The Debate on Treating Individuals Incompetent for Execution

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The question of whether to provide mental health treatment to prisoners under death sentence who have been judged incompetent for execution presents a powerful ethical dilemma for mental health professionals. Arguments that favor or oppose the provision of treatment are discussed in the context of the nature of the disorder to be treated, the type of treatment to be provided, the goals of treatment, and the relevant legal standard for determining competency for execution. Arguments against treating the incompetent include 1) the need to avoid harming those who are treated, 2) the risk that disclosures in therapy will be used for assessment purposes, 3) the need for paternalism when sufficient harm is necessary, 4) the adverse impact on the clinician, 5) the potential undermining of patient and public perceptions of mental health professionals, and 6) the poor allocation of limited resources. Arguments for treating the incompetent include 1) respect for the wishes of the prisoner, 2) the need to clarify the values underlying the refusal to treat, 3) the low risk of harm from some forms of treatment, and 4) the adverse impact on the milieu stemming from failure to treat. The authors conclude that treating incompetent prisoners may not violate ethical standards under some circumstances, and that some forms of treatment will require the informed consent of the prisoner.
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In recent years, the issue of competency for execution has become a hotly debated clinical/legal question. This surge of interest has occurred despite the fact that this form of competency is based in common law and dates back to the thirteenth century (1–4). There appear to be at least two reasons for the renewal of the debate. First, the number of prisoners under death sentence in American jurisdictions has grown rapidly and, as of January 1991, exceeded 2,400 individuals (5). Second, the U.S. Supreme Court, in *Ford v. Wainwright* (6), held that executing the mentally incompetent would violate the Eighth Amendment prohibition against cruel and unusual punishment.

Currently, the issue of competency for execution has significantly more implications for mental health professionals than ever before. Firmly entrenched in statutory and common law and now with a constitutional basis, the concept of this form of competency is solidly established in our criminal justice system. Moreover, with the rapidly increasing population under death sentence, it seems inevitable that increasing numbers of mental health professionals will be asked to become involved in cases concerning an individual's competency to be executed. Even for clinicians who will never be involved with inmates under death sentence, the competency issue is useful as a heuristic device with which to explore issues such as trust and beneficence. The approach we take to weighing competing considerations and developing a position could also be used for situations in which the need for treatment competes with other demands, such as retribution and public safety.

There are two separate avenues to mental health professionals' involvement with inmates who have received the death sentence. The first is assessment, either before or after a formal finding of incompetency for execution. The second is the provision of mental health treatment for prisoners who have been found incompetent. The question of whether mental health professionals can ethically provide an assessment of competency for execution has been debated by many, including the present authors (3, 7–13). The parameters of how such assessment should be provided, if done at all, have also been discussed (12, and paper by S.L. Brodsky presented at the annual meeting of the American Psychological Association, Washington, D.C., 1986). The distinction between preadjudication and postadjudication assessment has been discussed; the latter presents ethical questions of even greater complexity (12).

The issue of treating a condemned inmate found incompetent for execution raises perhaps the most troubling questions, as the prisoner will have received a stay of execution pending restoration of competency. The

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primary focus of this article is on the ethical aspects of providing mental health treatment under such circumstances. (The constitutional questions raised by the issue of involuntary administration of one kind of treatment—antipsychotic medication—to prisoners who are incompetent for execution were before the U.S. Supreme Court in *Perry v. Louisiana* [14]. The Court remanded the case back to Louisiana for reconsideration in light of their holding in *Washington v. Harper* [15]. It is possible that the U.S. Supreme Court will eventually rule on the constitutionality of involuntary medication of prisoners incompetent for execution, but it appears unlikely to the attorneys involved in arguing the case [presentations by K. Nordyke and R.I. Salomon at the annual conference of the Forensic Mental Health Association of California, Pacific Grove, 1991]). While elsewhere we have argued that the best solution to these dilemmas is to commute the death sentences of incompetent inmates to life imprisonment (3, 12), here we focus on the ethical dilemma regarding treatment in cases in which commutations have not been made. One of our important points is that this is a powerful ethical dilemma because it occurs in the context of capital cases. "Death is different," an axiom that has long been recognized within the criminal justice system, will apply as well to the involvement of mental health professionals in this process.

Most states provide for transfer to some kind of secure psychiatric hospital for inmates found incompetent for execution (4, 16). For example, an inmate in Florida who is found incompetent for execution shall be "committed to a Department of Corrections mental health treatment facility" where "he shall be kept . . . until the facility administrator determines that he has been restored to sanity" (Florida Statutes, 922.07, subsections 3 and 4). Such a procedure is consistent with that recommended in the American Bar Association's *Criminal Justice Mental Health Standards* (17). One clear expectation in transferring an incompetent prisoner to a secure mental health facility is that the individual will receive mental health treatment. In this article we discuss whether and under what circumstances mental health treatment should be provided to such an individual, since one consequence of treatment may be restoration of competency and subsequent execution of the prisoner. (Because arguments about treating the incompetent for execution can be, in our view, closely bound up with feelings and values related to capital punishment, we offer the following statement of personal values, endorsed by each of us: we are not convinced by any existing data that capital punishment, as practiced historically or presently, actually deters crime [18]. We are convinced that the death penalty as currently applied has strong liabilities, including racial bias [19, 20], costliness [21], and the possibility of executing the innocent [22]. Our experience with death row inmates has led us to conclude that there are few individuals who, by their wanton disregard for human life, their willful and measured decision to kill, and their believable promises to kill again, have effectively given up their right to continue living. Unfortunately, our criminal justice system is not able to distinguish accurately between those who meet these criteria and those who do not. Nor does any conceivable incremental benefit of execution over life imprisonment seem to justify capital punishment in light of these difficulties. Thus, while we may debate the merits of the death penalty in theory, we are opposed to the way it is currently practiced. These values may affect the discussion that follows.)

