



*Tracherous Corner*, by Martin J. Cervantez, oil on canvas, Afghanistan, 2009.  
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# Chapter 4

## SANITY BOARD EVALUATIONS

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## INTRODUCTION

Performing Sanity Board evaluations is an important role for the forensic evaluator interfacing with the military justice system. The so-called 706 Inquiry is a complex endeavor requiring the performance of various tasks often differentiated in other settings. The evaluator is typically tasked with answering four questions that inquire both about the mental state of the accused at the time of the alleged offense(s) and the current capacity to participate in the legal process. Therefore, the evaluator must perform both a mental state at the time of the offense (MSO) evaluation in answering the question of criminal responsibility and an assessment of current psycholegal functional ability in answering the question of current competency to proceed with a court-martial. Combining these inquiries can raise practical and logistic issues as well as legal and ethical concerns.

### Military Law and History of 706

In 1775 the Second Continental Congress established 69 Articles of Law to govern the Continental Army. In 1806 the Congress enacted 101 Articles of Law to regulate the Army and Navy. The military justice system established by these articles continued to operate until 31 May 1951, when the Uniform Code of Military Justice (UCMJ) was signed into law by President Truman. UCMJ is the foundation of military law and applies to all members of the uniformed services of the United States. UCMJ is found in Title 10, Subtitle A, Part II, Chapter 47 of the US Code. The *Manual for Courts-Martial United States* (2012 Edition) expands in detail on the military law and represents the official guide to the conduct of courts-martial in the military. This manual is often abbreviated *MCM*. The current version of UCMJ is printed in the *Manual for Courts-Martial*<sup>1</sup> in Appendix 2. The manual contains five parts and various appendices. Part II explains the Rules for Courts-Martials (RCM). Part III describes the Military Rules of Evidence (MRE) and Part IV contains the Punitive Articles.

The armed forces do not have permanently established courts, and courts-martial are convened by commanders possessing the authority to do so when necessary. A commander who possesses the authority to convene a court-martial is known as the Convening Authority (CA). The CA convenes a court-martial by issuing an order that an accused service member will be tried by a specified court-martial. This convening order designates the type of court-martial (summary, special, or general) that will try the charges. The CA appoints officers to serve as the military judge and as

potential members of the "panel," the military equivalent of a jury. While the final membership of the panel, as in the civilian system is established through voir dire, the CA details the potential panel members to the court-martial. After reaching a decision the court-martial reports back to the CA with a recommended verdict. Unlike a civilian trial, the CA's "command prerogative" entitles them to amend or overturn the sentence of a court-martial.

Inquiries into the ability of soldiers to participate meaningfully in a court-martial as well as inquiries into criminal responsibility are probably as old as the military system of justice. The tests and procedures in the military for examining competency to stand trial and criminal responsibility were not formally elucidated until the military began producing manuals for courts-martials in 1921.<sup>2</sup> Military law then, like today, generally mirrored federal courts. If the CA had concerns about a service member's mental condition, a medical officer would examine the accused.

In terms of performing evaluations for the court, as noted below, the 1921 *Courts-Martial Procedure, Based on Manual for Courts-Martial*<sup>3</sup> urged the medical officer to focus more on medical issues rather than answering ultimate legal questions.

Such examination to concern itself solely with the mental capacity and condition of the accused, with a view to learning whether he suffers from any mental defect or derangement marking him either temporarily or permanently abnormal or peculiar from the medical point of view. In such medical examination no attempt will be made to define his legal responsibility for the crime or to apply any legal tests or definitions, but the examination will be directed solely to ascertain whether in his mental condition there is any feature of abnormality which renders him not susceptible to ordinary human motives or appreciations of right or wrong, or to the normal control of his actions, and as to whether he is capable of conducting his defense intelligently. The medical examiner should, however, endeavor to ascertain, and should consider and weigh the accused's mental condition at the time of the act charged.<sup>3</sup>

The current legal framework for guiding the 706 inquiry is outlined in the *Manual for Courts-Martial United States*.<sup>1</sup> The forensic evaluator should be familiar with the relevant sections of this text. The 706 inquiry or Sanity Board derives its name from Rule 706 of the Rules for Courts-Martial and is often abbreviated RCM 706. It is critical for the forensic evaluator operating within the military justice system to be intimately conversant with this particular section.

## NATURE OF THE SANITY BOARD INQUIRY

### Referral Process

Consistent with most forensic evaluations there is a relatively low bar for ordering 706 evaluations, which can be summarized as a reasonable concern about the accused's mental state, such that it is affecting either ability to proceed (competency to stand trial) or responsibility at the time of the alleged offense or both. Note that within the military justice system the defendant is called the accused. According to Rule 706 the inquiry can be prompted by a wide variety of concerns. Examples of prompts for an inquiry include a history of mental health treatment, amnesia, post-traumatic stress disorder (PTSD), suicidal behavior, head trauma, or sleepwalking. In general and consistent with the Supreme Court decision *Pate v Robinson*,<sup>4</sup> the competency inquiry should be addressed whenever there is a "bona fide doubt" regarding the individual's ability to proceed. Military courts adopt a similar position. *The Military Judges' Benchbook*<sup>5</sup> states that "a good faith non-frivolous request for a sanity board should be granted." These two cases, *United States v Nix, 1965*<sup>6</sup> and *United States v Kish, 1985*<sup>7</sup> cite why non-frivolous requests should be granted. The wide range of concerns that can prompt an inquiry is consistent with the Supreme Court decision in *Drope v Missouri*,<sup>8</sup> where the Court elaborated by noting "there are, of course, no fixed or immutable signs, which invariably indicate the need for further inquiry to determine fitness to proceed; the question is often a difficult one in which a wide range of manifestations and subtle nuances are implicated."

The 706 inquiry can occur before or after referral. In military court per RCM 601(a) "referral is the order of a convening authority that charges against an accused will be tried by a specified court-martial." Rule 706(a) states:

#### **Rule 706. Inquiry into the mental capacity or mental responsibility of the accused**

(a) Initial action. If it appears to any commander who considers the disposition of charges, or to any investigating officer, trial counsel, defense counsel, military judge, or member that there is reason to believe that the accused lacked mental responsibility for any offense charged or lacks capacity to stand trial, that fact and the basis of the belief or observation shall be transmitted through appropriate channels to the officer authorized to order an inquiry into the mental condition of the accused. The submission may be accompanied by an application for a mental examination under this rule.

The inquiry can be initiated by various parties to the legal proceeding, including attorneys on either side, the judge, the investigating officer, or a member. The basis for the concern is communicated in writing to the individual authorized to order the inquiry, such as the commander or judge. The individual requesting the exam often submits a common template of an order for the 706. This template, called Forms for Court-Martial Orders, is contained in Appendix 17 in the *MCM*.<sup>1</sup> As noted, this inquiry may be ordered before or after charges have been referred. However, the *Military Judges' Benchbook*<sup>5</sup> recommends that "any question of mental capacity should be determined as early in the trial as possible." As in other legal contexts the threshold for issuing the order is generally low lest the judge's denial be overturned on appeal.

Given the diversity of concerns that can generate a 706 inquiry, there will probably be times when the inquiry may be prompted by reasons not directly related to competency or responsibility.<sup>9</sup> Data from interviews with attorneys outside the military indicate that confusion about legal issues, a desire to seek information about sentencing, a desire to procure treatment for their client, and strategic concerns may all prompt a request for a competency inquiry. While it is not known whether these concerns generalize to a military setting, it is reasonable to assume that they apply at least in part. The fact that the 706 inquiry renders diagnostic formulations increases the likelihood that it may have import at sentencing. Defense attorneys may use the diagnosis of a mental disorder such as Post-traumatic Stress Disorder or Bipolar Disorder for mitigation. Conversely, trial counsel may attempt to utilize diagnoses such as Malingering, Antisocial Personality Disorder, or Pedophilia to argue for an increased sentence.

### Compelled Examination

The 706 inquiry is a compelled examination and failure to cooperate can result in the exclusion of defense expert evidence. Part III of the *MCM* outlines the Military Rules of Evidence, abbreviated MRE. Under MRE 302(d) if the accused does not comply with the examination, the military judge "may prohibit an accused who refuses to cooperate in a mental examination authorized under RCM 706 from presenting any expert medical testimony as to any issue that would have been the subject of the mental examination."

## The Board

The Sanity Board is broadly defined to consist of “one or more persons.” Some orders specify the exact number or make recommendations for the qualifications of one or more board members. RCM 706 stipulates that “each member of the board shall be either a physician or a clinical psychologist” and “normally, at least one member of the board shall be either a psychiatrist or a clinical psychologist.”<sup>1(pII-70)</sup> A prior role in treating or diagnosing the accused does not automatically disqualify a mental health professional from performing a Sanity Board. In *United States v Best*<sup>10</sup> the Court of Appeals for the Armed Forces (CAAF) ruled that a prior relationship of having “diagnosed and/or treated” the appellant did not constitute a conflict of interest invalidating the results of the Sanity Board. In that case two of the three professionals performing the Sanity Board had a prior relationship of treating or assessing the appellant. After reviewing the applicable standards from the American Psychological Association’s (APA) *Ethical Principles of Psychologists and Code of Conduct with 2010 Amendments*<sup>11</sup> on Multiple Relationships (1.17) and Forensic Assessments (7.02) and the American Academy of Psychiatry and the Law (AAPL) *Ethical Guidelines for the Practice of Forensic Psychiatry*,<sup>12</sup> the CAAF concurred with the lower Court of Criminal Appeals, which “concluded that an actual conflict of interest exists if a psychotherapist’s prior participation materially limits his or her ability to objectively participate in and evaluate the subject of an RCM 706 sanity board.” Of course, this ruling does not prohibit qualified professionals from declining to perform the evaluation. In addition, the court found in *United States v Boasmond*<sup>13</sup> that “a provisional license may be enough to qualify a psychologist as a clinical psychologist.”

## Point of Contact

The usual point of contact (POC) for the 706 inquiry is trial counsel (government counsel). Typically, trial counsel will contact various qualified mental health professionals to ascertain their availability and strive to locate board member(s) to conduct the evaluation. Once selected, the POC will supply the evaluator with relevant documents, arrange travel if required, and procure appropriate funding. The POC should arrange to have the board member(s) officially appointed by the Court or Commander and this should be forwarded to the board.

## The Four Questions

The sanity inquiry typically requires the examiner to “make separate and distinct findings” with regard

to four different questions. These questions are listed below and are taken from RCM 706:

- (A) At the time of the alleged criminal conduct, did the accused have a severe mental disease or defect? (The term “severe mental disease or defect” does not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct, or minor disorders such as nonpsychotic behavior disorders and personality defects.)
- (B) What is the clinical psychiatric diagnosis?
- (C) Was the accused, at the time of the alleged criminal conduct and as a result of such severe mental disease or defect, unable to appreciate the nature and quality or wrongfulness of his or her conduct?
- (D) Is the accused presently suffering from a mental disease or defect rendering the accused unable to understand the nature of the proceedings against the accused or to conduct or cooperate intelligently in the defense?<sup>1(pII-70)</sup>

The 706 evaluation demands a complex, multifaceted, and wide-ranging inquiry from the examiner that assesses both current mental state and mental state at the time of the alleged offense. The examiner is asked to formulate conclusions on competency to stand trial, criminal responsibility, clinical diagnosis, and whether the diagnosis at the time of the alleged offense can be classified as “severe.”

While the legal framework provides valuable guidance as to how to answer these questions, there remains considerable ambiguity. For example, is the question asking for clinical psychiatric diagnosis requesting current diagnoses, a diagnostic formulation at the time of the alleged offense or both? With regard to the first question, while some guidance is offered in terms of what clinical conditions may be classified as severe, there is certainly room for a variance of opinion on this issue.

The sanity inquiry is not necessarily limited to these four questions and “other appropriate questions may be asked.” This author has seen instances of the examiner being asked to address more than 20 questions ranging from competency to stand trial, to criminal responsibility, to whether a particular condition is disabling, what treatments would be recommended, and what is the prognosis for recovery. The examiner receiving the Sanity Board order has the option of contacting the POC or referring attorneys and raising various legal, ethical, and practical concerns to request an amended order. As in other forensic settings, the first critical task may be to clarify the referral question. Answering too many questions on the short form may potentially jeopardize the privileged nature of the inquiry.

## Abbreviated Report and Full Report

To safeguard Fifth Amendment rights against self-incrimination, the examiner is required to generate two reports, often referred to as the “short form” or abbreviated report and the “long form” or full report. Per RCM 706 the short form contains “a statement consisting only of the board’s ultimate conclusions as to all questions specified in the order.”<sup>1(pII-70)</sup> The short form “shall be submitted to the officer ordering the examination, the accused’s commanding officer, the investigating officer, if any, appointed pursuant to an Article 32

and to all counsel in the case, the convening authority, and, after referral, to the military judge.”<sup>1(pII-70)</sup> Therefore, opinions on competency, mental responsibility, diagnosis, and whether a mental disease or defect is “severe” are transmitted to defense and trial counsel. The full report is typically sent only to defense counsel but on request it may also be sent to the commanding officer. In order to facilitate treatment it may under certain conditions be sent to medical personnel. Only if and when a mental health defense is raised can the government gain access to the information contained in the full report.

