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Competency to Execute: Unjustified Forcible Medication Regimes and the Insanity Defense

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COMPETENCY TO EXECUTE: UNJUSTIFIED FORCIBLE MEDICATION REGIMES AND THE INSANITY DEFENSE

By Ajay Gogna

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INTRODUCTION

According to statistics published by the U.S. Department of Justice, at the end of 2010, thirty-six states authorized the use of capital punishment and 3,158 inmates had been given the death sentence.¹ Mental Health America, a leading non-profit advocacy group, estimates that approximately five to ten percent of prisoners on death row have a serious mental illness such as Schizophrenia.² The average amount of time that a death row inmate had spent awaiting his eventual execution was 14 years and 10 months.³ Furthermore, the living conditions and the poor quality of life of death row inmates has been shown to not only cause prisoners psychological stress, but to also result in an increase in the number of prisoners who become incompetent after they are sentenced.⁴ The Supreme Court established that the execution of a prisoner who is insane is unconstitutional because it violates the Eighth Amendment and its ban against cruel and unusual punishment.⁵ In order to circumvent the ban on executing an insane prisoner, states have turned to the option of forcibly medicating a mentally incompetent prisoner with antipsychotic medication to restore the competency of the prisoner for the purpose of execution.⁶

However, states are not justified in promulgating forcible medication regimes to restore a mentally incompetent prisoners competency for execution, and the recent trend by states to mitigate the insanity defense has only worsened this problem. First, I will explain the current state of the law that relates to forcible medication regimes both generally, and in the capital

¹ Tracy L. Snell, *Capital Punishment, 2010 – Statistical Tables*, Bureau of Justice Statistics (Dec. 20, 2011), available at <http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=2236>.

² *Position Statement 54: Death Penalty and People with Mental Illnesses*, MENTAL HEALTH AM., <http://www.nmha.org/go/position-statements/54> (last visited Mar. 5, 2012).

³ Snell, *supra* note 1.

⁴ Rochelle Graff Salguero, *Medical Ethics and Competency to be Executed* 96 YALE L.J. 167, 171-72 (1986).

⁵ *Ford v. Wainwright* at 409-10.

⁶ Brent W. Stricker, *Seeking an Answer: Questioning the Validity of Forcible Medication to Ensure Mental Competency of Those Condemned to Die*, 32 MCGEORGE L. REV. 317, 323 (2000); *Singleton v. Norris*, 319 F.3d 1018 (8th Cir. 2003).

punishment context. Next, I will present a number of arguments and justifications in support of the idea that forcible medication regimes used by states for purposes of execution are unjustified. Then, I will present potential procedural solutions, which provide an alternative from the use of forcible medication regimes. Finally, in the last part of this paper I will explain why the states' recent trend to limit the use of the insanity defense is worsening the problem of forcible medication regimes.

I. THE CURRENT STATE OF THE LAW

The current state of the law governing forcible medication regimes is broken down into the following three sections. The first section discusses the forcible medication of mentally incompetent prisoners generally and is not limited to a capital punishment context. The second section discusses the Supreme Court mental health jurisprudence regarding application of the death penalty to mentally incompetent prisoners. The final section discusses cases where courts in different jurisdictions came to dissimilar conclusions with regards to the specific issue of whether a state can forcibly medicate mentally incompetent prisoners in order to restore their competency for execution.

A. *Forcible Medication of Mentally Incompetent Prisoners*

In 1976 Walter Harper was arrested and sentenced to prison after committing a robbery, and after his conviction he spent a number of years in the prison's mental health unit where he initially consented to antipsychotic medication.⁷ Harper refused to continue taking the medication in November of 1982, but the prison's Special Offender Center had established Policy 600.30 under which Harper's treating physician began to forcibly medicate him while disregarding his objections.⁸ Harper filed suit against the State in February 1985 alleging that the

⁷ *Washington v. Harper*, 494 U.S. 210, 213-14 (1990).

⁸ *Id.* at 214.

State's involuntary medication violated the Due Process Clause and the Washington Supreme Court eventually concluded that because of the "highly intrusive nature" of treatment with antipsychotic medications, the State needed to afford greater procedural protections to not violate Harper's liberty interests.⁹

On February 27, 1990, the Supreme Court of the United States held in *Washington v. Harper* that the Due Process Clause of the Fourteenth Amendment did not prohibit the State from forcibly medicating a mentally ill prisoner with antipsychotic drugs if (1) he is dangerous to himself or others; and (2) the treatment is in his medical interest.¹⁰ The Supreme Court held that because of the dangers of the prison environment, and because Harper himself was posing a threat to the other inmates and the staff of the prison, the Due Process Clause of the Fourteenth Amendment would allow the forced administration of antipsychotic medication.¹¹ However, the Supreme Court did recognize that a prisoner such as Harper retained a significant liberty interest in avoiding the administration of unwarranted antipsychotic drugs since "[t]he forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty."¹²

In *Sell v. United States*, Charles Sell was a practicing dentist who was plagued with a long history of mental illness.¹³ In 1998 he was indicted by the grand jury for attempting to murder an FBI agent and his fictitious insurance fraud claims were also joined together.¹⁴ Sell was then found to be mentally incompetent to stand trial and the Medical Center staff was trying

⁹ *Id.* at 217-18

¹⁰ *Washington v. Harper*, 494 U.S. 210 (1990).

¹¹ *Id.* at 227.

¹² *Id.* at 229 (explaining some of the dangerous side effects resulting from antipsychotic drugs such as acute dystonia which is a severe involuntary spasm of the throat, tongue, eyes, and upper body).

¹³ *Sell v. United States*, 539 U.S. 166, 169 (2003).

¹⁴ *Id.* at 170

to force Sell to take his medication against his will since had refused, leading to the issue in this case.”¹⁵

The Supreme Court also upheld the forcible medication of an incompetent prisoner in order to restore their competency to stand trial in 2003 in *Sell v. United States*.¹⁶ While the Court upheld the forcible medication, its holding was narrowed by the standard the Court adopted since it would permit the involuntary administration of medication solely for trial competency in certain situations.¹⁷ Pursuant to the *Sell* standard, for the State to forcibly medicate a prisoner for trial competency, (1) the court “must find that important governmental interests” exist; (2) the court “must conclude forced medication significantly further those concomitant state interests”; (3) the court must conclude that the forced medication is “necessary to further those state interests”; and (4) the court “must conclude that the administration of the drugs is medically appropriate, *i.e.*, in the patient’s best medical interest in light of his medical condition.”¹⁸

The Court held that the under the first prong of the *Sell* test “[t]he Government’s interest in bringing to trial an individual accused of a serious crime is important.”¹⁹ For the second prong of the test the Court held, “[i]t must find that administration of the drugs is substantially likely to render the defendant competent to stand trial.”²⁰ Under the third prong of this test the Court held that it “must find that any alternative, less intrusive treatments are unlikely to achieve substantially the same results.”²¹ Finally, under the fourth prong of this test the Court held that

¹⁵ *Id.* at 171.