HISTORICAL BACKGROUND OF COMPETENCY FOR EXECUTION

Extensive discussions of the history of competency for execution are available elsewhere (1–4) and thus will not be detailed here. Some of the early justifications for excluding the incompetent from execution were religious (executing incompetent individuals does not allow those persons to put their spiritual affairs in order and prepare to "meet their Maker"), humane (madness is punishment in itself), and normative (executing severely disturbed individuals reflects badly upon society). More recent justifications for excluding the incompetent from execution have included the retributive aspect (individuals are not fully punished if, due to mental disturbance, they do not fully understand the implications of their death), the incompetent person's inability to assist counsel with last-minute appeals, and the psychological aspect (the individual cannot go through the "stages of dying" necessary for a humane death).

Empirically, the construct of competency for execution is important because the vast majority of individuals under death sentence are removed from death row for reasons other than execution. (From 1972 through December 1990, 143 prisoners were executed in the United States. During this same period, however, a total of 1,078 prisoners under death sentence were removed from death row for reasons other than execution: dismissal of indictment, reversal of judgment, commutation, resentencing, and natural death [5]). The capacity to work with counsel on collateral appeals is thus more important than it might seem.

Case law prior to 1986 had established that the "evolving standards of decency" of a civilized society forbade suffering beyond that which is "necessary . . . to extinguish life humanely" (23) under the provisions of the Eighth Amendment. In the more recent *Ford* decision (6), the Supreme Court held that executing the incompetent would, for several reasons, also violate the Eighth Amendment. The majority opinion questioned the retributive value of executing a person who does not understand the reasons for being executed. It described the abhorrence of killing a person who has "no capacity to come to grips with his own conscience or deity" and who experiences "fear and pain without comfort of understanding." Finally, the majority asserted that such executions would "simply offend hu-

manity" and should be prohibited to "protect the dignity of society itself from the barbarity of exacting mindless vengeance." (Alvin Ford, still on death row in Florida and never having been judged incompetent for execution, died of natural causes on Feb. 28, 1991.)

CONTEXT OF TREATING PERSONS INCOMPETENT FOR EXECUTION

Three broad positions on the involvement of mental health professionals in the treatment of individuals incompetent for execution have been described: always treat, sometimes treat, and never treat (7, 8). The first position (always treat) is held by clinicians who maintain that they are responsible for treating severe mental illness whenever possible, without regard for consequences. Severe psychosis is a painful condition which they cannot ethically refuse to treat when they are in a position to provide relief. Adopting such a position does not necessarily imply endorsement of capital punishment but, rather, separates the delivery of clinical services (which is in the realm of mental health professionals) from the administration of punishment (which lies within the domain of judges and corrections officials). It is also possible that the refusal to treat actually represents a concealed protest against the death penalty (13).

An intermediate position (sometimes treat) is taken by those who would provide treatment to individuals incompetent for execution, but only when the latter want to be treated. An important consideration for those holding this position is whether the benefits of treatment would outweigh the risks under such circumstances. This stance does, however, create another problem: it is quite possible that an individual who is incompetent for execution might also be incompetent to consent to treatment. Potential solutions to this dilemma may involve a "living will," allowing the prisoner (while competent) to express a preference regarding treatment if he or she should become incompetent for execution, or the use of a "next friend" to make the treatment decision (8, 24).

The third position (never treat) holds that the relief of suffering is not sufficient justification for providing treatment, as such treatment is provided with the goal of making possible the infliction of even greater harm. Would it not be more humane, such proponents ask, to allow someone to suffer with psychosis than to administer a treatment that might restore competency and terminate life? Several commentators have forcefully articulated this position (11, 25).

Each of these positions provides a valid perspective on the ethical dilemmas created by the prospect of treating persons incompetent for execution. However, none of the positions is very specific. Treatment is not defined; at times one author seems to mean psychotropic medication, while another may include both medication and psychotherapy. The nature of the disorders that might result in an adjudication of incompetency for execution is not specified. "Psychotic" is the most often cited description of such conditions; this may be both too vague and too narrow. The goals of treatment are insufficiently specified. Finally, the nature of competency itself is discussed globally rather than specifically. In the following discussion we address the ethical issues in these more specific aspects.

