NO REASON FOR EXEMPTION:  
SINGLETON V. NORRIS AND INVOLUNTARY  
MEDICATION OF MENTALLY ILL CAPITAL  
MURDERERS FOR THE PURPOSE OF EXECUTION

Amir Vonsover*

INTRODUCTION

Since the evolution of the common law, the execution of the insane has consistently been seen as "savage and inhumane." Blackstone, Coke, and Hawles, among others, have condemned the practice. In *Ford v. Wainwright*, the Supreme Court "ke[pt] faith with our common law heritage" and explicitly held that it is a violation of the Eighth Amendment to execute the insane.

Neither the common law nor *Ford*, however, contemplated the evolving science of antipsychotic medications. As the effectiveness of these drugs dramatically improves, more and more inmates who would formerly have been incompetent either to stand trial or face execution are able to use medication to restore their competency. Most of the time, these inmates take the drugs voluntarily; they prefer to live without the symptoms of their illnesses. As execution approaches, though, condemned prisoners have every incentive to stop taking the drugs and revert to insanity. Under *Ford*, they would then be guaranteed a stay of execution. But in the last year, in *Singleton v. Norris*, the Court of Appeals for the Eighth Circuit sanctioned a prac-

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1 4 WILLIAM BLACKSTONE, COMMENTARIES *24–25.
2 *See infra* Part I.B.
3 477 U.S. 399, 401 (1986) (holding that the Constitution forbids the execution of the insane).
4 The Eighth Amendment provides that "cruel and unusual punishment [shall not be] inflicted." U.S. CONST. amend. VIII.
6 *See Brief for the American Psychiatric Association as Amicus Curiae, Sell v. United States, 539 U.S. 166 (2003) (No. 02-5664),* 2002 U.S. Briefs 5664, at 14 ("[t]he benefits of antipsychotic medications . . . are so palpably great.").
7 319 F.3d 1018, 1020 (8th Cir. 2003), *cert. denied,* 124 S. Ct. 74 (2003).
tice previously proscribed in Louisiana and South Carolina—the involuntary administration of antipsychotic medication to restore a capital inmate’s competency for execution.

It makes little sense to grant what is in effect a permanent stay of execution to inmates who not only can be, but, absent their death sentence, would prefer to be medically competent through antipsychotic medications. Further, there is simply no reason to proscribe this involuntary medication procedure. The rationales of *Ford* do not apply to inmates who are medically competent: the execution of these prisoners furthers the deterrent and retributive goals of capital punishment, it comports with the current law, and there are no viable alternatives if the state wishes to carry out the death sentence. The conclusion is inescapable that a state should be permitted to involuntarily medicate a mentally ill inmate for the purpose of execution. If the state wishes to engage in capital punishment, there is no persuasive reason to differentiate between inmates of medically-induced competence and other capital inmates.

For the purposes of this Comment, a few assumptions must be made. It must be assumed that the inmate was sane at the time of the crime and unable to make out a case of acquittal by reason of insanity. It must also be assumed that the inmate was competent to be sentenced, removing any improper foundation from the imposition of the death penalty. The inmate must lose his competency between sentencing and execution. Finally, it must be assumed that the inmate, when medicated, is in fact *Ford*-competent to be executed. Any defendant to whom these assumptions are inapplicable is outside the purview of this analysis.

This Comment will examine both the current case law on the trial and execution of the mentally ill and the applicability of that law to mentally ill inmates who can be restored to competency. Part I provides a history of the mentally ill on death row and a discussion of *Ford v. Wainwright*. Part II examines the case law of forcible medication of inmates and defendants in *Washington v. Harper*, *Riggins v. Nevada*, and *Sell v. United States*. Part III discusses the forced medication of death row inmates in terms of both state and federal (*Singleton v. Norris*) law. Part IV concludes both that the case law does not preclude the forcible medication of inmates to restore their competency for execution and that there are no other viable options for courts wishing to avoid forcible medication.

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8 The dissenting judge in *Singleton* describes Singleton as “arguably incompetent when treated.” It must be assumed that, when medicated, Singleton is competent to face execution. *See Singleton*, 319 F.3d at 1030.
I. THE MENTALLY ILL AND THE DEATH PENALTY: FORD

A. The Onset of Insanity on Death Row

Fifty years ago, Justice Frankfurter wrote that "[i]n the history of murder, the onset of insanity while awaiting execution of a death sentence is not a rare phenomenon."9 As the death row populations have increased sixfold over the last twenty-five years,10 mental deterioration among death row inmates has become even more common.

Prisoners on death row are subject to what has been described as "one of the least common and possibly the most stressful of all human experiences—the anticipation of death at a specific moment and time and in a known manner."11 In addition to this stress, death row inmates often experience "social isolation and a lack of exercise, education, and work programs; family visits are infrequent and burdened with security restrictions."12

An additional stress on the mental state of death row inmates is the growing tenure of the average inmate. In the past twenty-five years, the death row population has increased.13 The appeals process has multiplied in complexity and length, and courts have experienced significant backlogs of appeals, particularly petitions for the writ of habeas corpus.14 As a typical death row inmate "exercises every available appellate right,"15 inmate tenure on death row can reach lengths of ten years or more.16

10 In 1979, there were 593 people on death row and two executions; in 2002, there were 3,557 people on death row and seventy-one executions. BUREAU OF JUSTICE STATISTICS, U.S. DEP’T OF JUSTICE, BULLETIN, CAPITAL PUNISHMENT 2002 (2003).
12 Byers, supra note 11, at 368 (quoting Harvey Bluestone & Carl L. McGahee, Reaction to Extreme Stress: Impending Death by Execution, 119 AM. J. PSYCHIATRY 393, 393 (1962)).
13 See supra note 10.
14 In the Federal District Court for the Eastern District of New York, for example, the habeas backlog was so overwhelming that Senior Judge Jack B. Weinstein devoted, for the entire year of 2003, his docket almost exclusively to adjudicating the more than 500 pending habeas petitions. See In re Habeas Cases, 298 F. Supp. 303 (E.D.N.Y. 2003) (collecting of 500 habeas petitions for federal review).
15 Byers, supra note 11, at 369.
A 1984 study done in Florida estimated that "as many as fifty percent of Florida's death row inmates become intermittently insane." Describing the inmates, the author wrote:

They go in and out. Like most people with mental illness, they have crisis periods, and other periods when they can function. A lot depends on stress, bad diet, lack of medication, lack of exercise . . . . Some of these people are much too crazy to help their attorneys prepare appeals. They might have been able to assist their attorneys at trial time, three years, five years, earlier, but now they are totally psychotic, irrational. It doesn't take an expert to tell that . . . . Five to ten percent of the inmates go so far over the edge that we can never bring them back. We watch this happen to them. We saw it happen to [Alvin Bernard] Ford.

There is no reason to believe either that the mental condition of inmates elsewhere is any better than in Florida or that the situation in Florida (or elsewhere) has improved since 1984. As a result, "it should not be surprising that condemned prisoners could and do become incompetent before their death sentences are carried out." Whether the cause is latent mental illness, terrible prison conditions, an agonizingly long tenure on death row, or a combination of these, a significant number of death row inmates have begun "asserting that their prolonged confinement under sentence of death has left them mentally incompetent," forcing the courts to deal with such claims more frequently.

