of the relationship between the crime and his execution. The U.S. Supreme Court granted *certiorari* to review the Eleventh Circuit's decision.

Ruling and Reasoning

In a unanimous ruling, the U.S. Supreme Court reversed the Eleventh Circuit's decision. The Court reviewed the standards outlined in *Ford* and *Panetti*. In *Ford*, the Court questioned the "retributive value" of executing a prisoner who lacked comprehension of why he was being executed. In *Panetti*, the Court stated that a "prisoner's awareness of the State's rationale for an execution is not the same as a rational understanding of it" (*Panetti*, p 943). The Court stated neither *Ford* nor *Panetti* established that failure to remember the crime equates with incompetence to be executed. Rather, the prisoner must rationally understand that he is being executed for the crime that he committed.

The Court found that the trial court's decision did not unreasonably apply *Panetti* and *Ford*. They stated that despite his memory loss, Mr. Madison recognized that he was going to be executed for the murder for which he had been convicted. The Court also ruled that the state court's decision was not founded on an unreasonable assessment of the evidence. Both expert psychologists testified that Mr. Madison understood he was convicted of murder and that the state ordered him to be executed as punishment for the capital offense.

Discussion

While the U.S. Supreme Court's decision relied on the standards outlined in *Ford* and *Panetti*, this case is unique in terms of diagnosis. Although in *Ford* three psychiatrists gave conflicting diagnoses, the majority opined he had a psychotic disorder and the Court ruled that a state cannot execute an "insane" prisoner. In *Panetti*, the prisoner was having delusions. In this case, however, Mr. Madison was diagnosed with dementia and an emphasis was placed on his retrograde amnesia for the offense.

Retrograde amnesia was the topic of discussion in another landmark case, *Wilson v. United States*, 391 F.2d 460 (D.C. Cir. 1968). *In Wilson*, the defendant was involved in a high-speed chase after he highjacked a car at gunpoint and robbed a pharmacy. He crashed into a tree which resulted in loss of consciousness and retrograde amnesia. The U.S. Court of Appeals for the District of Columbia held that if a defendant with amnesia can construct an understanding of the offense from the available evidence, has the ability to follow the proceedings against him, and can discuss his case rationally with his attorney, then his amnesia does not necessarily equal incompetence if the state's case "is such as to negates all reasonable hypotheses of innocence" (*Wilson*, p 462)." Therefore, the U.S. Supreme Court's competency decision regarding amnesia and competency in *Dunn* is consistent with the decision in *Wilson*.

This case raises two interesting concerns for forensic evaluators. First, unlike Wilson's retrograde amnesia, dementia can affect anterograde memory as well. In jurisdictions that require inmates to be able to rationally assist their attorney as an element of the competency to be executed standard, assessing the impact of anterograde amnesia on their ability to recall conversations with their attorney, follow trial proceedings, and to provide rational assistance to their attorney may prove difficult. Finally, should forensic psychiatrists serve as advocates for death row inmates with dementia? Mr. Madison suffered blindness, incontinence, slurred speech, the inability to walk independently, and amnesia. In *Atkins v. Virginia*, 536 U.S. 304, 306 (2002), the U.S. Supreme Court, citing "evolving standards of decency," held that the constitution bars the execution of prisoners with intellectual disability. Whether these "evolving standards of decency" should bar the execution of inmates with dementia, including those with severe impairments such as Mr. Madison, may be a topic for further discussion and potential advocacy by professional organizations.

Disclosures of financial or other potential conflicts of interest: None.

Rehabilitative Potential as a Basis for Involuntary Commitment

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Wisconsin Supreme Court Rules That an Individual Is a Proper Subject for Treatment Under Wisconsin's Statute Governing Involuntary Commitment When That Individual Has Rehabilitative Potential

DOI:10.29158/JAAPL.3753L1-18

In the Matter of the Mental Commitment of J.W.J., 895 N.W.2d 783 (Wis. 2017), Mr. J. challenged the extension of his involuntary commitment and treatment, in part, on the basis that further involuntary commitment and treatment would not rehabilitate him, thus he was not a proper subject for treatment within the meaning of Wis. Stat. § 51.20(1) (2015–2016). The circuit court found that Mr. J continued to meet criteria for commitment. The court of appeals and the Wisconsin Supreme Court affirmed.

Facts of the Case

Mr. J. had a history of schizophrenia and substance use and was involuntarily committed to inpatient or outpatient treatment almost continuously from 1990 to 2008. Many of his hospitalizations occurred after he was noncompliant with medication, resulting in increased paranoia, agitation, rambling and pressured speech, and/or command hallucinations to kill himself or others. Mr. J. was released from prison in 2009 after serving an 18-month sentence for selling marijuana. At that point, he was adjudged to have mental illness and to be dangerous to others and was subjected to a new set of commitment orders that were renewed yearly.

In June 2015, the county filed a petition to extend Mr. J.'s involuntary outpatient commitment and treatment orders. At that time, he was living independently in the community, regularly attending appointments, and compliant with medications. During the prior 12-month period, Mr. J. had not required inpatient hospitalization; however, he continued to insist that psychotropic medications caused his mental health symptoms.