Relevant Disorders

"Competency" is a legal term, not a medical or psychological term, so some translation is necessary. There appear to be three major classes of *DSM-III-R* disorders that might render an inmate incompetent for execution. Functional psychotic disorders such as the schizophrenias, mood disorders with psychotic features, delusional disorder, and psychotic disorders not elsewhere classified (schizoaffective disorder, schizophreniform disorder, and atypical psychosis) would constitute the first class. The second class would include certain organic mental disorders, such as delirium, dementia, amnestic disorder, organic delusional disorder, organic hallucinosis, and organic mood disorder, in which the symptoms are of a nature and severity sufficient to impair the individual's competency for execution. The third class would be mental retardation. It is noteworthy that previous commentators, in discussing "psychosis," were probably referring to the first class and parts of the second. Mental retardation has been addressed less frequently but is perhaps even more likely to yield cognitive deficits impairing competency for execution (26). While the mentally retarded may still be considered incompetent for execution if they meet state statutory requirements, the U.S. Supreme Court has made it clear that mental retardation in itself is insufficient to bar execution under the Eighth Amendment (27).

The Nature of Competency

Any kind of legal competency implies tasks. The individual must be able to understand, know, believe, or do something related to the competency construct (28); there must be the ability to understand relevant concepts and act at a minimally acceptable level of skill on the basis of that understanding (29). In the case of competency for execution, the two most frequently cited elements within the standard are "understand" and "assist." The former refers to an individual's capacity to understand the nature of the death penalty and the reasons why this punishment is to be inflicted. The latter describes the capacity to assist legal counsel in ongoing appeals.

According to the *Criminal Justice Mental Health Standards* of the American Bar Association (17), the standard for competency for execution is that an individual should not 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 mental 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" (p. 290). Of the 37 jurisdictions in the United States that have a death penalty and a relevant law relating to competency for execution, only two have standards that conform to the "understand" element, and another eight have "understand and assist" standards. Two states define competency for execution in terms of "mentally ill and need for treatment"; the remaining states use only a brief, unelaborated definition (e.g., "insane," "incompetent," "unfit") (16). The U.S. Supreme Court had the opportunity in the *Ford* case (6) to provide a single standard for this competency, as it had done for competency to stand trial (30). It did not do so, although Justice Powell, in his concurring opinion, did conclude that the test of incompetency for execution should be whether the prisoner is aware of his or her impending execution and of the reason for it. As a result of the failure to define a standard for competency in the *Ford* majority opinion and the lack of specificity in their pre-*Ford* statutes, most states do not provide specific guidance regarding the necessary tasks for determining competency for execution. The states that offer more explicit guidelines differ about what these are.

In an effort to help construct a consensual definition of competency for execution, we offer the following three tasks as potential components: 1) understanding the nature of capital punishment and the reasons for its imposition, 2) assisting counsel in ongoing collateral appeals, and 3) spiritually and psychologically preparing for death. While the latter does not appear in any of the statutes or case law, it has been proposed (31). We include it because clinicians need to address all possible dimensions unless or until the definition of incompetency is restricted by appellate courts.

Treatment and Treatment Goals

The types of mental health treatment that might be provided to prisoners incompetent for execution also need further specification. Psychotropic medication is one such treatment, but we will refer to two other types as well. The first is psychotherapy; the second involves a combination of education, skills training, and behavioral therapy that might best be described as psychiatric rehabilitation (32, 33).

Such treatments might be delivered with a number of goals in mind. In any forensic setting, a primary purpose of treatment involves assisting an incompetent patient to regain legal competency. Some would argue that competency for execution is no exception and that a major reason for treating such an individual would involve promoting the recovery of competency. This treatment might be indirect (e.g., removing a disability, such as an actively psychotic condition, and thereby allowing the capacities to perform competency tasks to reemerge) or direct (e.g., enhancing the capacity to interact effectively with counsel through communication skills training). There are, however, other goals that therapists could pursue as well. These include relief of suffering brought on by a psychotic condition, provision of comfort and support and the opportunity for catharsis, enhancement of the individual's capacity to fight effectively for legal rights, and provision of an opportunity to prepare psychologically for death. While the last two goals may arguably relate to the individual's competency status in some jurisdictions, the first two are largely situation-independent treatment goals.

ARGUMENTS AGAINST TREATING THE INCOMPETENT

First, Do No Harm

The notion that psychiatrists and psychologists providing treatment should not harm patients is probably more of an implicit understanding than an explicit ethical canon of either profession. *Primum non nocere* (first, do no harm) is a long-established tenet of the medical profession, although it is no longer a part of the American Psychiatric Association's *Principles of Medical Ethics* (3, 34). Psychologists are ethically obligated to "protect the welfare of the people and groups with whom they work" (35, 36). This sets a similar tone, and the ethical issue here is the same for psychiatrists and psychologists. Mental health professionals are helpers, with a primary obligation to assist and not harm those who receive their services.