B. Ford v. Wainwright

In 1974, Alvin Bernard Ford was convicted of capital murder and sentenced to death. At the time of his crime, trial, and sentencing, Ford was competent and made no argument to the contrary. During the course of his appeals, however, he began to manifest strange behaviors. He became obsessed with the Ku Klux Klan and began to believe "that he had become the target of a complex conspiracy, involving the Klan and assorted others." He also claimed that his female relatives were being tortured and "sexually abused" within the prison. This delusion worsened, and Ford eventually reported that not only were "135 of his friends and family . . . being held hostage in

18 Ward, supra note 16, at 42.
19 Id. at 42-43 (quoting Sherrill, supra note 17, at 555-56).
20 Byers, supra note 11, at 371.
21 Ward, supra note 11, at 37.
22 Ford, 477 U.S. 399, 402 (1986)
23 Id.
the prison,” but also that Senator Ted Kennedy was among the hostages.24

At this time, Ford was evaluated by a psychiatrist. In 1983, after more than a year of evaluations, the psychiatrist concluded that “Ford suffered from ‘a severe, uncontrollable, mental disease which closely resembles Paranoid Schizophrenia With Suicide Potential’—a ‘major mental disorder . . . severe enough to substantially affect Mr. Ford’s present ability to assist in the defense of his life.’”25

In an interview with a second psychiatrist,26 Ford stated that “I’m free to go whenever I want because [my execution] would be illegal and the executioner would be executed.”27 He made this statement “amidst long streams of seemingly unrelated thoughts in rapid succession.”28 The second psychiatrist concluded that Ford did not understand why he was to be executed, made no connection between his crime and the penalty, and “sincerely believed that he would not be executed because he owned the prisons and could control the Governor through mind waves.”29 As time progressed, Ford’s mental health regressed even further.

After a competency hearing, at which three different state doctors found that Ford could comprehend “the death penalty and why it was imposed upon him,”30 Governor Bob Graham signed a warrant for Ford’s execution. Ford’s petitions for writ of habeas corpus were denied in turn by the United States District Court for the Southern District of Florida and a divided panel of the Court of Appeals of the Eleventh Circuit.31 The Supreme Court granted certiorari.32

The Court, by Justice Marshall, found that Ford was insane and held, in accordance with the common law, that “[t]he Eighth Amendment prohibits the State from inflicting the penalty of death upon a prisoner who is insane.”33 The Court failed to articulate a specific reason for this holding and instead, quoting Holmes, found

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24 Id.
26 Ford refused to see the first psychiatrist again, “believing him to have joined the conspiracy against him.” Id. at 403.
27 Id.
28 Id.
29 Id.
30 Id. at 403–04.
31 Ford v. Wainwright, 752 F.2d 526 (11th Cir. 1985) (affirming the Southern District of Florida’s denial of a writ of habeas corpus).
that "reasons for the rule are less sure and less uniform than the rule itself." Some of the many reasons mentioned by the Court include that the execution of the insane "simply offends humanity," it lacks "deterrence value," and it lacks sufficient retributive value, as the execution of an insane person "has a 'lesser value' than that of the crime for which he is to be punished."

In his concurrence, Justice Powell announced what has become the controlling standard of competency 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." This standard requires both that the inmate "perceive[] the connection between his crime and his punishment" and that he be "aware that his death is approaching." This standard comports with the common law standard of awareness of a conviction and impending execution.

II. THE FORCED MEDICATION OF INMATES AND DEFENDANTS: HARPER, RIGGINS, AND SELL

A. Washington v. Harper

In 1976, Walter Harper was sentenced to prison for robbery. For most of the next four years, he was incarcerated in the mental health unit of the Washington State Penitentiary, "where he consented to the administration of antipsychotic drugs." After parole and re-incarceration, Harper received treatment at the Special Offender Center ("SOC") for the treatment of "convicted felons with serious mental disorders." In November 1982, Harper "refused to continue taking the prescribed medications," whereupon his doctors sought to forcibly medicate him over his objections.

Pursuant to SOC policy, Harper was given a hearing "before a special committee consisting of a psychiatrist, a psychologist, and the
Associate Superintendent of the [SOC]"; the committee "found that [Harper] was a danger to others as a result of a mental disease or disorder, and approved the involuntary administration of antipsychotic drugs."

Harper filed suit under 42 U.S.C. § 1983, alleging violations of Due Process, Equal Protection, and Free Speech. After being denied relief in a bench trial, the Washington Supreme Court reversed, finding that forcible medication is permissible only if it is proven by "clear, cogent, and convincing evidence" that the administration of antipsychotic medication is both necessary and effective for furthering a compelling state interest. The Supreme Court granted certiorari.

The Court, per Justice Kennedy, held that Harper "possess[ed] a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment." The Court held that the standard by which the constitutionality of involuntary medication was judged was "reasonabl[e] relation to legitimate penological interests," as opposed to the Washington Supreme Court's standard of "'clear, cogent, and convincing' evidence." In particular, three factors were relevant "to determine the reasonableness of a challenged prison regulation":

First, there must be a valid, rational connection between the prison regulation and the legitimate governmental interest put forward to justify it. Second, a court must consider the impact accommodation of the asserted constitutional right will have on guards and other inmates, and on the allocation of prison resources generally. Third, the absence of ready alternatives is evidence of the reasonableness of a prison regulation, but this does not mean that prison officials have to set up and then shoot down every conceivable alternative method of accommodating the claimant's constitutional complaint.

Applying these factors, the Court noted the duty of the State to ensure the safety of both prisoners and prison staff and the lack of ac-

45 Id. at 215.
46 Id. at 217.
47 42 U.S.C. § 1983 creates a cause of action for "deprivation of any rights, privileges, or immunities secured by the Constitution and laws."
49 Id. at 364–65 (internal quotations omitted).
51 Harper, 494 U.S. at 221–22 (citations omitted).
52 Id. at 223 (quotations and citations omitted).
54 Harper, 494 U.S. at 224.
55 Id. at 224–25 (quotations and citations omitted).
56 Id. at 225.
ceptable alternatives. Thus the Court held that, within the prison environment, "the Due Process Clause permits the State to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest." The Court also held that the inmate’s rights were "adequately protected, perhaps better served," when the decision is made by medical professionals, as opposed to a judge.

B. Riggins v. Nevada

In November 1987, David Riggins was arrested and charged with murder and robbery. After complaining of "hearing voices in his head," Riggins began treatment with antipsychotic drugs. After being found competent to stand trial, Riggins moved to suspend the administration of the drugs, claiming that the drugs would have an effect on his mental state at trial, particularly since he planned to mount an insanity defense. The trial court denied the motion and continued the administration of the drugs involuntarily. Riggins was convicted of robbery and capital murder. The Nevada Supreme Court affirmed the conviction, holding that expert testimony on the effects of the drugs "was sufficient to inform the jury of the effect of [the drugs] on Riggins' demeanor and testimony." The Supreme Court granted certiorari.

The Court, in an opinion written by Justice O'Connor, reaffirmed Harper and emphasized that involuntary medication "represents a substantial interference with that person's liberty." The Court then held that "[u]nder Harper, forcing antipsychotic drugs on a convicted prisoner is impermissible absent a finding of overriding justification and a determination of medical appropriateness." The Court found that Nevada failed to make a Harper-showing that "treatment with antipsychotic medication was medically appropriate . . . [and] essential for the sake of Riggins' own safety or the safety of others." While

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57 Id. at 226–27.
58 Id. at 228.
59 Id. at 231.
61 Id.
62 Id. at 130.
63 Id. at 131.
64 Id.
68 Id. at 135.
69 Id.
implying that forcible medication of a defendant for the purpose of restoring competency for trial would be permissible if the proper showing was made, the Court reversed the Nevada Supreme Court's decision for failing to require such a showing.70