Mr. J. refused to participate in the commitment extension evaluation. Dr. Richard J. Koch, a licensed psychologist, who previously evaluated Mr. J. on five different occasions, reviewed Mr. J.'s medical records and other information. Dr. Koch opined that Mr. J. was mentally ill, dangerous, appropriate for outpatient treatment, and would continue to benefit from treatment. Dr. Koch concluded that Mr. J.'s status remained unchanged: his behaviors improved when he was compliant with medications, and he was unable to function in the community when he was noncompliant.

The circuit court extended the involuntary commitment and treatment orders for 12 months. It found that Mr. J. continued to have:

> . . . a mental illness (in the form of paranoid schizophrenia), he is a proper subject for treatment and benefits from it, he can function in the community in large part because of this treatment, and he satisfies the definition for "dangerousness" because if treatment were to cease, he would be a proper subject for commitment [*J.W.J.*, p 787].

The court of appeals affirmed and stated that he was the proper subject for treatment because he had rehabilitative potential. Mr. J. appealed to the Wisconsin Supreme Court.

Ruling and Reasoning

The Wisconsin Supreme Court ruled that both lower courts properly applied its ruling from *In the Matter of the Mental Commitment of Helen E.F.*, 814 N.W.2d 179 (Wis. 2012), to determine that Mr. J. is a proper subject for treatment because he has rehabilitative potential. Of note, Mr. J. did not dispute the findings regarding his mental illness or dangerousness. In *Helen E.F.* (a case involving a patient with Alzheimer's disease), the court separated treatment into two categories: those that bring about rehabilitation and those that do not. Citing *Helen E.F.*, "if treatment will go beyond controlling activity and will go to controlling the disorder and its symptoms, then the subject individual has rehabilitative potential, and is a proper subject for treatment" (*J.W.J.*, p 789). Mr. J. stated that this definition of "rehabilitation" did not take into account the unique features of schizophrenia and could lead to an inaccurate finding that the individual is a proper subject for treatment.

He asserted four problems with the court's framework in *Helen E.F.*:

> It is difficult to decide if treatment is controlling "behaviors" or "symptoms" in patients with schizophrenia.
>
> Which symptoms or how many symptoms treatment must be able to control before the patient is determined to have rehabilitative potential.
>
> A physician's word choice (as opposed to the patient's actual condition) could determine whether a person is a proper subject for treatment.
>
> Rehabilitative potential could be based on general characteristics of a class of disorders instead

of focusing on the individual's symptoms and condition.

Based on these problems, Mr. J. requested that the court modify the *Helen E.F.* framework for defining "rehabilitation," in part, as "if treatment will go to improving his or her disorder, then the subject individual has rehabilitative potential and is a subject for proper treatment" (*J.W.J.*, p 789). Under his suggested language, Mr. J. would not be a subject for treatment.

The court declined to differentiate between "behaviors" and "symptoms" and maintained that the proper categories are "activities" and "symptoms." The court relied on *C.J. v. State*, 354 N.W.2d 219 (Wis. Ct. App. 1984), which stated that "habilitation" addresses control of activities, and "rehabilitation" addresses control of symptoms. In the current case, "behavior" "comfortably resides in the 'symptom' side of our analytical dichotomy," in that behaviors are the direct result of symptoms (*J.W.J.*, p 791). The court related activities to functional capabilities such as eating and dressing. It distinguished whether the focus of treatment is "endogenous to the patient (symptoms) or exogenous (activities)," with symptom defined as "an expression of the disorder at work within the patient" (*J.W.J.*, p 792). The court concluded that habilitation refers to "interventions that help a patient put exogenous things to his benefit (that is, activities)" and rehabilitation refers to "improving the patient's condition through ameliorating endogenous factors such as symptoms and behaviors" (*J.W.J.*, p 792). A subject has rehabilitative potential, and thus is a proper subject for treatment, if treatment will control more than activities and will control the disorder and its symptoms.

The court determined that there was no need to identify which symptoms or the number of symptoms the treatment targets before concluding that an individual has rehabilitative potential. It noted that Mr. J.'s treatment reduced his symptoms such that he did not act on them and allowed him to live in society while undergoing outpatient treatment. As the state has an obligation to provide treatment in the least restrictive setting, "if a treatment controls symptoms to such a degree that withdrawing it would subject the patient to a more restrictive treatment alternative, then the treatment controls enough symptoms to establish the patient has rehabilitative potential" (*J.W.J.*, p 793). If treatment was withdrawn, the court reported that Mr. J.'s clinical condition would likely deteriorate to the point that he would require a more restrictive level of care. "It is enough that treatment can accomplish this to demonstrate that the patient has rehabilitative potential" (*J.W.J.*, p 793).

The court rejected Mr. J.'s assertion that providers' word choices to describe a patient's condition, rather than the patient's actual condition, could determine eligibility for treatment. Expert witness testimony would still be needed to differentiate treatments that improve a patient's disorder from those that do not. "So if we are currently at risk of deciding wrongly because of vagaries of an expert's choice of words, Mr. J.'s proposed change will do nothing to protect us. It would just give us an opportunity to err in making a different distinction" (*J.W.J.*, p 793).

