forcibly medicated.⁸⁰ The Washington Supreme Court reversed on appeal, holding that the “highly intrusive nature” of the antipsychotic drug treatment called for much greater procedural protections and thus demanded a full judicial hearing.⁸¹ Furthermore, the Court emphasized that the state must demonstrate that the unwanted drug treatment was essential and effective in advancing a compelling state interest.⁸²

The United States Supreme Court granted certiorari⁸³ and reversed the Washington Supreme Court decision.⁸⁴ The United States Supreme Court declared that “respondent possesses a significant liberty interest in avoiding unwanted administration of antipsychotic drugs.”⁸⁵ Nevertheless, the Court held that the Due Process Clause allows a state to treat a mentally ill prisoner 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.”⁸⁶ While balancing the interests, the Court reasoned that since prisons are comprised of inmates with “a demonstrated proclivity for antisocial criminal, and often violent, conduct,” the state had an obligation to maintain control and guarantee personal safety.⁸⁷

The *Harper* dissent contended that the majority failed to properly consider Harper’s liberty interest in refusing unwanted antipsychotic drugs.⁸⁸ In his dissent, joined by Justices Brennan and Marshall, Justice Stevens described how several aspects of Harper’s liberty, both physical and intellectual, were ignored:

⁷⁸ *Id.* at 217.

⁷⁹ *Id.*

⁸⁰ *Id.* at 217–18.

⁸¹ *Id.* at 218.

⁸² *Id.*

⁸³ *Washington v. Harper*, 489 U.S. 1064 (1989).

⁸⁴ *Harper*, 494 U.S. at 218.

⁸⁵ *Id.* at 221.

⁸⁶ *Id.* at 227.

⁸⁷ *Id.* at 225.

⁸⁸ *Id.* at 237.

Every violation of a person's bodily integrity is an invasion of his or her liberty. The invasion is particularly intrusive if it creates a substantial risk of permanent injury and premature death . . . And when the purpose or effect of forced drugging is to alter the will and the mind of the subject, it constitutes a deprivation of liberty in the most literal and fundamental sense.⁸⁹

According to the dissent, not only was Harper's bodily integrity violated, but also his right to be free from unpredictable, mind-altering medication was significantly undervalued.⁹⁰

B. When Drugs Affect a Defendant's Ability to Assist at Trial: Riggins v. Nevada

The *Harper* balancing test was again applied by the United States Supreme Court when it reversed the conviction of a defendant made competent to stand trial through forced medication. In *Riggins v. Nevada*,⁹¹ the Court considered whether a criminal defendant could be involuntarily medicated to achieve competency for trial.

Riggins faced charges of robbery and capital murder. While incarcerated, he confided in the jail psychiatrist that he heard voices in his head and was having trouble sleeping.⁹² Riggins also informed the psychiatrist of past successful treatment with an antipsychotic drug, Mellaril.⁹³ The psychiatrist prescribed Mellaril as well as Dilantin, an antiepileptic drug.⁹⁴

When brought before a panel of three court-appointed psychiatrists for a determination of his competence to stand trial, Riggins was found competent by two of the psychiatrists and incompetent by the third.⁹⁵ However, despite the defense's objections, the court found

⁸⁹ *Id.* at 237–38.

⁹⁰ *See id.*

⁹¹ 504 U.S. 127 (1992).

⁹² *Id.* at 129.

⁹³ *Id.* Mellaril (thioridazine) is a standard antipsychotic drug used in psychotic disorders. DRUMMOND, *supra* note 59, at 248. Common side effects include sedation, ataxia (zombielike feeling), akathisia (restlessness), pseudoparkinsonism (muscular tremor, rigidity), fatigue, low blood pressure, and tardive dyskinesia. *Id.* at 249.

⁹⁴ *Riggins*, 504 U.S. at 129.

⁹⁵ *Id.* at 129–30.

Riggins legally competent and ordered him to stand trial.⁹⁶ The defense counsel voiced concerns about the drugs' effect on Riggins' mental state, arguing that the medication would infringe on his freedom, by affecting his demeanor and mental state during trial.⁹⁷ Because the defense planned to offer an insanity defense, Riggins argued that he had a right to show jurors his "true mental state."⁹⁸

The trial court denied Riggins' motion to terminate the drug treatment and throughout the trial, Riggins was given extremely large doses of Mellaril 800.⁹⁹ Pleading insanity, Riggins testified on his own behalf as to the events of the murder.¹⁰⁰ The jury convicted Riggins of murder and sentenced him to death.¹⁰¹ On appeal, the Nevada Supreme Court affirmed the conviction and death sentence.¹⁰²

The United States Supreme Court granted certiorari to decide whether the forced administration of antipsychotic drugs during trial violated Riggins' Sixth and Fourteenth Amendment rights.¹⁰³ Finding that his rights were violated, the Court reversed the conviction.¹⁰⁴ In its reasoning, the Court declined to adopt a strict scrutiny standard.¹⁰⁵ Rather, it established a three-prong test. In order for the government to forcibly medicate an individual, the government must (1) "present an essential state interest that outweighs the individual's interest in remaining free from medication," (2) "prove that there is no less intrusive way of fulfilling its essential interest," and (3) "prove by clear and convincing evidence that the medication is medically appropriate."¹⁰⁶ The Supreme Court noted, "[u]nder *Harper*, forcing antipsychotic drugs on a convicted prisoner is impermissible absent a finding of overriding justification and a determination of medical appropriateness."¹⁰⁷ Therefore, according to the Court, once Riggins asked to be taken off antipsychotic medication, the State became

⁹⁶ *Id.* at 130.

⁹⁷ *Id.* As stated, common side effects of Mellaril include sedation, fatigue, restlessness, and ataxia (zombielike feeling), all observable symptoms to a jury that could greatly prejudice a defendant during trial. See DRUMMOND, *supra* note 59, at 249.

⁹⁸ *Riggins*, 504 U.S. at 130.

⁹⁹ *Id.* at 131. Riggins received 800 milligrams per day, which is the maximum dose recommended by the manufacturer. DRUMMOND, *supra* note 59, at 249.

¹⁰⁰ *Riggins*, 504 U.S. at 131.

¹⁰¹ *Id.*

¹⁰² *Riggins v. State I*, 808 P.2d 535 (Nev. 1991).

¹⁰³ *Riggins*, 504 U.S. at 132–33.

¹⁰⁴ *Id.*

¹⁰⁵ *Id.* at 135.

¹⁰⁶ *United States v. Sell*, 282 F.3d 560 (8th Cir. 2002) (citing *Riggins*, 504 U.S. at 135).

¹⁰⁷ *Riggins*, 504 U.S. at 135.

obligated to demonstrate that the medication was necessary to achieve a compelling state interest and that the drug was medically appropriate.¹⁰⁸

Extending the rule in *Harper*, the United States Supreme Court concluded that the administration of drugs during the trial was not supported by any necessary state interest and reversed the Nevada Supreme Court judgment.¹⁰⁹ Moreover, the Court noted that the forced medication had interfered with Riggins' liberty interest in freedom from unwanted antipsychotic drugs and also generated an unacceptable risk of prejudice, thus denying him a fair trial.¹¹⁰

Justice Kennedy authored a separate concurrence to emphasize his concerns that the Due Process Clause requires an extraordinary showing by a state before officials can forcibly medicate the defendant to achieve competency for trial.¹¹¹ Furthermore, Justice Kennedy expressed doubt that a state could meet the evidentiary requirement given the present understanding and unpredictability of the properties of antipsychotic medication.¹¹²

C. *Can Antipsychotics be Forcibly Administered to Achieve Competency for Trial?* *Sell v. United States*

The majority in *Riggins* emphasized that “the question whether a competent criminal defendant may refuse antipsychotic medication if cessation of medication would render him incompetent at trial is not before us.”¹¹³ However, the United States Supreme Court recently upheld the right to refuse unwanted antipsychotic medication when administered in order to render the defendant competent to stand trial in *Sell v. United States*.¹¹⁴

Dr. Charles Sell, a dentist with a long history of mental illness, was charged in a federal criminal complaint with Medicaid fraud, attempted murder, conspiracy, and solicitation to commit violence.¹¹⁵ Following a psychiatric examination by the United States Medical Center for Federal Prisoners at Springfield, Missouri (“Medical Center”) to determine his competence to stand trial, the Medical Center submitted a report to the Court stating that Sell was capable of standing trial at that

¹⁰⁸ *Id.*

¹⁰⁹ *Id.* at 138.

¹¹⁰ *Id.* at 137–38.

¹¹¹ *Id.* at 139.

¹¹² *Id.*

¹¹³ *Id.* at 136.

¹¹⁴ 539 U.S. 166 (2003).

¹¹⁵ *United States v. Sell*, 282 F.3d 560, 562 (8th Cir. 2002).

time.¹¹⁶ However, the Medical Center cautioned that there was a possibility that he could experience a psychotic episode in the future.¹¹⁷

The district court held that Sell was competent to stand trial.¹¹⁸ Subsequently, Sell was released on bond, but was later returned to court for allegedly violating the terms of his release by attempting to intimidate a witness.¹¹⁹ Furthermore, Sell's behavior was unrestrained before the magistrate judge. He screamed, shouted racial epithets, and spit in the magistrate's face.¹²⁰ The district court determined at a later hearing, in 1999, that Sell was incompetent to stand trial, finding that a mental disease made him unable to assist properly in his defense.¹²¹ Sell was then hospitalized to determine if there was a substantial probability that he would regain competency for trial.¹²²

Later that year, Sell testified at an administrative hearing that he did not want to be treated with mind-altering drugs.¹²³ However, the administrators determined that Sell's mental illness and delusions predisposed him to dangerous behavior and the administration of antipsychotic drugs was the preferred treatment.¹²⁴ After Sell's administrative appeal was denied, he sought review by the district court.¹²⁵

Concluding that Sell was a danger to himself and others, a federal magistrate authorized his involuntary medication.¹²⁶ Despite its finding that there was insufficient evidence to show Sell was a danger to himself and others,¹²⁷ the district court affirmed the order, holding that the state's interest in restoring Sell to competency in order to stand trial was necessary and sufficient to allow forced medication.¹²⁸ The Eighth Circuit Court of Appeals subsequently affirmed the district court judgment.¹²⁹

The United States Supreme Court granted certiorari to determine whether the Court of Appeals erred by permitting the state to forcibly

¹¹⁶ *Id.*

¹¹⁷ *Id.* at 562–63.

¹¹⁸ *Id.* at 562.

¹¹⁹ *Id.* at 563.

¹²⁰ *Id.*

¹²¹ *Id.*

¹²² *Id.*

¹²³ *Id.* at 564.