## LEGAL STANDARDS

### Competency to Stand Trial

Rule 909 of the *Manual for Courts-Martial* defines the capacity of the accused to stand trial by court-martial. Rule 909(a) states:

(a) *In general.* No person may be brought to trial by court-martial if that person is presently suffering from a mental disease or defect rendering him or her mentally incompetent to the extent that he or she is unable to understand the nature of the proceedings against them or to conduct or cooperate intelligently in the defense of the case.<sup>1(pII-70)</sup>

By military law, incapacity to stand trial must derive from “mental disease or defect.” However, exactly how “mental disease or defect” is defined is open to debate. Jeremy Ball<sup>14</sup> cites various military court decisions that support a broad interpretation of the concept. In *United States v Proctor*,<sup>15</sup> the Court of Military Appeals (COMA), the forerunner to the CAAF, found the personality disorders may qualify. In that case the appellant told defense counsel that God would deliver him at sentencing. Varying experts found that he was either delusional or that he was simply expressing religious views consistent with his fundamentalist Baptist background. Even if the beliefs undermined his ability to cooperate with counsel, he would not be viewed as incompetent, if the beliefs stemmed from his religion rather than a “mental disease or defect” as evidenced by delusions. In *Proctor* the court found “that Personality Disorders may qualify technically as mental diseases or defects.” In *United States v Benedict*<sup>16</sup> the COMA found that the accused need not be suffering from a psychosis to assert an insanity defense. An initial part of the inquiry for the forensic examiner performing a Sanity Board is to first establish the presence or absence of “mental disease or defect.” If no mental disease or defect is found, the accused is competent to proceed.

The military standard for competency to proceed with a courts-martial is arguably analogous to the Dusky standard for competency to stand trial widely found throughout the criminal justice system in the United States.<sup>17</sup> The Dusky standard as established by the Supreme Court in 1960 is listed below.

The test must be whether he [the defendant] has *sufficient present ability* to consult with his attorney with a *reasonable* degree of rational understanding and a rational as well as factual understanding of the proceedings against him.<sup>17</sup> [italics added]

Military court decisions affirm the applicability of the Dusky standard in a military setting. In *United States v Procter*<sup>15</sup> COMA citing *Dusky* found that to “understand the nature of the proceedings . . . or to conduct or cooperate intelligently in the defense of the case — means that the accused has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding — and . . . a rational as well as factual understanding of the proceedings against him.”

### Mental Responsibility

In general, the history of the insanity defense within the military has mirrored the course of that defense within the federal courts. In the 1800s the standard mirrored the *McNaughten* test, which was established in 1843. The *McNaughten*<sup>18</sup> standard states:

To establish a defense on the grounds of insanity, it must be proved that, at the time of the committing of the act, the party accused was laboring under such defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing or if he did know it, that he did not know he was doing what was wrong.<sup>18</sup>

Legal scholars Low, Jeffries, and Bonnie<sup>19</sup> point out that “know” may be defined narrowly or broadly. These scholars expound on an “affective” sense of knowledge that is more complex than simple awareness and requires an appreciation of the significance of one’s conduct. They state:

“Know” in the purely cognitive sense asks whether the defendant is able to perceive correctly certain objective features of his or her conduct. “Know” in the latter “affective” sense asks whether the defendant is able to fully “appreciate” the significance of cognitive observations, that is, whether the defendant is able to understand what he or she “knows” and to govern his or her conduct accordingly.<sup>19p12)</sup>

The M’Naughten test, often referred to as the “right-wrong test,” was adopted widely but was criticized for focusing solely on the “cognitive prong” in terms of what an individual knew and for requiring total deprivation of knowing any of the elements of “nature” or “quality” or “wrongfulness.” In response to the lack of focus on the capacity to control one’s impulses due to mental illness, many jurisdictions added a “volitional prong.” *Parsons v Alabama*<sup>20</sup> illustrates the concept.

... if by reason of the duress of such mental disease, he had so far lost the power to choose between right and wrong, and to avoid doing the act in question, as that his free agency was at the time destroyed.<sup>20</sup>

Subsequently, the federal and military legal standard incorporated both the cognitive and volitional prongs in the insanity standard. The *Manual for Courts-Martial*<sup>3</sup> stated:

... was the accused at the time of the commission of the alleged offense so far free from mental defects, mental disease or mental derangement as to be able, concerning the particular acts charged, both (1) to distinguish right from wrong and (2) to adhere to the right.<sup>3</sup>

In *United States v Frederick*<sup>21</sup> the COMA adopted the American Law Institute (ALI) standard, which combined the cognitive and volitional prongs. The ALI standard is stated below.

(1) A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality [wrongfulness] of this conduct or to conform his conduct to the requirements of the law.

The ALI standard included exclusionary criteria. As cited in *United States v Frederick*,<sup>21</sup> they were:

(2) As used in this Article, the terms “mental disease or defect” do not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct.

The ALI standard represents an amalgam of M’Naughten and “irresistible impulse” and uses the word “appreciate” rather than “know.” Low et al<sup>19</sup> argue that this choice favors the broader “affective” sense of “know.” In *United States v Frederick*<sup>21</sup> the court cited the application of the ALI standard in federal court and reasoned that “the ALI test is superior to the M’Naughten-irresistible impulse standard” and “more compatible with modern medical science and that it tends to lessen the influence of the experts on the non-medical aspects of mental responsibility.” Specifically, the court found that the use of the word “substantial” was “more compatible with medical terminology” since medical science “does not classify mental conditions in absolute terms.” The new standard did not require a total deprivation of the ability to appreciate or conform but rather “substantial” impairment in either prong. However, exactly what degree of impairment was required before the threshold of “substantial” was reached remained unclear and open to interpretation. With regard to the choice of the word “criminality” or “wrongfulness,” the COMA found that “the term ‘criminality’ is the preferable alternative.” Citing *United States v Freeman*<sup>22</sup> the COMA agreed with the exclusion of repeated antisocial behavior “as necessary to ensure that mental responsibility is a distinct and separate concept from criminal and antisocial conduct” adding that “repeated criminality cannot be the sole ground for a finding of a mental disorder; a contrary finding would reduce to absurdity a test designed to encourage full analysis of all psychiatric data and would exculpate those who knowingly and deliberately seek a life of crime.”

In 1982 a jury found that the prosecution had failed to meet the burden of proving beyond a reasonable doubt that John Hinckley Jr was sane and he was adjudicated not guilty by reason of insanity. In response to the public outcry that ensued, various calls for reform were generated. Both the American Bar Association (ABA)<sup>23</sup> and ApA<sup>24</sup> proposed more restrictive standards. Both organizations recommended rejection of the volitional prong. ApA reasoned that it was especially difficult to distinguish between an impulse resisted and one not resisted stating that “the line between an irresistible impulse and one not resisted is probably no sharper than that between twilight and dusk.”<sup>24</sup> Congress passed the Comprehensive Crime Control Act of 1984. Title IV of that Act was the Insanity Defense Reform Act. The burden shifted from the government to the defense and insanity became an af-

firmative defense. The volitional prong was eliminated and the modifying adjective “severe” was added to the threshold criteria of mental disease or defect. The burden of proof for the defense was clear and convincing evidence.

The current military standard for mental responsibility is codified in Article 50a of UCMJ. The standard is substantively identical to the Federal Statute 18 USC § 17 (1984), which states:

It is an affirmative defense to a prosecution under any Federal statute that, at the time of the commission of the acts constituting the offense, the defendant, as a result of a *severe* mental disease or defect, was *unable to appreciate the nature and quality* or the *wrongfulness* of his acts. Mental disease or defect does not otherwise constitute a defense. [italics added]

The standard has not changed since it was enacted in the Military Justice Amendments of 1986 following the passage of the Insanity Defense Reform Act in 1984 in federal civilian courts. Therefore, the federal and military standards for insanity are essentially identical. Similar to the M'Naughten standard, this formulation focuses on the cognitive capacity of the defendant to understand what one is doing at the time of the alleged offense and to grasp that it is wrong. The current military standard does not include a consideration of the volitional capacity of the defendant to control one's behavior at the time of the alleged offense. The standard reverts back from “substantial” impairment as reflected in the ALI standard to complete impairment as reflected in the choice of the word “unable.”

According to RCM 916(k) the sanity standard in the military for lack of mental responsibility is as follows:

*It is an affirmative* defense to any offense that, at the time of the commission of the acts constituting the offense, the accused, as a result of a severe mental disease or defect, was unable to appreciate the nature and quality or the wrongfulness of his or her acts. Mental disease or defect does not otherwise constitute a defense.

Once again various terms in the legal standard are arguably open to interpretation. Similar to competency to stand trial the threshold question is whether the service member has a “mental disease or defect,” which as noted is open to interpretation. In this case, however, that construct is further modified by the adjective “severe.” In addition, the evaluator is left with determining definitions for “appreciate,” “nature and quality” and “wrongfulness.” The CAAF offered some guidance for these terms in *United States v Martin*.<sup>25</sup> The military judge instructed the members that “the word

‘appreciate’ in terms of that a person was unable to appreciate the nature and quality of his acts, appreciation has three components, that is, a person is aware, that they are conscious of that, which is a type of awareness, and that they know it.”<sup>25</sup> The court found that “mere intellectual awareness that conduct is wrongful, when divorced from appreciation or understanding of the moral or legal import of behavior, can have little significance.”<sup>25</sup>

Jeremy Ball<sup>14</sup> citing *Black's Law Dictionary* argues that appreciate “connotes more than mere cognitive knowledge that a fact is true; it includes recognition of meaning and significance.”<sup>14</sup> If viewed as a higher cognitive threshold, it can be conceptualized as increasing the pool of individuals who would qualify for an insanity defense. In *United States v Segna*<sup>26</sup> the Court of Appeals outlined three possible definitions of “wrong:”

1. “contrary to the law,”
2. “contrary to public morality,” and
3. “contrary to one's own conscience.”<sup>26</sup>

In that case the court noted the choice of the word “wrongfulness” rather than “criminality” appeared to argue against the first definition and finally affirmed the third definition, embracing a subjective approach. The Martin decision appears to affirm a definition of “wrongfulness” other than the first definition but leaves unclear whether the second or third definition apply.

To explicate these terms Martin cites *Wharton's Criminal Law*,<sup>27</sup> which states:

“The first portion [nature and quality] relates to an accused who is psychotic to an extreme degree. It assumes the accused who, because of mental disease, did not know the nature and quality of his act; he simply did not know what he was doing. For example in crushing the skull of a human being with an iron bar, he believed that he was smashing a glass jar. The later portion [wrongfulness] of M'Naghten relates to an accused who knew the nature and quality of his act. He knew what he was doing; he knew that he was crushing the skull of a human being with an iron bar. However, because of mental disease, he did not know what he was doing was wrong. He believed, for example, that he was carrying out a command from God.”<sup>25</sup>

The forensic evaluator as far as possible should have definitions of these terms in mind that are consistent with relevant case law when performing the assessment, especially since the final product of such an evaluation is a conclusion to the court on mental

responsibility. The task of ascertaining what is going on in terms of a given person's appreciation of his or her actions at a particular point in time in the past is daunting enough without applying muddled or inappropriate standards. For example, with regard to wrongfulness, *United States v Martin* affirms that an individual who commits a criminal act under a mistaken belief, deriving from mental disease, that the act is morally justified, while still realizing the act is illegal, may qualify for lacking mental responsibility.

### **Mental Disease or Defect/Severe Mental Disease or Defect**

Two of the questions posed to the forensic evaluator deal with formulating diagnoses. One asks about current clinical diagnoses and the other asks whether the accused had a severe mental disease or defect at the time of the alleged criminal conduct. As noted some guidance as to what qualifies as severe is contained in question A, which notes that "the term 'severe mental disease or defect' does not include an abnormality manifested only by repeated criminal conduct or otherwise antisocial conduct, or minor disorders such as nonpsychotic behavior disorders and personality defects." This would appear to rule out antisocial personality disorder and perhaps argue against personality disorders in general. As to what constitutes nonpsychotic behavior disorders there is probably even more room for debate. What appears relatively clear from these instructions, however, is that psychotic disorders can be considered as a severe mental disease or defect.

The origin of the modifying adjective "severe," which first appeared in the federal insanity standard after the Insanity Defense Reform Act, may be rooted in the recommendations made by various groups to reform the insanity standard. The ApA workgroup<sup>23</sup> suggested that "any revision of insanity defense standards should indicate that mental disorders potentially leading to exculpation must be serious" adding that "such disorders should usually be of the severity (if not always the quality) of conditions that psychiatrists diagnose as psychoses."<sup>23(p685)</sup> ApA cited the work of Richard Bonnie, who recommended an insanity standard "if it is shown that as a result of mental disease or mental retardation he was unable to appreciate the wrongfulness of his conduct at the time of the offense."<sup>27</sup> Bonnie added:

As used in this standard, the terms mental disease or mental retardation include only those *severely* abnormal mental conditions that grossly and demonstrably impair a person's perception or understanding of

reality and that are not attributable primarily to the voluntary ingestion of alcohol or other psychoactive substances.<sup>28</sup> [italics added]

Bonnie's definition of a mental disorder that qualifies for consideration for an insanity defense appears to borrow from the definition offered in *McDonald v United States*<sup>29</sup>:

[A] mental disease or defect includes any abnormal condition of the mind which substantially affects mental or emotional processes and substantially impairs behavior controls.<sup>29</sup>

The COMA in *United States v Benedict*<sup>16</sup> addressed the issues of what constituted a mental disease or defect. A general court-martial had convicted the accused of three specifications of conduct unbecoming an officer and a gentleman by taking indecent liberties with a female child. At the government's request the court took judicial notice of the aforementioned ApA workgroup article. Experts disagreed on how to classify pedophilia in terms of its legal status as a "mental disease or defect." When asked by trial counsel if pedophilia as a nonpsychotic mental disorder met the legal criteria of mental disease or defect as defined by the aforementioned ApA workgroup article, the expert answered that it would not. The COMA reversed the lower court noting that "military law has never recognized as an absolute rule that an accused must suffer from a psychosis in order to merit acquittal by reason of insanity."