Risk That Disclosures in Therapy Will Be Used for Assessment Purposes

The establishment of an effective treatment relationship depends on whether the individual receiving treatment can trust the professional who is rendering it. This would seem particularly true for psychotherapy with persons who are incompetent for execution. Being under death sentence can have a powerful polarizing effect on a prisoner's perceptions: others are seen as either friends or enemies. There is thus the temptation to view the therapist in one of these two roles. It is not clear whether the prisoner can be accurately informed that information provided in therapy will not be disclosed except in instances involving an increased risk of violence by the patient toward another individual or himself or instances of escape. There is the very real possibility that psychotherapy with a prisoner who is incompetent for execution could result in the use of confidential disclosures for the purpose of assessing the person's competency for execution. In many inpatient settings, disclosures made during therapy are shared within a "circle of confidentiality" that may include supervisors in the chain of clinical responsibility, social workers, nurses, and other treatment team members (37). The risk that disclosures made during therapy will

be used for assessing competency for execution is particularly acute under this model and when there is not a strict separation between treatment and assessment functions (3, 12).

Paternalism Is Necessary When Significant Harm Is Possible

There are times when it is necessary to decide that the potential risks of treatment sufficiently outweigh the benefits, so that treatment should be withheld whatever the wishes of the patient or the external demands. Surely, the treatment of those incompetent for execution must be among such cases. Psychotropic medication, which may have an immediate impact on the symptoms rendering an individual incompetent for execution, is the best example. The physician must weigh the potential gain from this form of intervention against the risk that the individual will quickly have a remission of symptoms, regain competency, and be executed.

There is certainly the possibility that an individual who is incompetent for execution might also be incompetent to consent to psychotropic medication (7). This must be considered in any decision to prescribe medication. While the legal right to refuse medication may be limited in prison (14, 15), there are also ethical considerations confronting a physician under these circumstances. Given the potential consequences that could follow a medication-induced improvement in mental condition, the ethics-induced demand for the necessary level of competency to consent to this particular treatment should be very stringent.

Adverse Impact on the Clinician

A clinician attempting to administer any kind of treatment to an individual who is incompetent for execution can experience powerful feelings of confusion, anger, and ambivalence. The awareness that the application of one's craft may result in the death of another human being, even indirectly, creates a situation in which a clinician can feel strong pulls in two directions. On one hand, it is very difficult to be in proximity to someone who is suffering from a mental disturbance, and who may even be asking for help, and not render help. Such a decision, in our experience, is far easier to make in the abstract than in the clinical situation. On the other hand, the awareness that death could ensue soon after treatment is enough to give almost any clinician pause. This conflict is exacerbated by personal contact with the inmate.

In one recent instance, the feelings of clinicians were described in these terms, and they unanimously voted against repeating the entire process, having failed "by bitter experience" to resolve the difficult emotional dilemma created by this situation (25). (The dilemma has never been resolved. The prisoner was transferred from the forensic service at Florida State Hospital to the Corrections Mental Health Institution in 1985 as a result of a change in state statute. After having been evaluated by the Corrections Mental Health Institution treatment team, he was returned to Florida State Prison 2 years later. The team did not express a clear opinion with regard to the prisoner's competency for execution. They did state that he apparently understood the nature of his legal situation at the time of the report—although given the nature of his mental illness, it would be hard to tell on any given day in the future whether he would understand—and had also obtained maximum benefit from treatment. Following his transfer to Florida State Prison, the prisoner refused to cooperate when a new team of three psychiatrists attempted to assess his competency for execution. The stay of execution that had been granted because of his incompetency was therefore vacated by the governor. The prisoner remained on death row as of February 1992.) There have been no other cases in which an individual has been judged incompetent for execution. However, the emotional impact upon clinicians from this single case provides an ominous foreboding of things to come.

Undermining Patient and Public Perceptions of Mental Health Professionals

The professions of medicine and psychology are multifaceted. Both include scientific, professional, and public policy components. However, the facet involving direct patient services is arguably the most visible and the most prominent in the public eye. Actions that run counter to the "healing profession" image may thus have a disproportionately large impact on these professions as a whole. There can be little doubt that there will be widespread dissemination of information about the actions of psychiatrists and psychologists in cases of incompetency for execution. The avid public interest in death penalty cases, fueled by intense media scrutiny, is a potentially volatile situation. The spectacle of the smiling, white-coated doctor, syringe in one hand and hangman's noose in the other, may be quickly dismissed as outrageous hyperbole—until it appears in a national magazine (38) or on the editorial page of a prominent newspaper.

Poor Allocation of Limited Resources

The supply of mental health professionals is far outstripped by the demand, particularly from forensic and correctional facilities (39, 40). Treatment (of whatever form) provided to an inmate who is incompetent for execution can be extremely time-consuming. Because of the high visibility of the case, intense media interest, heightened concern for security, other institutional concerns, ethical issues, and personal reactions of the clinician, such a case can require more clinical resources than even presentencing capital punishment cases of comparably high visibility. Treating prisoners incompetent for execution is simply a poor way to spend valuable resources, from an individual clinical standpoint, from a psychiatric institutional standpoint, and as a matter of public policy.

ARGUMENTS FOR TREATING THE INCOMPETENT

Respect for the Wishes of the Prisoner

The strongest argument for treating persons incompetent for execution is that they have a right to such treatment if they want it. "Informed consent" followed by delivery of mental health service is an ethical cornerstone of both psychiatry (34) and psychology (36) that arguably applies in many forensic contexts (41, 42). A situation analogous to the treatment of incompetent prisoners involves the ongoing legal appeal process following a death sentence. There are some prisoners who wish to discontinue collateral appeals, presenting a similar dilemma for the attorney: abiding by the expressed wish of the client may hasten his or her death, yet there is a compelling argument that this respect for the client's wishes actually enhances the dignity and humanity of the client (8, 24).