¹²⁴ *Id.*

¹²⁵ *Id.*

¹²⁶ *Id.*

¹²⁷ *Id.*

¹²⁸ *Id.*

¹²⁹ *Sell v. United States*, 539 U.S. 166 (2003).

medicate Sell without his consent in order to achieve competency to stand trial.¹³⁰ Vacating the Eighth Circuit's decision, the Court held that involuntarily medicating the accused solely to make them competent to stand trial may be appropriate in limited circumstances, but those instances would likely be "rare."¹³¹ Agreeing with an amicus brief filed by the American Psychological Association arguing that courts should consider "alternative, less intrusive means" before forcibly medicating mentally ill criminal defendants,¹³² the United States Supreme Court stated:

[T]he Constitution permits the Government involuntarily to administer antipsychotic drugs to a mentally ill defendant facing serious criminal charges in order to render that defendant competent to stand trial, but only if the treatment is medically appropriate, is substantially unlikely to have side effects that may undermine the fairness of the trial, and, taking account of less intrusive alternatives, is necessary significantly to further important governmental trial-related interests.¹³³

As a result, the Court set forth four requirements for determining whether forcible medication is necessary to further a state's interest. First, the Court stated that there must be a finding of *important* state interests.¹³⁴ The Court pointed out that while evaluating the government's interest in prosecution, not only must courts consider the facts of the individual case, but also, careful attention must be given to any special circumstances that may lessen the importance of that interest.¹³⁵ As an example of a special circumstance, the Court noted that a defendant's failure to take drugs voluntarily might result in lengthy confinement in an institution, thus diminishing "the risks that ordinarily attach to freeing without punishment one who has committed a serious crime."¹³⁶

Second, a court must conclude that forcing drugs on an inmate will *significantly further* the stated governmental interests.¹³⁷ In order to

¹³⁰ *Id.* at 175.

¹³¹ *Id.* at 180, 186.

¹³² *Id.* at 181.

¹³³ *Id.* at 179.

¹³⁴ *Id.* at 180.

¹³⁵ *Id.*

¹³⁶ *Id.*

¹³⁷ *Id.* at 181.

satisfy this prong, the medication must be substantially likely to restore competency for trial and substantially unlikely to have adverse side effects that will interfere in a defendant's ability to construct a mitigating case.¹³⁸ Third, there must be no alternative, less intrusive treatment approach likely to further those interests.¹³⁹ Finally, the medication must be found to be in the patient's best medical interest and medically appropriate after considering various side effects and the rate of success.¹⁴⁰ The Court stated that the above standard will "permit involuntary administration of drugs solely for trial competence purposes in certain instances. *But those instances may be rare.*"¹⁴¹

III. THE DEATH PENALTY, THE EIGHTH AMENDMENT, AND THE EXECUTION OF THE INSANE: AN HISTORICAL PERSPECTIVE

A. *The Evolution of the Eighth Amendment's Prohibition of Cruel and Unusual Punishments*

As early as the 1600s, English colonists in American colonies adopted a version of the English death penalty.¹⁴² In England, and subsequently in American colonies, treason, murder, manslaughter, rape, robbery, burglary, arson, counterfeiting, theft, and witchcraft were all crimes punishable by death.¹⁴³ However, in the late 1700's, opposition to the death penalty began to grow as spectators increasingly sympathized with those condemned for lesser crimes, casting doubt on the practice.¹⁴⁴ Until the 1800's, execution remained a public event, conducted outdoors with thousands of spectators, with the elaborate ritual at times spanning several hours.¹⁴⁵

In 1791, the Eighth Amendment to the United States Constitution was ratified, prohibiting "cruel and unusual punishments."¹⁴⁶ However, with virtually no debate recorded on the meaning of the cruel and unusual clause and a lack of early litigation on the issue, little is known

¹³⁸ *Id.*

¹³⁹ *Id.*

¹⁴⁰ *Id.*

¹⁴¹ *Id.* at 180. (emphasis added).

¹⁴² STUART BANNER, *THE DEATH PENALTY: AN AMERICAN HISTORY* 5 (2002).

¹⁴³ *Id.* at 5, 70.

¹⁴⁴ *Id.* at 31, 100.

¹⁴⁵ *Id.* at 24.

¹⁴⁶ *Id.* at 231. The Eighth Amendment states: "[e]xcessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted." U.S. CONST. amend. VIII.

about the late eighteenth century understanding of “cruel and unusual punishment.”¹⁴⁷ Beginning in the early 1900’s, the United States Supreme Court began to define the contours of the cruel and unusual clause with cases such as *United States v. Weems*.¹⁴⁸

In *Weems*, the trial court convicted an American official in the Philippines of falsifying a minor public document and sentenced him to “twelve years and one day, a chain at the ankle and wrist of the offender, hard and painful labor.”¹⁴⁹ In interpreting the Eighth Amendment, the United States Supreme Court held that the sentence amounted to cruel and unusual punishment because it was grossly disproportionate to the crime.¹⁵⁰ Acknowledging that the Eighth Amendment authors did not define the term “cruel and unusual punishments,” the Court set the tone for future Eighth Amendment jurisprudence when Justice McKenna stated, “[t]ime works changes, brings into existence new conditions and purposes. Therefore a principle, to be vital, must be capable of wider application than the mischief which gave it birth.”¹⁵¹ According to the Court, the concept of cruel and unusual punishment was capable of expansion over time.¹⁵²

The idea that the Eighth Amendment should be understood with reference to current values was developed further in 1947 when the United States Supreme Court decided *Louisiana ex rel. Francis v. Resweber*.¹⁵³ The *Resweber* Court emphasized that, “[m]ore than any other provision in the Constitution, the prohibition of cruel and unusual punishment depends largely, if not entirely, upon the humanitarian instincts of the judiciary. We have nothing to guide us in defining what is cruel and unusual apart from our own conscious.”¹⁵⁴ By 1957, in *Trop v. Dulles*,¹⁵⁵ the United States Supreme Court openly confirmed its willingness to overlook the original meaning of the term “cruel and unusual punishments” by stating, “[t]he Amendment must draw its meaning from the evolving standards of decency that mark the progress of a maturing society.”¹⁵⁶

¹⁴⁷ BANNER, *supra* note 142, at 232.

¹⁴⁸ 217 U.S. 349 (1910).

¹⁴⁹ *Weems*, 217 U.S. at 366.

¹⁵⁰ *Id.* at 366–67.

¹⁵¹ *Id.* at 373.

¹⁵² *Id.*

¹⁵³ *Louisiana ex rel. Francis v. Resweber*, 329 U.S. 459 (1947).

¹⁵⁴ *Id.* at 460.

¹⁵⁵ 356 U.S. 86 (1957).

¹⁵⁶ *Id.* at 101 (holding that the Nationality Act of 1940 violated the Eighth Amendment as cruel and unusual punishment).

For a brief period during the 1970's the United States Supreme Court halted the use of the death penalty, declaring in *Furman v. Georgia*¹⁵⁷ that existing death penalty laws were unconstitutional due to their arbitrary application.¹⁵⁸ However, four years later, after Georgia became the first of many states to reform its system to satisfy *Furman*, the United States Supreme Court determined in *Gregg v. Georgia*¹⁵⁹ that the death penalty did not constitute cruel and unusual punishment under the Eighth Amendment.¹⁶⁰ In *Gregg*, the Court found that Georgia had sufficiently rewritten its capital punishment statute to satisfy constitutional requirements, thus permitting the reinstatement of execution.¹⁶¹

B. History of the Execution of the Mentally Ill

As noted above, prior to the nineteenth century, insanity was attributed to supernatural origins.¹⁶² However, in the mid-1800's, the understanding of insanity shifted to the belief of criminal behavior as a disease.¹⁶³ Death penalty abolitionists attempted to use this reasoning to argue that all criminals were insane and unable to appreciate the nature of their crimes and punishment, and thus, capital punishment should be abandoned.¹⁶⁴ While even supporters of the death penalty agreed that insane prisoners should not be executed because they lacked the "power to distinguish between right and wrong,"¹⁶⁵ the decision whether or not to execute the criminally insane remained with individual states until the late twentieth century.¹⁶⁶

In 1897, in *Nobels v. Georgia*, the United States Supreme Court considered its first case dealing with the execution of the insane.¹⁶⁷ The *Nobels* Court held that where the inmate was incompetent after verdict and sentencing, a competency hearing for execution was not

¹⁵⁷ 408 U.S. 238 (1972).

¹⁵⁸ *Id.* at 239–40.

¹⁵⁹ 428 U.S. 153 (1976).

¹⁶⁰ *Id.* at 179 (“[I]t is not evident that a large portion of American society continues to regard [capital punishment] as an appropriate and necessary criminal sanction.”).

¹⁶¹ *Id.* at 196–98.

¹⁶² BANNER, *supra* note 142, at 119.

¹⁶³ *Id.*

¹⁶⁴ *Id.*

¹⁶⁵ *Id.*

¹⁶⁶ See *Ford v. Wainwright*, 477 U.S. 399, 405 (1986) (holding that the execution of the insane violated the Eighth Amendment’s prohibition of “cruel and unusual punishments”).

¹⁶⁷ 168 U.S. 398 (1897).

necessary.¹⁶⁸ Wanting to leave the procedures for determining competency to the individual states, the Court in *Nobels* declined to establish a constitutional prohibition of the execution of the insane.¹⁶⁹

Not until 1948 was the issue again brought before the United States Supreme Court in *Phyle v. Duffy*.¹⁷⁰ In *Phyle*, a state doctor declared that the prisoner, sentenced to death, had been restored to sanity, and was thus eligible for execution. Phyle was not afforded notice or an opportunity to obtain a court sanity hearing and was not allowed to obtain review of the doctor's conclusion.¹⁷¹ Phyle sought a writ of habeas corpus, claiming that California's procedure of determining the sanity of death row inmates, when there was already "good reason to believe" that the prisoner is insane, violated Fourteenth Amendment due process rights.¹⁷² His petition was denied by the California Supreme Court, and the United States Supreme Court denied certiorari, finding that the case presented no federal constitutional question.¹⁷³

Shortly after, in *Solesbee v. Balkcom*,¹⁷⁴ the United States Supreme Court held that it did not violate due process for the governor of Georgia to determine an inmate's sanity for execution since relief from a death sentence was merely a privilege, not a right.¹⁷⁵ Declining to consider the Eighth Amendment, the Court in *Solesbee* did not address the relevance of the "cruel and unusual punishments" prohibition, not yet incorporated to the states, to the execution of the insane.¹⁷⁶

Not until 1986, in *Ford v. Wainwright*,¹⁷⁷ a case involving a Florida death row inmate whose mental condition began to deteriorate while incarcerated, did the United States Supreme Court hold that the Eighth Amendment's prohibition against cruel and unusual punishments bars the execution of a prisoner who is insane.¹⁷⁸ Writing for the majority, Justice Marshall stated, "[w]hether its aim be to protect the condemned from fear and pain without comfort of understanding, or to protect the dignity of society itself from the barbarity of exacting

¹⁶⁸ *Id.* at 401–02.

¹⁶⁹ *See id.* at 409.

¹⁷⁰ 334 U.S. 431 (1948).

¹⁷¹ *Id.* at 433.

¹⁷² *Id.* at 433–34.

¹⁷³ *Id.* at 444.

¹⁷⁴ 339 U.S. 9 (1950).

¹⁷⁵ *Id.* at 11, 14.

¹⁷⁶ *Id.* at 11.

¹⁷⁷ 477 U.S. 399 (1986).