¹⁶ *Id.*

¹⁷ *Id.* at 180.

¹⁸ *Id.* at 180-82.

¹⁹ *Id.* at 180.

²⁰ *Id.* at 181.

²¹ *Id.*

the “specific kinds of drugs at issue may matter here as elsewhere. Different kinds of antipsychotic drugs may produce different side effects and enjoy different levels of success.”²²

B. *Prohibition Against Executing the Mentally Incompetent*

In 1974, Alvin Bernard Ford was convicted of murder and was later given the death sentence with no signs of mental illness or incompetency at the time of his trial or sentence.²³ Ford’s behavior began to gradually change in 1982 beginning with an obsession with the Ku Klux Klan which eventually led to many more severe delusions ranging from a belief that prison guards were keeping bodies in certain concrete enclosures used as beds to the notion that Ford’s family was being held hostage within the prison and that Ford himself was the only person that could rescue them.²⁴ Ford’s counsel realized that the client’s competency was clearly at issue and eventually the Governor of Florida appointed a panel of psychiatrists to determine if he understood why the death penalty was being enforced against him, and even after determinations acknowledging Ford’s psychosis, the Governor signed a death warrant to execute Ford.²⁵

After the Supreme Court granted certiorari, it narrowed the issue in the case as to whether the Constitution and the Eighth Amendment created a substantive restriction on the power of the State to administer the death penalty to an insane prisoner.²⁶ The Supreme Court concluded that the Eighth Amendment, which bans cruel and unusual punishment,²⁷ prohibits a “State from carrying out a sentence of death upon a prisoner who is insane.”²⁸ The Court further explained

²² *Id.*

²³ *Ford v. Wainwright*, 477 U.S. 399, 401 (1986)

²⁴ *Id.* at 402.

²⁵ *Id.* at 402-04 (discussing that two of Ford’s psychiatrists that were not included on the Governor’s panel believed that he was suffering from a major mental disorder resembling Paranoid Schizophrenia and that he had “no understanding of why he was being executed, made no connection between the homicide of which he had been convicted and the death penalty, and indeed sincerely believed that he would not be executed because he owned the prisons and could control the Governor through mind waves”).

²⁶ *Id.* at 405.

²⁷ U.S. Const. amend. VIII.

²⁸ *Ford v. Wainwright* at 409-10.

that as society has continued to evolve so has the interpretation and protection afforded under the Eighth Amendment, and that Amendment was not meant only to outlaw condemned practices of the 18th century, but that the “Court takes into account objective evidence of contemporary values before determining whether a particular punishment comports with the fundamental human dignity that the Amendment protects.”²⁹

Justice Powell concurred that execution of the insane is in and of itself cruel and unusual and that the Eighth Amendment contains an “evolving standard of decency.”³⁰ Justice Powell further recognized that an issue existed regarding what standard should be adopted by courts in determining the meaning of insanity in the Eighth Amendment context. The competency determination articulated by Justice Powell held that the Eighth Amendment forbids executing those persons who are unaware of the punishment they will suffer and why they are suffering the punishment, further indicating that this standard defines the type of “mental deficiency that should trigger the Eighth Amendment prohibition.”³¹ Furthermore, Justice Powell explained “only if the defendant is aware that his death is approaching can he prepare himself for passing.”³²

The Supreme Court faced a similar issue of whether the Eighth Amendment permitted the execution of a prisoner who lacks the mental capacity to understand, that as a punishment for a crime he is being executed because of his mental illness in 2007 in *Panetti v. Quarterman*, and it also clarified its holding in *Ford v. Wainwright*.³³ In 1992 Scott Louis Panetti broke into his estranged wife’s parents home, where he then proceeded to shoot and kill his wife’s father and

²⁹ *Id.* at 405-10 (listing a number of historical and current justifications of why a State should not execute an insane prisoner including that it simply is offensive to humanity and because it does not have any deterrence value nor a retributive purpose)

³⁰ *Id.* at 418-19 (Powell, J., concurring)

³¹ *Id.* at 422 (Powell, J., concurring) (explaining that Ford’s plea of insanity clearly falls within this standard).

³² *Id.* at 422 (Powell, J., concurring)

³³ *Panetti v. Quarterman*, 551 U.S. 930, 954 (2007).

mother and took his wife and daughter as hostages, before he eventually surrendered to the police a short time later.³⁴ Panetti then chose to represent himself as a *pro se* litigant in his trial for capital murder and the court ordered a psychiatric evaluation which revealed not only that Panetti suffered from serious delusions and hallucinations, but also that he had previously been hospitalized for these mental disorders on a number of occasions.³⁵ Irrespective of the “bizarre”, “scary”, and “trance-like” behavior Panetti displayed during his trial and clear indications that he was suffering from mental illness affecting his competency, the jury found Panetti guilty of committing capital murder, thus authorizing his death sentence.³⁶

After numerous procedural actions taken by Panetti, the Supreme Court finally considered his second habeas corpus application.³⁷ The Supreme Court held that the standard applied by the Fifth Circuit Court of Appeals to determine Panetti’s competency incorrectly foreclosed Panetti from providing evidence that would show that his mental illness obstructed him from obtaining a rational understanding of why and for what reason the State was executing him.³⁸ The Court further explained that the Fifth Circuit’s refusal to consider evidence of Panetti’s psychological dysfunction was to mistake the holding and logic of *Ford*.³⁹ Finally the Court held that “therefore [it is] error to derive from *Ford*, and the substantive standard for incompetency its opinions broadly identify, a strict test for competency that treats delusional

³⁴ *Id.* at 935-36

³⁵ *Id.* (citing that his wife had explained one of his severe delusions where he believed the devil had possessed their house and in an attempt to cleanse the house Panetti buried a number of valuable items in the nearby ground)

³⁶ *Id.* at 936-37.