Justice Kennedy, concurring in the judgment, expressed concern with the side effects of antipsychotic drugs on defendants at trial. He mentioned that these drugs may prejudice a defendant in two ways: "(1) by altering his demeanor in a manner that will prejudice his reactions and presentation in the courtroom, and (2) by rendering him unable or unwilling to assist counsel."71 According to Kennedy, "[i]f the defendant cannot be tried without his behavior and demeanor being affected in this substantial way by involuntary treatment," the state must civilly commit him in lieu of trial. As long as these drugs continue to have significant side effects, Kennedy would "permit their use only when the State can show that involuntary treatment does not cause alterations raising [constitutional] concerns."72

C. Sell v. United States

Charles Sell, formerly a practicing dentist with a long history of mental illness, was charged in 1997 with mail fraud, Medicaid fraud, money laundering, and, in a separate indictment, the attempted murder of the FBI agent who arrested him.73 After a bail revocation hearing, at which Sell's behavior "was in the judge's words, 'totally out of control,'"74 Sell was found mentally incompetent to stand trial and ordered to be hospitalized "to determine whether there was a substantial probability that he would attain the capacity to allow his trial to proceed."75 Two months later, hospital staff recommended that Sell take antipsychotic medication; when Sell refused to do so, "the staff sought permission to administer the medication against Sell's will."76 A reviewing psychiatrist authorized the involuntary medication,77 and that order was affirmed by the Eighth Circuit.78

70 Id. at 138.
71 Id. at 142 (Kennedy, J., concurring); see also Brief for American Psychiatric Association as Amicus Curiae, Riggins v. Nevada, 504 U.S. 127 (1990) (No. 90-8466), 1990 U.S. Briefs 8466 at 9 (outlining the potential side effects of antipsychotic drugs, including nervousness and restlessness or sedation "as to appear bored, cold, unfeeling, and unresponsive"); Rebecca A. Miller-Rice, Comment: The "Insane" Contradiction of Singleton v. Norris: Forced Medication in a Death Row Inmate's Medical Interest Which Happens to Facilitate His Execution, 22 U. ARK. LIT. ROCK L. REV. 659, 668 n.41 (discussing the effects the drug Mellaril had upon Riggins).
72 Riggins, 504 U.S. at 145 (Kennedy, J., concurring).
74 Id. at 173 (quoting the Court's appellate record).
75 Id. (quoting the Court's appellate record).
76 Id.
77 Id. at 171.
The Supreme Court granted certiorari on the question of whether it is violative of the Constitution to permit "the government to administer antipsychotic medication against [Sell's] will solely to render him competent to stand trial for non-violent offenses."

The Court, in an opinion by Justice Breyer, held that "the Constitution allows the Government to administer [antipsychotic] drugs, even against the defendant's will, in limited circumstances." The Court found that Harper and Riggins, taken together, stand for the proposition:

The 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.

Thus, it is permissible for a state to involuntarily administer drugs solely for trial-related purposes. Moreover, the Court held in the above proposition a requirement of four findings that a court must make before ordering a defendant to be involuntarily medicated to restore his trial competency.

First, a court must find that "important governmental interests are at stake." The Court reaffirmed that the state has an important and substantial interest in both "bringing to trial an individual accused of a serious crime" and "timely prosecution." Second, a court must conclude that "involuntary medication will significantly further those concomitant state interests." A court must find that the drug is "substantially likely to render the defendant competent" while also being "substantially unlikely to have side effects that will interfere significantly with the defendant's ability to assist counsel in conducting a trial defense, thereby rendering the trial unfair." Third, the

79 United States v. Sell, 282 F.3d 560 (8th Cir. 2002).
81 Sell, 539 U.S. at 173 (quotations and citation omitted).
82 Id. at 167.
83 Id. at 181.
84 Id.
85 Id. (emphasis in original).
86 Id. The Court also noted that "[s]pecial circumstances may lessen the importance of [these] interest[s]." Id. Specifically, the Court suggested that "the potential for future confinement" or "lengthy confinement in an institution for the mentally ill" might affect, but not obviate, the Government's need for prosecution (as defendants ordinarily receive credit for time already served (18 U.S.C. § 3585(b))). Id.
87 Id. (emphasis in original)
88 Id. (citing Riggins v. Nevada, 504 U.S. 127, 142-45 (1992)) (Kennedy, J., concurring). It seems that this second required finding, namely that the drug(s) will not have significant side
court must find that "involuntary medication is necessary to further those interests"; i.e., "any alternative, less intrusive treatments [must be] unlikely to achieve substantially the same results." Finally, "the court must conclude that administration of the drugs is medically appropriate, i.e., in the patient’s best medical interest in light of his medical condition." If the drugs would not ordinarily be medically appropriate to a person with the defendant’s condition, the fact that the state has an interest in trying the defendant does not make a given course of treatment more appropriate.

Because the Court of Appeals did not make the inquiries required by the opinion, the Court vacated and remanded the case for re-evaluation based on Dr. Sell’s current medical condition.

III. THE FORCED MEDICATION OF DEATH ROW INMATES: PERRY, SINGLETON v. SOUTH CAROLINA, AND SINGLETON v. NORRIS

A. Louisiana v. Perry

In a case of first impression for state supreme courts, the Louisiana Supreme Court found that forcibly medicating an otherwise insane inmate to “circumvent” Ford v. Wainwright was violative of the Louisiana State Constitution.

effects that would render the trial unfair, was tailored to allay the fears expressed by Justice Kennedy in his concurrence in Riggins. See also, Brief for the American Psychiatric Association and American Academy of Psychiatry and the Law as Amici Curiae Supporting Respondent, Sell v. United States, 539 U.S. 166 (2003) (No. 02-5664), 2002 U.S. Briefs 5664 at 27–30 (advocating the use of antipsychotic drugs and discussing the possible fair trial side effects on forcibly-medicated defendants).

Id. (second emphasis added).

The Court also noted that the inquiry mandated by Sell is not needed "if forced medication is warranted for a different purpose, such as the purposes set out in Harper related to the individual's dangerousness." Id. at 2185-86 (quoting Washington v. Harper, 494 U.S. 210, 225-26 (1990)) ("If a court authorizes medication on these alternative grounds, the need to consider authorization on trial competence grounds will likely disappear."). The Court felt that, as a general matter, courts should attempt to justify forced drug administration under these grounds before inquiring into plausible Sell grounds, if possible, for two primary reasons:

(1) "the inquiry into whether medication is permissible, say, to render an individual non-dangerous is usually more 'objective and manageable' than the inquiry into whether medication is permissible to render a defendant competent" (quoting Riggins, 504 U.S. at 140); and

(2) "courts typically address involuntary medical treatment as a civil matter, and justify it on these alternative, Harper-type grounds" (citing examples of state civil guardianship statutes).

Compare Sell with United States v. Weston, 255 F.3d 873, 883-85 (D.C. Cir. 2001) (focusing, in a case with facts similar to Sell, on the effects the drugs would have on the defendant’s trial rights, namely his behavior on the witness stand, his right to testify in his own words, and his possibly altered demeanor).

Michael Owen Perry was diagnosed as a schizophrenic at age sixteen and was committed to mental institutions several times during his life. In 1983, at age twenty-eight, Perry brutally murdered five of his close family members. After an eighteen-month period in which he was treated with antipsychotic drugs, Perry was found to be competent to stand trial. A jury convicted him and sentenced him to death, whereupon a committee was convened to evaluate Perry’s sanity to be executed. The medical experts found that Perry “suffers from an incurable schizoaffective disorder”, while these symptoms “can be temporarily diminished with antipsychotic drugs,” . . . “his underlying insanity can never be permanently cured.” The lower court found, in essence, that “without the influence of antipsychotic drugs, Perry is insane and incompetent for execution.” Thus, the lower court ordered the involuntary medication of Perry. After the United States Supreme Court granted certiorari and subsequently remanded the case in light of Harper, the Supreme Court of Louisiana granted certiorari.