The court stated that its previous rulings explicitly required an inquiry into each individual's condition and potential for rehabilitation and not an inquiry based on determination of a group of disorders. Here, the county proved all elements for continued commitment by clear and convincing evidence.

Discussion

In this case, the court did not equate rehabilitation with cure, and it goes beyond returning to a previous level of functioning; it said that an individual is capable of rehabilitation if symptoms can be controlled and the ability to manage the illness is improved. In *Helen E.F.*, the patient had Alzheimer's disease, and the court determined that her condition could not be improved and thus that she could not be rehabilitated.

The court's determination of rehabilitative potential relies heavily on diagnostic accuracy as certain illnesses can be "rehabilitated" and others cannot. Psychiatrists may conceptualize the etiology of a patient's symptoms differently and subsequently reach different conclusions regarding diagnosis. For example, individuals with schizophrenia can develop neurocognitive disorders, and individuals with neurocognitive disorders can have psychotic symptoms. The determination of which condition is causing the psychotic symptoms has ramifications as the court has inferred that schizophrenia is capable of rehabilitation but Alzheimer's disease is not.

Although the court may have implicitly overestimated the importance of diagnosis, the overall decision may have a positive impact on individuals who

have a history of poor compliance with treatment. If it adopted Mr. J.'s arguments, the court stated that:

> . . . we would condemn him to a never-ending yo-yo of uncontrolled paranoid schizophrenia, followed by involuntary confinement for inpatient treatment until his symptoms are controlled and his inpatient commitment order is lifted, followed by another bout of uncontrolled paranoid schizophrenia, and on and on *ad mortem*. Nothing in law or logic instructs us to ignore this reality, so we will not" (*J.W.J.*, p 794–5).

With the definition of rehabilitative potential as it stands currently, Mr. J. is able to live in society and be treated in the least restrictive setting (i.e., outpatient treatment). Wisconsin's statute for recommitment does not require a recent act or threat of harm to self or others for a finding of dangerousness because a history of medication noncompliance and subsequent decompensation satisfies the dangerousness prong.

Disclosures of financial or other potential conflicts of interest: None.

Eighth Amendment Claims in Prison Suicide Litigation

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Eighth Amendment Claims Alleging Unconstitutional Conditions of Solitary Confinement Are Not Barred in Prison Suicide Litigation

DOI:10.29158/JAAPL.3753L2-18

In Palakovic v. Wetzel, 854 F.3d 209 (3rd Cir. 2017), the Third Circuit Court of Appeals vacated and remanded the District Court for the Western District of Pennsylvania's decision to dismiss Eighth Amendment claims against prison officials and mental health care staff, brought by the parents of an inmate who committed suicide while in solitary confinement.

Facts of the Case

In April 2011, Brandon Palakovic, began serving a 16–48-month sentence for burglary at the State Correctional Institution at Camp Hill (SCI Camp Hill), Pennsylvania. During a mental health screening, Mr. Palakovic informed SCI Camp Hill mental health staff that he had previously attempted suicide and he reported active suicidal thoughts, including plans on how to kill himself. Diagnosed with an impulse control disorder, alcohol dependence, and antisocial personality disorder, he was placed on the mental health roster, identified as a "suicide behavior risk," and assigned the lowest possible stability rating offered by the Pennsylvania Department of Corrections (DOC).

In June 2011, Mr. Palakovic was transferred to SCI Cresson. While there, he continued to show signs of depression, including suicidal thoughts. Over his 13-month incarceration at SCI Cresson, a comprehensive suicide risk assessment was not completed. Despite requesting individual therapy and reporting a poor response to his prescribed antidepressant, he did not receive individual therapy or medication management appointments. He served multiple "30-day stints" in solitary confinement at the Restricted Housing Unit (RHU), which consisted of 23 hours of isolation per day in a 100-square-foot cell, one hour of outdoor exercise in a cage, no phone calls, and minimal outside visibility.

During Mr. Palakovic's incarceration, the United States Department of Justice (DOJ) launched an investigation into allegations of Eighth Amendment violations at SCI Cresson. The alleged violations included that SCI Cresson provided prisoners with inadequate mental health care, failed to protect them from harm, and placed them in isolation for prolonged periods. On June 16, 2012, before the completion of the DOJ investigation, Mr. Palakovic committed suicide while in solitary confinement.

On July 16, 2014, Mr. Palakovic's parents filed a five-count civil rights complaint in the U.S. District Court for the Western District of Pennsylvania naming several staff at SCI Cresson. The Palakovics presented Eighth Amendment claims alleging that all named defendants were deliberately indifferent to the inhumane conditions their son suffered in solitary confinement and to his serious need for mental health care.

On June 26, 2015, the district court granted the defense's motion to dismiss the claim. The district court reasoned because the case involved a prisoner suicide, the Third Circuit Court of Appeal's "vulnerability to suicide" legal framework applied. This legal