³⁷ *Id.* at 941-47.

³⁸ *Id.* at 956-60

³⁹ *Id.* at 960 (“Gross delusions stemming from a severe mental disorder may put an awareness of a link between a crime and its punishment in a context so far removed from reality that the punishment can serve no proper purpose”).

beliefs as irrelevant once the prisoner is aware the State has identified the link between his crime and the punishment to be inflicted.”⁴⁰

C. *Split Decisions Regarding the Forcible Medication of Mentally Incompetent Prisoners in Order to Restore Their Competency for Execution*

While significant progress has been made in mental health jurisprudence, the lack of a decision by the Supreme Court on the specific issue of whether the State can forcibly medicate a death row inmate to make them competent for execution has resulted in criticism and confusion for courts that are faced with the issue.⁴¹ In October of 2003, the Supreme Court chose to decline to hear the case of Charles Singleton who eventually was executed in 2004 while he still suffered from his mental illness.⁴² The Eight Circuit Court of Appeals faced this issue in the controversial case of *Singleton v. Norris* where it held that a State did 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.”⁴³

The State of Arkansas convicted Singleton in 1979 of the capital felony murder of Mary Lou York, but his mental state did not begin to deteriorate until 1987 when he began to believe that his prison cell was possessed by demons and that there was demon blood in the cell.⁴⁴ Singleton was then forcibly medicated a number of times from 1997 until the time of his eventual execution because of his severe psychotic symptoms that he displayed, and his medication was even increased more than once when he would begin to show symptoms of his

⁴⁰ *Id.*

⁴¹ American Civil Liberties Union, *Mental Illness and the Death Penalty* (May 5, 2009) <http://www.aclu.org/capital-punishment/mental-illness-and-death-penalty>.

⁴² Kevin Drew, *Executed Mentally Ill Inmate Heard Voices Until End*, CNN (Jan. 6, 2004), http://articles.cnn.com/2004-01-06/justice/singleton.death.row_1_charles-singleton-singleton-case-mentally-ill-inmate?_s=PM:LAW.

⁴³ *Singleton v. Norris*, 319 F.3d 1018 (8th Cir. 2003).

⁴⁴ *Id.* at 1030-32

psychosis.⁴⁵ One of Singleton’s strongest arguments against the forcible medication by the State was the contention that the medication was not in his “best medical interest” since one of the main effects of the medication would be to render the patient competent, which would result in his execution.⁴⁶ Alternatively, Singleton presented the court with a different solution in support of which he argued that instead of a prisoner choosing from a choice between forced medication that is subsequently followed with his execution or with the choice of not receiving any treatment at all and thus continuing to suffer from his mental illness and his imprisonment, there should be a “stay of execution until involuntary medication is no longer needed to maintain his competence.”⁴⁷ Singleton also conceded that if the medication was given during a stay of execution that it would be in his medical interest, but the court rejected his argument, not granting a stay of execution and reasoned that, “the best medical interests of the prisoner must be determined without regard to whether there is a pending date of execution.”⁴⁸

The Supreme Court of Louisiana in *State v. Perry* took the exact opposite view on this issue when it granted a stay of a forcible medication order against a mentally incompetent prisoner and held the attempt by the State to circumvent the prohibition against the execution of the insane by “forcibly medicating an insane prisoner with antipsychotic drugs violates his rights under our state constitution.”⁴⁹ The *Perry* court distinguished this case from the Supreme Court’s decision in *Washington v. Harper* for the following three reasons: (1) the forced medication of a mentally ill prisoner in order to facilitate his execution is not medical treatment, but is antithetical to the “basic principles of the healing arts”; (2) in this case the state has not addressed the safety of its prison and other inmates as its reason for the forcible medication, but

⁴⁵ *Id.*

⁴⁶ *Id.* at 1026.

⁴⁷ *Id.*

⁴⁸ *Id.* at 1026

⁴⁹ *State v. Perry*, 610 So. 2d 746, 747 (La. 1992).

instead is seeking to forcibly medicate the prisoner as an “instrument of his execution”; and (3) the *Harper* decision clearly implies that forced medication of prisoners with antipsychotic drugs may “**not** be used by the state for the purpose of punishment.”⁵⁰ The court then concluded that application of the death penalty applied to a mentally incompetent prisoner by forcibly medicating him to restore competency is:

[C]ruel 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.⁵¹

II. ARGUMENTS AND JUSTIFICATIONS AGAINST FORCIBLE MEDICATION REGIMES

The arguments and justifications against states adopting forcible medication regimes to execute mentally incompetent prisoners can be organized into the following categories: (1) best medical interest; (2) artificial competency; (3) the goals of criminal law; and (4) dignity.

A. *Best Medical Interest*

The best medical interest argument stands for the proposition that when a mentally incompetent prisoner with a definite date of execution is forcibly medicated by the State, the forced medication of antipsychotic drugs is not in the prisoner’s best medical interest, because if the medication is effective in rendering the prisoner competent it will result in the prisoner’s execution.⁵² The reasoning in support of this argument is that (1) forcible medication regimes are

⁵⁰ *Id.* at 751-52 (emphasis added).

⁵¹ *Id.* at 761.

⁵² Lisa N. Jones, *Singleton v. Norris: The Eight Circuit Maneuvered Around the Constitution by Forcibly Medicating Insane Prisoners to Create an Artificial Competence for Purposes of Execution* 37 CREIGHTON L. REV. 431, 437 (2004).