The Court initially reaffirmed the rule, under Ford and Louisiana common law, that “executing the insane is barred in [Louisiana].” The Court then distinguished Harper, finding that, while a Harper-medication regime would promote healing in accordance with the Hippocratic Oath, an involuntary medication regime for the purpose of restoring competency for execution “is antithetical to the basic principles of the healing arts.” The Court also found that Harper focused on the inmate’s “medical interest,” which is clearly not served by so-called “drugging for execution.” The Court also held that forcibly medicating an inmate solely for the purpose of restoring competency to be executed was cruel, excessive, and unusual:

The punishment is cruel because it imposes significantly more indignity, pain and suffering than ordinarily is necessary for the mere extinguish-

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94 Id. at 748.
95 Id. (citations omitted).
96 Id.
97 Id. The effects of this disorder were such that “his days [were] a series of hallucinations, delusional and disordered thinking, incoherent speech, and manic behavior.” Id. 
99 Id.
102 State v. Perry, 584 So. 2d 1145 (La. 1991).
103 Perry, 610 So. 2d at 750.
104 Id. (citing Washington v. Harper, 494 U.S. 210 (1990)).
105 Id. at 753, 755. See also Miller-Rice, supra note 71 (discussing the medical ethical implications of “drugging for execution”).
ment 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.\footnote{Perry, 610 So. 2d at 761.}

Finally, the Court found that such an execution would not "measurably further either goal of [capital punishment]: deterrence or retribution."\footnote{Id. at 765.} As such, the medication regime ordered by the lower court "would offend civilized standards of decency" and is violative of the Louisiana State Constitution.\footnote{Id. at 768.} The Court reversed the medication regime and ordered a stay of execution until "Perry achieves or regains his sanity independently of and without the influence of antipsychotic drugs."\footnote{Id. at 747.}

B. Singleton v. South Carolina

Fred Singleton was convicted of "murder, burglary, larceny of a motor vehicle, and first-degree criminal sexual conduct" and was sentenced to death.\footnote{Singleton v. South Carolina, 437 S.E.2d 53 (S.C. 1993).} In a petition for post-conviction relief (PCR), Singleton alleged that he was not competent to be executed.\footnote{Id. at 55.} The PCR judge held Singleton "incompetent to be executed under either the A.B.A. Standard or the standard set forth in Justice Powell's concurring opinion in Ford v. Wainwright."\footnote{Id. (quoting Ford v. Wainwright, 477 U.S. 399 (1986)).} The government appealed.

The South Carolina Supreme Court adopted "a slightly modified" A.B.A. standard to satisfy federal due process, common law, and the South Carolina Constitution:

[T]he appropriate test in South Carolina [is] a two-prong analysis. The first prong is the cognitive prong which can be defined as: whether a convicted defendant can understand the nature of the proceedings, what

\begin{quote}
A convict is incompetent to be executed if, as a result of mental illness or mental retardation, the convict cannot understand the nature of the pending proceedings, what he or she was tried for, the reason for the punishment or the nature of the punishment. A convict is also incompetent if, as a result of mental illness or retardation, the convict lacks sufficient capacity to recognize or understand any fact which might exist which would make the punishment unjust or unlawful, or lacks the ability to convey such information to counsel or the court.
\end{quote}

\footnote{A.B.A. Criminal Justice Mental Health Standard 7-5.6. (1989), available at http://www.abanet.org/crimjust/standards/mentalhealth_blk.html#7-5.6 (last visited Sept.14, 2004). Justice Powell's standard in \textit{Ford} is: "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." \textit{Ford}, 477 U.S. at 422 (Powell, J., concurring).
he or she was tried for, the reason for the punishment, or the nature of
the punishment. The second prong is the assistance prong which can be
deﬁned as: whether the convicted defendant possesses sufﬁcient capacity
or ability to rationally communicate with counsel. Under this standard, the court held that Singleton was “incapable of
meeting even a modicum of competency.”

As to the question of whether the State could forcibly medicate
Singleton to restore his competency, the court relied on Louisiana v. Perry, as the Louisiana Constitution is “strikingly similar” to the
South Carolina Constitution. Like the Louisiana court, the South
Carolina Supreme Court held that “the South Carolina Constitutional right of privacy would be violated if the State were to sanction
forced medication solely to facilitate execution.” Further, referring
to the American Medical Association (“AMA”) and the American Psychiatric Association (“APA”), the court found that “the medical ethical
position reinforces the mandates of our constitutional law.” In
closing, the court unequivocally found that “justice can never be
served by forcing medication on an incompetent inmate for the sole
purpose of getting him well enough to execute.” The court therefore reversed the involuntary medication order and granted a per-
manent stay of execution.

C. Singleton v. Norris

In 1979, in an apparent attempted robbery, Charles Laverne Sin-
gleton stabbed his victim twice in the neck. As the victim was taken
to the hospital, she identiﬁed Singleton as her killer several times be-
fore she died. He was convicted of capital felony murder and sentenced to death. Singleton never alleged that he was insane or in-

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115 Singleton, 437 S.E.2d at 58.
114 Id. The court cited evidence from the record to this effect, including “Singleton is com-
pletely unaware that he is capable of dying in the electric chair” and “Singleton is incapable of
rational communication.” Id. The court doubted that Singleton could meet either prong, let
alone both. Id.
117 Id.
118 Id.
119 Id. at 62.
120 Singleton v. Norris, 319 F.3d 1018, 1020 (8th Cir. 2003), cert. denied, 124 S. Ct. 74 (2003); see also Neil A. Lewis, Justices Let Stand Ruling That Allows Forcibly Drugging an Inmate Before Execu-
tion, N.Y. TIMES, Oct. 7, 2003, at A16. It should be noted that Singleton was decided between the
Eighth Circuit’s opinion in United States v. Sell, 282 F.3d 560 (8th Cir. 2002), and the Supreme
Court’s opinion in Sell v. United States, 539 U.S. 166 (2003), which vacated and remanded the
case back to the Eighth Circuit.
121 Singleton, 319 F.3d at 1021 (citations omitted).
122 Id. at 1020.
No Reason for Exemption

Competent at the time of the crime, trial, or sentencing. In 1992, after ten years of appeals, Singleton alleged, for the first time, that he was incompetent to be executed. In 1992, after ten years of appeals, Singleton alleged, for the first time, that he was incompetent to be executed.123 He requested that his treatment with antipsychotic drugs be terminated and that a competency examination be held after the effect of the drugs had subsided.124 In 1997, after all of his petitions were dismissed, "the State placed Singleton on an involuntary medication regime after a medication review panel unanimously agreed that he posed a danger to himself and others."125 The medication took effect and the psychotic symptoms abated. Arkansas proceeded to set an execution date for Singleton, whereupon he filed another petition for habeas corpus, "arguing that the State could not constitutionally restore his Ford competency through use of forced medication and then execute him."126 In denying the petition, the district court found that "Singleton was not Ford-competent at the time the involuntary medication regime began in 1997."127 It could not determine whether he would become Ford-incompetent if he stopped taking the medication.128 However, "Singleton does not argue that under medication he is unaware of his punishment and why he is to be punished."129 In 1997, during the course of these appeals, "Singleton was placed under a Harper involuntary medication order" that was not renewed because Singleton had been taking his medication voluntarily.130

A sharply divided Court of Appeals for the Eighth Circuit began by reviewing Ford, Harper, Riggins, and the Eighth Circuit's ruling in Sell.131 The court cited Moran v. Burbine132 for the proposition that "the government has an essential interest in carrying out a lawfully imposed sentence."133 The court found that, as "Singleton prefers to take the medication rather than be in an unmedicated and psychotic state" and that "[he] suffered no substantial side effects ... the State's interest in carrying out its lawfully imposed sentence is ... su-