*The Diagnostic and Statistical Manual of Mental Disorders (4th Edition) (DSM-IV-TR)* cautions forensic clinicians "about the imperfect fit between the questions of ultimate concern to the law and information contained in a clinical diagnosis."<sup>30(p.xxxiii)</sup> Clinicians should be wary about assuming that a clinical diagnosis constitutes a mental disease or defect or a severe mental disease or defect. DSM-IV-TR cautions clinicians about applying diagnostic categories to answer ultimate legal questions.

In most situations, the clinical diagnosis of a DSM-IV mental disorder is not sufficient to establish the existence for legal purposes of a "mental disorder," "mental disability," "mental disease," or "mental defect." In determining whether an individual meets a specified legal standard (eg, for competence, criminal responsibility, or disability), additional information is usually required beyond that contained in the DSM-IV diagnosis. This might include information about the individual's functional impairments and how these impairments affect the particular abilities in question. It is precisely because impairments, abilities, and disabilities vary widely within each

diagnostic category that assignment of a particular diagnosis does not imply a specific level of impairment or disability.<sup>30(p.xxxiii)</sup>

A given diagnosis may or may not result in significant impairment. A given diagnosis may result in significant impairment in one domain but not in another. In a Sanity Board the question is whether the mental condition resulted in significant impairment in the psycholegal capacity to either navigate the legal system or at a point in the past to understand nature and quality or wrongfulness of one's actions. The Sanity Board also requests a "separate and distinct inquiry" into the question of whether the mental disease or defect was "severe."

The *Military Judges' Benchbook* offers advice that is not particularly illuminating, when it states, "The term severe mental disease or defect can be no better defined in the law than by the use of the term itself."<sup>5</sup> It does make clear that "If the accused at the time of the offense(s) of (state the alleged offense(s)) was not suffering from a severe mental disease or defect, (he) (she) has no defense of lack of mental responsibility."<sup>5</sup> The *Military Judges' Benchbook* gives an example of a delusion rendering the accused unable to appreciate the nature and quality or wrongfulness of one's conduct.

An additional ambiguity in terms of addressing the question of severe mental disease or defect is whether the evaluator is answering this question in terms of whether the mental disorder in general should be classified as severe or whether the mental disorder at a particular point in time should be classified as severe. In other words, if the individual is diagnosed with Bipolar I Disorder, should the disorder automatically be classified as severe or should there be further inquiry to establish whether the person was manic or psychotic or impaired in reality testing at the time of the alleged offense. The author interprets the question as asking the evaluator to ascertain within the context of a disorder that may fluctuate over time, whether there was significant impairment in reality testing at the time of the alleged offense. For example, a soldier with PTSD may or may not be classified as having a severe mental disease or defect at the time of the alleged offense depending on whether or not he or she had significant impairment in reality testing due to a dissociative flashback.

If the evaluator utilizes this framework for addressing the question of severe mental disease or defect, the specifiers in DSM-IV-TR may be utilized for guidance. DSM-IV-TR strives to refine diagnoses by adding subtypes and specifiers. The specifiers are meant to provide additional information about the severity or course of the mental disorder. Severity specifiers in-

clude mild, moderate, or severe. DSM-IV-TR advises that when the clinician is deciding which of these specifiers to apply, he or she "should take into account the number and intensity of the signs and symptoms of the disorder and any resulting impairment in occupational or social functioning."<sup>30(p2)</sup> "Severe" is defined in DSM-IV-TR as "many symptoms in excess of those required to make a diagnosis, or several symptoms that are particularly severe, are present, or the symptoms result in marked impairment in social or occupational functioning."<sup>30</sup> The guidelines in DSM-IV-TR for use of the word "severe" were not designed to address the legal issue of whether the accused has a severe mental disease or defect in a Sanity Board evaluation, but may be worth considering. If the evaluator does so, this should be explicated in the report.

Since a compendium of Sanity Board reports is not available for available for review, it is not clear how the question of severe mental disease or defect has been routinely addressed in 706 reports. There appears to be room for variance in clinical judgment in answering this question. Some reports that the author has reviewed summarily conclude that in the absence of a psychotic disorder there is no severe mental disease or defect. In the author's view this is not advisable, and each of the four questions posed should be addressed fully. Take the case of a high functioning individual with encapsulated delusions. In this case the evaluator finds that the individual did not have a severe mental disease or defect and therefore does not meet the threshold criteria for lacking mental responsibility and without further analysis summarily concludes that he or she is responsible. However, more careful analysis demonstrates that while the individual was high functioning overall, the encapsulated delusion was directly linked to his or her criminal behavior and his or her appreciation of wrongfulness. Furthermore, keep in mind that the finder of fact may disagree with one's answer to the question about severe mental disease or defect. If the examiner provided no further analysis of how the symptoms did or did not impair appreciation of nature and quality or wrongfulness, the finder of fact will be deprived of important information necessary to consider in making a determination to answer the question of criminal responsibility.

Another way of addressing the question of severe mental disease or defect is to discuss the degree of functional impairment secondary to the mental illness. One way of conceptualizing a manifestation of a disorder as being severe is that there will be significant and severe distress, impairment in one or more important areas of functioning, or that the disorder will significantly increase risk of suffering death, pain, disability, or an important loss of freedom. Of course, that can vary

even within a given diagnosis. In this regard, it may also be worth considering whether the Global Assessment of Functioning scale in DSM-IV-TR is relevant to addressing this question. For example, to qualify for a rating of 30 or below DSM-IV-TR states, "Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment OR inability to function in almost all areas."<sup>30</sup> While not suggesting that any particular score would serve as a cutoff for qualification as a severe mental disease of defect, the Global Assessment of Functioning scale may provide some framework for addressing this question, especially since the standard makes clear that impairment in the ability to appreciate the nature and quality or wrongfulness of one's actions due to severe mental disease or defect is pivotal in addressing the question of mental responsibility. It must be kept in mind that the question of criminal responsibility specifically focuses on impairment in appreciation of "nature and quality" or "wrongfulness." Furthermore, it should be kept in mind that a given individual may be impaired in many domains but not those specific ones. Conversely, an individual may be relatively unimpaired in many domains but possess an encapsulated delusion that specifically impairs appreciation of wrongfulness.

### Burden and Standard of Proof

The burden of proof indicates who has responsibility for proving a particular fact. The standard of proof refers to the degree of certainty necessary to prove a fact. According to RCM 909 the accused is presumed competent to stand trial and the burden of proof is on the accused to demonstrate incompetency to stand trial by a preponderance of the evidence. Rule 909(b) states, "A person is presumed to have the capacity to stand trial unless the contrary is established."<sup>1(pII-100)</sup> Rule 909(e)(2) states:

Trial may proceed unless it is established by a preponderance of the evidence that the accused is presently suffering from a mental disease or defect rendering him or her mentally incompetent to the extent that he or she is unable to understand the nature of

the proceedings or to conduct or cooperate intelligently in the defense of the case.<sup>1(pII-100)</sup>

This is consistent with the Supreme Court decisions of *Medina v California*,<sup>31</sup> which held that due process was not violated by placing the burden of proof on the defendant by a preponderance of the evidence and with *Cooper v Oklahoma*,<sup>32</sup> which held that due process did not require the standard of clear and convincing evidence and that the preponderance standard was sufficient.

With regard to mental responsibility, the burden and standard of proof are analogous to the federal standard. Under the Insanity Defense Reform Act of 1984, the burden of proof was shifted from the prosecution to the defense and the standard became clear and convincing. The *Military Judges' Benchbook* states:

The accused is presumed to be mentally responsible. This presumption continues throughout the proceedings until you determine, by clear and convincing evidence, that (he) (she) was not mentally responsible. Note that, while the Government has the burden of proving the elements of the offense(s) beyond a reasonable doubt, the defense has the burden of proving by clear and convincing evidence that the accused was not mentally responsible. As the finders of fact in this case, you must first decide whether, at the time of the offense(s) of (state the alleged offense(s)), the accused actually suffered from a severe mental disease or defect.<sup>5</sup>

In military court there is a two-stage process for determining mental responsibility. First, the government must prove the elements of the case beyond a reasonable doubt. If a panel has been selected to hear the case, two-thirds of the members must find the accused guilty for a conviction. Capital cases, however, require a unanimous verdict. If there is a conviction on any charge, then the members proceed with a second vote on mental responsibility. The members are instructed that the accused is presumed mentally responsible and the defense must prove by clear and convincing evidence that he or she lacked mental responsibility. A simple majority vote is required to find that the accused lacked mental responsibility.

## ETHICAL AND LEGAL CONCERNS

### Privilege and Confidentiality

Attorney-client privilege is a legal concept that protects communications between a client and his or her attorney and keeps those communications private. Confidentiality for mental health professionals is typically conceptualized as the duty of

the professional to keep information private unless authorized by the individual from whom it was obtained to release it. Some conditions warrant release without specific authorization by the client. However, within a military context there is in general no psychotherapist-patient privilege. MRE 501(d) states:

Notwithstanding any other provision of these rules, information not otherwise privileged does not become privileged on the basis that it was acquired by a medical officer or civilian physician in a professional capacity.

This should be contrasted with MRE 513, which protects psychotherapist-patient privilege within the context of pending action under the UCMJ:

#### MRE 513-Psychotherapist-Patient Privilege

(a) General Rule of Privilege. A patient has a privilege to refuse to disclose and to prevent any other person from disclosing a confidential communication made between the patient and a psychotherapist or an assistant to the psychotherapist, in a case arising under the UCMJ, if such communication was made for the purpose of facilitating diagnosis or treatment of the patient's mental or emotional condition. [underline added]

Within the context of performing a forensic examination under UCMJ it is imperative for legal and ethical reasons to inform the accused of the nature and purpose of the examination. When performing a Sanity Board, the accused should be specifically informed that two reports will be generated, told to whom the reports will be sent, and what may happen to all the notes, recordings, or tests that are produced. As noted, the short form is sent to both trial and defense counsel, whereas the long form is typically sent only to defense counsel.

Since the majority of Sanity Boards conducted in military courts are performed by active duty military psychiatrists and psychologists, who typically have nonforensic primary duties, the privileged nature of the 706 inquiry is worth emphasizing. Military providers who typically document all their work in an electronic medical information management system the Armed Forces Health Longitudinal Technology Application, called AHLTA, should take heed in deciding if and what to document in AHLTA. While AHLTA is governed by the Health Insurance Portability and Accountability Act, any medical provider in the military can access the system. Therefore, if the examiner has documented statements, test results, mental status results or notes about compliance with the examination, a military provider, including one retained by the government, could access that information, even though such access would not be appropriate and arguably a violation of the Health Insurance Portability and Accountability Act.

According to RCM 706 (3)(c), "neither the contents of the full report nor any matter considered

by the board during its investigation shall be released by the board or other medical personnel to any person not authorized to receive the full the report, except pursuant to an order by the military judge."<sup>1</sup> In addition to protect privilege and prevent self-incrimination, RCM 706 (5) states that "no person, other than the defense counsel, accused, or after referral of charges, the military judge may disclose to the trial counsel any statement made by the accused to the board or any evidence derived from such statement."

According to Article 31 of UCMJ compulsory self-incrimination is prohibited:

#### Article 31. Compulsory Self-Incrimination Prohibited

(a) No person subject to this chapter may compel any person to incriminate himself or to answer any question the answer to which may tend to incriminate him.

(b) No person subject to this chapter may interrogate, or request any statement from an accused or a person suspected of an offense without first informing him of the nature of the accusation and advising him that he does not have to make any statement regarding the offense of which he is accused or suspected & that any statement made by him may be used in evidence against him in a trial by court-martial.

MRE 302 explains how the privilege of the accused is maintained during a 706 inquiry. Rule 302(a) is listed below:

- (a) General rule. The accused has a privilege to prevent any statement made by the accused at a mental examination ordered under R.C.M. 706 and any derivative evidence obtained through use of such a statement from being received into evidence against the accused on the issue of guilt or innocence or during sentencing proceedings. This privilege may be claimed by the accused notwithstanding the fact that the accused may have been warned of the rights provided by MRE 305 at the examination.