The best medical interest argument relates back to *Washington v. Harper* where the Court held that, “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.”

contrary to a medical professional's ethical standards; and (2) the use of a forcible medication regime as a method for the state to inflict a capital sentence results in a detrimental psychological effect to the prisoner.⁵³

Ethical standards for medical professionals begin with the Hippocratic Oath, which is “a primary source of medical ethics which defines the role of healer, requiring respect for the patient and imposing a duty to do no harm and take no life.”⁵⁴ Moreover, the American Medical Association (AMA) expressly prohibits a physician from participating in legal executions and also states that, “[w]hen a condemned prisoner has been declared incompetent to be executed, physicians should not treat the prisoner for the purpose of restoring competence unless a commutation order is issued before treatment begins.”⁵⁵ While states may exempt a physician from legal liability for his or her participation in the states forcible medication regime, this does not vindicate the physician from a professional ethical violation.⁵⁶ When a psychiatrist forcibly medicates a mentally incompetent prisoner to restore his competency to further the states interest in execution, not only is he in violation of his professional ethical standards, but he has also compromised his patient's welfare and best medical interest in favor of the interest of the state.⁵⁷ Additionally, when a physician participates in a forcible medication regime, the public

494 U.S. 210, 227 (1990); *Singleton v. Norris*, 319 F.3d 1018, 1026 (8th Cir. 2003) (“Central to Singleton’s argument is his contention that medication ‘obviously is not in the prisoner’s ultimate best medical interest’ where one effect of the medication is rendering the patient competent”); American Civil Liberties Union, *Mental Illness and the Death Penalty* (May 5, 2009) <http://www.aclu.org/capital-punishment/mental-illness-and-death-penalty> (criticizing the *Singleton* court because the Eighth Circuit “refused to consider the fact that the medication would permit his execution in the calculation when deciding whether the medication was ‘appropriate medical care’”).

⁵³ Michaela P. Sewall, *Pushing Execution Over the Constitutional Line: Forcible Medication of Condemned Inmates and the Eight and Fourteenth Amendments* 51 B.C. L. REV. 1279, 1310 (2010), <http://lawdigitalcommons.bc.edu/bclr/vol51/iss4/7>.

⁵⁴ Rochelle Graff Salguero, *Medical Ethics and Competency to be Executed* 96 YALE L.J. 167, 173 (1986).

⁵⁵ American Medical Association, *Opinion 2.06 – Capital Punishment* (Jun. 2000) <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion206.page#>.

⁵⁶ See Salguero, *supra* note 54, at 178.

⁵⁷ Kursten B. Hensl, *Restored to Health to be Put to Death: Reconciling the Legal and Ethical Dilemmas of Medicating to Execute in Singleton v. Norris*, 49 VILL. L. REV. 291, 325 (2004) (noting that “this practice jeopardizes the fiduciary nature of the traditional physician-patient relationship”); See Salguero, *supra* note 54, at 178 (“Each treatment strategy to heal the inmate is in fact another strategy to ensure his death”).

perception of a medical professional as a person who provides care and as a healer can shift to person who actually is causing harm, thus undermining the “overall integrity of the medical profession.”⁵⁸ Surely if a forced medication regime is contrary to the ethical standards of the medical profession in the aggregate, it cannot be in the prisoner’s best medical interest, can it?⁵⁹ Therefore, since consensus among medical practitioners is that “forcible medication regimens are no longer medically appropriate once an execution date has been set, the legal community is obligated to defer to this professional judgment.”⁶⁰

Another justification supporting the best medical interest argument is that forcible medication regimes lead to a distortion of the mentally ill prisoners experience of his treatment, and that the “distortions transform medication from a source of healing into a source of punishment that inflicts acute psychological distress and suffering.”⁶¹ This distortion is furthered by the idea that mentally ill prisoner is not treated with the proper trust and care he would most likely receive in an ordinary physician-patient relationship since the physician here is acting to further the capital punishment interest of the state.⁶² Thus, the forcible medication regime is actually causing a type of detrimental psychological effect, and is not in the prisoner’s best medical interest.⁶³

⁵⁸ See Hensl, *supra* note 57, at 326.

⁵⁹ See *id.* at 324.

⁶⁰ See Sewall, *supra* note 53, at 1311-12.

Constitutional doctrine relevant to the issue of forcibly medicating condemned inmates to restore competence, including the Eighth Amendment prohibition against execution of the insane and the due process requirement that a forcible medication regimen be medically appropriate, has made it impossible for states to accomplish execution of incompetent death row inmates without direct participation from physicians, the only experts capable of assessing, diagnosing, and treating the psychosis of these inmates.

Id. Since states require a medical professional’s participation in a forcible medication regime, they should adopt a punitive scheme that does not conflict with the medical professional’s ethical standards.

⁶¹ See Sewall, *supra* note 53 at 1317 (“A condemned inmate is not only forced to submit body and mind to powerful and invasive medications, but is also forced into an inequitable situation where any positive response to medication will have the perverse effect of contributing to his ultimate doom”).

⁶² *Id.* at 1318.

⁶³ *Id.*

B. Artificial Competency

The method most favored by state legislatures in restoring the competency of a mentally incompetent prisoner is the use of antipsychotic drugs.⁶⁴ However, commentators argue against the practice of forcibly medicating prisoners with a sentence of capital punishment based “on the understanding that antipsychotic drugs are capable of calming and repressing symptoms of psychosis, but not of curing the underlying mental illness.”⁶⁵ Another deficiency in antipsychotic medication is that not only is the relief the medication provides temporary, but the effectiveness of the medication is not easily predictable causing a reliability problem, which leads to the term “artificial competency”.⁶⁶ If the prisoner were to stop taking the medication, his mental illness and its symptoms that made him incompetent in the first place will return.⁶⁷

The reason this practice becomes problematic is in light of the standard articulated by Justice Powell in his concurring opinion in *Ford v. Wainwright* that at the moment of his execution the prisoner must be aware of his punishment and why he is to suffer that punishment,

⁶⁴ See Hensl, *supra* note 57, at 303.

⁶⁵ Sewall, *supra* note 53, at 1304; Lyn Suzanne Entzeroth, *The Illusion of Sanity: The Constitutional and Moral Danger of Medicating Condemned Prisoners in Order to Execute Them*, 76 TENN. L. REV. 641, 649 (2009) (“More important, antipsychotic medication does not cure the underlying mental illness”); see Hensl, *supra* note 57, at 304; Michelle K. Bachand, *Antipsychotic Drugs and the Incompetent Defendant: A Perspective on the Treatment and Prosecution of Incompetent Defendants*, 47 WASH. & LEE L. REV. 1059, 1061 (1990) (“Additionally, health practitioners agree that antipsychotic drugs do not cure mental illness, but instead provide only temporary relief”).

The dissent in *Singleton v. Norris* explained that these drugs are not providing a cure for the mentally incompetent prisoner, but are merely masking their psychotic symptoms, which will return when the medication is removed. 319 F.3d 1018, 1033-34 (Heaney, J., dissenting).