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123 Id. at 1021. While not enumerated in the court's majority opinion, some manifestations of Singleton's illness were that "he believed his prison cell was possessed by demons and that the authorities had planted a device in his ear. He insisted that his victim, whom he had known at the time of the murder, was still alive." Lewis, supra note 120.
124 Singleton, 319 F.3d at 1021.
125 Id.
126 Id.
127 Id. at 1022.
128 Id.
129 Id. See also id. at 1025 ("Singleton has never argued, and in fact has agreed repeatedly, that he is competent while he is medicated").
130 Id.
131 United States v. Sell, 282 F.3d 560 (8th Cir. 2002). This ruling was later vacated and remanded by the Supreme Court's decision in Sell v. United States, 539 U.S. 166, 169 (2003).
132 475 U.S. 412, 426 (1986) (discussing "society's compelling interest in finding, convicting, and punishing those who violate the law").
133 Singleton, 319 F.3d at 1025.
perior" to Singleton's interest in being free from unwanted\textsuperscript{134} medication.\textsuperscript{135} After finding that there were "no less intrusive means of ensuring . . . competence short of antipsychotic medication," the court reached "the core of the dispute: whether the antipsychotic medication is medically appropriate for Singleton's treatment."\textsuperscript{136}

Singleton argued that the medication was obviously not in his "ultimate best medical interest" where the result was competency for execution.\textsuperscript{137} Singleton, according to the court, presented a choice between "medication followed by execution and no medication followed by psychosis and imprisonment."\textsuperscript{138} As neither of these was particularly desirable to him, Singleton offered the court a third option: "a stay of execution until involuntary medication is no longer needed to maintain his competence."\textsuperscript{139} The court rejected this focus on long-term medical interest, finding that "Singleton implicitly concedes that the medication is in his short-term medical interest."\textsuperscript{140} The court held that the only unwanted consequence of medication was competency for execution. Since Singleton's due process interest in life had been "foreclosed by the lawfully imposed sentence of execution and the Harper procedure," the court concluded that his best medical interest must be determined "without regard to whether there is a pending date of execution."\textsuperscript{141} As such, the court held that a "mandatory medication regime, valid under the pendency of a stay of execution, does not become unconstitutional under Harper when an execution date is set."\textsuperscript{142}

Furthermore, the court found that such an execution would not violate Ford, as Singleton would be aware of his punishment and why he was to receive it. The 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

\textsuperscript{134} The court described the medication as "unwanted" only in the shadow of an impending execution; if the execution date were stayed, the court found that Singleton would prefer to take his medication. The court also cited a psychiatrist's notes of his interview with Singleton: "I advised him to consider changing the medication to pill form. Mr. Singleton indicated that he could not do this. His exact words were as follows, 'I don't want it to seem like I'm running a game, but I have a case going involving forced medication.'" Id. at 1025 n.3 (quoting Dr. Kenneth D. Wright).

\textsuperscript{135} Id. at 1025.

\textsuperscript{136} Id.

\textsuperscript{137} Id. at 1026.

\textsuperscript{138} Id.

\textsuperscript{139} Id.

\textsuperscript{140} Id.

\textsuperscript{141} Id.

\textsuperscript{142} Id.
The court affirmed the district court’s denial of habeas corpus.\textsuperscript{144} The dissent, by Judge Haney and joined by three others, found that the execution of “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.’”\textsuperscript{145} The dissent discussed a number of Singleton’s mental abnormalities and symptoms, such as his belief that he was God but could nevertheless be executed because of his physical body.\textsuperscript{146} The dissent differentiated between Singleton’s drug treatment and an actual cure, as the drugs “merely calm and mask the psychotic symptoms which usually return to debilitate the patient when the medication is discontinued.”\textsuperscript{147} As Singleton would never be cured by these drugs, the dissent argued that “Ford’s prohibition on executing the insane should apply with no less force to Singleton than to untreated prisoners.”\textsuperscript{148} Further, the dissent would hold that “[o]nce an execution date was set . . . justification for medicating Singleton under Harper evaporated.”\textsuperscript{149} Finally, mentioning the Hippocratic Oath, the AMA and APA ethical standards, and the Supreme Court’s reliance on medical ethics in Washington v. Glucksberg,\textsuperscript{150} the dissent noted that the majority holding will “inevitably result in forcing the medical community to practice in a manner contrary to its ethical standards.”\textsuperscript{151} Thus, according to the dissent, the state should medicate Singleton for his best medical interest, but it cannot execute him. The dissent believed “that the appropriate remedy is for the district court to enter a permanent stay of execution.”\textsuperscript{152}

\textsuperscript{143} Id. at 1027.
\textsuperscript{145} Singleton, 319 F.3d at 1050 (Haney, J., dissenting) (quoting Ford v. Wainwright, 477 U.S. 399, 410 (1986)).
\textsuperscript{146} Id. at 1032 (Haney, J., dissenting).
\textsuperscript{147} Id. at 1033 (Haney, J., dissenting) (quoting State v. Perry, 610 So. 2d 746, 759 (La. 1992)); see also Gutheil & Appelbaum, supra note 98; Nancy S. Horton, Comment, Restoration of Competency for Execution: Furiousus Solo Furore Punitur, 44 Sw. L.J. 1191, 1204 (1990) (“Despite their beneficial effects, antipsychotic drugs merely mask the debilitating symptoms of major mental disorders; the drugs do not cure the mental disorder.”)
\textsuperscript{148} Id. at 1034 (Haney, J., dissenting).
\textsuperscript{149} Id. at 1036 (Haney, J., dissenting).
\textsuperscript{151} Id. Singleton, 319 F.3d at 1036 (Haney, J., dissenting).
\textsuperscript{152} Id. at 1037 (Haney, J., dissenting).
There is no persuasive reason why a state should not be permitted to involuntarily medicate an incompetent inmate for the purpose of restoring his competency for execution. The state has a compelling interest in punishing those who violate the law; such an execution furthers that interest within the bounds of the law. None of the rationales put forth by *Ford* to justify the prohibition on the execution of the insane are applicable to medically competent inmates. Moreover, forcible medication comports with the Supreme Court's holding in *Sell*, as such medication is in the inmate's best medical interest in light of his medical condition. Finally, as a practical matter, such executions are the only reasonable option for states facing inmates like Charles Singleton, both to further penological interests and avoid potential malingering. Involuntary medication of inmates to restore their competency for execution should remain available to the states.

A. *The Rationales of Ford Are Inapplicable to Drug-Induced Competency for Execution*

As the Supreme Court found in *Ford v. Wainwright*, the common law bar against the execution of the insane "bears impressive historical credentials." The Court noted that Blackstone called the practice "savage and inhuman" in 1769, and Coke referred to it as "a miserable spectacle, both against Law, and of extream [sic] inhumanity and cruelty" in 1680. In holding the execution of the insane violative of the Eighth Amendment, the Court could not find an overarching reason for the rule at common law; the Court instead listed many reasons for the prohibition. These divergent rationales, however, cease to apply in the context of involuntarily medicated inmates who have been restored to competency for execution, and *Ford* does not bar their execution.

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154 *Id.* (quoting BLACKSTONE, supra note 1, at *24–25). Blackstone also wrote:

[I]diots and lunatics are not chargeable for their own acts, if committed when under these incapacities: no, not even for treason itself. Also, if a man in his sound memory commits a capital offence, and before arraignment for it, he becomes mad, he ought not to be arraigned for it: because he is not able to plead to it with that advice and caution that he ought. And if, after he has pleaded, the prisoner becomes mad, he shall not be tried: for how can he make his defence? If, after he be tried and found guilty, he loses his senses before judgment, judgment shall not be pronounced; and if, after judgment, he becomes of nonsane memory, execution shall be stayed: for peradventure, says the humanity of the English law, had the prisoner been of sound memory, he might have alleged something in stay of judgment or execution.