The exceptions in MRE 302(b) are essentially that the defense is free to introduce into evidence the full report or portions of the report, including statements of the accused, but that once this has been done, the government is allowed access to this information and produce expert testimony in rebuttal. The following exceptions from MRE 302(b) are noted below:

- (b) Exceptions
- (1) There is no privilege under this rule when the accused first introduces into evidence such statements or derivative evidence.
  - (2) An expert witness for the prosecution may testify as to the reasons for the expert's conclusions and the reasons therefore as to the mental state of the accused if expert testimony offered by the defense as to the mental condition of the accused has been received in evidence, but such testimony may not extend to statements of the accused except as provided in (1).<sup>1</sup>

### Notification

Since the 706 inquiry is an order by the court or the commander, the accused is limited in his or her ability to refuse to cooperate with the examination. In light of the directed nature of the evaluation, it is arguably more apt to characterize the service member's agreement to participate as assent rather than consent. According to the *Specialty Guideline for Forensic Psychology* assent "refers to the agreement, approval or permission, especially verbal or nonverbal conduct, that is reasonably intended and interpreted as expressing willingness, even in the absence of unmistakable consent."<sup>33</sup> According to Specialty Guideline for Forensic Psychology 8.03, the evaluator should "disclose information that may include but is not limited to the purpose, nature and anticipated use of the examination, who will have access, limitations on privacy, confidentiality and privilege as well as who is authorized to release the information" and "disclose whether participation is voluntary or involuntary and the potential consequences of participation or non-participation."<sup>33</sup> As noted according to MRE 302(d) a potential consequence for noncompliance is that the military judge may prohibit the accused from present-

ing mental health evidence. The AAPL outlines similar recommendations.<sup>34</sup>

While the 706 examination is ordered to address specific pretrial issues, it may have consequences for sentencing. Recall that the short form, which lists diagnoses, is distributed to both defense and trial counsel. Therefore, as previously noted, defense counsel may utilize a diagnosis of PTSD to mitigate at sentencing; whereas trial counsel may utilize a diagnosis of malingering to aggravate at sentencing. In addition, the diagnosis of a mental disorder may have ramifications for a continued military career. If viewed as suffering from a mental disease, the service member may be administratively separated. Army regulations (AR 635-200) govern rules for separation from the military. According to AR 635-200,<sup>35</sup> Section VI, 1-33, when designated medical personnel believe a soldier does not meet standards for retention, the soldier is referred to a medical evaluation board (MEB). If the MEB findings warrant, the case is referred to a physical evaluation board (PEB) for disability processing. For example, if the forensic evaluator opines that the accused has a severe mental disease or defect, even if found competent and responsible, the service member may be referred to a MEB to be medically discharged from the military. Furthermore, according to AR 635-200,<sup>35</sup> 5-13, a soldier with less than 24 months of active duty service may be separated for a personality disorder that does not amount to a disability. There are limitations in some administrative procedures for soldiers facing UCMJ action. According to AR 635-40,<sup>36</sup> a soldier charged with an offense or under investigation for an offense chargeable under UCMJ may not be referred for disability processing, unless the investigation ends without charges or the charges are dismissed. The author thinks the service member should be informed of such potential consequences up front before initiation of the examination. An example of a notification form developed by Major Samantha Benesh at the Center for Forensic Behavioral Sciences at the Walter Reed National Military Medical Center is included as the first attachment at the end of the chapter.

## CONDUCTING THE INQUIRY

### Forensic Evaluation

In conducting the 706 inquiry the forensic examiner should adhere to the principles espoused in the practice of forensic mental health assessment (FMHA). Such principles are outlined in texts such as *Principles of Forensic Mental Health Assessment*<sup>37</sup> and *A Principles Based Approach to Forensic Mental Health Assessment*.<sup>38</sup>

The principles are divided into four categories: 1)

preparation; 2) data collection; 3) data interpretation; and 4) communication. They are summarized below:

#### Preparation

1. Identify relevant forensic issues
2. Accept referrals only within area of expertise
3. Decline referral when evaluator impartiality is unlikely
4. Clarify the evaluator's role with the attorney

5. Clarify financial arrangements
6. Obtain appropriate authorization
7. Avoid playing the dual role of therapist and forensic evaluator
8. Determine the particular role to be played within the forensic assessment if the referral is not accepted
9. Select the most appropriate model to guide data gathering, interpretation, and communication

#### Data Collection

10. Use multiple sources of information for each area being assessed
11. Use relevance and reliability (validity) as guides for seeking information and selecting data sources
12. Obtain relevant historical information
13. Assess clinical characteristics in relevant, reliable, and valid ways
14. Assess legally relevant behavior
15. Ensure that conditions for the evaluation are quiet, private, and distraction-free
16. Provide appropriate notification of purpose and/or obtain appropriate authorization before beginning
17. Determine whether the individual understands the purpose of the evaluation and the associated limits on confidentiality

#### Data Interpretation

18. Use third-party information in assessing response style
19. Use testing when indicated in assessing response style
20. Use case-specific (idiographic) evidence in assessing clinical condition, functional abilities, and causal connection
21. Use nomothetic evidence in assessing causal connection between clinical condition and functional abilities
22. Use scientific reasoning in assessing causal connection between clinical condition and functional abilities
23. Do not answer the ultimate legal question
24. Describe findings and limits so that they need change little under cross-examination

#### Communication

25. Attribute information to sources
26. Use plain language; avoid technical jargon

27. Write report in sections, according to model and procedures
28. Base testimony on the results of the properly performed FMHA
29. Testify effectively

#### Preparation

The evaluator begins the process when he or she decides to take a case or is ordered to perform the evaluation. In a 706 the relevant forensic issues are identified by the order. Some orders may contain additional questions and the evaluator should carefully assess their relevance to the typical 706 inquiry and whether answering additional questions on the short form could jeopardize the privileged nature of the evaluation. The evaluator should carefully assess his or her qualifications and objectivity to perform the evaluation and whether there are any influences that could jeopardize impartiality.

One source of influence unique to a military context is unlawful command influence. Article 37 prohibits any authority from attempting to influence a court-martial. Unlawful command influence is one of the major reasons that the UCMJ was adopted after WWII and it is considered a "mortal enemy of military justice."<sup>39</sup> CAAF further emphasized that "this Court has repeatedly reaffirmed that the military judge is the 'last sentinel' in the trial process to protect a court-martial from unlawful command influence."<sup>40</sup> If the prospective Sanity Board member knows the commander or authority who ordered the evaluation, or knows any statements that authority has made about the case, that individual should carefully consider whether to perform the 706.

#### Data Collection

In terms of the sequence of the inquiry it is generally recommended that the evaluator begin by requesting that trial counsel, who is the POC, forward all relevant information. Since the 706 inquiry requires an assessment of current mental state as well as an assessment of mental state at some point in the past, it is reasonable to request a considerable amount of information. Relevant information includes but is not necessarily limited to family and developmental history, relationship history, educational history, work history, military history, mental health history, medical history, alcohol/substance abuse history, and criminal justice history.

In terms of the evaluation of the accused, the evaluator begins with a detailed notification regarding the nature and purpose of the evaluation and the limits of confidentiality. The evaluator typically proceeds to

establish rapport by gathering relevant background information. While no rigid sequence of inquiry is required, the evaluator should bear in mind that the 706 evaluation combines inquiries into criminal responsibility and competency. It is recommended that before examining the client for criminal responsibility the evaluator should assess and determine competency to stand trial. If the accused is assessed as incompetent, it is debatable as to whether a detailed inquiry into criminal responsibility should be conducted. Professional guidelines may differ on how to proceed. Psychiatry practice guidelines<sup>41</sup> from the AAPL indicate that if the evaluator believes the defendant is incompetent to stand trial and the defendant is disclosing potential incriminating information, “the evaluator should terminate the evaluation and inform the retaining party of the defendant’s incompetency.”

While there are no strict recommendations for psychologists, there may be reasons to interview the accused regarding the offense in order to obtain a record of the accused’s report as close to the occurrence of the alleged offense as possible. However, this information should not be put in the report until the defendant is competent to stand trial. Therefore, if a defendant is currently incompetent, an opinion and data on criminal responsibility are deferred until such time as the defendant is restored to competency. Similarly, if the evaluator has interviewed the accused about the alleged offense before concluding that he or she is incompetent, this information should not be included in the report until the accused is deemed competent. If and when the accused is competent, the evaluator can compare and contrast various self-report versions of the alleged offense by the accused. Within a military context the risk of self-incriminating statements being broadcast is protected by the fact that the full report is sent only to defense counsel.

### Multiple Sources of Information

Consistent with good forensic practice, FMHA Principle 10<sup>42</sup> recommends gathering information from multiple sources to increase the likelihood of achieving convergent validity for any conclusions. The Specialty Guidelines for Forensic Psychologists<sup>33</sup> also emphasize the importance of seeking data from multiple sources and corroborating information whenever possible. Two primary sources of information aside from the self-report of the accused are records and interviews with collateral informants. Data collection is potentially time consuming and this should be carefully considered before agreeing to perform the evaluation. Some orders will have relatively short deadlines, called “suspenses” in the military. If the evaluation is likely

to entail contacting various individuals, perhaps stationed throughout the world or in theatre, this should be considered before agreeing to perform the evaluation within the proposed deadline. Concerns should be relayed to the POC before agreeing to perform the evaluation. Since the forensic evaluator performing a 706 is tasked with rendering diagnostic formulations and opinions on mental state both currently and at some point or points in the past, gathering sufficient historical information from varied and relevant sources is critical to reaching well-grounded conclusions.

### Records

If the evaluator is not familiar with the nuances and unique labels given to various documents in a military context, he or she should consult with an evaluator experienced in conducting forensic evaluations for the military as well as with attorneys working within the system of military justice. Various criminal investigative agencies exist depending on the branch of service. The US Army Criminal Investigation Command (CID) is a federal law enforcement agency that investigates crimes within the Army. CID special agents operate as independent federal agents within the Department of the Army to investigate felony crimes. There is the Naval Criminal Investigative Service (NCIS) for the Navy/Marine Corps and there is the Air Force Office of Special Investigations (OSI) for the Air Force. Forms and acronyms may therefore vary from branch to branch.

The following types of documents may be frequently encountered. Department of Defense Form 458 is the Charge Sheet listing the violations of UCMJ. The report of investigation details the criminal investigation leading to the referral of charges. Agent investigative reports may be included. The rights warning waiver, where the accused is informed of the right to remain silent, is DD Form 3881. Various statements should be available from the accused if he or she agrees to give a statement as well as statements from various witnesses. The evaluator should request information regarding prior misconduct, which resulted in an Article 15 or nonjudicial punishment. Article 15 as outlined in the UCMJ gives commanders the option of resolving misconduct without a formal courts-martial. The soldier does have the right to refuse to submit to nonjudicial punishment and demand a trial by courts-martial. A detailed source of information is the transcript from the Article 32 proceedings. An Article 32 hearing is a proceeding under UCMJ similar to a grand jury in civilian criminal law. However, the 706 may be ordered before the Article 32 hearing has occurred.

Service records should be requested. In the Army a one-page summary of the service record is contained in the enlisted record brief. The enlisted record brief lists when the service entry date, the military occupational specialty (MOS), dates of promotion, dates of deployment, duty locations, awards, and scores on the Armed Services Vocational Aptitude Test. Comparison of the Armed Services Vocational Aptitude Test scores to current test results on cognitive measures may be relevant to the inquiry. In terms of occupational specialties, the Army has the MOS, the Navy and Marine Corps have ratings, and the Air Force has Air Force Specialty Codes. Performance reports, counseling packets, and letters of admonishment or reprimand may be available. Criminal justice records should also be requested. Complete medical records are directly relevant to the 706 inquiry. Medical records for the Armed Forces are contained in electronically in AHLTA. The examiner may need to specifically request medical records dated before 2005, the AHLTA implementation date. Civilian healthcare records will not be in AHLTA and should be requested from the agency providing care.

### Collateral Sources

Collateral information is a critical component of a 706 inquiry. The forensic evaluator seeks third-party information and should not rely solely on the accused's self-report. Heilbrun, Warren, and Picarello define third-party information as "any information that is not obtained directly from the party being evaluated as part of the criminal adjudication or civil litigation."<sup>42(p69)</sup> They suggest that third-party information "is one of the most essential components of a high-quality forensic assessment, enhancing the integrity of the process."<sup>42(p72)</sup> They also emphasize the importance of this information in assessing response style and in generating and testing rival hypotheses.

One task for the forensic evaluator is to assess response style and rule out malingering. Information from collateral sources is vital to this task. For example, a relatively common concern in a military setting is to ascertain whether a service member qualifies for a diagnosis of PTSD. If the service member describes certain purportedly traumatic experiences in theater, he or she should be asked to provide names of other soldiers who were there. These individuals can be contacted to verify that the event occurred and perhaps to provide additional observations about the how the individual being evaluated responded over time to the event(s). Family members, supervisors, and friends can be interviewed. A service member may claim that he or she was in the midst of a flashback during the time frame of the alleged offense. Collateral sources can provide

information as to whether the person being evaluated has a history of prior flashbacks to help ascertain the reliability of the current self-report.

In one survey of forensic psychiatrists and psychologists, third-party information was deemed especially valuable in criminal responsibility evaluations.<sup>43</sup> In that survey, mental health records, police information, and collateral descriptions of the alleged circumstances of the instant offense were all deemed essential or recommended by more than 93% of the participants. In accord with ethical guidelines, collateral sources should be informed of the nature and purpose of the interview, what will happen with the information gathered, and whether their participation is voluntary. Refer to the Specialty Guidelines for Forensic Psychology<sup>33</sup> (see 6.04) and the AAPL Ethics Guidelines for the Practice of Forensic Psychiatry.<sup>12</sup>

Sources of information that are emerging in importance include computer and video records. This information may be especially relevant in a criminal responsibility inquiry if the records are in the time frame close to the alleged offense. For example, a detailed record of email correspondence can help ascertain an individual's thought process and may indicate thought disorder or in contrast careful planning. Video footage may be useful in providing information about an individual's functioning. An example from a forensic criminal responsibility case was of an individual who claimed he was hallucinating and delusional at the time of a murder of an elderly lady. Shortly thereafter, he could be observed on a video at a store carefully counting change.