⁶⁶ See Keith Alan Byers, *Incompetency, Execution, and the Use of Antipsychotic Drugs*, 47 ARK. L. REV. 361, 377 (1994) (explaining that it is difficult to determine if a prisoner is free of his mental illness at the precise moment of his execution when antipsychotic medication is being used to restore competence); see Bachand, *supra* note 52, at 1061 (“The majority of health practitioners maintain that predicting whether antipsychotic drugs will be effective for any given patient is impossible”); Entzeroth, *supra* note 52, at 649 (“Rather, the medication ameliorates the symptoms providing the afflicted individual relief from the delusions, hallucinations, and psychosis that plague him or her”).

One of the most controversial problems that exists with the use of antipsychotic drugs is that when the resulting artificial drug-induced sanity is assumed to be true sanity is that the artificial sanity is “temporary and unpredictable: ‘the effect of psychoactive drugs on a particular recipient is uncertain; the drugs may affect the same individual differently each time they are administered.’” *Singleton v. Norris*, 319 F.3d 1018, 1034 (Heaney, J., dissenting).

⁶⁷ Entzeroth, *supra* note 52, at 649 (“If the patient discontinues the medication, the individual’s symptoms return”).

for the punishment to not violate the Eighth Amendment.⁶⁸ Therefore, a mentally incompetent prisoner whose symptoms are being treated by forcible medication with antipsychotic drugs will not satisfy the *Ford* standard previously mentioned because his symptoms are only being repressed, but his disease is not being cured, thus he will still be insane at the time of his execution.⁶⁹

C. *The Goals of Criminal Law*

The consensus among a majority of criminal law commentators is that there are the following possible purposes behind the concept of criminal punishment: “retribution, general deterrence, specific deterrence, incapacitation, and rehabilitation.”⁷⁰ In the capital punishment context, the two goals of criminal punishment that are promoted and justified are the goals of retribution and deterrence.⁷¹ The theory of retribution is that when a person makes a choice that offends the moral views of society, that person then deserves blame and punishment for that particular choice, and thus he must payback a societal debt, which was caused by his morally

⁶⁸ *Ford v. Wainwright*, 477 U.S. 399, 422 (1986); see Hensl, *supra* note 57, at 304-5 (“This distinction is particularly important in light of Justice Powell’s assertion in *Ford* that an inmate must be ‘cured of his disease’ to be executed”);

⁶⁹ *Ford v. Wainwright*, 477 U.S. 399, 409-10 (1986) (concluding that the Eighth Amendment does not allow the state to execute an insane prisoner); see Sewall, *supra* note 53, at 1304 (“Considering such ‘artificial’ or ‘synthetic’ competence to fall below the standard articulated in the U.S. Supreme Court’s 1986 decision in *Ford v. Wainwright* and its 2007 decision in *Panetti v. Quarterman*, these scholars view execution of the forcibly medicated as intrinsically cruel and unusual, and argue that if there has once been a determination of incompetence, then there should be a permanent stay of execution”).

This artificial sanity becomes even more troubling when a court is trying to determine if the prisoner has met the *Ford* test for competency at the precise moment of his execution. *Singleton v. Norris*, 319 F.3d 1018, 1034 (Heaney, J., dissenting).

⁷⁰ Christopher Slobogin, Arti Rai & Ralph Reisner, *Law and The Mental Health System: Civil and Criminal Aspects* 540 (5th ed. 2009).

⁷¹ Olga Vlasova, *Towards Exempting the Severely Mentally Ill from the Death Penalty*, JURIST - Dateline, (Apr. 30, 2012), <http://jurist.org/datetime/2012/04/olga-vlasova-death-penalty.php> (“Imposing the death penalty on the severely mentally ill is unnecessary and amounts to wanton infliction of pain, as it does not serve the principal social purposes of capital punishment: deterrence and retribution”); *State v. Perry*, 610 So. 2d 746, 766 (La. 1992) (noting that a sentence of capital punishment can really promote only two of the social goals of criminal punishment, which would be the retribution and deterrence against capital crimes); *Gregg v. Georgia*, 428 U.S. 153, 183 (1976) (“The death penalty is said to serve two principal social purposes: retribution and deterrence of capital crimes by prospective offenders”).

offensive conduct.⁷² Alternatively, deterrence theory stems from the idea that punishment can be used as a means to discourage future criminals from conduct that is detrimental to society as a whole, regardless of the criminal's culpability or guilt.⁷³

A forcible medication regime for mentally incompetent prisoners on death row does not satisfy the theory of deterrence, nor does it satisfy the retribution theory for the following two reasons. One reason is that deterrence theory is ineffective when it is applied to the execution of an insane prisoner because "the insane are not representative of society at large. They are a special class considered to be incompetent and therefore not responsible for their own actions."⁷⁴ This ineffective deterrence concept applies equally to mentally incompetent prisoners since studies have shown that approximately five to ten percent of prisoners on death row suffer from a serious mental illness,⁷⁵ and therefore this small amount of prisoners do not represent society in the aggregate.

The second reason is that since the theory of retribution is based on the culpability and blameworthiness of the offender for his morally reprehensible conduct, a prisoner that is insane will not be able to appreciate and understand the substantial significance of his capital punishment sentence.⁷⁶ Furthermore, the insane prisoner does not possess the ability to understand the reasoning behind his punishment, therefore stripping the retributory effect of the punishment.⁷⁷ This reasoning is applicable to mentally incompetent prisoners who are forcibly medicated based on the previous argument regarding artificial competency, because if the

⁷² Slobogin, *supra* note 57, at 540.

⁷³ *Id.*

⁷⁴ Brent W. Stricker, *Seeking an Answer: Questioning the Validity of Forcible Medication to Ensure Mental Competency of Those Condemned to Die*, 32 MCGEORGE L. REV. 317, 321 (2000); Vlasova, *supra* note 58 ("Making an example of a severely mentally ill individual is unlikely to serve as a deterrent to others. And capital punishment is even less likely to deter future severely mentally ill offenders").

⁷⁵ *Position Statement 54: Death Penalty and People with Mental Illnesses*, MENTAL HEALTH AM., <http://www.nmha.org/go/position-statements/54> (last visited Mar. 5, 2012)

⁷⁶ Stricker, *supra* note 74, at 322

⁷⁷ *Id.*

antipsychotic drugs only provide relief of symptoms and do not cure the underlying mental illness, then the prisoner is still insane at the time of his execution and is therefore not able to understand the significance and reasoning behind his punishment.⁷⁸ Thus, for the following reasons mentioned above, forcible medication regimes created to execute mentally incompetent prisoners are contrary to the goals of criminal law.