*Id.* (quoting Blackstone, supra note 1, at *24–25).
155 *Id.* (quoting Coke, supra note 35, at 6).
1. Execution of the Insane Does Not Serve the Two Principal Social Purposes of the Death Penalty

The death penalty has traditionally been justified on two grounds: "retribution and deterrence of capital crimes by prospective offenders." Like the execution of the mentally retarded in Atkins, "[u]nless the imposition of the death penalty on [a forcibly medicated inmate] 'measurably contributes to one or both of these goals, it is nothing more than the purposeless and needless imposition of pain and suffering, and hence an unconstitutional punishment.' While the execution of an insane inmate does not contribute to these goals, that is not the case for the execution of a competent but medicated inmate: such an execution does serve the deterrence and retribution goals of capital punishment.

A. Deterrence

Deterrence has been defined as "the interest in preventing capital crimes by prospective offenders." The deterrent value of executing the insane has been in doubt since the time of Coke: "it provides no example to others and thus contributes nothing to whatever deterrence value is intended to be served by capital punishment." It has been argued that "the refusal to execute incompetent prisoners... does not send a counterproductive message to potential offenders, since no potential offender commits a capital offense on the theory that he might subsequently become incompetent and thereby have his life spared from execution." One famous response to that argument is that "if the purpose [of capital punishment] is to serve as an example to others, the demonstration that not even supervening insanity will halt the execution of one who commits a capital crime will... make the in terrorem effect so much the stronger." Even more importantly, however, such an ar-


158 Id. See also David L. Katz, Perry v. Louisiana: Medical Ethics on Death Row—Is Judicial Intervention Warranted?, 4 GEO. J. LEGAL ETHICS 707, 709 (1991) (defining deterrence as "the act or process of discouraging others from acting in a similar fashion.").

159 Ford, 477 U.S. at 407 (citing COKE, supra note 35, at 6).

160 Byers, supra note 11, at 374; see also Matthew S. Collins, Note, Involuntarily Medicating Condemned Incompetents for the Purpose of Rendering Them Sane and Thereby Subject to Execution, 70 WASH. U. L.Q. 1229, 1237-38 (1992) (describing the deterrence rationale in the involuntary mediation context).

argument looks at deterrence from too narrow a perspective. The deterrent effect in the execution of an inmate who subsequently became incompetent (and was involuntarily administered competency-restoring drugs) is not directed solely towards other potential offenders who expect to subsequently become incompetent. The deterrent effect is equally applicable to any potential offender: commit a capital crime, and you will be executed. Just as the execution of a diabetic inmate would deter the diabetic and non-diabetic alike, so too does the execution of an inmate who has been medicated to restore competency deter all potential capital criminals. A scheme of deterrence premised on the above argument (i.e., the execution of those who subsequently became incompetent deters only those who predict that they may also become subsequently incompetent) would fail to reach a significant percentage of potential offenders, eliminating the effectiveness of deterrence. Whatever deterrent value capital punishment has on prospective criminals,\(^6\) the execution of an inmate who has been forcibly medicated to restore his competency has the same (or greater) aggregate deterrent effect as any other execution.

B. Retribution

The Supreme Court has defined retribution as “the interest in seeing that the offender gets his ‘just deserts’”\(^6\) and as “the need to offset a criminal act by a punishment of equivalent ‘moral quality.’”\(^6\) The Court in Ford found that retribution is not served by the execution of the insane because “execution of an insane person ... has a ‘lesser value’ than that of the crime for which he is to be punished.”\(^6\) Therefore, as “each wrong must be offset by a punitive act of the same quality,” and as “killing an insane person does not have the

\(^6\) In Gregg v. Georgia, 428 U.S. 153 (1976), the Court analyzed the statistical studies of the deterrent effect of capital punishment, finding

[s]tatistical attempts to evaluate the worth of the death penalty as a deterrent to crimes by potential offenders have occasioned a great deal of debate. The results simply have been inconclusive.

[Thus, t]he value of capital punishment as a deterrent of crime is a complex factual issue the resolution of which properly rests with the legislatures . . . .

Id. at 184–86 (plurality opinion); see also Robert F. Schopp, Wake Up and Die Right: The Rationale, Standard, and Jurisprudential Significance of the Competency to Face Execution Requirement, 51 LA. L. REV. 995, 1002–03 (1991) (“If the death penalty deters at all, then it will do so more effectively without the exception for those who are incompetent to face execution.”).

\(^6\) Atkins v. Virginia, 536 U.S. 304, 319 (2002); accord BLACK'S LAW DICTIONARY 1318 (7th ed. 1999) (defining retribution as “punishment imposed as a repayment or revenge for the offense committed” and “something justly deserved.”).

\(^6\) Ford, 477 U.S. at 408; see also Katz, supra note 158, at 709 (“[R]etribution commonly is defined as restoring a previously existing equilibrium to what it had been before the offensive behavior had been committed.”) (internal quotations and citation omitted).

\(^6\) Id. (quoting Hazard & Louisell, supra note 37, at 387).
same moral quality as killing a sane one," the retributive goal of capital punishment is not served by executing the insane.\textsuperscript{166}

With respect to the execution of an insane offender, this argument has been criticized on practical grounds:

If the punishment must qualitatively and quantitatively match the crime, then this theory becomes impossible to apply because the official performing the punishment lacks any method for comparing incommensurate evils. Does the principle require, for example, that the state torture torturers? . . . This theory would preclude punishment of those who committed crimes for which no comparable punishment was possible. How, for example, could the state punish the vandal who destroys a work of art but has never created one that could be destroyed in return? Would incarceration never be a justified punishment except for crimes of false imprisonment?\textsuperscript{167}

In addition to these practical criticisms, even more important is that the retributive goals of capital punishment are served by the execution of one who is medically competent, insofar as it has the same moral quality as any other execution. If the inmate was competent at the time of the crime and is competent (due to medication) at the time of execution, the execution achieves the goal of "balancing the moral scales."\textsuperscript{168} The inmate knew the nature of the crime when he committed it, and he knows the punishment that is about to be imposed upon him; from a cognitive perspective he is no different than any other capital inmate. His competence, therefore, renders his execution of equal value, satisfying the retributive goal of "offset[ting] a criminal act by a punishment of equivalent "moral quality."\textsuperscript{169} As such, because the retributive goals of capital punishment are achieved through these executions, the state should not be deprived of this course of action.

Retribution has also been described as "the satisfaction of the society's thirst for vengeance."\textsuperscript{170} That thirst\textsuperscript{171} is adequately quenched by the execution of an inmate who has been forcibly medicated to restore his competence. Such an inmate's culpability at the time of the crime cannot be doubted (as he was properly held responsible for his actions and convicted), and his execution should comport with "the

\textsuperscript{166} Hazard & Louisell, supra note 37, at 386–87; see also Schopp, supra note 162, at 1005 ("[E]xecuting insane offenders will not restore the moral balance because the harm or suffering produced in the severely disturbed offender will not be comparable to that which the offender caused in the presumably [sane] victim.").

\textsuperscript{167} Schopp, supra note 162, at 1006.

\textsuperscript{168} Id. at 1005.

\textsuperscript{169} Ford, 477 U.S. at 408.

\textsuperscript{170} Schopp, supra note 162, at 1006.

\textsuperscript{171} Furman v. Georgia, 408 U.S. 238, 308 (Stewart, J., concurring) ("The instinct for retribution is part of the nature of man, and channeling that instinct in the administration of criminal justice serves an important purpose in promoting the stability of a society governed by law.").
community's belief that certain crimes are themselves so grievous an
affront to humanity that the only adequate response may be the pen-
alty of death."