The question of whether consent to mental health treatment under these circumstances can be validly given is clearly a difficult one. In the civil commitment context, there are three essential elements to determining the validity of consent to treatment: disclosure, competency, and voluntariness (43, 44). It may well be that competency to consent to such treatment could always be questioned under such circumstances (45) and that such competency should be assessed broadly and include both the rationality and informed nature of the decision (10). Thus, a large percentage of prisoners who are incompetent for execution might also be incompetent to consent to treatment. However, if it can be assumed that valid consent to some forms of treatment can be obtained in some cases of incompetency for execution, then we are left with a clearly stated, competently given preference to receive treatment.

There are also other ways in which competent consent might be obtained: 1) from the prisoner before the incompetency issue is ever raised (comparable to the living will), 2) from the prisoner after a brief trial of medication designed to restore competency to consent, and 3) from a "next friend" appointed by the court. (Keith Nordyke, the attorney representing Michael Perry in *Perry v. Louisiana* [14], filed a motion for his own appointment as Perry's "next friend" for the purpose of deciding about the administration of psychotropic medication. This motion was granted by the trial court, and Perry's medication was stopped when Nordyke refused permission for its administration. The trial court removed this decision-making authority from Nordyke after 6 months. This points to a practical difficulty in applying the "next friend" concept: a trial judge inclined toward or against the death penalty can greatly influence the medication decision by appointing a "next friend" who is similarly inclined.) When competent consent can be obtained, by whatever means, it seems reasonably clear that any subsequent refusal to treat would be simply a substitution of the clinician's values for those of the prisoner.

Confusion of Values

The second argument for providing treatment is based on the notions that 1) refusing to treat is a veiled protest against the death penalty and 2) the principles of beneficence (doing good) and nonmaleficence (doing no harm), so clearly important in nonforensic treatment situations, are far less applicable in a forensic treatment context. The first point has been made by Mossman (13), who gives the example of a mentally disordered convicted murderer serving a life sentence who is subsequently transferred to a mental hospital. Few mental health professionals would have qualms about providing treatment under those circumstances, although it might "bring about" punishment by returning the individual to prison. A comparable example might be that of individuals who are charged with first-degree or life-sentence felonies but are incompetent to stand trial on these charges. To our knowledge, nobody has cited ethical difficulties in treating under these circumstances, even though treatment might again facilitate the administration of punishment through restoration of competency to stand trial.

Since it is not the administration of punishment per se but rather the punishment by death that creates the ethical difficulties, this argument concludes that such difficulties are really a protest against the death penalty under the guise of professional ethics, a conclusion also reached by Bonnie (9). While there is no doubt that mental health professionals should, like any other citizens, be free to express their opposition to capital punishment, some would argue that such opposition should be presented in an intellectually honest way: openly and in their roles as citizens rather than as professionals.

Further, a strong argument has been made that the principles of beneficence and nonmaleficence are not central to forensic ethics (46). When there is not a promise that such principles will govern the relationship, as in cases of evaluation for the purpose of court testimony to advance the general interests of justice, then they arguably do not attain primacy. While Appelbaum (46) draws a distinction between forensic and treatment procedures, it is not clear whether treatment for the purpose of regaining a prisoner's criminal competency is serving the needs of the state (by advancing the general interests of justice) or of the individual (by diminishing suffering). It can be argued that it is largely the needs of the state which should be addressed in the context of competency for execution and that treatment decisions should not be made solely on the basis of the interests and needs of the incompetent prisoner.

Some Forms of Treatment Have Low Risk of Harm

Much of the discussion about treating persons incompetent for execution seems to assume a strong causal connection between treatment and regaining competency. This assumption may not be accurate, at least for some forms of treatment. The clearest connection between treatment and psychotic symptoms occurs in re-

gard to antipsychotic and mood-stabilizing medications. In cases of schizophrenia, affective disorders, and organic mental disorders with psychotic symptoms, the prescription of appropriate medications can directly ameliorate symptoms such as perceptual disturbances, severe communication disturbances stemming from formal thought disorder, and disturbances in thought content, such as delusions. These kinds of symptoms in turn may have a direct impact on an individual's ability to understand the nature of death and the reason it is being inflicted upon him or her. Within the broader view of competency for execution, such symptoms could also have an adverse impact upon an individual's ability to work productively with counsel on collateral appeals and could impair the capacity to prepare for death. On the other hand, medication would not have an effect on the cognitive deficits stemming solely from mental retardation.

Other forms of treatment may present a different picture. The evidence shows that psychotherapy or counseling alone, in the absence of other forms of treatment, is not effective in alleviating the biologically based "positive" symptoms of schizophrenia, affective disorders, and organic mental disorders (47). Psychotherapy could therefore be delivered to an individual found incompetent for execution with the assumption that the risk of harm stemming from improvement would be low. The comfort, catharsis, and support from such psychotherapy would be valuable, and the therapist might assist the individual in preparing for death with as much dignity and humanity as possible under the circumstances, if this were not part of the competency criteria.