D. *Dignity*

The final argument against the states use of forcible medication regimes to execute mentally incompetent prisoners is that it is “offensive to the ‘dignity of man, which is the basic concept underlying the Eighth Amendment.’”⁷⁹ This dignity is essential to the Eighth Amendment and its “evolving standards of decency”⁸⁰ and the “core value of protecting human dignity requires that a punishment not result in ‘gratuitous infliction of suffering.’”⁸¹ Furthermore, the cruelty that exists with the execution of a mentally incompetent prisoner is that unlike a sane prisoner, the insane prisoner is unable to properly prepare in a spiritual and mental way for his death.⁸² Additionally, since the mentally incompetent prisoner is not as adequately prepared for his death as the sane prisoner, he could potentially face an additional amount of suffering “because the condemned was taken through an unknown and frightening process that would culminate in his own death.”⁸³ More specifically, when a state forcibly medicates mentally incompetent prisoners for execution purposes, the state is forcing the prisoner to take unwanted antipsychotic medication irrespective of any harmful side effects in order to render the

⁷⁸ See Keith Alan Byers, *Incompetency, Execution, and the Use of Antipsychotic Drugs*, 47 ARK. L. REV. 361, 377 (1994); see Stricker, *supra* note 74, at 322.

⁷⁹ See Sewall, *supra* note 53, at 1286

⁸⁰ *Ford v. Wainwright*, 477 U.S. 399, 419 (1986)

⁸¹ See Stricker, *supra* note 74, at 320, 322

⁸² *Id.* at 322.

⁸³ *Id.*

prisoner competent for execution.⁸⁴ This action by the State could represent a “gratuitous infliction of suffering” when compared to the execution of a sane person and thus would be offensive to notions of human dignity under the Eighth Amendment.⁸⁵ Finally, the rationale offered by Professor Richard J. Bonnie supporting the prohibition against executing a mentally incompetent prisoner is based solely on this theory of dignity:

If this prohibition has any continuing justification in the contemporary context, I believe it must be found in respect for the dignity of the condemned. The prisoner has a right, even under imminent sentence of death, to be treated as a person, worthy of respect, not as an object of the State’s effort to carry out its promises. As Justice Powell suggested, a person under the shadow of death should have the opportunity to make the few choices that remain available to him. He should have the opportunity to decide who should be present at his execution, what he will eat for his last meal, what, if anything, he will utter for his last words, and whether he will repent or go defiantly to his grave. A prisoner who does not understand the nature and purpose of the execution is not able to exercise the choices that remain to him. To execute him in this condition is an affront to his dignity as a person and to the “dignity of man,” the core value of the Eighth Amendment.⁸⁶

III. POTENTIAL PROCEDURAL SOLUTIONS

There are two potential procedural solutions, which address and try to resolve at least some of the issues associated with forcible medication regimes. The first solution is based off of a statute enacted by the State of Maryland and will be referred to as the “Maryland Solution.” The second solution is based on the recommendation that psychiatrists should have a larger role in working with the State regarding competency issues related to capital punishment.

A. *The Maryland Solution*

⁸⁴ See *State v. Perry*, 610 So. 2d 746, 768 (La. 1992) (“Unlike sane death row prisoners who retain dignity until the end, Perry would be forced to endure the usurpation of control of his body and mind by the state and the deprivation of medical treatment in his best interests before he is dispatched by the lethal injection”).

⁸⁵ See Stricker, *supra* note 74, at 322.

⁸⁶ Richard J. Bonnie, *Panetti v. Quarterman: Mental Illness, the Death Penalty, and Human Dignity*, 5 OHIO ST. J. CRIM. L. 257, 277 (2007).

The State of Maryland, under the Annotated Code of Maryland Correctional Services §3-904 (hereinafter “Maryland Law”) has promulgated a statute, which specifically addresses death penalty procedures for an incompetent inmate.⁸⁷ First, §3-904(c) of this statute has codified the Eighth Amendment’s prohibition against the execution of an inmate “who has become incompetent.”⁸⁸ The term “inmate” is further defined under the statute to mean “an individual who has been convicted of murder and sentenced to death.”⁸⁹ Pursuant to §3-904(a)(2) the Maryland Law also defines the term “incompetent” to mean “the state of mind an inmate who, as a result of mental disorder or mental retardation, lacks awareness of the fact of the inmate’s impending execution; and that the inmate is to be executed for the crime of murder.”⁹⁰ Finally, §3-904(h)(1)-(2) of this statute is the most significant and it requires that upon finding an inmate to be incompetent, “the court shall stay any warrant of execution that was previously issued and has not yet expired and remand the case to the court in which the sentence of death was imposed. The court in which the sentence of death was imposed shall strike the sentence of death and enter in its place a sentence of life imprisonment without the possibility of parole.”⁹¹ Furthermore, the American Psychological Association, American Psychiatric Association, National Alliance on Mental Illness, and the American Bar Association have all adopted identical versions of a recommendation that is similar to the Maryland Solution, and it recommends that when a prisoner is found to be suffering from a mental disability or disorder, and is unable to understand

⁸⁷ MD. CODE ANN., CORR. SERVS. §3-904 (LexisNexis 2012).

⁸⁸ MD. CODE ANN., CORR. SERVS. §3-904(c) (LexisNexis 2012)

⁸⁹ MD. CODE ANN., CORR. SERVS. §3-904(a)(3) (LexisNexis 2012)

⁹⁰ MD. CODE ANN., CORR. SERVS. §3-904(a)(2) (LexisNexis 2012)

⁹¹ MD. CODE ANN., CORR. SERVS. §3-904(h)(1)-(2) (LexisNexis 2012)

the purpose behind the punishment or unable to appreciate why the punishment is being imposed upon him, the death sentence should be replaced with a less severe form of punishment.⁹²

The most significant benefit of adopting the Maryland Solution when states use forcible medication regimes are that it allows medical practitioners to practice their profession ethically without focusing on any extraneous circumstances. First, under this solution a medical professional would not be put into the uncomfortable position of forcibly medicating a mentally incompetent prisoner with the knowledge that if his treatment were effective in restoring competency, then the prisoner would most likely be executed. The Maryland Solution, which parallels the American Medical Association's ethical code regarding capital punishment,⁹³ will therefore allow a medical practitioner to focus his treatment toward what is truly in the prisoner's best medical interest. By limiting these ethical controversies, the Maryland Solution would allow a psychiatrist to increase and decrease the use of anti-psychotic drugs depending only on what would be best for the treatment of his patient, instead of fearing that his treatment would lead to a professional ethical violation.