¹⁷⁸ *Id.* at 409–10.

mindless vengeance, the restriction finds enforcement in the Eighth Amendment.”¹⁷⁹

Justice Powell, in his concurring opinion, articulated the governing two-prong competency standard for determining whether an inmate is eligible for execution: “the Eighth Amendment forbids the execution only of those who are unaware of the punishment they are about to suffer and why they are to suffer it.”¹⁸⁰

C. Justifications for Exempting the Mentally Ill from Execution

When considering whether the penalty of death is appropriate, the United States Supreme Court evaluates the goals of capital punishment in addition to “evolving standards of decency.”¹⁸¹ In order to accurately contemplate the issue of forced medication for execution, the rationales behind the prohibition of executing the insane, beyond the notion that it simply offends humanity, must be taken into account and serve as a reminder of why the mentally insane were exempt from execution in the first place.

According to the Supreme Court in *Ford*, one often cited rationale is that executing the mentally ill has no educative or deterrent value.¹⁸² Under this view, there is no sense in executing a person incapable of comprehending the nature of the death penalty and why it was imposed on them. Similarly, retribution is not served by the execution of the insane, which the Court in *Ford* stated has a “lesser value” than the crime for which the prisoner is to be punished.¹⁸³ True retribution demands an understanding of what is happening as well as the reasons why, a requirement often not possessed by the mentally ill.

Furthermore, insanity is often considered its own punishment.¹⁸⁴ Under this view, execution serves no purpose.¹⁸⁵ Yet another commentary, Sir John Hawles, suggested that it is “against Christian charity to send a great offender quick . . . into another world, when he is not of a capacity to fit himself for it.”¹⁸⁶ Other rationales that may influence a death penalty decision are the offensiveness to humanity,

¹⁷⁹ *Id.* at 410.

¹⁸⁰ *Id.* at 422.

¹⁸¹ *Id.* at 406.

¹⁸² *Id.* at 407.

¹⁸³ *Id.* at 408.

¹⁸⁴ *Id.* at 407.

¹⁸⁵ *Id.*

¹⁸⁶ Sir John Hawles, *Remarks on the Trial of Mr. Charles Bateman*, 11 STATE TRIALS 474, 477 (T.B. Howell, ed., 1685).

underlying spiritual aspects, the ability to prepare one's own defense, and the basic rationale of vengeance.¹⁸⁷ As recognized by the Court in *Ford*, the infliction of the death penalty upon mentally insane criminals is one area where the rationales fail to justify death for the crime of death.

IV. DOES A PERSON WHO IS FOUND INCOMPETENT HAVE A RIGHT TO REFUSE TREATMENT THAT WILL RESTORE COMPETENCY FOR EXECUTION?

While an inmate's right to refuse medication while incarcerated and during trial is fairly settled, the United States Supreme Court has yet to decide the issue of whether a state can forcibly medicate a prisoner in order to bring him to competency for execution. Of the three courts that have addressed the issue to date, there has been no consensus.

A. State v. Perry

The Supreme Court of Louisiana has refused to allow the forced medication of death row inmates to enable execution. In *State v. Perry*,¹⁸⁸ the Court held that the involuntary medication of an incompetent prisoner violated various provisions of the state constitution and constituted "cruel, excessive, and unusual punishment."¹⁸⁹

1. Facts and Procedural Posture

Michael Perry, who had an extensive history of mental illness, was convicted and sentenced to death for murdering his parents, nephew, and two cousins.¹⁹⁰ Before his trial, Perry was diagnosed with paranoid schizophrenia and placed on an antipsychotic medication regimen.¹⁹¹ He was later found competent to stand trial.¹⁹² Despite his counsel's advice to the contrary, the court allowed Perry to replace his insanity plea with a

¹⁸⁷ BANNER, *supra* note 142, at 216; *see also* Anthony J. Bishop, *Ford v. Wainwright: Insanity of the Death Row Inmate— A Second Chance*, 11 AM. J. TRIAL ADVOC. 311, 321–22 (1987).

¹⁸⁸ 610 So. 2d 746 (La. 1992).

¹⁸⁹ *Id.* at 747.

¹⁹⁰ *Id.* at 748.

¹⁹¹ *Id.*

¹⁹² *Id.*

plea of not guilty.¹⁹³ Perry was then convicted of murder and sentenced to death.¹⁹⁴

Perry appealed to the Louisiana Supreme Court, which affirmed his conviction and sentence, but recommended a competency hearing before execution.¹⁹⁵ The commission found that Perry suffered from schizophrenic behavior and thought patterns, including delusions, disorganized thinking, hallucinations, mania, and irrational speech.¹⁹⁶ The medical team also reported that Perry's psychotic symptoms could only be temporarily masked with appropriate drug treatment; his mental illness could never be completely cured.¹⁹⁷ The trial court that convened the sanity commission determined that Perry was incompetent, and thus, ineligible for execution without antipsychotic drug treatment.¹⁹⁸ Consequently, the court ordered that Perry be kept on medication, administered "forcibly to defendant and over his objection" if necessary.¹⁹⁹

Perry's appeal to the Louisiana Supreme Court was denied.²⁰⁰ However, the United States Supreme Court granted certiorari²⁰¹ and vacated the trial court's order, remanding the case for reconsideration in light of *Washington v. Harper*.²⁰² The trial court reinstated its order without considering any additional evidence, holding that *Harper* does not apply to a competency proceeding for execution.²⁰³ Perry appealed to the Louisiana Supreme Court, and this time he was granted certiorari.

2. *The Louisiana Supreme Court Decision*

Characterizing the State's intent to forcibly medicate as an attempt to circumvent the centuries old prohibition against the execution of the insane,²⁰⁴ the Louisiana Supreme Court reversed, holding that forcibly medicating a prisoner to bring him to competency for execution

¹⁹³ *Id.*

¹⁹⁴ *Id.*

¹⁹⁵ *State v. Perry*, 502 So. 2d 543, 564 (La. 1987).

¹⁹⁶ *Perry*, 610 So. 2d at 748.

¹⁹⁷ *Id.*

¹⁹⁸ *Id.*

¹⁹⁹ *Id.*

²⁰⁰ *Id.*

²⁰¹ *Perry v. Louisiana*, 494 U.S. 1015, 1015–16 (1990).

²⁰² *Perry v. Louisiana*, 498 U.S. 38 (1990).

²⁰³ *Perry*, 610 So. 2d at 748.

²⁰⁴ *Id.* at 747.

constitutes cruel and unusual punishment, and thus, is impermissible.²⁰⁵ The *Perry* Court described the cruel and unusual aspects of forced medication as follows:

The punishment is cruel because it imposes significantly more indignity, pain and suffering than ordinarily is necessary for the mere extinguishment of life, excessive because it imposes a severe penalty without furthering any of the valid social goals of punishment, and unusual because it subjects to the death penalty a class of offenders that has been exempt therefrom for centuries and adds novel burdens to the punishment of the insane which will not be suffered by sane capital offenders.²⁰⁶

The Court distinguished *Harper* by first concluding that “forcing a prisoner to take antipsychotic drugs to facilitate his execution does not constitute medical treatment but is antithetical to the basic principles of the healing arts.”²⁰⁷ The Court then noted that the State in *Perry* failed to satisfy the due process test set forth in *Harper*.²⁰⁸ Under *Harper*, forcing antipsychotic medication on a prisoner is impermissible absent a finding of overriding justification and a determination of medical appropriateness.²⁰⁹ The *Perry* Court pointed out that in contrast to *Harper*, where the State’s intent was to “require a prisoner to accept appropriate medical treatment that was in his own best medical interest,” the object in *Perry*’s case was to forcibly medicate him in order to “implement his execution.”²¹⁰ Therefore, the Court concluded that involuntary medication for execution cannot be justified under *Harper* because “forcible administration of drugs to implement execution is not medically appropriate.”²¹¹ Furthermore, the Court reasoned that *Harper* implied that intrusive medication could not be used for punishment, as attempted in this case.²¹²

B. Singleton v. State

²⁰⁵ *Id.* at 747.

²⁰⁶ *Id.* at 761.

²⁰⁷ *Id.* at 751.

²⁰⁸ *Id.*

²⁰⁹ *Washington v. Harper*, 494 U.S. 210, 223 (1990).

²¹⁰ *Perry*, 610 So. 2d at 754.

²¹¹ *Id.*

²¹² *Id.* at 752.

Following the Louisiana Court's reasoning in *Perry*, the Supreme Court of South Carolina held that the forced medication of an insane prisoner to facilitate execution would constitute an unwarranted intrusion of the right of privacy afforded by South Carolina's state constitution.²¹³ After Fred Singleton was convicted and sentenced to death for murder, burglary, larceny of a motor vehicle, and first degree criminal sexual conduct, he was found incompetent for execution.²¹⁴ According to the Court, allowing the state to forcibly medicate Singleton in order to enable execution violated the South Carolina State Constitution, particularly the provision that barred unreasonable invasions of privacy.²¹⁵ The Court declared, "we find that justice can never be served by forcing medication on an incompetent inmate for the sole purpose of getting him well enough to execute."²¹⁶ Furthermore, the Court determined that the State Constitution, along with Federal Constitutional due process guarantees, required that inmates could only be forcibly medicated when the medication was in their best medical interests and if they were a danger to themselves or others.²¹⁷

C. Singleton v. Norris

In *Singleton v. Norris*,²¹⁸ the Eighth Circuit reached a different conclusion than the Louisiana and the South Carolina Supreme Courts on the issue of forced psychotropic medication to restore competency for execution.

1. *Facts and Procedural Posture*

In 1979, Charles Laverne Singleton received a death sentence in Ashley County, Arkansas for the murder of a grocery store clerk.²¹⁹ The facts giving rise to Singleton's conviction were described in the Arkansas Supreme Court opinion as follows:

²¹³ *Singleton v. State*, 437 S.E.2d 53, 61 (S.C. 1993).

²¹⁴ *Id.* at 58.

²¹⁵ *Id.* at 61.

²¹⁶ *Id.* at 62.

²¹⁷ *Id.* at 61.

²¹⁸ 319 F.3d 1018 (8th Cir. 2003).

²¹⁹ *Id.* at 1020.

The victim, Mary Lou York, was murdered in York's Grocery Store at Hamburg on June 1, 1979. She died from loss of blood as a result of two stab wounds in her neck.

The evidence of guilt in this case is overwhelming. Patti Franklin saw her relative Singleton enter York's Grocery at approximately 7:30 p.m. on the day of the crime. Shortly after he entered Patti heard Mrs. York scream, "Patti go get help, Charles Singleton is killing me." Patti then ran for help. Another witness, Lenora Howard, observed Singleton exit the store and shortly thereafter witnessed Mrs. York, who was "crying and had blood on her," come to the front door. Police Officer Strother was the first to arrive at the scene and found Mrs. York lying in a pool of blood in the rear of the store. The officer testified Mrs. York told him that Charles Singleton "came in the store, said this is a robbery, grabbed her around the neck, and went to stabbing her." She then told Officer Strother that "there's no way I can be all right, you know I'm not going to make it. I've lost too much blood." Mrs. York was taken to the hospital in an ambulance and was attended by her personal physician, Dr. J. D. Rankin. While en route to the hospital, she told Dr. Rankin several times that she was dying and that Singleton did it. Mrs. York died before reaching the emergency room of the hospital.²²⁰

After his sentencing, Singleton sat on the Arkansas Department of Correction's Death Row.²²¹ The Arkansas Supreme Court affirmed his criminal conviction and death sentence.²²² Singleton challenged the constitutionality of the Arkansas death penalty statute and claimed ineffective assistance of counsel at the penalty phase.²²³ The federal district court denied the petition and the United States Court of Appeals for the Eighth Circuit affirmed.²²⁴

²²⁰ Singleton v. State, 623 S.W.2d 180, 181 (Ark. 1981).