### Clinical Interview

The clinical interview of the accused is an important component of the Sanity Board. The mental state of the accused, both now and around the time of the alleged offense, is critical to answering questions posed by the 706 inquiry. The point of view and subjective perspective of the accused, if it can be ascertained, helps answer the legal question of whether he or she could appreciate the nature and quality or wrongfulness of his or her actions at a point in the past. The reliability of the accused's self-report should be assessed and carefully compared with collateral descriptions and measures of response style.

In terms of the scope and focus of the clinical interview, the 706 inquiry requires the evaluator not only to answer questions of competency and responsibility but also to formulate diagnoses. To accurately formulate diagnoses a comprehensive interview should be conducted in order to gather the requisite information. Questions only marginally relevant to determining competency or responsibility may be relevant to generating accurate diagnostic formulations.

Relevant areas of inquiry include developmental history, family history, social and interpersonal history, educational history, vocational history, mental health history, medical history, legal history, and substance abuse history. In a 706 there should be a detailed inquiry into military history. At times a cultural or religious history should also be gathered. With some forensic evaluations, a critical distinction to be made is whether certain beliefs are delusional or part of an accepted religious or cultural belief system. A thorough mental status examination should be conducted. Packer<sup>44</sup> recommends assessing the following areas:

1. behavior/demeanor,
2. orientation,
3. attention/concentration,
4. memory,
5. mood,
6. affect,
7. thought content,
8. thought process,
9. perception,
10. insight,
11. intellectual functioning, and
12. medications.

Structured measures such the Mini-Mental State Examination, 2nd Edition, (MMSE-2)<sup>45</sup> may be incorporated into this section to assess various domains and provide an opportunity to compare scores with normative data.

It is recommended that there be a section in the 706 titled "Accused's Current Version of the Alleged Offense." If the accused has already given a statement, this can be compared and contrasted with the current version. It is recommended that this particular inquiry be conducted after some rapport has been established and typically after gathering some background information. In addition for legal and ethical reasons, it may be wise to establish competency to stand trial before this specific inquiry is conducted. Packer recommends that the offense inquiry start with an "open-ended approach, asking the defendant for a free-form narrative."<sup>44(p108)</sup>

It is often helpful to have the accused describe in detail his or her thoughts, feelings, and behaviors starting in the hours or days leading up to the alleged instant offense and then continuing for some time after. Once this narrative has been obtained the evaluator can encourage the accused to fill in gaps and comment on information in the official criminal investigation, as well as on his or her own prior statements or witnesses' statements. After obtaining this information, it is often helpful to ask the accused to review the sequence of

events again and ask about discrepancies or gaps. While the forensic examiner may well need to probe the accused repeatedly and ask about inconsistencies, this author believes, it is counterproductive to adopt a confrontational approach, because it may lead the accused to shut down and thus limit the amount of information on which to base an opinion.

### Forensic Assessment Instruments

Forensic assessment instruments (FAIs)<sup>46</sup> are tools specifically designed to address legally relevant constructs such as competency to stand trial. Other types of tests are typically utilized to generate hypotheses about constructs such as response style or diagnosis. When feasible it is generally recommended that the evaluator use such instruments.<sup>47</sup> Different forensic clinicians have parsed the competency to stand trial standard into various prongs. One commonly utilized heuristic is to disaggregate the standard into three prongs:

1. ability to assist counsel;
2. factual understanding of the proceedings; and
3. rational understanding of the proceedings.

FAIs such the Evaluation of Competency to Stand Trial-Revised (ECST-R),<sup>48</sup> the MacArthur Competence Assessment Tool-Criminal Adjudication (MacCAT-CA),<sup>49</sup> and the Fitness Interview Test-Revised (FIT-R)<sup>50</sup> may be used in military settings, while keeping in mind that these instruments were not specifically standardized on a military population or within the military legal system. The FAI is one part of comprehensive assessment that is not meant to replace a detailed inquiry with the accused regarding his competency with regard to the specific pending charges. Instruments such as the ECST-R, which strive to operationalize the Dusky standard, are applicable, because as noted in *United States v Proctor*,<sup>15</sup> the Dusky standard applies in the military.

### Psychological Testing

Psychological testing may be a valuable adjunct to the 706 inquiry. As noted by Melton, Petrila, Poythress, and Slobogin, the "primary determinant of whether to administer a test is the degree to which the results will inform the judgment to be made."<sup>51</sup> Keep in mind that the examiner is being asked to perform "a separate and distinct inquiry" regarding four questions, including rendering a diagnostic formulation. While a specific psychological test may have limited relevance to competency or responsibility, it may have relevance

to generating hypotheses regarding current diagnoses. Furthermore, in a forensic examination, an important component of the inquiry is a thorough assessment of response style. Is there evidence of overreporting symptoms, exaggeration, or feigning? Is there evidence of underreporting symptoms or defensiveness? Various tests or procedures may provide useful information in assessing response style or in determining whether the results of other tests are valid. For example, a very low score on a test of intellectual functioning would be viewed differently, if additional testing revealed that the subject had scored substantially below chance on measures of cognitive effort.

### Other Techniques and Procedures

Depending on the case, additional procedures or tests may be indicated. If traumatic brain injury (TBI) is suspected, various neuroimaging tests may be indicated. In addition, consultations with professionals with specific expertise in the field, such as neurologists or neuropsychologists, may be sought. A full neuropsychological evaluation may be obtained. Even if it is not necessary to answer the questions of competency or criminal responsibility, the consult or procedure may be necessary to rule in or rule out TBI. To re-emphasize a point made earlier, the evaluator should not give short shrift to formulating an accurate answer to any of the four questions posed in the 706 inquiry, including diagnosis, especially because the answer to that question is the one most likely to have import at sentencing, even though the results of the procedure provide little relevant information to the questions regarding criminal responsibility or competency.

### Data Interpretation

In general, sound scientific principles and reasoning should be relied upon to interpret the data gathered. The evaluator should gather sufficient information from multiple sources to answer the referral questions. The Specialty Guidelines for Forensic Psychology (2.05) emphasize that practitioners provide opinions that “are sufficiently based upon adequate scientific foundation, and reliable and valid principles and methods”<sup>33</sup> are applied and that practitioners use multiple sources of information (9.02). The evaluator should be open to entertaining multiple competing hypotheses and when possible present competing points of view in the report with an explanation as to why one version was viewed as more plausible. Structured methods such as FAIs can be used when appropriate to reduce bias and seek convergent validity. Because the 706 examination is often performed by multiple staff members, an atmosphere

of open inquiry should be established. Competing viewpoints should be encouraged. Differences in experience, discipline, and rank should be acknowledged but not used to quash the airing of competing hypotheses. When disagreements are hard to resolve, additional consultation should be sought. If there are differing points of view as to the ultimate conclusions, they should be represented in the final report. Packer<sup>44</sup> provides a good summary of some of the common errors that occur in reaching opinions on criminal responsibility.

### Diagnostic Assessment

A critical component of the 706 evaluation is a thorough diagnostic assessment of the accused both currently and at the time of the alleged offense. In deciding what domains to cover during the clinical interview, what tests to administer and who to select for collateral interviews, the evaluator should assess the relevance of such procedures to yielding information helpful in formulating a diagnosis. In a military context the threshold criteria for incompetency or insanity is the presence of a mental disease or defect. Getting a complete background history might not be directly relevant to assessing competency to stand trial, but it may still be directly relevant to formulating a diagnosis. Another consideration is that “repeated antisocial conduct” is excluded from consideration for an insanity defense. Therefore, gathering information relevant to establishing that construct or the related construct of Antisocial Personality Disorder is arguably a relevant area of inquiry.

At times, forensic evaluators are criticized for selecting tests or inquiring in depth about certain background factors because they are not directly relevant to an assessment of competency or responsibility; however, if they are relevant to formulating a diagnosis, this author thinks that they are justifiable since the 706 board entails “a separate and distinct inquiry” into each of the four questions, including the one asking for a “clinical psychiatric diagnosis.” Needless to say, the evaluator has only established the threshold criteria for incompetency or insanity by establishing the presence of mental disorder. The critical task of establishing a linkage between the disorder and competency or responsibility remains as well as establishing the specific functional impairment related to the psycholegal capacity in question.

### The Ultimate Issue

In *Principles of Forensic Mental Health Assessment* Heilbrun and colleagues<sup>38</sup> recommend that the forensic evaluator avoid answering the ultimate legal question.

Heilbrun et al classified this principle as emerging and not established, suggesting ongoing disagreement. Various legal and forensic professionals have debated this issue. Melton, Petrila, Poythress, and Slobogin<sup>51</sup> provide an array of arguments that discourage mental health professionals from offering ultimate opinions, which is viewed as within the purview of the legal decision-maker. In a contrasting view, Rogers and Ewing<sup>52</sup> argue that judges and attorneys expect such opinions and that little harm is incurred by doing so. Wherever the forensic evaluator stands on this debated issue, it should be noted that the MRE permit opinions on the ultimate issue. While the MRE generally parallel the Federal Rules of Evidence, this is one important difference.

FRE 704(b) states:

No expert witness testifying with respect to the mental state or condition of a defendant in a criminal case may state an opinion or inference as to whether the defendant did or did not have the mental state or condition constituting an element of the crime charged or of a defense thereto. Such ultimate issues are matters for the trier of fact alone.

MRE Rule 704 states:

Testimony in the form of an opinion or inference otherwise admissible is not objectionable because it embraces an ultimate issue to be decided by the trier of fact.

The order for the 706 inquiry directs the forensic examiner to submit “ultimate conclusions” in the short form to the four questions posed, including criminal responsibility and competency to stand trial. In the full report the evaluator should present in depth what led to these conclusions and include any caveats or cautionary statements.

Since many professionals who perform 706 evaluations in the military are primarily clinical providers, it is worth emphasizing that there are critical differences between therapeutic and forensic roles.<sup>53</sup> In a 706 inquiry the referral source is the court not the client. Individuals examined for forensic examination are not patients and self-report should be corroborated by additional sources of information. The evaluator is not in a helping role but performing a court-ordered or command-directed evaluation to answer various psycholegal questions.

### Communication: Report Writing and Testimony

In composing a 706 report, the evaluator should follow the principles and guidelines established for forensic practice. Sample reports that explicate enu-

merated guidelines are provided in *Forensic Mental Health Assessment: A Casebook* by Heilbrun, Marczyk, and DeMatteo.<sup>54</sup> Four case examples are provided on competency to stand trial, and two case examples are provided on sanity at the time of the offense. There is an extensive discussion on whether to provide an ultimate opinion. However, as noted previously, military law as opposed to federal law permits offering ultimate opinions. In terms of FMHA principles outlined by Heilbrun et al<sup>58</sup> communication of results should be guided by attributing information to sources, using plain language that avoids technical jargon, writing the report in sections, preparing it according to a model, and basing testimony on the results of the properly performed FMHA.

Grisso provides guidance for improving common errors in forensic reports.<sup>55</sup> The 10 most frequent errors were:

1. opinions without sufficient explanation;
2. forensic purpose not clear;
3. organization problems;
4. irrelevant data or opinions;
5. failure to consider alternative hypotheses;
6. inadequate data;
7. data and interpretation mixed;
8. overreliance on a single source of data;
9. language problems; and
10. improper test use.

Based on this research Phillip Witt<sup>56</sup> has developed a checklist that the evaluator can use to review the forensic work product. Administrators or supervisors, who regularly review forensic reports, may find the checklist helpful.

Once a comprehensive, objective, and reasoned report has been completed, the forensic evaluator should have the foundation for effective testimony. Pretrial preparation and consultation with attorneys should facilitate effective presentation. Packer notes that “although forensic clinicians must begin the evaluation process in a neutral manner, once a conclusion has been reached and testimony is required, the clinician should be prepared to present his opinions in a clear and persuasive fashion.”<sup>44(p158)</sup> Packer<sup>44</sup> provides a succinct summary of the areas to be covered when testifying about sanity and Zapf and Roesch<sup>57</sup> provide a summary of the areas to be covered when testifying about competency.

When functioning as an expert witness in a military context, one should be aware of unique aspects of the military justice system. Before testifying, the expert should be prepared to be questioned by opposing counsel. This process is somewhat analogous

to depositions in civil cases. Under the rules for discovery and according to the RCM 701(e), “each party shall have adequate opportunity to prepare its case and equal opportunity to interview witnesses and inspect evidence.” This phrase means that the expert may be called and questioned about his/her methods and conclusions before trial or during trial but before testifying. First, the expert should be prepared to answer these questions and to be cross-examined later vigorously about any discrepancies between the initial questioning and subsequent testimony. Second, at the judge’s discretion the court-martial may extend well into the evening or even convene during the weekend. Third, panel members can ask the expert questions. After an expert has finished testifying, the judge will ask the panel if there are any questions for the expert. The members who wish to respond will write them on a piece of paper and at the judge’s discretion certain questions may be asked. Finally, the forensic professional should be prepared to go directly from the merit or guilty phase of the trial to sentencing. There is essentially no break between the two phases of the court-martial and the expert should not be surprised by the pace of proceedings.