Psychosocial rehabilitation involves teaching a mentally ill patient the additional skills to permit him or her to behave and interact in a relatively nonpathological manner, despite the continued existence of the underlying illness (48). The connection between this kind of treatment and competency-relevant behavior seems potentially strong. In effect, one might be teaching an individual to behave "as if" he or she understood the nature of the death penalty and the reasons for its being administered. One might also be teaching the individual to communicate more effectively, which could improve the ability to interact with counsel. Other skills, however, such as stress management techniques, could theoretically improve the person's coping ability without having a direct effect on competency-relevant capacities. It therefore makes a difference which skills are taught and which deficits are to be remediated. Clinicians could conceivably deliver certain kinds of psychosocial treatment to individuals incompetent for execution without the concern that such treatment would immediately make it more likely that competency would be regained.

Adverse Impact of Failure to Treat on the Milieu

Since most states provide for the transfer of an incompetent prisoner to a high-security mental health institution (16), we must consider the impact of selective refusal to treat certain patients within such facilities. What will happen to incompetent prisoners who are not treated in any way? Will they be confined to their rooms and ignored by the staff? Will they interact with the direct care staff but not the treatment staff? What impact would such selective treatment refusal have on the other patients and on the therapeutic milieu? It seems likely that it would increase the sense of isolation and estrangement of incompetent prisoners and exacerbate the confusion and mistrust of the staff that may already be exhibited by acutely disturbed patients in an inpatient setting. Both kinds of effects are antithetical to the goals of an effective inpatient milieu: to increase patients' sense of security and interpersonal trust and diminish their isolation and confusion. To the extent that the therapeutic milieu is an important element in the effectiveness of inpatient treatment, the selective refusal to treat one patient could damage the treatment prospects for more than that single individual.

SYNTHESIS

The arguments presented in this article primarily encompass the ethical and moral considerations relevant to treating persons incompetent for execution. Legal considerations have been relatively less emphasized; while they are neither mutually exclusive of nor synonymous with ethical concerns, it is possible to envision a constitutional analysis that reaches a different set of conclusions.

Despite this caveat, however, the arguments we have presented help clarify the ethical issues involved in the provision of mental health treatment to prisoners who are incompetent for execution. The decision about whether to provide such treatment should depend on the nature of the treatment to be provided, the goals of treatment, the standard for competency for execution, and determination of the prisoner's ability and willingness to consent to the treatment.

Specificity is important because one of the major objections to providing treatment concerns the possibility that a treated individual will be put to death if the treatment is successful. Some kinds of treatment have a low causal connection with improvement in competency-relevant capabilities but may nevertheless "help" under some circumstances. Psychotherapy or counseling is the class of mental health treatment for which there is the lowest causal connection between treatment and competency-relevant behavior. Certain kinds of psychosocial education interventions—in the area of stress management, for example—are also unlikely to affect an individual's ability to understand or assist in relevant ways. Cognitive deficits experienced by the mentally retarded are unlikely to be altered with either medication or therapy, although perhaps the relevant understanding could be improved through certain kinds of training.

On the other hand, the administration of antipsy-

chotic or mood-stabilizing medications is much more likely to effect a change in the competency-relevant thinking and behavior of individuals with schizophrenia, organic mental disorders with psychotic features, and affective disorders with psychotic features. It is in these cases that the importance of informed consent to treatment becomes paramount. The importance of obtaining consent—informed, voluntary, and competent—thus varies according to the kind of treatment being considered. For treatments having a strong therapeutic link to competency-relevant symptoms (e.g., psychotropic medications) and thus presenting a high risk to the prisoner, there appears to be an ethical demand to obtain informed consent prior to delivery of treatment. For other forms of treatment (e.g., milieu, psychotherapy) having a weaker link to competency-relevant symptoms but potentially providing other benefits (e.g., support, catharsis, contributing to the broader milieu), the demand for fully informed consent seems less compelling, and the threshold for consent should be lower.

Even with medication, however, if informed consent can be obtained, then there is an argument for providing the treatment requested by the patient. Respect for the prisoner's autonomy versus the need for paternalism under compelling circumstances are the considerations that must be weighed against each other. A legal analogy would be the predominant position of the courts regarding the insanity defense for defendants who refuse to invoke it when it would be worthwhile. Until recent years, in order to preserve the "moral integrity" of the law, this defense was interposed by the court against the defendant's wishes (for example, *Whalem v. United States* [49], in which the Circuit Court of Appeals for the District of Columbia appeared to establish a duty for trial judges to impose an insanity defense when it would be likely to succeed, regardless of the defendant's wishes.) Now, however, the prevailing view seems to involve honoring the decision of a competent defendant to avoid using this defense (8, 44, and several post-*Whalem* decisions by the U.S. Supreme Court, including *North Carolina v. Alford* [50] and *Faretta v. California* [51], and by the District of Columbia Court of Appeals in *Frendak v. United States* [52]).