²²¹ Brief for Appellant at 10, Singleton v. Norris, 319 F.3d 1018 (8th Cir. 2003) (No. 00-1492).

²²² Singleton, 623 S.W. 2d at 181. His death sentence was then set aside by the United States District Court in 1986. Singleton v. Lockhart, 653 F. Supp. 1114 (E.D. Ark. 1986). Then, in 1989, the Court of Appeals reinstated Singleton's death sentence. Singleton v. Lockhart, 871 F.2d 395 (8th Cir. 1989).

²²³ Singleton v. Lockhart, 962 F.2d 1315, 1316 (8th Cir. 1992).

²²⁴ *Id.* at 1323.

Singleton had a long history of psychiatric problems.²²⁵ While incarcerated on Death Row, Singleton's psychiatric problems worsened, and he spent most of his time in prison on antipsychotic medication.²²⁶ Shortly after Singleton entered prison, he complained of visual hallucinations, claiming that his cell was possessed by a demon.²²⁷ He also lost a great deal of weight and was placed on antipsychotic medication.²²⁸ Singleton's medication was discontinued in June 1988, after Dr. W. R. Oglesby, the prison psychiatrist, noticed an improvement in Singleton's condition.²²⁹ However, by October 1988, Singleton, once again delusional and experiencing both visual and auditory hallucinations, was involuntarily medicated.²³⁰

Singleton continued to receive antipsychotic medication until June 1991, when Dr. Oglesby interrupted the treatment "to see how long [Singleton] could go without having any further mental symptoms."²³¹ Within five months, Singleton had relapsed and was once again placed on an involuntary medication regime.²³² In December 1992, Singleton filed an action in state court claiming that he was incompetent and asked for a declaratory judgment that he was not competent to be executed.²³³ He was denied relief in the Arkansas state courts.²³⁴ In his successor federal habeas petition, Singleton claimed he was not competent to be executed and after two hearings, the district court dismissed his habeas petition.²³⁵

In July 1997, Dr. Oglesby determined that Singleton was psychotic, delusional and suffering from paranoid schizophrenia and again prescribed antipsychotic medication.²³⁶ By the end of 1997,

²²⁵ Brief for Appellant, *supra* note 221, at 10.

²²⁶ *Id.* at 14.

²²⁷ Singleton v. Norris, 267 F.3d 859, 862 (8th Cir. 2001).

²²⁸ *Id.*

²²⁹ *Id.*

²³⁰ *Id.*

²³¹ *Id.* at 862–63 (citing Mrad Report of 8/14/00, at 7).

²³² *Id.* at 863. By this time, Singleton was once again delusional, stripping off his clothes, talking loudly, and accusing prison staff of using "subliminal suggestions" on him. *Id.*

²³³ Brief for Appellant, *supra* note 221, at 10. In 1993, Singleton believed his food turned into worms and his cigarettes were bones. *Singleton*, 267 F.3d at 863. He also asked to be castrated for religious reasons. *Id.* As a result, the psychiatrist increased his antipsychotic dosage. *Id.*

²³⁴ Singleton v. Endell, 870 S.W.2d 742, 743 (Ark. 1994).

²³⁵ Singleton v. Norris, 108 F.3d 872, 874 (8th Cir. 1997).

²³⁶ Brief for Appellant, *supra* note 221, at 11. According to the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), the essential

Singleton refused to take the drugs and displayed severely psychotic behavior.²³⁷ As a result, the Medication Review Panel of the Arkansas Department of Correction, established as a result of the United States Supreme Court's decision in *Washington v. Harper*,²³⁸ held a hearing to determine if the State could forcibly medicate him.²³⁹ After the Medication Review Panel concluded that Singleton posed a danger to himself and others,²⁴⁰ the State ordered that Singleton be involuntarily medicated with antipsychotic drugs, Prolixin and Cogentin.²⁴¹ Singleton exhausted his federal appeals while on antipsychotic medication.²⁴² An execution date was set for March 11, 1998.²⁴³

Singleton then filed a lawsuit in Jefferson Circuit Court, the venue of the Maximum Security Unit and the offices of the Department of Correction, claiming, in part, that his artificially created sanity for execution violated his Fourth, Eighth, and Fourteenth Amendment rights and asking that the State be prohibited from executing him as long as he was involuntarily medicated.²⁴⁴ On March 9, 1998, the Supreme Court of Arkansas granted Singleton a stay of execution.²⁴⁵ The Jefferson County Circuit Court subsequently denied Singleton's petition after a hearing, and Singleton then appealed to the Arkansas Supreme Court.²⁴⁶

The Arkansas Supreme Court affirmed the trial court decision, holding that the institutional needs of the prison system and Singleton's medical interest controlled the result of the case.²⁴⁷ The State then set

features of Paranoid Type of Schizophrenia are "prominent delusions or auditory hallucinations in the context of a relative preservation of cognitive functioning and affect." DSM-IV, *supra* note 37, at 313.

²³⁷ Singleton v. Norris, 267 F.3d 859, at 863. For example, Singleton told a prison doctor that he was on a religious mission to kill the President and Dr. Oglesby. *Id.* He also believed that the United States Supreme Court had set him free. *Id.* A prison doctor reported that Singleton has shredded his mattress and stuffed it in the toilet, sink, air vents, and he had stopped eating. *Id.*

²³⁸ 494 U.S. 210, 216 (1990).

²³⁹ Brief for Appellant, *supra* note 221, at 11-12.

²⁴⁰ *Id.*

²⁴¹ *Id.* Prolixin (fluphenazine), as mentioned above, is a standard antipsychotic used in the treatment of psychotic disorders. Cogentin (benztrpine), is an antiparkinsonian agent, used in the treatment of side effects induced by antipsychotics: akathisia (restlessness), dystonia (muscle spasms), and pseudoparkinsonism (tremor, rigidity, akinesia, and nighttime drooling). DRUMMOND, *supra* note 59, at 161.

²⁴² Singleton v. Norris, 522 U.S. 840 (1997) (denying certiorari).

²⁴³ Brief for Appellant, *supra* note 221, at 12.

²⁴⁴ *Id.* at 12-13.

²⁴⁵ Singleton v. Norris, 964 S.W.2d 366 (Ark. 1998).

²⁴⁶ Brief for Appellant, *supra* note 221, at 13.

²⁴⁷ Singleton v. Norris, 992 S.W.2d 768, 769-70 (Ark. 1999).

his execution for March 1, 2000.²⁴⁸ In February 2000, Singleton filed a petition for habeas corpus pursuant to 28 U.S.C. § 2241 to which the United States District Court denied relief but granted a certificate of appealability.²⁴⁹

Singleton appealed, filing a petition for writ of habeas corpus and seeking a stay of execution.²⁵⁰ Finding that Singleton lacked competency necessary for execution, an Eighth Circuit panel granted a permanent stay of execution and reduced Singleton's sentence to life imprisonment without the possibility of parole.²⁵¹ However, the State of Arkansas requested an en banc rehearing, which was granted. In a six to five decision, the federal appeals court decided that the Eighth Amendment's prohibition against cruel and unusual punishments would not be violated if Singleton was forcibly medicated and his death sentence was reinstated.²⁵²

2. *The En Banc Eighth Circuit Court Decision*

The Eighth Circuit Court in *Singleton v. Norris* confronted the issue of whether an insane prisoner can be forcibly medicated to render him competent for execution.²⁵³ The Court also considered the related issue of whether a prisoner medicated under *Harper* may be executed.²⁵⁴ The majority held that Singleton satisfied the *Harper* test, that he was a danger to himself or others and, contrary to the court in *Perry*, that it was in Singleton's best medical interest to be medicated.²⁵⁵ The Court rejected Singleton's argument that once an execution date had been set, the forced medication once permitted under *Harper* was no longer in the best interest of the patient and thus, should not be allowed.²⁵⁶ The Court

²⁴⁸ Brief for Appellant, *supra* note 221, at 13.

²⁴⁹ *Id.* at 13–14.

²⁵⁰ *Singleton v. Norris*, 267 F.3d 859 (8th Cir. 2001) (*Singleton I*).

²⁵¹ *Id.* In the opinion, Judge Heaney stated, “Singleton does not have the understanding necessary to permit the State to execute him. It is therefore time to bring this case to an end and grant a permanent stay of execution. To do otherwise under the circumstances of this case would, in the words of Justice Marshall, subject Singleton to ‘the barbarity of exacting mindless vengeance.’” *Id.* at 871.

²⁵² *Singleton v. Norris*, 319 F.3d 1018 (8th Cir. 2003) (*Singleton II*).

²⁵³ *Id.* at 1023.

²⁵⁴ *Id.*

²⁵⁵ *Id.* at 1026.

²⁵⁶ *Id.* at 1023, 1026. In addressing whether the medication was medically appropriate, the Court stated, “[e]ligibility for execution is the only unwanted consequence of the medication. The due process interests in life and liberty that Singleton asserts have been foreclosed by the lawfully imposed sentence of execution and the Harper

also concluded, as required by *Riggins*, that the state's interests in executing sentences and in prison security outweighed Singleton's liberty interest in remaining free from unwanted antipsychotic medication.²⁵⁷

However, in its decision, the Eighth Circuit Court disregarded its own cautionary statements made in *United States v. Sell* regarding the narrow scope of forcible medication:

We do not believe this standard will be met in all circumstances in which the government wishes to restore competence . . . [W]e note that *an entirely different case is presented when the government wishes to medicate a prisoner in order to render him competent for execution* . . . Therefore, our holding must be read narrowly.²⁵⁸

Consequently, there was sharp disagreement among the eleven Eighth Circuit judges over what should be done. Judge Wollman, writing for the majority, declared that "the state was under an obligation to administer antipsychotic medication, thus any additional motive or effect is irrelevant."²⁵⁹

In contrast, Judge Heaney, in his dissent, believed that Singleton should have been allowed to receive medication without the consequence of execution. He stated that "to execute a man who is severely deranged without treatment, and arguably incompetent when treated, is the pinnacle of what Justice Marshall called 'the barbarity of exacting mindless vengeance.'"²⁶⁰ Heaney stressed that antipsychotic medication creates "artificial" or "synthetic" sanity, but does not cure the disease of mental illness. After reviewing the medical history of Singleton's case, Heaney concluded, "Singleton is not 'cured;' his insanity is merely muted, at times, by the powerful drugs he is forced to take. Underneath this mask of instability, he remains insane."²⁶¹ In the end, the majority decided to permit the State to forcibly medicate Singleton so that he may "qualify" for execution.

procedure. In the circumstances presented in this case, the best medical interests of the prisoner must be determined without regard to whether there is a pending date of execution." *Id.* at 1026.

²⁵⁷ *Id.* at 1025.

²⁵⁸ *United States v. Sell*, 282 F.3d 560, 571 (8th Cir. 2002) (emphasis added).

²⁵⁹ *Singleton v. Norris*, 319 F.3d 1018, 1027 (8th Cir. 2003).