One caveat for testifying about the results and opinions of a Sanity Board composed of more than one member is to only represent one’s findings and opinions. While on firm footing when describing the process of the Sanity Board, it may be viewed as hearsay or prejudicial to represent the opinions or findings of professionals not available to testify. In *United States v Parmes*<sup>58</sup> one member of a three-member Sanity Board testified that the opinion he reached was unanimous. On appeal the US Army Court of Military Review stated, “there can be hardly any doubt that trial counsel was striving to show, and emphasize, the unanimity of opinion among the three psychiatrists composing the board.” The court concluded that there was “more than a fair risk” that the panel members “considered the hearsay disclosure of the opinions of the two doctors, for it was presented to them in the same manner as other, admissible evidence.” The court ruled that “because of this, the rights of the accused suffered substantial prejudice” and a rehearing was required. In *United States v Smith*<sup>59</sup> the US Army Court of Military Review ruled that the trial judge “erred to appellant’s prejudice by permitting the government expert psychiatric witness to testify over defense objection to the ‘unanimous’ and collective opinion of the Sanity Board.” The court concluded that “there was more than a fair risk” that the testimony “was improperly bolstered in the minds of the court members to the prejudice of the appellant” and “we can’t pass lightly over the fact that one side got in ef-

fect the weight of three witnesses for the price of only one cross-examination in a field so fertile for such.” One should resist the temptation to inflate the basis of one’s conclusions and stick to effectively articulating the basis of one’s findings and opinions.

### Competency to Stand Trial Assessment

Excellent references on conducting assessments of competency to stand trial are available. These include:

- *Evaluation of Competence to Stand Trial* by Zapf and Roesch<sup>57</sup>;
- *AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial*<sup>34</sup>;
- Guidelines for evaluation in the chapter titled “Competency to Stand Trial” from Melton et al<sup>51</sup>;
- the chapter “Competency to Stand Trial: A Guide for Evaluators” by Zapf and Roesch<sup>60</sup> in *The Handbook of Forensic Psychology* (Third Edition) by Weiner and Hess; and
- the chapter titled “Assessment of Competence to Stand Trial” by Stafford from Goldstein and Weiner<sup>61</sup> in the *Handbook of Psychology, Volume 11, Forensic Psychology*.

In this particular section some of the unique nuances and performing these evaluations in a military context will be highlighted. There are differences between the military court system and the civilian court system that the evaluator should bear in mind. The military panel for general courts-martial is composed of 5 to 12 members. Rather than a relatively random selection from an available pool as in civilian courts, according to Rule 502 the members are active duty officers and “persons who in the opinion of the convening authority are best qualified for the duty by reason of their age, education, training, experience, length of service, and judicial temperament.” The president of the court-martial is not selected by the members but is the member who is senior in rank. Similar to civilian courts, according to Rule 903, the accused may request a trial with a panel or by a military judge alone. Contrasted with the unanimity required for a guilty finding in civilian court, according to Rule 921 the accused in military court will be found guilty, in any non-capital case, if at least two-thirds vote for a finding of guilty beyond a reasonable doubt. This rule may be an important consideration for a defendant charged with a crime in military court as well as the qualifications of the panel members he or she would be facing in a trial with a panel.

At sentencing a wide range of punishments is available that are unique to the armed forces. Hard labor

may be imposed as well as reduction in rank, forfeiture of pay and allowances, and a bad conduct discharge. The latter usually results in the loss of retirement and health benefits and this is often a consideration when a service member is offered a pretrial agreement that includes a bad conduct discharge. Furthermore, if an accused agrees to enter a guilty plea, they will undergo a detailed "Care inquiry" in court to demonstrate that he or she is making a knowing, intelligent, and conscious waiver of their rights, as shown in *United States v Care*.<sup>62</sup> In some cases, an accused may agree to plead guilty after entering into a pre-trial agreement, or plea bargain, with the prosecution, that sets a maximum cap on time in confinement. Another difference is that there is no Alford plea in the military.<sup>63</sup> The military legal system insists that a plea of guilty should be rejected if the accused presents evidence inconsistent with that plea. RCM 910(e) requires that the accused's testimony during the providence inquiry be given "under oath." The legal foundation for this requirement is outlined in a US COMA decision.<sup>64</sup>

Another important difference is the likely low base rate of incompetency findings. Currently, no centralized database exists within the military for tracking the findings of 706 boards but the available anecdotal evidence from experienced forensic evaluators uniformly described such a finding as very infrequent compared to other settings.

### Amnesia

Within the general population there is a frequent incidence of TBI. The Centers for Disease Control and Prevention estimates 1.7 million people annually sustain a TBI.<sup>65</sup> Head injury occurs in the military context with increased frequency, especially within the context of active theaters of combat. It is estimated that 25% of those medically evacuated from Iraq or Afghanistan have suffered head or neck injuries.<sup>66</sup> Efforts to screen service members returning from deployment suggest that 10% to 20% may have suffered a concussion during deployment.<sup>67</sup> A RAND report<sup>68</sup> indicates that as many as 320,000 returning veterans from Iraq and Afghanistan may have experienced TBI.

The US COMA in *United States v Olvera*<sup>69</sup> found that an accused's inability to remember the details of the offense, does not, without more, compel a finding of incompetency. The court acknowledged that the amnesia put the accused at a disadvantage but opined that the abilities that remained were sufficient to permit him to meaningfully participate in the trial. The court found that "the capacity to cooperate in one's own defense is a matter of inquiry directed to disorders existing at the time of trial" and that "a person who does not recall

accomplishment of the acts alleged is not by that fact exempt from trial." In *United States v Barreto*<sup>70</sup> CAAF affirmed the decision in *Wilson v United States*<sup>71</sup> from the US Court of Appeals for the District of Columbia. In *Wilson v United States*, six factors were put forth to consider. These factors include the following:

1. The extent to which the amnesia affected the defendant's ability to consult with and assist his lawyer.
2. The extent to which the amnesia affected the defendant's ability to testify in his own behalf.
3. The extent to which the evidence is suit could be extrinsically reconstructed in view of the defendant's amnesia. Such evidence would include evidence relating to the crime itself as well as any possible alibi.
4. The extent to which the Government assisted the defendant and his counsel in that reconstruction.
5. The strength of the prosecution's case. Most important here will be whether the Government's case is such as to negate all reasonable hypotheses of innocence. If there is any substantial probability that the accused could, but for his amnesia, establish an alibi or other defense, it should be presumed that he would have been able to do so.
6. Any other facts and circumstances which would indicate whether or not the defendant had a fair trial.<sup>71</sup>

In *Barreto* the accused was charged with reckless driving and negligent homicide. He suffered from a closed head injury and had amnesia for the alleged offense. While not directly stated, in *Barreto* the court appeared to accept that amnesia would qualify as a "mental disease or defect." In *Barreto* the court ruled that his "decision to plead guilty reflected a rational decision made in light of the prosecution's overwhelming evidence of his guilt."

### Mental Responsibility Assessment: Mental State at the Time of the Offense Inquiry

Excellent references on conducting assessments of criminal responsibility include the following:

- *Evaluation of Criminal Responsibility* by Packer<sup>44</sup>;
- "Mental State at the Time of the Offense" from Melton et al<sup>51</sup>;
- the chapter titled "Criminal Responsibility and the Insanity Defense" by Zapf, Golding

and Roesch<sup>72</sup> in *The Handbook of Forensic Psychology* (Third Edition) by Weiner and Hess;

- “Practice Guideline: Forensic Psychiatric Evaluation of Defendants Raising the Insanity Defense” by Giorgi-Guarnieri, Janofksy, Keram, Lawsky, Merideth, Moss, Schwartz-Watts, Scott, Thompson Jr, and Zonana<sup>41</sup>; and
- the chapter “Evaluation of Criminal Responsibility” by Goldstein, Morse and Shapiro from Goldstein and Weiner<sup>73</sup> in the *Handbook of Psychology, Volume 11, Forensic Psychology*.

In this section some of the unique nuances of performing these evaluations in a military context will be highlighted. In general, the evaluator must first determine whether the accused met criteria for a mental disease or defect at the time of the alleged offense. Next there should be some analysis of the severity of the mental condition and to what degree it was specifically linked to the alleged offense. Finally, the evaluator should perform a functional test derivative of the linkage and ascertain as far as possible whether the person was able to understand the nature and quality or wrongfulness of his or her behavior due to the mental illness.

First the evaluator strives to ascertain what diagnoses, if any, were present at the time of the alleged offense. Was there evidence of a major mental disorder, of substance intoxication, of a personality disorder? If more than one was present, which was primary and which had the most direct link to the alleged offense? The evaluator should ask the accused to provide a detailed account of his or her feelings, thoughts and behaviors before during and after the alleged offense, inquire why he or she did it, and what was his or her motivation. Look for data pertaining to the accused’s knowledge of wrongfulness both in thinking and behavior. An inquiry should be conducted about the use of drugs, alcohol and medication before, during and after.

The accused’s self-report should be compared and contrasted with available records and collateral reports. Records of phone calls, computer messages, text messages, or even videos of the accused may be available to compare and contrast. In assessing appreciation of wrongfulness, the assessor should look for evidence the accused attempted to evade detection or arrest or

concealed evidence. The sophistication or lack thereof may provide data about mental responsibility. The evaluator should assess for malingering, gather relevant information, and perform relevant testing to differentially weigh that hypothesis. Keeping an open mind to alternative explanations and hypotheses is essential to a fair and objective inquiry and reduces confirmatory bias. As Packer succinctly points out, “forensic evaluators should endeavor to determine which explanation is the best fit for the data, while acknowledging alternative explanations.”<sup>44(p128)</sup> Please refer to his book, *Evaluation of Criminal Responsibility*,<sup>44</sup> for a comprehensive analysis of how to perform a criminal responsibility evaluation.

As noted earlier, in general the history of the insanity defense in the military has mirrored the federal standard. One important difference is that as opposed to other contexts there is in all likelihood an even lower base rate of insanity findings in the military than in other jurisdictions. No centralized database exists within the military tracking the findings of 706 Boards, but the available anecdotal evidence from experienced forensic evaluators uniformly describe such a finding as very infrequent compared to other settings.

In a study of five states during the 1970s and early 1980s, insanity acquittals averaged well below 1% of all felony arrests, ranging from 0.0005 in Wyoming to 0.65 in New York.<sup>51</sup> Steadman et al<sup>74</sup> estimated that the insanity defense prevails nationally around one out of every four times it is raised. Based on data provided by the Deputy Clerk of Courts for the Army Judiciary from 1990 to 2005, Mona et al<sup>75</sup> found that the annual rate in the Army for a not guilty by reason of insanity finding is less than 0.15 percent. Personal communications with the paralegal specialist for the Office of the Clerk of Criminal Appeals for the US Army Court of Criminal Appeals found only 7 not guilty by reason of insanity acquittals from 1990 to September 2010 of a total of 29,513 cases, yielding a rate of 0.02. Fellow evaluators at the Center for Forensic Behavioral Sciences are aware of at least one other insanity acquittal in the Army in October 2011. These findings are offered cautiously because the methods of data collection have not been verified. It is likely, however, that the rate of insanity acquittals in the military is lower than in other settings because individuals with active mental illness may be screened out during enlistment or administratively discharged during service.

## EXCLUSIONARY CRITERIA

### Repeated Criminal or Otherwise Antisocial Conduct

Mental disease or defect has long constituted the threshold criteria for an insanity defense. The ambiguity of this term was highlighted in the so-called “week-

end flip flop case” at Saint Elizabeths Hospital.<sup>76,77</sup> On a Friday a psychiatrist testified that an individual with a sociopathic personality did not have a mental disease. By Monday it was determined through a policy change that psychopathic or sociopathic personality did

constitute a mental disease. While Antisocial Personality or a variant has appeared in various versions of *DSM* for some time, mental health professionals appeared to vacillate over regarding it as a mental disorder at least in terms of applying the concept to legal standards. As previously noted as far back as 1966 the COMA in *United States v Freeman*<sup>22</sup> agreed with the exclusion of repeated antisocial behavior for consideration for an insanity defense. With the passage of the Insanity Defense Reform Act, the exclusionary criteria for “repeated or otherwise antisocial conduct” were officially added by legislative action.

In terms of performing an MSO evaluation of criminal responsibility, the forensic clinician should strive to exclude criminal actions that appear driven by an antisocial personality structure or solely by antisocial traits. Arguably to the extent that an accused is perceiving and behaving due to an antisocial personality structure, he or she does not qualify for a defense of insanity. In some cases in which an individual has multiple disorders it can prove a difficult task to parse out, how the behavior and perceptions of a given individual are linked to one disorder more than another. For example, if an individual has antisocial traits, significant substance abuse problems, and a bipolar disorder, the evaluator should carefully sift through the available information, generate multiple hypotheses from as many sources as possible, and strive to make a reasoned judgment.