It is crucial, however, to verify that consent is indeed valid under circumstances of competency for execution. It is possible that an incompetent prisoner might be treated with medication only to the point that he or she is able to make a competent decision about further treatment, although this would increase the risk of alleviating competency-relevant symptoms. It is possible to assume that an individual who is both incompetent for execution and incompetent to consent to treatment would not, if competent, give consent to be treated. The preferable course here would seem to involve having a "next friend" (a role played by a relative or advocate rather than the defense attorney or mental health professional) weigh these possibilities in order to make a substituted judgment. It has been argued that there is probably no legal right for a prisoner to refuse treatment under these circumstances (8), a position that is consistent with the U.S. Supreme Court's recent decision in *Washington v. Harper* (15). However, we would conclude that there is an *ethical* demand for mental health professionals to abstain from the involuntary treatment of someone who is incompetent for execution, at least with treatments likely to alleviate competency-relevant symptoms. On the other hand, it would not appear unethical to integrate an incompetent inmate into a therapeutic milieu, even without the prisoner's consent, because of the potential benefits to the prisoner and the other patients and the relatively low risk of "harm."

The atmosphere surrounding the death penalty is powerfully charged. One's position on capital punishment can play a large role in determining whether to treat individuals who are incompetent for execution. Reluctance to provide any kind of treatment can be a veiled protest against the death penalty, although not necessarily against punishment itself. "Above all, do no harm" is not necessarily a relevant principle for treating individuals in the criminal justice system, if one includes criminal sanctions under "harm." There are two reasons why this dictum is not applicable. It does not offer a distinction between evaluations of competency for execution and presentencing evaluations, and it would also condemn other kinds of clinical evaluation in the postsentencing phase of the criminal justice system that have never been seen as problematic by those who accept any kind of clinical forensic involvement in the criminal justice system (8). However, the close temporal proximity to drastic harm, even if it is an indirect rather than a direct consequence of treatment, can create intense difficulty in the treatment of persons who are incompetent for execution. This is the mental health variant of considering punishment by death as "different," something that has been recognized within the criminal justice system for some time (8, 53).

The entire question of treatment for persons incompetent for execution presents a "lose-lose" situation for mental health professionals. It is difficult to abstain from treating a person in need. It is equally difficult to provide treatment to an individual under these circumstances. The personal consequences are also difficult. In addition, the potential loss of public esteem for the profession, stemming from the public's perception that treatment professionals are closely involved with capital punishment, may be a powerful consideration.

CONCLUSIONS

One of the recommendations made elsewhere (12) is that mental health professionals should consider very carefully the decision about whether to participate in the assessment of competency for execution. This recommendation seems equally apt for the decision about providing treatment. Clinicians should carefully weigh any decision to participate under these circumstances. However, it also seems appropriate to conclude that

such a decision should be made on an individual basis rather than as a profession. We have argued that any decision about treating persons incompetent for execution should involve a variety of considerations. A blanket recommendation against participation does not seem indicated on ethical grounds.

There are, however, some unresolved questions about how to participate that might be usefully addressed by the professional psychiatric and psychological associations. To what extent is treatment of incompetent prisoners a clinical situation, emphasizing the principles of beneficence and nonmaleficence, and to what extent is it a forensic situation, in which the needs of society may be weighed more heavily than those of the individual? Clearer answers may await our professions' responses to Appelbaum's call (46) for the development of a comprehensive set of forensic ethical standards.

Competency for execution presents a very complex set of ethical and moral problems for mental health professionals involved with these cases. The discussion in this article leads us to conclude that there is no single, ethically proper position on the treatment of persons found incompetent for execution. It appears unethical to administer against the prisoner's wishes treatment that is highly relevant to competency, such as antipsychotic medication for psychotic disorders. It may not be unethical if the prisoner consents to receiving such medication, although there are problems in determining what constitutes "consent." If the treatment is unlikely to affect competency-relevant symptoms, however, then it is not unethical to provide it. Finally, the circumstances of each case will influence some of the treatment decisions for which there are no clear ethical mandates. We hope that these conclusions, and the discussion on which they are based, will introduce more shades of gray into a debate that has often been treated in black and white.