²⁶⁰ *Id.* at 1030 (quoting *Ford v. Wainwright*, 477 U.S. 399, 410 (1986)).

²⁶¹ *Singleton*, 319 F.3d at 1034.

On October 6, 2003, the United States Supreme Court declined to review the Eighth Circuit's ruling in *Singleton*, allowing Arkansas state officials to continue forcibly medicating mentally ill death row inmates to maintain competency for execution.²⁶² At 8:06 p.m. on Tuesday, January 6, 2004, Charles Singleton was pronounced dead by lethal injection at Cummins Prison in Varner, Arkansas.²⁶³

V. JUVENILE OFFENDERS AND MENTALLY RETARDED: EXEMPT FROM EXECUTION?

In examining our society's "evolving standards of decency," it is essential to consider the United States Supreme Court's exclusions of entire groups from the death penalty. For example, as mentioned above, the Supreme Court in *Ford* previously excluded the legally insane. Recently, yet another group has come under judicial scrutiny, juvenile offenders. Continuing the trend of whittling down possible death penalty candidates, the United States Supreme Court has also chosen to categorically exclude from execution the mentally retarded.²⁶⁴

A. *Juvenile Offenders*

In the 1988 case, *Thompson v. Oklahoma*, the United States Supreme Court found it unconstitutional to execute juveniles age fifteen and under.²⁶⁵ One year after *Thompson*, the United States Supreme Court in *Stanford v. Kentucky* refused to extend this death penalty exemption to juveniles age sixteen and over.²⁶⁶ However, since that time, there has been an increasing understanding that juvenile offenders lack judgment and ability to clearly understand the consequences of their actions.²⁶⁷ As a result, on January 26, 2004, the Supreme Court decided

²⁶² *Singleton v. Norris*, 540 U.S. 832 (2003).

²⁶³ Brian Cabell, *Arkansas Executes Mentally Ill Inmate*, Jan. 7, 2004, <http://www.cnn.com/2004/LAW/01/06/arkansas.executions/index.html> (last visited Oct. 27, 2004).

²⁶⁴ *Atkins v. Virginia*, 536 U.S. 304 (2002).

²⁶⁵ 487 U.S. 815 (1988).

²⁶⁶ 492 U.S. 361 (1989).

²⁶⁷ *See In re Stanford*, 537 U.S. 968 (2002). Justice Stevens' dissent, joined by Justice Souter, Justice Ginsburg, and Justice Breyer, stated, "[t]he practice of executing [juveniles under the age of eighteen] is a relic of the past and is inconsistent with evolving standards of decency in a civilized society. We should put an end to this shameful practice." *Id.* at 475.

to reconsider whether the execution of an inmate who committed the crime before age eighteen constitutes cruel and unusual punishment.²⁶⁸

I. Thompson v. Oklahoma

In 1988, the United States Supreme Court declared that the execution of juveniles fifteen years or younger violated the Eighth Amendment's prohibition against the infliction of "cruel and unusual punishments."²⁶⁹

In January 1983, William Wayne Thompson, along with his older brother and two older cohorts, murdered Charles Keene, Thompson's former brother-in-law.²⁷⁰ Having been certified to stand trial as an adult, Thompson was convicted of first degree murder and sentenced to death for an offense he committed at the age of fifteen.²⁷¹ The Oklahoma Court of Criminal Appeals affirmed²⁷² and Thompson sought a writ of certiorari from the United States Supreme Court.²⁷³

The United States Supreme Court granted certiorari to consider whether sentencing a fifteen-year-old child constituted "cruel and unusual punishment."²⁷⁴ Following the principle established in *Furman v. Georgia* that a court must look to objective signs of how current society views a particular punishment,²⁷⁵ the Court first reviewed relevant legislative enactments regarding the issue of juvenile execution to determine the general treatment of juveniles fifteen and under.²⁷⁶ The Court determined that a national consensus existed against execution of juvenile offenders under the age of sixteen.²⁷⁷

²⁶⁸ Linda Greenhouse, *Court to Review Using Execution in Juvenile Cases*, N.Y. TIMES, Jan. 27, 2004, at A1.

²⁶⁹ *Thompson v. Oklahoma*, 487 U.S. 815 (1988).

²⁷⁰ *Id.* at 819. The four participants were tried separately and each received a death sentence. *Id.*

²⁷¹ *Thompson v. State*, 724 P.2d 780, 782 (Okla. Crim. App. 1986).

²⁷² *Id.* at 786.

²⁷³ Brief of Petitioner at 1, *Thompson v. Oklahoma*, 487 U.S. 815 (1988) (No. 86-6169).

²⁷⁴ *Thompson*, 487 U.S. at 820.

²⁷⁵ *Furman v. Georgia*, 408 U.S. 238, 277-79 (1972).

²⁷⁶ *Thompson*, 487 U.S. at 822.

²⁷⁷ *Id.* at 824-29. The *Thompson* Court stated that "[w]hen we confine our attention to the 18 States that have expressly established a minimum age in their death penalty statutes, we find that all of them require that the defendant have attained at least the age of 16 at the time of the capital offense." *Id.* at 828-29. The Court also noted that professional organizations, such as the American Bar Association and the American

Beyond national consensus, the Court emphasized the importance of culpability. Because minors “lack the experience, perspective, and judgment expected of adults,” the Court observed that juveniles as a class are “less mature and responsible than adults.”²⁷⁸ In addition, a juvenile’s inexperience, lack of education, and lesser intelligence makes the child “less able to evaluate the consequences of his or her conduct.”²⁷⁹ Because of this diminished culpability, the Court found that the justifications often cited for the death penalty, retribution and deterrence, were inapplicable to a fifteen-year-old offender.²⁸⁰ As a result, the Court concluded that the execution of a juvenile under the age of sixteen violated the Eighth Amendment.²⁸¹

2. Stanford v. Kentucky

A year after *Thompson*, the United States Supreme Court consolidated two cases in *Stanford v. Kentucky*²⁸² in order to decide whether the Eighth Amendment’s prohibition against cruel and unusual punishment precludes the death penalty for juveniles who commit capital crimes at sixteen or seventeen years of age. Ultimately, the Court found that such a punishment did not offend the constitutional prohibition.²⁸³

The first case involved Kevin Stanford, who was seventeen years old at the time he murdered twenty-year-old Barbel Poore.²⁸⁴ Under authority of a Kentucky State statute, the juvenile court certified Stanford for trial as an adult.²⁸⁵ Stanford was convicted of murder, sodomy, robbery, and receiving stolen property.²⁸⁶ He was then sentenced to death.²⁸⁷ The Kentucky Supreme Court affirmed the death sentence on appeal.²⁸⁸

In the second case, Heath Wilkins was approximately sixteen years old when he stabbed Nancy Allen to death.²⁸⁹ The juvenile court

Law Institute, and most other countries oppose the application of the death penalty to juveniles. *Id.* at 829.

²⁷⁸ *Id.* at 834.

²⁷⁹ *Id.* at 835.

²⁸⁰ *Id.* at 836–38.

²⁸¹ *Id.* at 838.

²⁸² 492 U.S. 361 (1989).

²⁸³ *Id.* at 380.

²⁸⁴ *Id.* at 365.

²⁸⁵ *Id.*

²⁸⁶ *Id.* at 366.

²⁸⁷ *Id.* Stanford was also sentenced to 45 years in prison. *Id.*

²⁸⁸ *Id.*

²⁸⁹ *Id.*

certified Wilkins for trial as an adult.²⁹⁰ Although a testifying psychiatrist indicated that Wilkins suffered from personality disorders, the psychiatrist agreed that Wilkins was aware of his actions and knew the difference between right and wrong.²⁹¹ After the court found Wilkins competent, he pleaded guilty to charges of first degree murder, armed criminal action, and carrying a concealed weapon.²⁹² Wilkins was sentenced to death, and the Supreme Court of Missouri affirmed.²⁹³

The United States Supreme Court gave great weight to the national consensus inquiry in *Stanford*. Of the thirty-seven states that allowed capital punishment at the time, “fifteen decline to impose it upon sixteen-year-old offenders and twelve decline to impose it on seventeen-year-old offenders.”²⁹⁴ From those statistics, the Court concluded that no national consensus existed to support an exemption from the death penalty for juveniles sixteen years and older under the Eighth Amendment.²⁹⁵ According to the majority in *Stanford*, the lack of a national consensus was reason enough to refuse to exempt juveniles offenders over fifteen from the death penalty, and the Court therefore disregarded the views of professional organizations and public interest polls.²⁹⁶

As mentioned above, the United States Supreme Court recently granted certiorari to reconsider the issue of juvenile offenders under the age of eighteen.²⁹⁷

B. *Mental Retardation*

1. *Mental Retardation Defined*

Mental retardation is determined by measuring a person’s general intellectual functioning as well as social and adaptive functioning.²⁹⁸ There are three basic diagnostic criteria for Mental Retardation: (1) significantly subaverage intellectual functioning, (2) concurrent impairments in present adaptive functioning, and (3) the onset must

²⁹⁰ *Id.* at 367.

²⁹¹ *Id.*

²⁹² *Id.*

²⁹³ *Id.* at 368.

²⁹⁴ *Id.* at 371.

²⁹⁵ *Id.*

²⁹⁶ *Id.* at 377.

²⁹⁷ Linda Greenhouse, *Court to Review Using Execution in Juvenile Cases*, N.Y. TIMES, Jan. 27, 2004, at A1.

²⁹⁸ DSM– IV, *supra* note 37, at 41.

occur before age eighteen.²⁹⁹ General intellectual functioning is the intelligence quotient (IQ) result from a standardized, individually administered intelligence test.³⁰⁰ Additionally, impaired adaptive functioning symptoms are also present in those with mental retardation.³⁰¹ To satisfy the impairment prong of mental retardation, a person must display significant limitations in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety.³⁰²

2. Atkins v. Virginia

In 1989, the United States Supreme Court held in *Penry v. Lynaugh* that the Eighth Amendment did not categorically prohibit the execution of mentally retarded people convicted of capital offenses.³⁰³ However, a recent United States Supreme Court decision, *Atkins v. Virginia*,³⁰⁴ overruled *Penry*, holding that the execution of the mentally

²⁹⁹ *Id.* at 49.

³⁰⁰ *Id.* at 41. For a point of reference, an IQ of approximately 70 or below is defined as “significantly subaverage intellectual functioning.” *Id.*

³⁰¹ *Id.*

³⁰² *Id.* According to the Diagnostic and Statistical Manual of Mental Disorders (DSM–IV), mental retardation is characterized by four degrees of severity based on the level of intellectual impairment: mild mental retardation, moderate mental retardation, severe mental retardation, and profound mental retardation. *Id.* at 42. There is also an alternate category, mental retardation, severity unspecified, which is used to describe those whose intelligence is unable to be tested by standardized tests, such as infants or uncooperative individuals. *Id.* at 43. Mild mental retardation is characterized by an IQ level 50–55 to approximately 70. *Id.* at 42. Eighty–five percent of those with mental retardation fall within the mild category. *Id.* at 43. Moderate mental retardation is comprised of roughly ten percent of the mentally retarded population. *Id.* Those with moderate mental retardation possess an IQ level of 35–40 to 50–55. *Id.* at 40. An IQ of a person with severe mental retardation will range from 20–25 to 35–40. *Id.* This group with severe mental retardation constitutes three to four percent of people with mental retardation. *Id.* at 41. Only one to two percent of individuals with mental retardation fall within the profound mental retardation category. *Id.* Profound mental retardation is characterized by an IQ level below 20 or 25. *Id.* at 40.