### **Minor Disorders Such as Nonpsychotic Behavior Disorders and Personality Defects**

This exclusion criterion appears to relate to the requirement that the disorder must be “severe.” Because of the wide variety of mental health opinions as to what constitutes a mental disorder for legal purposes, the courts have offered some guidance. As noted in *McDonald v United States* mental disease or defect was defined as “any abnormal condition of the mind which substantially affects mental or emotional processes and substantially impairs behavior controls.”<sup>29</sup> The APA workgroup recommended that to qualify for insanity a disorder should be “serious” and that “such disorders should usually be of the severity of conditions that psychiatrists diagnose as psychoses.”<sup>24</sup> Exactly what diagnoses would be classified as “minor,” such as “nonpsychotic behavior disorders and personality defects,” is unclear. The prior discussion on “severe” should shed some light on this topic. The phrase would appear to discount personality disorders, but as noted in *United States v Proctor*<sup>15</sup> the court found that personality disorders may qualify. At any rate, available data suggest that whereas nonpsychotic disorders should not be ruled out from consideration, psychotic

disorders account for the majority of individuals who are found not criminally responsible. Melton et al summarized the findings of six studies from four states and found that “the presence of major psychosis is usually required for the insanity defense to succeed.”<sup>51</sup> Moreover, when comparing different time frames, the research indicated that “this conclusion is especially valid in more recent years.”<sup>51</sup>

### **Voluntary Intoxication**

Voluntary intoxication means ingesting alcohol or drugs with the knowledge that impairment may result. According to RCM 916 (1)(2), “Voluntary intoxication, whether caused by alcohol or drugs, is not a defense.” Acute intoxication secondary to recent ingestion of substances may result in impaired reality testing. However, some conditions related to intoxication may still qualify for an insanity defense. Packer<sup>44</sup> cites various conditions that are more difficult to assess. Packer refers to three conditions, including “the cumulative effects of intoxication,” “a psychotic disorder initiated by substance abuse, but continuing past the period of intoxication,” and “impairments brought about by cessation of substance use.”<sup>44</sup> Repeated substance abuse over time may result in a relatively stable organic or psychotic condition, which may serve as the basis for an insanity defense. Such a condition is referred to as “fixed” or “settled.” “Fixed” refers to a permanent condition and “settled” to a condition extending beyond the point of intoxication. An example of “settled psychosis” is long-term PCP abuse resulting in a psychosis beyond what would be expected during acute intoxication. Such a “settled psychosis” may be valid for an insanity acquittal.<sup>78</sup> Alcohol withdrawal delirium or other withdrawal deliriums such as from benzodiazepine may similarly result in impaired conditions such as delirium that warrant consideration for an insanity defense. Bear in mind, however, that in a military context evidence of voluntary intoxication while not qualifying for insanity may still negate mens rea in specific intent crimes.

### **Cultural Considerations**

One cultural consideration for assessing a service member is the degree of familiarity of the evaluator with military culture in general and more specifically with the particular branch involved as well as with further subdivisions such as the particular company, platoon, and squad. The evaluator might also benefit from knowledge of the soldier’s particular function or what is referred to in the Army as the MOS. For example, when considering whether a given soldier warrants a diagnosis of PTSD, the evaluator should

become familiar with the experiences of that soldier during deployment, contact other soldiers in the accused's squad, and learn what is required of an army combat medic or 68W in a combat zone. If performing the evaluation as a civilian outsider to military culture, it may be worthwhile to seek consultation from active duty forensic mental health professionals or civilians conversant with military culture.

Most forensic evaluations contain a mental status evaluation. This assessment provides information about the subject's thinking, emotional regulation, and behavior and may provide data relevant to a diagnostic formulation. Within a military context, the evaluator should be cognizant of what constitutes military bearing and appropriate military dress. The expectation to uphold these standards applies to individuals charged with crimes and individuals in pre-trial confinement. Deviations from appropriate expectations may provide clues to the evaluator about the mental status of the accused. Some degree of familiarity with what constitutes appropriate military bearing is necessary to discern deviations.

At times soldiers are charged with crimes in other countries. The status of force agreement regulates who has jurisdiction over the prosecution. In general the typical provision in a status of force agreement is that US courts, such as military courts, will have jurisdiction over crimes committed by one service member against another or by a service member as part of his or her military duty, but the host nation retains jurisdiction over other crimes. If the alleged crime is committed while the service member is off duty, local authorities will often be involved in the initial investigation. Depending on the country and their laws, access to attorneys, Miranda rights, and other features of the American justice system may or may not be present. Victims or witnesses may speak another language, which complicates the task of an independent English speaking evaluator. If the case is high profile and being tried in a military court, this may complicate the task of accessing full information from local authorities or interviewing citizens of the host country.

At other times the forensic clinician may be called upon to assess individuals from another culture, who are being tried in a military court. As Mossman et al point out, "individuals who come from countries or

cultures where governmental systems are all-powerful or corrupt may believe that persons in or appointed by authority do not have their best interests at heart."<sup>34(p29)</sup> Furthermore, defendants charged with crimes related to so-called "terrorism" may refuse to talk with attorneys assigned to them by military courts. Determining what is normative behavior for an avowed member of Al-Qaeda is very difficult without knowledge of that group's norms and expectations. Disdain for a system of law viewed as ungodly may be normative and not necessarily a sign of a paranoid psychosis. To the extent possible the evaluator should be familiar with beliefs and behaviors espoused by the organization, group, or culture to which the individual belongs before labeling such beliefs a symptom of mental illness.

A cultural issue appearing with some regularity in forensic contexts is differentiating between mental illness and an accepted cultural belief, especially those beliefs that at first glance appear rather strange. Recall that in *United States v Proctor*<sup>15</sup> there was a divergence of opinion by experts as to whether certain beliefs were delusional or part of a fundamental Baptist belief system. A more contemporary example of this in a military context is a male service member charged with a crime, who joined a group focused on spiritual healing, that espoused a unique amalgam of Christian, Buddhist, and New Age beliefs. Some of the beliefs could be viewed as rather grandiose or delusional. Complicating the analysis was a history of treatment. Varying hypotheses emerged concerning the accused's diagnostic formulation. Was he delusional or simply a fervent believer or both? His beliefs appeared to significantly interfere with his legal decision making. Therefore, depending on whether the evaluator classified these beliefs as delusional or part of his newfound spiritual identity, he could be viewed as competent or incompetent. Accepting for the sake of argument that his legal decision making was significantly impaired, he would be competent if the impairment did not stem from a mental disease or defect but incompetent if the impairment stemmed from delusions. Familiarizing oneself with the belief system, interviewing collaterals from the spiritual group, and assessing the pervasiveness and rigidity of the beliefs as well as the possible presences of other strange beliefs not found in this particular belief system were all important considerations in reaching a conclusion.

## FORENSIC OUTCOMES

### Competent and Responsible

If the findings of the accused as being competent and responsible are accepted by the court, the accused

proceeds to trial. It is within the discretion of the court to appoint additional experts for the defense or government to perform additional evaluations and it is within the discretion of the court to order another 706 inquiry.

## Incompetent

An adjudication of incompetency to stand trial is an infrequent event in the military justice system. Keep in mind that certain types of mental disorders can disqualify a soldier from military service and initiate administrative separation or a medical evaluation board discharge. When there is a finding of incompetency to stand trial, different procedures exist depending on whether the adjudication of incompetence occurs before or after referral. In summary, at the discretion of the CA, the accused can be sent to the federal system, typically to a federal hospital in the Bureau of Prisons. RCM 401 stipulates procedures for the forwarding and disposition of charges and indicates that charges “should be disposed of in accordance with the policy of RCM 306(b).” This policy allows the commander to take a wide range of administrative actions, proceed with nonjudicial punishment, or dispose of the charges. Administrative actions can include various corrective measures such as counseling, reprimand, censure, or separation. In this particular instance, the accused may have been diagnosed with a significant mental disorder, which would require action, even if he or she did not have an investigation pending. Army administrative regulations (AR 635-200) govern separation from the military.

RCM 909(c) states:

Determination before referral. If an inquiry pursuant to RCM 706 conducted before referral concludes that an accused is suffering from a mental disease or defect that renders him or her mentally incompetent to stand trial, the convening authority before whom the charges are pending for disposition may disagree with the conclusion and take any action authorized under RCM 401, including referral of the charges to trial. If the convening authority concurs with the conclusion, he or she shall forward the charges to the general court martial convening authority. If, upon receipt of the charges, the general court-martial convening authority similarly concurs, then he or she shall commit the accused to the custody of the Attorney General. If the general court-martial convening authority does not concur, that authority may take any action that he or she deems appropriate in accordance with RCM 407, including referral of the charges to trial.

In *United States v Salahuddin*<sup>79</sup> the petitioner contested the legal authority of the CA to order him into the custody of the Attorney General and to the Federal Bureau of Prisons, pursuant to RCM 909(c), arguing that in addition to being incompetent, there should be a finding that he “requires hospitalization for his own welfare and protection of others.” The US Air Force

Court of Criminal Appeals affirmed the transfer stating that the finding of incompetency alone was sufficient.

After referral, the CA has less discretion and the military judge is directed to conduct a hearing on competency.

RCM 909 (d) Determination after referral. After referral, the military judge may conduct a hearing to determine the mental capacity of the accused, either *sua sponte* or upon request of either party. If an inquiry pursuant to RCM 706 conducted before or after referral concludes that an accused is suffering from a mental disease or defect that renders him or her mentally incompetent to stand trial, the military judge shall conduct a hearing to determine the mental capacity of the accused.

If the military judge finds the accused incompetent, this is reported to the general court-martial CA, who according to RCM 909(e)(3) “shall commit the accused to the custody of the Attorney General.” The next section discusses hospitalization:

RCM 909 (f) Hospitalization of the accused. An accused found incompetent to stand trial under this rule shall be hospitalized by the Attorney General as provided in section 4241(d) of title 18, United States Code. If notified that the accused has recovered to such an extent that he or she is able to understand the nature of the proceedings and to conduct or cooperate intelligently in the defense of the case, then the general court-martial convening authority shall promptly take custody of the accused. If, at the end of the period of hospitalization, the accused’s mental condition has not so improved, action shall be taken in accordance with section 4246 of title 18, United States Code.

Under 4241(d) of Title 18, the initial hospitalization should not exceed four months. However, RCM 909 notes that “in determining whether there is a substantial probability the accused will attain the capacity to permit the trial to proceed in the foreseeable future, the accused may be hospitalized for an additional reasonable period of time.” If the accused does not regain competency and the charges are dismissed because of his or her mental condition, the accused is subject to hospitalization under section 4246 of Title 18. If the accused “is presently suffering from a mental disease or defect as a result of which his release would create a substantial risk of bodily injury to another person or serious damage to property of another,” a certificate for civil commitment can be filed. If commitment is pursued, a hearing will be held and “if the court finds by clear and convincing evidence that the person is presently suffering from a mental disease or defect as

a result of which his release would create a substantial risk of bodily injury to another person or serious damage to property of another, the court shall commit the person to the custody of the Attorney General." If a service member is transferred to a federal facility for competency restoration, the Federal Bureau of Prisons will determine the placement based on internal considerations, such as space availability.

### Lacking Mental Responsibility

Mona et al<sup>75</sup> note that until 1996, no official policy existed within the military legal system regarding the disposition of service members found not guilty by reason of lack of mental responsibility. At times this led to debate over jurisdiction of the case between the federal government and the state in which the case was adjudicated. In 1998 the UCMJ was amended with Article 76b(b). Created in section 1133 of the National Defense Authorization Act for Fiscal Year 1996, Pub L No 104-106, 110 Stat 186, 464-66 (1996), it provides for a post-trial hearing within forty days of the finding that the accused is not guilty by reason of a lack of mental responsibility. Depending on the offense, the accused has the burden of proving either by a preponderance of the evidence, or by clear and convincing evidence, that his or her release would not create a substantial risk of bodily injury to another person or serious damage to property of another due to a present mental disease or defect. The intent of the drafters is for RCM 1102A to mirror the provisions of sections 4243 and 4247 of Title 18, United States Code.

In 1996, the *Manual for Courts-Martial* was amended with Article 76b to state "the [acquittee] shall be committed to a suitable facility until the person is eligible for release." Due process is satisfied via a hearing 40 days post-commitment.

Forensic practitioners interfacing with the military justice system should be aware of the unique aspects of military culture and military law. A competent evaluation requires knowledge of these features. Familiarity with relevant sections of the *Manual for Courts-Martial* is a prerequisite to performing a 706 inquiry.

This author believes that consideration should be given to differentiating the questions posed in RCM 706 and specifically to differentiating the investigations and evaluations of competency to stand trial and criminal responsibility. The content of the re-

ports would be short and more specifically tailored to answering the specific referral question. In the author's view, it makes sense to address competency to stand trial before addressing mental responsibility. Once it has been established that the accused is competent to stand trial and knowingly, intelligently and voluntarily elects to raise an insanity defense, the criminal responsibility inquiry into his or her MSO can be initiated. This would provide an additional safeguard against an incompetent defendant disclosing potentially incriminating information. Standard

Rule 1102A(3) states:

An accused found not guilty by reason of lack of mental responsibility of an offense involving bodily injury to another person, or serious damage to the property of another, or involving a substantial risk of such injury or damage, has the burden of proving by clear and convincing evidence that his or her release would not create a substantial risk of bodily injury to another person or serious damage to property of another due to a present mental disease or defect. With respect to any other offense, the accused has the burden of such proof by a preponderance of the evidence.

There is no centralized database to yield information on where military insanity acquittees are sent or on how long they are hospitalized before release to the community. Since federal insanity acquittees are often confined in institutions far from family support systems, the transition to a community setting can be complicated. According to Title 18, Section 4243, efforts can be made to have the state assume the responsibility of caring for and monitoring the insanity acquittee. However, all the Attorney General can do is petition for the state to assume authority. It is not known how often states assume this responsibility and cost.