REFERENCES

1. Broderick D: Insanity of the condemned. Yale Law Journal 1979; 88:533–564
2. Larkin P: The Eighth Amendment and the execution of the presently incompetent. Stanford Law Rev 1980; 32:765–805
3. Radelet ML, Barnard GW: Ethics and the psychiatric determination of competency to be executed. Bull Am Acad Psychiatry Law 1986; 14:37–53
4. Ward B: Competency for execution: problems in law and psychiatry. Florida State University Law Rev 1986; 14:35–107
5. Death Row, USA. New York, NAACP Legal Defense and Educational Fund, Jan 21, 1991
6. Ford v Wainwright, 477 US 399 (1986)
7. Appelbaum PS: Competence to be executed: another conundrum for mental health professionals. Hosp Community Psychiatry 1986; 37:682–684
8. Bonnie RJ: Dilemmas in administering the death penalty: conscientious abstention, professional ethics and the needs of the legal system. Law and Human Behavior 1990; 14:67–90
9. Bonnie RJ: Grounds for professional abstention in capital cases: a reply to Brodsky. Law and Human Behavior 1990; 14:99–102
10. Brodsky SL: Professional ethics and professional morality in the assessment of competence for execution: a response to Bonnie. Law and Human Behavior 1990; 14:91–97
11. Ewing CP: Diagnosing and treating "insanity" on death row: legal and ethical perspectives. Behavioral Sciences and the Law 1987; 5:175–185
12. Heilbrun K, McClaren HA: Assessment of competency for execution? a guide for mental health professionals. Bull Am Acad Psychiatry Law 1988; 16:205–216
13. Mossman D: Assessing and restoring competency to be executed: should psychiatrists participate? Behavioral Sciences and the Law 1987; 5:397–409
14. Perry v Louisiana, 111 S Ct 449 (1990)
15. Washington v Harper, 58 USLW 4249 (1990)
16. Heilbrun K: The assessment of competency for execution: an overview. Behavioral Sciences and the Law 1987; 5:383–396
17. American Bar Association: Criminal Justice Mental Health Standards. Washington, DC, ABA, 1986
18. Hood R: The Death Penalty: A World-Wide Perspective. New York, Oxford University Press, 1989, pp 117–148
19. Baldus DC, Woodworth GC, Pulaski CA: Equal Justice and the Death Penalty. Boston, Northeastern University Press, 1990
20. Gross SR, Mauro R: Death and Discrimination: Racial Disparities in Capital Sentencing. Boston, Northeastern University Press, 1989
21. Spangenberg RL, Walsh ER: Capital punishment or life imprisonment: some cost considerations. Loyola of Los Angeles Law Rev 1989; 23:45–58
22. Bedau HA, Radelet ML: Miscarriages of justice in potentially capital cases. Stanford Law Rev 1987; 40:21–179
23. Louisiana ex rel Francis v Resweber, 329 US 459 (1947)
24. Bonnie RJ: The dignity of the condemned. Virginia Law Rev 1988; 74:1363–1391
25. Radelet ML, Barnard GW: Treating those found incompetent for execution: ethical chaos with only one solution. Bull Am Acad Psychiatry Law 1988; 16:297–308
26. Blume J, Bruck D: Sentencing the mentally retarded to death: an Eighth Amendment analysis. Arkansas Law Rev 1988; 41:725–764
27. Penry v Lynaugh, 109 S Ct 2934 (1989)
28. Grisso T: Evaluating Competencies: Forensic Assessments and Instruments. New York, Plenum Press, 1986
29. Ellis JW, Luckasson RA: Mentally retarded criminal defendants. George Washington Law Rev 1985; 53:414–493
30. Dusky v United States, 362 US 402 (1960)
31. Brief for Petitioner, Ford v Wainwright, cert granted (US Dec 9, 1985) (No 85-5542)
32. Anthony WA: The Principles of Psychiatric Rehabilitation. Baltimore, University Park Press, 1979
33. Anthony WA, Cohen M, Farkas M: Psychiatric Rehabilitation. Boston, Center for Psychiatric Rehabilitation, 1990
34. American Psychiatric Association: The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry. Washington, DC, APA, 1981
35. American Psychological Association: Casebook on Ethical Principles of Psychologists. Washington, DC, APA, 1987
36. American Psychological Association: Ethical principles of psychologists. Am Psychol 1990; 45:390–395
37. Gutheil T: Confidentiality in mental health treatment. Harvard Ment Health Letter 1988; 4:8
38. Rosenbaum R: Travels with Dr Death. Vanity Fair, May 1990, pp 140–174
39. Directory of Programs and Facilities for Mentally Disordered Offenders: Department of Health and Human Services Publication (ADM) 86-1483. Washington, DC, DHHS, 1986
40. Kerr C, Roth J: Populations, practices, and problems in forensic psychiatric facilities. Annals Am Acad Political and Social Science 1986; 484:127–143
41. American Academy of Psychiatry and the Law: Ethical Guidelines for the Practice of Forensic Psychiatry. Baltimore, Md, AAPL, 1989
42. Monahan J (ed): Who is the Client? The Ethics of Psychological Intervention in the Criminal Justice System. Washington, DC, American Psychological Association, 1980
43. Lidz C, Meisel A, Zerubavel E, Carter M, Sestak R, Roth L: Informed Consent: A Study of Decision-Making in Psychiatry. New York, Guilford Press, 1984
44. Melton G, Petrila J, Poythress N, Slobogin C: Psychological

Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers. New York, Guilford Press, 1987
45. Dix G: Legal and ethical issues in the treatment and handling of violent behavior, in Clinical Treatment of the Violent Person. Edited by Roth LH. New York, Guilford Press, 1987
46. Appelbaum PS: The parable of the forensic psychiatrist: ethics and the problem of doing harm. Int J Law Psychiatry 1990; 13: 249–259
47. May P, Tuma A, Dixon W: Schizophrenia: a follow-up study of the results of five forms of treatment. Arch Gen Psychiatry 1981; 38:776–784
48. Paul GL, Lentz RJ: Psychosocial Treatment of Chronic Mental Patients. Cambridge, Mass, Harvard University Press, 1977
49. Whalem v United States, 346 F 2d 812 (1965)
50. North Carolina v Alford, 400 US 25 (1970)
51. Faretta v California, 422 US 806 (1975)
52. Frendak v United States, 408 A 2d 364 (1979)
53. Woodson v North Carolina, 428 US 280 (1976)