³⁰³ 492 U.S. 302 (1989) (“[M]ental retardation is a factor that may well lessen a defendant’s culpability for a capital offense. But we cannot conclude today that the Eighth Amendment precludes the execution of any mentally retarded person of *Penry*’s ability convicted of a capital offense simply by virtue of his or her mental retardation alone.” *Id.* at 340.).

³⁰⁴ 536 U.S. 304 (2002).

retarded constitutes a per se violation of the Constitution's bar against cruel and unusual punishment.³⁰⁵

In November 1996, a jury convicted Daryl Renard Atkins of abduction, robbery, capital murder, and associated firearms crimes.³⁰⁶ During the penalty phase, the jury found Atkins a future danger to society and his murder of Eric Nesbitt outrageously and wantonly vile.³⁰⁷ Accordingly, Atkins was sentenced to death.³⁰⁸

On appeal, the Supreme Court of Virginia affirmed Atkins' conviction for capital murder, but remanded the case to the trial court for a new penalty proceeding on the capital murder conviction.³⁰⁹ The jury again sentenced Atkins to death.³¹⁰ On appeal, Atkins argued that "he is mentally retarded and thus cannot be sentenced to death,"³¹¹ basing his argument on his purported IQ of 59 and contending that the State of Virginia had never before imposed the death penalty on a defendant with an IQ as low as his.³¹² However, citing *Penry*, the Supreme Court of Virginia affirmed the death sentence.³¹³ In their dissent, Justice Hassell and Justice Koontz expressed that "it is indefensible to conclude that individuals who are mentally retarded are not to some degree less culpable for their criminal acts. By definition, such individuals have substantial limitations not shared by the general population. A moral and civilized society diminishes itself if its system of justice does not afford recognition and consideration of those limitations in a meaningful way."³¹⁴

Because of the sharp dissents and the gravity of the concerns addressed by Justice Hassell and Justice Koontz, the United States Supreme Court granted certiorari to reexamine the constitutionality of executing the mentally retarded.³¹⁵ In a 6-3 decision, the Supreme Court effectively overturned *Penry*, holding that the Eighth Amendment prohibits the execution of mentally retarded criminals.³¹⁶

³⁰⁵ *Id.* at 321.

³⁰⁶ *Atkins v. Virginia*, 510 S.E.2d 445, 448 (Va. 1999).

³⁰⁷ *Id.* at 453.

³⁰⁸ *Id.*

³⁰⁹ *Id.* at 457.

³¹⁰ *Atkins v. Virginia*, 536 U.S. 304, 309 (2002).

³¹¹ *Id.* at 386.

³¹² *Id.*

³¹³ *Atkins v. Virginia*, 534 S.E.2d 312, 321 (Va. 2000).

³¹⁴ *Id.* at 325.

³¹⁵ *Atkins*, 536 U.S. at 310.

³¹⁶ *Id.* at 321.

In support of its decision, the Court discussed the trend of state legislatures across the nation, since *Penry*, of explicitly prohibiting the execution of the mentally retarded.³¹⁷ The Court noted that the consistency of the direction of change provided powerful evidence that “today our society views mentally retarded offenders as categorically less culpable than the average criminal.”³¹⁸ Additionally, the Court stated that mentally retarded persons have “diminished capacities to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand the reactions of others,” attributes which diminish personal culpability.³¹⁹ In light of these observations, the Court determined that executing the mentally retarded will not further the goals of deterrence or retribution.³²⁰

³¹⁷ *Id.* at 314. The United States Supreme Court stated: “[r]esponding to the national attention received by the Bowden execution and our decision in *Penry*, state legislatures across the country began to address the issue. In 1990, Kentucky and Tennessee enacted statutes similar to those in Georgia and Maryland, as did New Mexico in 1991, and Arkansas, Colorado, Washington, Indiana, and Kansas in 1993 and 1994. In 1995, when New York reinstated its death penalty, it emulated the Federal Government by expressly exempting the mentally retarded. Nebraska followed suit in 1998. There appear to have been no similar enactments during the next two years, but in 2000 and 2001 six more States—South Dakota, Arizona, Connecticut, Florida, Missouri, and North Carolina—joined the procession. The Texas Legislature unanimously adopted a similar bill, and bills have passed at least one house in other States, including Virginia and Nevada.” *Id.*

³¹⁸ *Id.* at 315–16.

³¹⁹ *Id.* at 318.

³²⁰ *Id.* at 319–20. With regard to retribution, the United States Supreme Court stated, “[i]f the culpability of the average murderer is insufficient to justify the most extreme sanction available to the State, the lesser culpability of the mentally retarded offender surely does not merit that form of retribution. Thus, pursuant to our narrowing jurisprudence, which seeks to ensure that only the most deserving of execution are put to death, an exclusion for the mentally retarded is appropriate.” *Id.* at 319. Furthermore, with respect to deterrence, the Court declared, “[t]he theory of deterrence in capital sentencing is predicated upon the notion that the increased severity of the punishment will inhibit criminal actors from carrying out murderous conduct. Yet it is the same cognitive and behavioral impairments that make these defendants less morally culpable . . . that also make it less likely that they can process the information of the possibility of execution as a penalty and, as a result, control their conduct based upon that information. Nor will exempting the mentally retarded from execution lessen the deterrent effect of the death penalty with respect to offenders who are not mentally retarded.” *Id.* at 320. The Court concluded, “[w]e are not persuaded that the execution of mentally retarded criminals will measurably advance the deterrent or the retributive purpose of the death penalty. Construing and applying the Eighth Amendment in the light of our ‘evolving standards of decency,’ we therefore conclude that such punishment is excessive and that the Constitution ‘places a substantive restriction on

The United States Supreme Court also observed that reduced capacity may render mentally retarded offenders less able to work with counsel, and thus unable to effectively construct a mitigating case.³²¹ The Court stated, “[m]entally retarded defendants may be less able to give meaningful assistance to their counsel and are typically poor witnesses, and their demeanor may create an unwarranted impression of lack of remorse for their crimes.”³²² Since mentally retarded offenders are faced with a literal life or death situation in a capital sentencing and are considered to be less effective advocates for their own welfare, the Court found it proper to exempt the mentally retarded as a class from execution.

VI. CRITIQUE OF *SINGLETON V. NORRIS* AND FORCED MEDICATION FOR EXECUTION

A. *Singleton in Light of United States Supreme Court Precedents and Louisiana’s Decision in Perry v. Louisiana*

In *Singleton*, the Eighth Circuit relied on *Ford*, *Harper*, *Riggins*, and *Sell*.³²³ As previously noted, in *Sell v. United States*, the United States Supreme Court reversed the Eighth Circuit’s *Sell* opinion, relied on by the Court in *Singleton*.³²⁴ While instructive, none of these cases resolve the question of whether a state can forcibly medicate an inmate in order to render him competent for execution.

In its reasoning, the Eighth Circuit disregarded the fundamental principle in *Ford* that the mentally ill cannot be executed for crimes they do not understand. To do so clearly constitutes cruel and unusual punishment. As a result of artificially created sanity, it is virtually impossible to determine if an inmate is truly aware of his actions and able to comprehend his punishment at the moment of execution, a prerequisite for capital punishment eligibility.³²⁵ In addition to the issue of whether antipsychotic drugs restored Singleton to “sanity”³²⁶ for purposes of execution, questions of “reliability and predictability” arise

the State's power to take the life' of a mentally retarded offender.” *Id.* at 321 (citing *Ford v. Wainwright*, 477 U.S. 399,405 (1986)).

³²¹ *Id.* at 320–21.

³²² *Id.*

³²³ See *Singleton v. Norris*, 319 F.3d 1018 (8th Cir. 2003).

³²⁴ *Sell v. United States*, 529 U.S. 166 (2003).

³²⁵ See *Singleton v. Norris*, 267 F.3d 859, 870 (8th Cir. 2001).

³²⁶ In his *Singleton* dissent, Justice Heaney stated, “drug-induced sanity is not the same as true sanity.” *Singleton v. Norris*, 319 F.3d 1018, 1034 (8th Cir. 2003).

since psychotropic medications merely mask symptoms and do not provide a cure.³²⁷ The effectiveness of the drugs remains unpredictable, which causes debate over reliability among psychiatrists.³²⁸ As Judge Heaney emphasized in his *Singleton* dissent, “receiving treatment is not synonymous with being cured. Antipsychotic drugs ‘merely calm and mask the psychotic symptoms which usually return to debilitate the patient when the medication is discontinued.’”³²⁹ He continued, “[t]hus, when antipsychotic medication results in an improved mental state, the patient is merely displaying what has been termed, ‘artificial’ or ‘synthetic’ sanity . . . ‘the effect of psychoactive drugs on a particular recipient is uncertain; the drugs may affect the same individual different each time they are administered.’”³³⁰ An individual whose psychotic symptoms are alleviated through forced medication is no more competent than before the administration of the treatment.³³¹

Singleton was only able to function rationally under the influence of antipsychotic medication. The Eighth Circuit pointed out that the district court’s report determined that without antipsychotic drugs, “Singleton would revert to a delusional psychotic state.”³³² The antipsychotic medication could not cure Singleton’s mental illness, nor could it ensure his competency at the moment of execution. Before the decision was overturned by the requested en banc review, the three judge panel in *Singleton v. Norris*,³³³ concluded:

[E]ven if we assume Singleton is *Ford* competent while on his medication—an assumption we hesitate to make—it appears that there is no way of knowing how long [Singleton] will remain competent once the medication is discontinued or how long it will take him to regain *Ford* competency once he begins taking the medication. In short, there is no way for us to know whether Singleton will be competent on the day he is executed.³³⁴

³²⁷ Ptolemy H. Taylor, Comment, *Execution of the “Artificially Competent”: Cruel and Unusual?* 66 TUL. L. REV. 1045, 1060 (1992).

³²⁸ Feeman, *supra* note 63, at 698.

³²⁹ *Singleton v. Norris*, 319 F.3d 1018, 1034 (8th Cir. 2003) (quoting *State v. Perry*, 610 So. 2d 746, 759 (La. 1992)).

³³⁰ *Id.*

³³¹ Kathy Swedlow, *Forced Medication of Legally Incompetent Prisoners: A Primer*, 30 HUM. RTS. Q. 3, 4 (Spring 2003).

³³² *Singleton*, 319 F.3d at 1025.

³³³ 267 F.3d 859 (8th Cir. 2001).

³³⁴ *Id.* at 870.

However, the en banc court in *Singleton* condoned the use of harsh, unpredictable, and potentially harmful drugs to create artificial sanity and the facade of competency to circumvent a long-standing practice and protection of the mentally ill.³³⁵

On this record, treatment with antipsychotic drugs is necessary to alleviate Singleton's psychosis, and there is no less intrusive medical treatment by which the government can *ensure* Singleton's competence.³³⁶

Moreover, the *Singleton* Court held that a "state does not violate the Eighth Amendment as interpreted by *Ford* when it executes a prisoner who became incompetent during his long stay on death row but who *subsequently regained* competency through *appropriate medical care*."³³⁷ The Court permitted the execution of a prisoner whose insanity was temporarily masked through the forced administration of unpredictable and potentially harmful antipsychotic medication.