Finally, retribution also serves the goal of "proportionate punish-
ment, . . . requir[ing] punishment in relative proportion to the of-
fender's guilt." This backward-looking retributivism ignores the
current mental state of the offender. Assuming that the inmate
committed a capital crime and the sentence was lawfully imposed,
"psychopathology at the time of execution [would] not alter the de-
gree of guilt attributed to the actions performed while sane." If this
goal of retribution is taken to its logical extreme, then not only may
the state execute an inmate who has been medically-restored to com-
petency, it may in fact execute an unquestionably *insane* inmate, in
direct contravention of *Ford v. Wainwright*.

As Justice Powell wrote, "one of the death penalty's critical justifi-
cations, its retributive force, depends on the defendant's awareness
of the penalty's existence and purpose." That justification is satisfied
when the death penalty is imposed upon those that have been medi-
cally restored to competency. The execution of these inmates "meas-
urably contributes" to the retributivism of capital punishment in the
same degree as the execution of a sane inmate. Retribution offers no
reason to exempt those who have been medically restored to compe-
tence from execution.

2. Furiosus Solo Furore Punitur

Another reason posited by *Ford* for the prohibition on executing
the insane is that "execution serves no purpose in these cases because
madness is its own punishment: *furiosus solo furore punitur*." This
argument fails for a number of reasons. First, if madness itself were
sufficient punishment, "incompetent offenders would have their sen-
tences commuted and would be released upon recovering their men-
tal capabilities." Second, "severe mental disorder does not neces-
arily entail extreme distress," and thus is not coextensive with

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173 Schopp, supra note 162, at 1008 ("[M]urder must be punished more severely than assault,
intentional homicide more severely than negligent homicide, and unprovoked assault more
severely than provoked assault.").
174 Id.
175 See supra Part I.B.
176 Ford, 477 U.S. at 421 (Powell, J., concurring).
177 Id. at 407 (quoting Blackstone, supra note 1, at *395).
178 Schopp, supra note 162, at 1002.
punishment. Third, madness is not its own punishment "simply because it is not punishment at all." Mental disorder is not imposed by an authority on an offender for commission of an offense, and, "[a] fortiori, a condition that does not constitute punishment cannot constitute punishment comparable to death." Finally, and most significantly, even if madness itself were a punishment comparable to death, inmates who can be restored to competency through antipsychotic drugs can also escape their punishment (i.e., madness) by voluntarily taking these drugs. In this sense, the madness referred to by Blackstone is quite different than madness today if symptoms can be alleviated by antipsychotic drugs. For inmates whose competency can be restored by medication, madness cannot be its own punishment.

3. Religious and Spiritual Reasons

Ford also justifies its holding on religious underpinnings: "it is uncharitable to dispatch an offender 'into another world, when he is not of a capacity to fit himself for it.'" Justice Powell espoused a similar reason, writing that "only if the defendant is aware that his death is approaching can he prepare himself for his passing."

This justification for banning the execution of the insane has been attacked on First Amendment grounds. It has been said that "[t]his rationale is difficult to reconcile with the principle of neutrality toward religion that the First Amendment of the Constitution is usually understood to mandate." Such a rationale, the argument goes, "elevates one particular religious tradition to a privileged status."

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179 Id.
180 Id.
182 Schopp, supra note 162, at 1002.
183 It is assumed that a defendant can alleviate his symptoms by taking drugs; otherwise that defendant would be unable to be restored to competency and would fall outside the purview of this Comment.
184 Ford v. Wainwright, 477 U.S. 399, 407 (1986) (quoting Sir John Hawles, Remarks on the Trial of Mr. Charles Bateman, 11 How. St. Tr. 474, 477 (1685)); accord Solesbee v. Balkcom, 339 U.S. 9, 18 (1950) (Frankfurter, J., dissenting) ("[I]t is inconsistent with Religion, as being against Christian Charity to send a great Offender quick, as it is stil'd, into another World, when he is not of a capacity to fit himself for it.") (quoting Hawles, supra, at 477).
185 Ford, 477 U.S. at 422 (Powell, J., concurring).
186 "Congress shall make no law respecting an establishment of religion." U.S. CONST. amend. I.
187 Schopp, supra note 162, at 998.
188 Id. at 999. The argument that a defendant should be able to prepare himself for his passing has also been criticized on religious grounds, as it suggests that "humanity must exercise
Regardless of the veracity of the argument that the condemned inmate should be able to prepare for his passing, the argument is simply inapplicable to inmates whose competency can be restored through the administration of antipsychotic drugs. If the inmate is competent to be executed after taking drugs—that is, he is aware of his punishment and why he is to suffer it—then he should undoubtedly be able to fit himself for death however he chooses. Unlike Ford, for example, such an inmate would be "of a capacity to fit himself" for his death. In that sense, a forcibly medicated but competent inmate is no different from any other capital inmate, and the requirement that he be able to prepare for death is met.

4. Ability to Assist Counsel

Finally, the rule against executing the insane is justified on grounds that a competent inmate "might have been able to make allegations which would stay judgment or execution," or aid counsel in some fashion during the appeals process. This argument theoretically assures that "convicted persons will not die only because they lack the ability to raise exculpatory or mitigating arguments." Some commentators have argued that this argument lacks veracity by dint of the extensive state and federal appeals process, during which "the right to counsel... [will] assure effective review of death sentences." Further, it has been argued that "appeals that occur late in the sequence of events leading to execution tend to address legal rather than factual issues, emphasizing the competence of the attor-
ney rather than that of the condemned prisoner." While these arguments are inconsistent with the wave of recent exonerations and death penalty moratoria, their primary failing is that, vis-à-vis inmates who have been forcibly medicated to restore competency, they simply do not apply. As these inmates are able to function competently through the use of antipsychotic drugs, they should be able to help their attorneys to the same extent as otherwise competent inmates. The fear that executing an insane person will increase the risk of executing the innocent is allayed when the condemned is made competent through the use of antipsychotic drugs.

B. If not Forcible Medication, Then What?: Other Options

With increasing frequency, courts are being presented with an inmate who, though competent at the time of the crime, trial, and sentencing, has subsequently become insane. Antipsychotic drugs alleviate the symptoms to the point where the inmate is competent for execution as well. The medication is taken voluntarily; he, in fact, prefers his life with the drugs to his reversion to mental incompetency without them. However, as execution day approaches, the inmate voluntarily ceases his medication regime, reverting to incompetency and avoiding execution. As delineated in Singleton, courts in this situation are faced with three alternatives—no medication followed by psychosis and imprisonment, a stay of execution until medication is no longer needed to maintain competency, or involuntary medication followed by execution.

1. No Medication Followed by Psychosis and Imprisonment

If an inmate cannot be executed due to incompetence, but also cannot be forcibly medicated to restore that competence, a court could resort to "no medication followed by psychosis and imprisonment." This would essentially consist of a standing threat to the

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198 See The Innocence Project, supra note 197 (listing thirty-seven people who were exonerated in 2002 and 2003).


200 Singleton v. Norris, 319 F.3d 1018, 1026 (8th Cir. 2003).

201 Id.
inmate: voluntarily take antipsychotic drugs that will alleviate your mental disease, and you will be executed as soon as the drugs begin to take effect and your competency is restored. This puts the inmate to a Hobbesian choice: insanity (when there are drugs that can significantly alleviate the affliction) or death. A court-imposed choice of this nature is unimaginably horrible; it is "the pinnacle of what Justice Marshall called 'the barbarity of exacting mindless vengeance.'" This would patently violate "the evolving standards of decency that mark the progress of a maturing society." Putting this choice to a capital inmate is simply not a permissible alternative.