Another benefit is that this solution could potentially limit issues that arise from "artificial competency." Since the Maryland Solution would strike a capital punishment sentence on a finding a death row inmate incompetent and replace it with life imprisonment,⁹⁴ the concern that antipsychotic medication does not cure mental illness would be lessened here.⁹⁵ This would be because death row prisoner's who are deemed incompetent under the Maryland Solution

⁹² See Brief for *Amici Curiae* American Psychological Association, American Psychiatric Association, and National Alliance on Mental Illness in Support of Petitioner, *Panetti v. Quarterman*, 127 S. Ct. 2842 (2007) (No. 06-6407); see Bonnie, *supra* note 74, at 258; American Medical Association, *Opinion 2.06 – Capital Punishment* (Jun. 2000) <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion206.page#>.

⁹³ American Medical Association, *Opinion 2.06 – Capital Punishment* (Jun. 2000) <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion206.page#> ("When a condemned prisoner has been declared incompetent to be executed, physicians should not treat the prisoner for the purpose of restoring competence unless a commutation order is issued before treatment begins").

⁹⁴ MD. CODE ANN., CORR. SERVS. §3-904(h)(1)-(2) (LexisNexis 2012)

⁹⁵ See Bachand, *supra* note 52, at 1061

would not be facing a capital punishment sentence⁹⁶ and therefore there would not be an issue of determining competency at the exact moment when an execution occurs. Therefore, the Maryland Solution provides a more effective and more ethical alternative when compared with forcible medication regimes.

B. *An Increased Role for Psychiatrists*

While there is significant variation between different states with regards to how much involvement a psychiatrist or physician would have in relation to its laws regarding capital punishment,⁹⁷ I would propose creating an express statutory role for psychiatrists in all capital punishment cases. For instance, a Nevada statute allows the Director of the Department of Corrections to determine that “[i]f, after judgment of death, there is a good reason to believe that the defendant has become insane”, the defendant could be entitled to a hearing before either two psychologists or two psychiatrists.⁹⁸ Additionally, psychiatrists can provide a benefit to the State because “mental health experts can provide testimony that can meaningfully inform judicial decisions about competency to be executed with established procedures that have a record of producing reliable, consistent results.”⁹⁹

I would further propose that there should be an express statutory provision requiring a baseline competency hearing for all capital punishment cases. This express statutory provision would be most effective when coupled with the Maryland Solution presented above. The reason behind coupling the two together is that even in cases where there is ineffective assistance of

⁹⁶ MD. CODE ANN., CORR. SERVS. §3-904(h)(1)-(2) (LexisNexis 2012)

⁹⁷ Jacob M. Appel, *Capital Punishment, Psychiatrists and the Potential “Bottleneck” of Competence*, 24 J.L. & HEALTH 45, 71 (2011) (noting that some state statutes “specify a role for physicians and/or psychiatrists”).

⁹⁸ NEV. REV. STAT. ANN. § 176.425 (LexisNexis 2012); see Appel, *supra* note 85 at 71.

⁹⁹ See Brief for *Amici Curiae* American Psychological Association, American Psychiatric Association, and National Alliance on Mental Illness in Support of Petitioner, *Panetti v. Quarterman*, 127 S. Ct. 2842 (2007) (No. 06-6407) (“The evaluation of an individual’s capacity to appreciate—or rationally understand—information is a fundamental and uncontroversial aspect of forensic mental health assessment that can be, and regularly is, performed by mental health professionals”).

counsel regarding a client's competency, these mandatory competency hearings will bring to light whether a prisoner is mentally incompetent. The specific timing of these mandatory hearings would be immediately after the conviction stage and before the sentencing stage. By creating this procedural mechanism, states will have a high probability of determining whether an individual is incompetent and is therefore not a candidate for the death penalty before the prisoner is sentenced with capital punishment. Another benefit of this baseline competency hearing is that it establishes a starting point for courts to look back at when a competency challenge is brought up in the future. The courts will at least have a baseline level of the prisoner's mental health, which would help the court in the future to determine whether a prisoner's mental health has truly deteriorated and he is now incompetent, or if the prisoner is attempting to falsely misuse the system to lessen his or her punishment.

IV. STATES LIMITATION OF THE INSANITY DEFENSE

While the Maryland Solution and the statutorily authorized role of psychiatrists in capital punishment cases address some potential solutions against forcible medication regimes, more universal problems still persist. The biggest of which, as I argue, is the recent mitigation of the insanity defense by states. Also for clarification purposes, this section regarding the states recent trend to limit the insanity defense only applies to the class of offenders who were suffering from a mental illness when they committed their crime, and does not apply to those offenders who became insane awaiting their execution.

A. The Last Forty Years

The changes the State of Arizona has made to its insanity defense will provide an appropriate example to understand the overall trend by states recently to weaken the insanity

defense.¹⁰⁰ Arizona enacted its first insanity defense statute in 1977 under which it codified the *M’Naughten* test, which stated:

A person is not responsible for criminal conduct if at the time of such conduct the person was suffering from such a mental disease or defect as not to know the nature and quality of the act or, if such person did know, that such person did not know that what he was doing was wrong.¹⁰¹

The Arizona legislature then proceeded to amend the insanity statute in 1983 to raise and shift the burden of proof to the insane defendant to prove that he or she is insane by “clear and convincing evidence” and that burden of proof is still just as steep today.¹⁰² The most current version of the insanity statute in Arizona functions under a “guilty except insane verdict” and the current insanity test is that “[a] person may be found guilty except insane if at the time of the commission of the criminal act the person was afflicted with a mental disease or defect of such severity that the person did not know the criminal act was wrong.”¹⁰³ The key difference between the 1977 insanity test and this test above is the removal of the cognitive prong which gave a defense to a person who did not know the nature or quality of his or her actions because of a mental illness.¹⁰⁴

The reasoning behind this trend by states in mitigating the effectiveness of the insanity defense can primarily be explained by a societal shift during the 1980’s where a great amount of emphasis was put on keeping the community safe, even if it came at the cost of the mentally ill.¹⁰⁵ In 1982 after John W. Hinckley Jr. trial succeeded in his affirmative defense after his failed

¹⁰⁰ Jennifer Gibbons, *Clark v. Arizona: Affirming Arizona’s Narrow Approach to Mental Disease Evidence*, 48 ARIZ. L. REV. 1155, 1158 (2006); Slobogin, *supra* note 57, at 546-51.