In many ways, the forced drugging of inmates is an attempt to circumvent the long-standing prohibition against the execution of the insane. The United States Supreme Court stated in *Harper* that "[t]he drugs may be administered for no purpose other than treatment, and only under the direction of a licensed psychiatrist."³³⁸ In *Singleton*, however, the medication was forced to effectuate an execution, a "prerequisite to punishment."³³⁹ In his dissent, Judge Heaney commented:

At the very least, the setting of an execution date calls into question the State's true motivation for administering the medication in the first instance. The circumstances of Singleton's case changed once the execution date was set,

³³⁵ See *State v. Perry*, 610 So. 2d 746, 761(1992) (stating that forcibly medicating a prisoner to reach competency for execution constitutes "unusual" because it "subjects to the death penalty a class of offenders that has been exempt therefrom for centuries").

³³⁶ *Singleton*, 319 F.3d at 1025 (emphasis added).

³³⁷ *Id.* at 1027 (emphasis added).

³³⁸ *Washington v. Harper*, 494 U.S. 210, 277 (1990). Even though the United States Supreme Court in *Harper* held that an inmate may only be involuntarily medicated if the treatment is justified by a sufficient and legitimate state interest, the case did not directly address the question presented in *Singleton*. See *id.*

³³⁹ Brief for Appellant, *supra* note 221, at 35.

and changed in such a way that *Harper* no longer supports the prison forcing him to take medication.³⁴⁰

The *Singleton* dissent emphasized its dissatisfaction with the majority's application of *Harper* to a case where forcible medication facilitates execution.³⁴¹

Likewise, in *Riggins*, the United States Supreme Court confronted the issue of forcible medication to restore competency for trial, not execution.³⁴² Under *Riggins*, a state cannot involuntarily medicate a prisoner without first establishing an overriding justification and a determination of medical appropriateness.³⁴³ However, when a state attempts to forcibly medicate an incompetent inmate for execution, the claim of medical necessity is extinguished. At the very least, in the interest of due process, a state's desire to forcibly medicate a prisoner to carry out an execution should not be dispositive.

In cases involving forcible medication for execution, the state argues that its interest in carrying out a criminal sentence outweighs any rights of the mentally ill to refuse treatment. There is no doubt that governments have a genuine interest in following through with lawfully imposed sentences, especially those for violent crimes such as murder.³⁴⁴ However, in cases such as *Singleton*'s, the state interest is not merely being weighed against an individual's interest in being free from medicine. Rather, a much more comprehensive issue is at stake: the manipulated execution of the artificially competent mentally ill.

In a *Harper* balancing test, side effects and other possible tribulations of the medication are taken into account when weighed against a state's interest. Furthermore, the United States Supreme Court in *Sell* urged that while assessing a government's interest in bringing a defendant to trial, not only must courts consider the facts of the individual case, but careful attention must be given to any *special circumstances* that may lessen the importance of that interest.³⁴⁵ In addition to creating a false mental state, antipsychotic drugs may cause many negative, even fatal, side effects. To force medication on an individual despite the existence of negative effects is itself a cruel

³⁴⁰ *Singleton*, 319 F.3d at 1036.

³⁴¹ *Id.*

³⁴² *See Riggins v. Nevada*, 504 U.S. 127 (1992).

³⁴³ *Id.* at 135.

³⁴⁴ *Singleton* 319 F.3d at 1025 (citing *Moran v. Burbine*, 475 U.S. 412, 426 (1986) (recognizing "society's compelling interest in finding, convicting, and punishing those who violate the law"))).

³⁴⁵ *Sell v. United States*, 539 U.S. 166, 179–180 (2003).

punishment. The barbarity and extremity of forcibly medicating a death row inmate for execution should qualify as a “special circumstance.”³⁴⁶ At minimum, Singleton’s case warranted a thorough consideration of the issues raised by *Harper* and *Sell* rather than the quick dismissal given by the Eighth Circuit. As Sherry F. Colb, Professor at Rutgers Law School and FindLaw columnist, remarked, “there is something vaguely grotesque about utilizing a therapeutic intervention to facilitate a scheduled execution. The process of improving a person’s health in order to kill him feels like a cruel betrayal.”³⁴⁷

It has been recognized that involuntarily medicated prisoners “have to endure greater suffering than the typical condemned inmates.”³⁴⁸ In deciding the issue of forcible medication for execution, the *Perry* Court explained:

Such involuntary medication requires the unjustified invasion of his brain and body with discomfiting, potentially dangerous and painful drugs, the seizure of control of his mind and thoughts, and the usurpation of his right to make decisions regarding his health or medical treatment. Furthermore, implementation of the state’s plan to medicate forcibly and execute the insane prisoner would constitute cruel, excessive and unusual punishment. This particular application of the death penalty fails to measurably contribute to the social goals of capital punishment. Carrying out this punitive scheme would add severity and indignity to the prisoner’s punishment beyond that required for the mere extinguishment of life.³⁴⁹

The *Perry* reasoning is analogous to the Eighth Amendment’s protection against cruel and unusual punishment and thus should be adopted by the United States Supreme Court to forbid the execution of those being forcibly medicated into competency. As the court stated in *Perry*, “[t]his type of punitive treatment system is not accepted anywhere in contemporary society and is apt to be administered erroneously,

³⁴⁶ See *supra* notes 138–39 and accompanying text.

³⁴⁷ Sherry F. Colb, *Medicating Prisoners so they can be Killed: A Federal Court Approves Forcible Antipsychotic Treatment for Mentally Incompetent Convicts*, Feb. 26, 2003, <http://writ.corporate.findlaw.com/colb/20030226.html> (last visited Mar. 20, 2004).

³⁴⁸ *Singleton*, 319 F.3d at 1034 n.8.

³⁴⁹ *State v. Perry*, 610 So. 2d 746, 747 (La. 1992).

arbitrarily or capriciously.”³⁵⁰ Even before the rule in *Ford* was established, no state condoned the execution of the insane,³⁵¹ and there is no reason to curtail that standard now.

B. Forcible Medication for Execution and the United States Supreme Court’s Treatment of the Mentally Retarded and Juveniles

Both the mentally retarded and juveniles under the age of sixteen have been categorically excluded from the death penalty for reasons including diminished culpability, lack of both general and specific deterrence, inability to effectively work with counsel to construct a mitigating case, and incapability of understanding and appreciating the nature of and punishment for crimes committed.³⁵² The forced medication of the mentally ill for execution has been criticized for similar reasons.³⁵³

Like the mentally retarded and juveniles, diminished culpability also applies to the mentally ill. A defendant’s mental illness is a factor at every stage of a case, from competence to stand trial to providing a defense to a charge. In addition, the Court in *Riggins* criticized forcible medication and its potential for interfering with a defendant’s ability to construct a mitigating case,³⁵⁴ another significant factor commonly cited by the United States Supreme Court when determining categorical exemption from execution. The Court noted in *Atkins* that “[m]entally retarded defendant’s may be less able to give meaningful assistance to their counsel and are typically poor witnesses, and their demeanor may create an unwarranted impression of lack of remorse for their crimes.”³⁵⁵ Likewise, as noted above, the onset of antipsychotic medication side

³⁵⁰ *Id.* at 748.

³⁵¹ *Id.* at 749–50.

³⁵² Relying on its reasoning in *Thompson*, the United States Supreme Court in *Atkins* excluded the mentally retarded from execution because of the “diminished capacit[y] to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand the reactions of others.” *Atkins v. Virginia*, 536 U.S. 304, 318 (2002). Because of this disability, the Court deduced that mentally retarded individuals “do not act with the level of moral culpability that characterizes the more serious adult criminal conduct.” *Id.* at 306. *See also* *Thompson v. Oklahoma*, 487 U.S. 815, 837 (1988).

³⁵³ *See* Kristen Wenstrup Crosby, *State v. Perry: Louisiana’s Cure-to-Kill Scheme Forces Death-Row Inmates to choose between a Life Sentence of Untreated Insanity and Execution*, 77 MINN. L. REV. 1193 (1993).

³⁵⁴ *See Riggins v. Nevada*, 504 U.S. 127 (1992).

³⁵⁵ *Atkins v. Virginia*, 536 U.S. 304, 320–21 (2002).

effects can negatively affect an individual's appearance, causing one to appear "bored, lethargic and indifferent to what is going on around them . . . being drowsy, confused and unable to stay awake or think clearly."³⁵⁶

The Supreme Court noted in *Thompson* that "[i]nexperience, less education, and less intelligence" make a juvenile "less able to evaluate the consequences of his or her conduct."³⁵⁷ Similarly, because of the uncertainty in drug-induced competence, it cannot be positively stated that an inmate will understand and appreciate the reasons for punishment at the exact moment of execution, an essential *Ford* prerequisite. As recognized by the Court in *Ford*, executing the mentally ill, who are incapable of comprehending the imposition of the death penalty, serves no deterrent purpose,³⁵⁸ a principle justification for the exclusion of juveniles and the mentally retarded from the death penalty.³⁵⁹ Accordingly, the following conclusion by the Court in *Thompson* should be applicable to the preservation of *Ford's* categorical exemption of the mentally ill:

[W]e are not persuaded that the imposition of the death penalty for offenses committed by persons under 16 years of age has made, or can be expected to make, any measurable contribution to the goals that capital punishment is intended to achieve. It is therefore, "nothing more than purposeless and needless imposition of pain and suffering" and thus an unconstitutional punishment.³⁶⁰

Juveniles, the mentally retarded, and the mentally ill are the most vulnerable and the least culpable candidates for the death penalty. Therefore, every precaution, including prohibiting the forcible medication of the mentally ill, should be taken to ensure that our criminal justice system uphold our notions of what is just, decent and humane.

C. Singleton's Effect on Medical Field Ethics

³⁵⁶ Feeman, *supra* note 63, at 699.

³⁵⁷ *Thompson v. Oklahoma*, 487 U.S. 815, 837 (1988).

³⁵⁸ *Ford v. Wainwright*, 477 U.S. 399, 407 (1986).

³⁵⁹ *Atkins v. Virginia*, 536 U.S. 304, 320 (2002) ("executing the mentally retarded will not measurably further the goal of deterrence"); *see Thompson v. Oklahoma*, 487 U.S. 815, 837 (1988) ("[f]or such a young offender, the deterrence rationale is equally unacceptable").

³⁶⁰ *Thompson*, 487 U.S. at 837.