2. Stay of Execution Until Involuntary Medication Is no Longer Needed to Maintain Competence

Courts are also presented with the option, suggested by Charles Singleton, of "a stay of execution until involuntary medication is no longer needed to maintain competence." This was the alternative advocated by the Singleton dissent: "the appropriate remedy is... a permanent stay of execution." This approach certainly comports with Ford and Sell (as there would be no need to involuntarily medicate, except under a possible Harper justification). Further, it comports with the "evolving standard of decency" on which the Eighth Amendment is based. States are, of course, free to adopt this policy when confronted with insane but medically competent inmates, but this would fail to further "society's compelling interest in... punishing those who violate the law."

3. Involuntary Medication Followed by Execution

A final option for states faced with an inmate who refuses to take antipsychotic drugs that would restore his competency is "involuntary medication followed by execution." While proscribed in Louisiana and South Carolina, this is the best option for states. Involuntary medication avoids the practical problem of opportunistic inmates,

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202 Id. at 1030 (Heaney, J., dissenting) (quoting Ford v. Wainwright, 477 U.S. 399, 410 (1986)).
204 Id.
205 Id. at 1037 (Heaney, J., dissenting).
206 Louisiana and South Carolina have judicially adopted this approach. See supra Parts III.A–B, respectively.
208 Id.
209 See supra Parts III.A–B, respectively.
carries out a legally imposed sentence in furtherance of society's "essential interest in carrying out a lawfully imposed sentence," and comports with the law of Ford and Sell.

a. Opportunistic Inmates

In Sell, Justice Scalia expressed a concern that the majority's holding would "allow criminal defendants in [Sell's] position to engage in opportunistic behavior. They can, for example, voluntarily take their medication until halfway through trial, then abruptly refuse and demand an interlocutory appeal from the order that medication continue on a compulsory basis." A similar concern exists with respect to medically competent inmates awaiting execution. If the State is not permitted to involuntarily medicate for the purpose of execution, an inmate would be able to voluntarily take his medication in the period leading up to his execution, but cease taking it voluntarily as execution draws near. In such a case, the inmate would virtually force the state into adopting the second option above, i.e., granting a permanent stay of execution. Permitting the state to involuntarily medicate an inmate to restore his competency for execution nullifies such opportunistic behavior.

This type of behavior is more than merely theoretical. Singleton himself made no secret of his desire to take the antipsychotic medication. However, when faced with an impending date of execution, he made repeated attempts "to avoid the penalty Arkansas has imposed on him." In an interview with Singleton on March 27, 2000, Dr. Kenneth Wright wrote:

I advised Mr. Singleton that he was taking the medication in shot form that was a tranquilizer and frequently had a side effect of being sedating. I advised him to consider changing the medication to pill form. Mr. Singleton indicated that he could not do this. His exact words were as follows, "I don't want it to seem like I'm running a game, but I have a case going involving forced medication."

At this point, I interrupted Mr. Singleton and advised him that several months ago I had elected not to return him to the Forced Medication Review Panel because he appeared to be in remission from psychotic symptoms and he had been taking his medication voluntarily. Mr. Singleton, at this point, became enraged, indicating that I did not have the

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210 Singleton, 319 F.3d at 1025 (citing Moran, 475 U.S. at 426).
212 Singleton, 319 F.3d at 1025 n.3 ("Singleton stated several times that he desires to take the antipsychotic medication.").
213 Id.
authority to change his medication from being forced. . . Mr. Singleton stormed out of the interview. 214

While it is perfectly understandable that Singleton would use any means necessary to delay his impending execution, 215 permitting forcible medication if the drugs will render an inmate competent will eliminate Justice Scalia’s concerns 216 about opportunistic inmates in the realm of execution (just as the Sell case has presumably done in the trial realm). 217

b. Ford and Sell: Best Medical Interest

The practice of forcibly medicating an inmate for the purposes of restoring competence for execution is in accordance with the law of Ford and Sell.

Ford prohibits the execution of the insane; 218 that is, according to Justice Powell, “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.” In Singleton and similar cases, where the inmate is competent while under medication, 220 the requirements of Ford, awareness and ability to relate punishment to crime, are met. Further, as discussed above, 221 the rationales proffered by the Ford Court for exempting the insane from execution are inapplicable to inmates whose competency can be restored through administration of antipsychotic medication. Ford should serve no barrier to the forcible medication and execution of Singleton and similarly situated capital inmates.

Nor should Sell serve as a barrier to such involuntary medications and executions. Sell requires that “administration of the drugs [be] medically appropriate, i.e., in the patient’s best medical interest in light of his medical condition.” 222 Singleton argued forcefully that “medication obviously is not in [his] ultimate best medical interest where

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214 Id. (citation omitted).
215 It is not only understandable for capital defendants to delay their executions by any means necessary, it is in fact quite common, as evidenced by the proliferation of capital appeals (both mandatory, optional and petitions for habeas corpus). See supra note 7 and accompanying text (delineating the expanding appeals process for capital defendants).
217 See supra Part IV.A.
219 Id. at 422 (Powell, J., concurring).
220 Singleton v. Norris, 319 F.3d 1018, 1025 (8th Cir. 2003) (“Singleton has never argued, and in fact has agreed repeatedly, that he is competent while he is medicated.”).
221 See supra Part IV.A.
222 Sell, 539 U.S. at 181 (emphasis in original).
one effect of the medication is rendering [him] competent for execu-
tion. This interpretation of “best medical interest,” however, be-
lies the holding in Sell. The phrase “medical condition,” by its plain
meaning, does not take into account effects on competency to be
executed (or to stand trial); it refers only to Singleton’s diagnosable
mental illnesses, and there is no dispute that medication is in the best
interest of his mental illnesses.

It is clear that “Singleton [did] not dispute that the antipsychotic
medication [was] in his medical interest during the pendency of a
stay of execution. He has stated he takes it voluntarily because he
does not like the symptoms he experiences without it.” According
to Sell, that should end the inquiry. “[A]n assertion that execution is
not in his medical interest” simply misinterprets the phrase “medical
interest” by expanding its meaning to cover a lawfully-imposed pun-
ishment that should not be relevant to “medical interest.” As the
Eighth Circuit found, “the best medical interests of the prisoner must
be determined without regard to whether there is a pending date of
execution.” Such a holding comports with Sell’s command that
“best medical interest” be determined “in light of [the prisoner’s]
medical condition.” Sell unquestionably permits the involuntary
medication of inmates for the purpose of restoring them to compe-
tence for execution.

CONCLUSION

There is simply no persuasive reason for proscribing the involun-
tary medication of insane capital inmates for the purpose of restoring
competency to be executed. It furthers the retributive and deterrent
goals of capital punishment while comporting with the law of Sell and
Ford. If the state chooses to engage in capital punishment, then its
goals are served by these executions as surely as they are by the exe-
cution of a sane inmate. Neither the Constitution, nor the law, nor
public policy prohibits a state from involuntarily medicating mentally
ill capital inmates if it would restore their competence for execution.

\[^{223}\text{Singleton, 319 F.3d at 1026 (quotations omitted). While Singleton was decided without the benefit of the Supreme Court’s opinion of Sell, his contentions must be evaluated in light of the most current law.}\]
\[^{224}\text{Id. (“The medication [is] effective in controlling Singleton’s psychotic symptoms.”).}\]
\[^{225}\text{Id. The Singleton court also found that “the due process interests in life and liberty that Singleton assert[ed] have been foreclosed by the lawfully imposed sentence of execution.” Id.}\]
\[^{226}\text{Id.}\]
\[^{227}\text{Sell, 539 U.S. at 181.}\]