¹⁰¹ *Id.*

¹⁰² Gibbons, *supra* note 89, at 1158; ARIZ. REV. STAT. § 13-502(C) (LexisNexis 2012) (“The defendant shall prove the defendant’s legal insanity by clear and convincing evidence”).

¹⁰³ ARIZ. REV. STAT. § 13-502(A) (LexisNexis 2012)

¹⁰⁴ See Gibbons, *supra* note 89, at 1159 (“In addition to eliminating the cognitive incapacity prong of the *M’Naughten* test, the revised statute also limited what could be considered ‘mental disease or defect’ by excluding certain undefined disorders

¹⁰⁵ See Julie E. Grachek, *The Insanity Defense in the Twenty-First Century: How Recent United States Supreme*

attempt at assassinating President Ronald Reagan, “[t]he popularity among the public of the insanity defense dramatically decreased.”¹⁰⁶ After the Hinckley acquittal, both states and the federal government were motivated in weakening the insanity defense based on this public outcry.¹⁰⁷

However, states rely too heavily on the public perception of the insanity defense, which is normally shaped by “the media, and the portrayal is not always accurate.”¹⁰⁸ Recent research further indicates that the affirmative defense of insanity is not a very successful defense, as the public might believe, and that “only one percent of felony defendants nationwide raise the insanity defense.”¹⁰⁹ Finally, theories that defendants are able to abuse the insanity defense by pretending to have a mental illness are misguided and do not have empirical support.¹¹⁰

B. *How the Insanity Defense Affects Forcible Medication*

The connection between the insanity defense and forcible medication regimes can be explained by the idea that the insanity defense serves as a gatekeeper. The insanity defense provides a gatekeeper function because it at least limits the class of offenders who were insane during the trial and conviction proceedings, and limits the total amount of offenders who can be capital punished. However, since the states in recent years have limited the insanity defense, more and more offenders that might have been limited by the insanity defense, now are sentenced and put in prison facing sentences of capital punishment. Therefore, since the insanity

Court Case Law Can Improve the System, 81 IND. L.J. 1479, 1484 (2006).

¹⁰⁶ See Grachek, *supra* note 105, at 1484;

¹⁰⁷ See Slobogin, *supra* note 57, at 550 (“Soon after the insanity acquittal of John Hinckley, both the American Bar Association and the American Psychiatric Association recommended the elimination of the so-called ‘control’ inquiry”); see Grachek, *supra* note 105, at 1484-85 (“The 1984 federal test also shifted the burden of proving insanity from the prosecution to the defense”).

¹⁰⁸ Grachek, *supra* note 105, at 1486 (noting that much of the inaccuracy from the media results from the fact that the media generally only covers high profile cases, and the public then forms its opinion based on that small sample).

¹⁰⁹ *Id.* at 1487.

¹¹⁰ *Id.* at 1488 (“Mental health doctors are between ninety-two and ninety-five percent successful in determining whether a defendant is faking mental illness, making abuse of the insanity defense unlikely in reality”).

defense has been so significantly limited, states have come up with the alternative that they believe is best in light of the increase of prisoners with competency issues, thus resulting in the unjustified forcible medication regimes to execute mentally incompetent prisoners.

C. *A Case Study: Clark v. Arizona*

An appropriate example that demonstrates the recent trend of the weakening of the insanity defense is in *Clark v. Arizona*. During the early hours of June 21, 2000, Eric Clark who was seventeen at the time shot and killed Jeffrey Moritz, who was a police officer of the Flagstaff Police.¹¹¹ Officer Moritz was responding to complaints there was someone in a pick-up truck blaring loud music in a residential area.¹¹² After he pulled Clark over, Clark shot Officer Moritz and then fled the scene of the crime on foot, but was eventually arrested the next day.¹¹³ During his trial Clark provided significant evidence that he suffered from paranoid schizophrenia when the incident occurred, and also provided evidence from friends, family, and even a psychiatrist with regards to his bizarre behavior during the time period before he killed Officer Moritz.¹¹⁴ The trial judge then found Clark guilty of killing Officer Moritz, found that he was not insane at the time of his crime, and then sentenced him to life imprisonment with no possibility of parole.¹¹⁵ Furthermore, Clark's appeal to the Supreme Court was unsuccessful as the Court affirmed the lower court.¹¹⁶

The real issue now becomes what would happen if Clark had been given a sentence of capital punishment instead of life imprisonment? Would the State try to forcibly medicate him if he argued that he was incompetent? Hypothetically, if Clark were under the sentence of capital

¹¹¹ *Clark v. Arizona*, 548 U.S. 735, 743 (2006).

¹¹² *Id.*

¹¹³ *Id.*

¹¹⁴ *Id.* at 743-45 (“A psychiatrist testified that Clark was suffering from paranoid schizophrenia with delusions about ‘aliens’ when he killed Officer Moritz, and he concluded that Clark was incapable of luring the officer or understanding right from wrong and that he was thus insane at the time of the killing”).

¹¹⁵ *Id.* at 746.

¹¹⁶ *Id.* at 779.

punishment, he would clearly be someone who was failed by the insanity defense and will now be the target of a states forcible medication regime. Even with all of the evidence that he was suffering from paranoid schizophrenia was not enough for him to be found insane under the current Arizona defense. *Clark v. Arizona* demonstrates how the weakening of the insanity defense will unfortunately lead someone like Clark to suffer both the hardships of imprisonment along with the hardships of possibly being forcibly medicated by the State.

V. CONCLUSION

While states have tried to use forcible medication regimes to restore a mentally incompetent prisoner's competency to execute mentally incompetent prisoners, this practice is unjustified and should be halted by states. There are potential procedural solutions that states can adopt here that would be more effective and ethical resulting in a better outcome for both the State and the mentally incompetent prisoners. Finally, as states continue to restrict the use of the insanity defense, they will continue to be faced with competency issues at later points of an imprisonment of a prisoner. For the following reasons states should stop the use of forcible medication regimes, and bring back more bite into the insanity defense.