In addition to the constitutional issues raised above, there are many vital ethical and policy implications that the majority in *Singleton v. Norris* neglected to address. Deciding whether or not Singleton should be forced to take antipsychotic medication affects more than just the immediate players; the judgment affects the mentally ill in general and the medical community as well. Both the American Medical Association and the American Psychiatric Association oppose the participation of medical practitioners in a prisoner's execution.³⁶¹ The American Psychiatric Association ("APA") takes the position that "it matters little if the drugs benefit the prisoner in the short term when the overall effect of the drug treatment is his ultimate death."³⁶²

Treating psychiatrists face a tremendous amount of pressure in cases such as Singleton's, especially with knowledge that a patient's drug treatment will ultimately enable execution.³⁶³ In an amicus brief to the United States Supreme Court concerning forcible medication to achieve competency for execution, the APA characterized this situation as "an excruciating ethical dilemma for treating physicians."³⁶⁴ The medical profession is bound not only by personal ethics, which may have risen from family values, religion, and other personal beliefs, but also by esteemed ethical guidelines, such as the Hippocratic Oath and association ethical codes.³⁶⁵ The APA emphasized that "administering involuntary medication in circumstances like the present is only a small step away from participating in the execution itself . . . Such a role stretches medical ethics to, if not beyond, the breaking point."³⁶⁶

³⁶¹ *Singleton v. State*, 437 S.E.2d 53, 61 (S.C. 1993). The Court states, "[t]heir reasoning is the causal relationship between administering a drug which allows the inmate to be executed, and the execution itself. They opine that the administration of the drug is responsible for the inmate's ultimate death." *Id.*

³⁶² Chris Adams, *Death Watch: Delusional Justice*, 27 CHAMPION 46, 46 (May 2003).

³⁶³ See Brief for the American Psychiatric Association and the American Medical Association as Amici Curiae in Support of Petitioner, *Perry v. Louisiana*, 111 S. Ct. 449 (1990) (No. 89-5120) (addressing the issue of whether forcibly medicating the petitioner for the purpose of restoring competency for execution violates the United States Constitution). In its brief, the American Psychiatric Association emphasized the ethical quandaries for treating physicians and urged the court to commute the death sentence to a life sentence without the possibility of parole. *Id.* at 25.

³⁶⁴ *Id.* at 16.

³⁶⁵ See, e.g., AM. PSYCHIATRIC ASS'N, THE PRINCIPLES OF MEDICAL ETHICS: WITH ANNOTATIONS ESPECIALLY APPLICABLE TO PSYCHIATRY § 1, Annot. 4 (1984).

³⁶⁶ Brief for the American Psychiatric Association and the American Medical Association as Amici Curiae in Support of Petitioner, *supra* note 263, at 17-18. The APA continued, "[p]hysicians' ethical dilemma in giving medical treatment to facilitate capital punishment is mirrored in the resulting corruption of their treatment function. Physicians, and especially psychiatrists, require the trust of their patients. A treating

The Hippocratic Oath directs physicians to “First, do no Harm.”³⁶⁷ As Hippocrates stated:

I swear by Apollo the physician, by Aesculapius, Hygeia, and Panacea, and I take to witness all the gods, all the goddesses, to keep according to my ability and my judgment the following Oath: . . . I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone. To please no one will I prescribe a deadly drug, nor give advice which may cause his death . . . I will preserve the purity of my life and my art . . . In every house where I come I will enter only for the good of my patients, keeping myself far from all the intentional ill-doing.³⁶⁸

This Oath has long been the standard for medical ethics and the ethical guidelines of treatment.³⁶⁹ Since doctors are duty-bound to act in a patient’s best interest, mentally ill prisoners cannot be treated in an attempt to achieve competency for execution.³⁷⁰ In response to Louisiana’s claim in *Perry* that while attempting to restore competency for execution, the involuntary medication was in the patient’s best interest, the APA declared, “[t]hat remarkable claim is obviously incorrect . . . [the state’s] efforts are aimed not at benefiting [the inmate] as a ward of the state, but rather at facilitating his death to serve separate state interests.”³⁷¹ The APA concluded, “[i]n our view, involuntary medical treatment may never constitutionally be justified if, as here [in a case of forced medication to restore competency for execution], it is

psychiatrist must build a relationship with the patient to encourage communication of symptoms and to allow monitoring of the effects of medication. The psychiatrist must encourage the patient to speak openly to facilitate individual and group therapy. There can be few more certain ways of jeopardizing these necessary treatment functions than for the psychiatrist to become an instrument of punishment.” *Id.* at 18.

³⁶⁷ Richard E. Redding & Kursten Hensel, *Do No Harm: Should we Medicate to Execute?*, June 20, 2003, <http://www.commonwealmagazine.org/12003/june202003/6202003st.htm> (last visited Jan. 20, 2004).

³⁶⁸ *State v. Perry*, 610 So. 2d 746, 752 (La. 1992) (citing Hippocrates c. 460–400 B.C., *Stedman’s Medical Dictionary* 647 (4th Unabridged Lawyer’s Ed. 1976)).

³⁶⁹ *Id.* at 752.

³⁷⁰ *Id.*

³⁷¹ Brief for the American Psychiatric Association and the American Medical Association as Amici Curiae in Support of Petitioner, *supra* note 263, at 9–10.

contrary to the patient's medical interests."³⁷² Furthermore, the ethical code of the American Psychiatric Association prohibits a psychiatrist from being "a participant in a legally authorized execution."³⁷³ In a national survey of psychiatrists on the issue of forcible medication for execution, one doctor strongly opposed the involvement of health care professionals, reasoning that such "participation" is "comparable to medical involvement in torture."³⁷⁴

In addition to the medical field's position that involuntary medical treatment to facilitate execution is contrary to a patient's medical interests, other important rationales exist for ending this practice. The APA argued in its brief opposing forcible medication for execution that if psychiatrists are now perceived as assisting in the execution process, "the ability of all physicians to maintain an effective patient-physician relationship with prisoners will be significantly impaired."³⁷⁵ Physicians are also troubled by the fact that "numerous factors already operate to discourage psychiatrists from working with prison populations," including poor working conditions, inadequate funding, the potential for conflicts with prison staff, and diminished emphasis on rehabilitation.³⁷⁶ The APA noted that both prisons and prisoners, especially those on death row, cannot afford to be deprived of effective psychiatric care, a result that is likely to occur if treating physicians are continually faced with this daunting ethical dilemma.³⁷⁷ As such, the APA concluded that allowing forcible medication to facilitate execution would "undermine important state interests without any evidence that the state legislatures are ready to sacrifice them."³⁷⁸

In his dissent from the majority opinion in *Singleton*, joined by Judges Bright, McMillian and Bye, Judge Heaney remarked, "I am gravely concerned that the majority has created a serious ethical dilemma for the medical community as a result of its opinion. I would hold that the State may continue to medicate Singleton, voluntarily or involuntarily, if it is necessary to protect him or others and is in his best medical interest, but it may not execute him."³⁷⁹ By administering

³⁷² *Id.* at 12.

³⁷³ AM. PSYCHIATRIC ASS'N, *supra* note 365, at § 1, Annot. 4.

³⁷⁴ Robert D. Miller, *Evaluation of and Treatment to Competency to be Executed: A National Survey and an Analysis*, 16 J. PSYCHIATRY & L. 67, 74 (1988).

³⁷⁵ Brief for the American Psychiatric Association and the American Medical Association as Amici Curiae in Support of Petitioner, *supra* note 263, at 18..

³⁷⁶ *Id.* at 19.

³⁷⁷ *Id.* at 18.

³⁷⁸ *Id.* at 19–20.

³⁷⁹ *Singleton v. Norris*, 319 F.3d 1018, 1037 (8th Cir. 2003).

antipsychotic medication against a death row inmate's will, the physician would help the state circumvent *Ford* and carry out the execution. Health practitioners should not be forced to compromise their personal and professional ethics by providing treatment that will facilitate execution.

VII. POSSIBLE SOLUTIONS FOR PROTECTING THE MENTALLY ILL

A. *What Steps Should be Taken in Response to Singleton v. Norris?*

As times change and the medical and technological fields advance, the competency requirement for execution must be reassessed, paying particular attention to the diagnosed mentally ill. Rather than destroying an established and time-honored paradigm of excluding the mentally ill from execution, the United States Supreme Court, as well as lower courts, should consider the issue and clarify the parameters of the capital punishment exclusion for the mentally ill. In the spirit of *Ford*, the courts should evaluate the constitutionality of drugging the mentally ill in order to facilitate execution, while considering other categorical exclusions from death penalty. In addition, courts should bear in mind the dilemma the decision thrusts upon medical professionals.

Perhaps courts should also consider formalizing a blanket exemption for mentally ill prisoners from execution, since chemically induced competence does not satisfy *Ford's* requirement that an inmate understand his crime and punishment. Shifting a mentally ill prisoner's death sentence to life imprisonment without parole will preserve the rights of the mentally ill and alleviate the pressures experienced by treating physicians.

Recognizing that there is concern about feigning mental illness to evade execution, the American Psychiatric Association pointed out in its brief opposing forcible medication for execution that such attempts can be prevented through the use of clinical malingering techniques³⁸⁰ and legal burdens of proof.³⁸¹ The APA also noted that medical literature

³⁸⁰ See, e.g., Michael R. Harris & Phillip J. Resnick, *Suspected Malingering: Guidelines for Clinicians*, 20 PSYCHIATRIC TIMES (Dec. 2003), available at <http://www.psychiatristimes.com/p031268.html> (“[w]hen evaluating the potential for malingering, clinicians should utilize multiple sources of data, including interviews, collateral sources of information and psychometric tests”).

³⁸¹ Brief for the American Psychiatric Association and the American Medical Association as Amici Curiae in Support of Petitioner, *supra* note 263, at 22. The APA stated, “[t]he foregoing clinical and legal safeguards, taken together, greatly reduce the danger that a prisoner will be able to feign a mental condition that constitutes

demonstrates the difficulty of successful feigning.³⁸² In addition to useful guidance provided by the DSM-IV in identifying fakery, conditions can be verified in other ways, such as with a particularly close inspection of an individual's past psychiatric, school or vocational records.³⁸³

In any regard, the United States Supreme Court should revisit the issue of the execution of the insane to continue our common-law heritage and "evolving standards of decency."³⁸⁴

VIII. CONCLUSION

While the Eighth Amendment prohibits the infliction of cruel and unusual punishments, the drafters made no attempt to define the contours of that category. Accordingly, the authors delegated that task to future generations of judges who have been guided by the "evolving standards of decency that mark the progress of a maturing society."³⁸⁵ The United States Supreme Court in *Ford* established that it is unlawful and inhumane to execute those who cannot understand their crimes and the capital punishment they face.³⁸⁶ Drug-induced competence is merely artificial and therefore should not be considered when applying the *Ford* competency standard for determining execution eligibility.³⁸⁷ To forcibly medicate those who suffer from mental illness for the functional purpose of execution is unjustified and cruelly inhumane.

Hopefully, sometime in the near future, the United States Supreme Court will revisit the issue of forcibly medicating the insane for execution and put an end the inhumane practice of circumventing *Ford*, which is presently occurring in the Eighth Circuit.

incompetence, at least under the standards suggested by Justice Powell in *Ford*." *Id.* at 24.

³⁸² *Id.*

³⁸³ *Id.*

³⁸⁴ *Ford v. Wainwright*, 477 U.S. 399, 419 (1986) (Powell, J., concurring).

³⁸⁵ *Trop v. Dulles*, 356 U.S. 86, 101 (1958).

³⁸⁶ *Ford*, 477 U.S. at 419.

³⁸⁷ See TAYLOR, *supra* note 327, at 1060.