### CONCLUSION

ports would be short and more specifically tailored to answering the specific referral question. In the author's view, it makes sense to address competency to stand trial before addressing mental responsibility. Once it has been established that the accused is competent to stand trial and knowingly, intelligently and voluntarily elects to raise an insanity defense, the criminal responsibility inquiry into his or her MSO can be initiated. This would provide an additional safeguard against an incompetent defendant disclosing potentially incriminating information. Standard

7-6-4(d) of the American Bar Association's Criminal Justice Mental Health Standards<sup>80</sup> recommends that "the defendant's mental condition at the time of the offense charged should not be combined in any evaluation ordered to determine competency to stand trial, unless the defendant should so request or for good cause shown."

With regard to the four questions typically posed by the 706 inquiry, additional guidance would be helpful to promote more uniformity in addressing the questions. While still encouraging a wide range of opinions, the orders could stipulate whether psychiatric diagnoses are being requested currently and/or at the time of the alleged offense or both. With regard to the question of severe mental disease or defect, additional guidance could be provided as to whether one is being asked to classify the disorder in general as severe at the time of the alleged offense or severe in its particular manifestation at time of the alleged offense. If a service member can be diagnosed with PTSD, for example, one evaluator might simply label that as severe and another might label it as severe only if there was dissociation associated with the PTSD at the time.

For the evaluator tasked with answering the four questions currently posed by RCM 706, it is important to bear in mind that RCM 706 directs the examiner to "make separate and distinct findings" to each of the four questions. This underscores the importance of addressing each question in depth and not giving short shrift to any question. Sanity Board evaluations can be found that summarily conclude that in the absence of a psychotic condition, the accused was criminally responsible and did not have a severe mental disease or defect. Such quick summary conclusions should be avoided. In this author's experience the vast majority of Sanity Board reports will conclude that the accused is competent and responsible and if found guilty the court-martial will proceed to sentencing. At that point the diagnostic formulation may have import and depending on the diagnosis may be used to mitigate or aggravate at sentencing. Since the answer to the question of "clinical psychiatric diagnosis" is the one most likely to impact the service member's future, this highlights the importance of addressing this question fully.

There has been debate on the appropriateness of offering ultimate opinions. Although FRE 704 prohibits ultimate opinions on mental state at the time of the alleged offense, MRE 704 does not and RCM 706 specifically asks for "ultimate conclusions" to the four questions posed. In the author's view asking for an ultimate conclusion on whether the accused had a "severe mental disease or defect" at the time

of the alleged offense is problematic. As noted, there is room for a range of opinion on what constitutes a "mental disease or defect" and for what constitutes a "severe mental disease or defect." In addition, once the evaluator concludes that there is no "severe mental disease or defect," he or she is also concluding that the accused is mentally responsible, with or without a careful analysis of how the mental disease or defect specifically impaired an appreciation of nature and quality or wrongfulness on one's actions. Given the ambiguity of these terms and the differing schemas for analyzing what "severe" means, the author thinks it would be better to describe in detail how the mental disease or defect impaired functioning in various domains around the time of the alleged offense, without specifically opining as to whether this the accused had a "severe mental disease or defect" at the time. If the evaluator concludes that the mental condition resulted in the accused being unable to appreciate the nature and quality of wrongfulness of his/her behavior, then he or she has necessarily concluded that the defendant had a severe mental disease or defect at the time of the alleged offense. However, if the evaluator concludes that the accused was responsible but had a mental disorder, the author is not sure why it is necessary to strive to answer this difficult question about severe mental disease or defect, which is open to varying interpretations. The evaluator can describe the nature and manifestation of disorder at the time of alleged offense in detail and the court after reviewing reports and hearing testimony can answer this question.

In 2006 Mona et al recommended "a centralized database containing detailed information of all 706 Boards."<sup>75(p543)</sup> The author agrees with this recommendation. At this point no reliable database exists of how often individuals are assessed incompetent or not responsible and/or adjudicated incompetent or not responsible. The database would reveal how often 706 reports find "severe mental disease or defects" and what they are. In addition, the database could track what happens to individuals adjudicated incompetent or not responsible and provide information about the percentage of individuals, who were restored to competency, and how long this took. For the small number of individuals found to lack responsibility, there would be data on their diagnoses, where they were sent, how long they stayed and how many recidivated. Furthermore, the system could track whether various administrative actions ensued from the 706 report, such as an administrative separation for medical reasons. This information could be compared to other databases in the civilian system.

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## ATTACHMENT 1

Walter Reed National Military Medical Center  
Center for Forensic Behavioral Science  
NOTIFICATION: Rule for Courts-Martial 706 Evaluation

### Purpose

You have been directed by (military judge/ convening authority) for an evaluation of your competence to stand trial and criminal responsibility under Rule for Courts-Martial 706. The evaluator(s) will be answering the following four questions.

- 1) Your mental health diagnosis, if any;
- 2) Your ability to understand the legal case against you and assist in your defense;
- 3) Whether you have a severe mental disease or defect, and;
- 4) Whether the severe mental disease or defect (if present) affected your ability to understand your actions in the alleged crime(s).

The goal of the evaluation is to answer these questions as accurately as possible. This evaluation is being conducted by the following evaluator(s): \_\_\_\_\_

### Procedures

You will be interviewed about your history. You will be asked about details related to the alleged crime(s) and your understanding of the case against you. You will also be asked about how legal trials work and your past and current psychological functioning. You may be given psychological tests or asked to complete forms that will assist the evaluator(s) in learning more about you. The evaluator(s) may need to talk with other professionals, family members, friends, and/or co-workers in order to obtain additional background information. The evaluator(s) will also review your legal, medical, mental health, educational, and/or military records.

### Reporting

As a part of this evaluation two reports will be written.

- A. A short report will be given to your defense counsel, the trial counsel, the judge, and/or the convening authority in your case. Your unit commander may also receive a copy of the short report. This short report will contain the answers to four questions listed above.
- B. A second, longer report will also be written for your defense counsel containing more detailed information on the results from this evaluation. This longer report will not be disclosed by your defense counsel unless you decide to use mental health evidence in your defense or during sentencing (if you are found guilty of the alleged crime(s)). At that time, the full contents of the long report may be given to the judge and trial counsel. The long report may also become part of the public record at trial. In addition, the evaluator(s) may be asked to testify in court about information obtained during the evaluation.

### Other Limits on Confidentiality

Other than the reports listed above and the possible testimony just noted, all information given by you is treated as confidential (private), except under the following circumstances. Information related to known or suspected child abuse and abuse of a person over age 65 may be reported in accordance with state law. Threats to national security and plans for engaging in future criminal activity are required to be reported. Also, information may be released if you present a risk to yourself or someone else.

### Possible Outcomes

The findings of this evaluation may result in a recommendation for you to receive treatment prior to going forward with your case or the evaluation may indicate that your case should proceed at this time. The findings of this evaluation, including your mental health diagnosis, may be used at sentencing by either your defense counsel or the trial counsel. Following the conclusion of your case, your mental health diagnosis may also be used as the basis for military administrative action. This action may include separation from service, a medical evaluation board (MEB), or a bar to re-enlistment.

### Refusal to Participate

You have been ordered by the court to participate in this evaluation. If you refuse to participate in this evaluation you may not be allowed to use medical or mental health experts to testify in your defense regarding any issues that would have been considered as a part of this evaluation. In addition, you may be subject to additional legal action under the Uniform Code of Military Justice.

**Agreement**

My signature below indicates that I have read this statement (or have had it read to me). I have had an opportunity to ask questions about the evaluation and to have issues explained in terms that I understand. I understand the evaluation has been ordered as a part of my court-martial. I further understand that I will be participating in an evaluation only; no treatment will be provided by the evaluator(s). By my signature below, I agree to the evaluation under the conditions stated above.

Signature of Participant \_\_\_\_\_ Date \_\_\_\_\_

Signature of Evaluator \_\_\_\_\_ Date \_\_\_\_\_

ATTACHMENT 2

MEMORANDUM FOR: xxxxxx, Defense Counsel, xxxxxx, Defense Counsel  
SUBJECT: Sanity Board (RCM 706) Evaluation of SS, Specialist (SPC) SSN xxx-xx-xxxx

1. In accordance with the order of the commander, a Sanity Board convened to inquire into the competency, mental responsibility, and psychiatric diagnosis of SPC SS.
2. The Board reached the following answers to the specific questions of the order for the Board:

a. At the time of the alleged criminal conduct, did the accused have a severe mental disease or defect?

The Board replies: No, SPC SS did not have a severe mental disease or defect at the time of the alleged misconduct.

b. What is the clinical psychiatric diagnosis?

The Board replies:

At the Time of Charges I-II the DSM-IV-TR Diagnosis was:

- Axis I:
- Axis II:
- Axis III:

The Current (At the Time of the Evaluation) DSM-IV-TR Diagnosis is:

- Axis I:
- Axis II:
- Axis III:

c. Was the accused, at the time of the alleged criminal conduct and as a result of such severe mental disease or defect, unable to appreciate the nature and quality or wrongfulness of his conduct?

The Board replies: No, SPC SS did not have a severe mental disease or defect at the time of the alleged criminal conduct that resulted in him being unable to appreciate the nature and quality or wrongfulness of his conduct.

d. Is the accused presently suffering from a mental disease or defect rendering the accused unable to understand the nature of the proceedings against the accused or to conduct or cooperate intelligently in the defense?

The Board replies: No, SPC SS is not presently suffering from a mental disease or defect rendering him unable to understand the nature of the proceedings against him or to conduct or cooperate intelligently in his defense.

3. Questions regarding this case can be directed to xxxx.

Name  
Title  
Signature

ATTACHMENT 3

MEMORANDUM FOR: xxxxxx, Defense Counsel, xxxxxx, Defense Counsel  
SUBJECT: Sanity Board (RCM 706) Evaluation of SS, Specialist (SPC) SSN xxx-xx-xxxx

1. IDENTIFYING INFORMATION:

Specialist (SPC) SS is a 30-year-old (DOB xx July 1980), White male, with approximately xxxx of active duty service. He is referred for a Sanity Board evaluation pursuant to R.C.M. 706. He is currently assigned to xxx, as a xxx, Military Occupation Specialty (MOS): xxx.

R.C.M. 706 requires that the following four questions be addressed by the Board:

- a. At the time of the alleged criminal conduct as set out in the alleged charges, did the accused have a severe mental disease or defect? (The term "severe mental disease or defect" does not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct, or minor disorders such as non-psychotic disorders and personality defects).
- b. What is the clinical psychiatric diagnosis?
- c. Was the accused, at the time of the alleged criminal conduct and as a result of such severe mental disease or defect, unable to understand the nature and quality or wrongfulness of his conduct? If so what is the degree of impairment of this capacity?
- d. Is the accused presently suffering from mental disease or defect rendering the accused unable to understand the nature of the proceedings against him (trial by courts-martial) and to conduct or cooperate intelligently in the defense?

2. LIST OF CHARGES:

Charge I: Violation of the UCMJ, Article 118	Murder
Charge II: Violation of the UCMJ, Article 92	Failure to Obey Order or Regulation

3. NOTIFICATION:

SPC SS was informed of the nature of this evaluation and the potential limitations on confidentiality. He was specifically informed that a full report of the evaluation would be sent to his defense counsel, and that a summarized report consisting only of the Board's answers to the court's questions would be sent to the trial counsel. SPC SS was also notified that if the full report was presented in open court, that any self-incriminating information provided by him would be redacted from the full report according to MRE 302. He was further informed that it was possible that the results of the report such as the diagnostic formulations could be used at the sentencing phase of the trial or for administrative action such as separation from service, a medical evaluation board (MEB), or a bar to re-enlistment. He was informed that if called to testify, the information obtained from this evaluation, as well as the conclusions thereof, could be made public. He voiced understanding of these warnings and consented to the evaluation.

4. SOURCES OF INFORMATION CONSIDERED:

Legal Orders  
Legal Records Related to Index Offense  
Additional Legal Records  
Criminal Investigative Records  
Educational Records  
Military Records  
Medical Records  
Miscellaneous Sources  
Collateral Interviews and Electronic Correspondence  
Consultations  
Evaluation Procedures of SPC SS

5. SOURCES OF INFORMATION NOT AVAILABLE:

6. ALLEGED VIOLATIONS OF UCMJ:
7. SWORN STATEMENT OF SPC SS:
8. ACCUSED'S CURRENT VERSION OF THE ALLEGED OFFENSE:

Charge I: Violation of the UCMJ, Article 118	Murder
Charge II: Violation of the UCMJ, Article 92	Failure to Obey Order or Regulation

9. LEGAL HISTORY:
10. PSYCHOSOCIAL AND FAMILY HISTORY:
11. INTERPERSONAL AND SEXUAL HISTORY:
12. FAMILY MEDICAL AND PSYCHIATRIC HISTORY:
13. EDUCATIONAL HISTORY:
14. OCCUPATIONAL AND MILITARY HISTORY:
15. PSYCHIATRIC HISTORY / MENTAL HEALTH RECORDS:
16. ALCOHOL AND SUBSTANCE ABUSE HISTORY:
17. MEDICAL HISTORY:
18. MEDICATION PROFILE:
19. MENTAL STATUS EXAMINATION:
20. PREVIOUS PSYCHOLOGICAL TESTING:
21. PSYCHOLOGICAL TESTING:

TESTS AND PROCEDURES ADMINISTERED:

Test Results:

22. DIAGNOSTIC ASSESSMENT:
23. DIAGNOSIS (At the Time of the Alleged Criminal Conduct):

Axis I:  
Axis II:  
Axis III:  
Axis IV:  
Axis V: GAF= xx (At the Time of the Alleged Criminal Conduct)

24. CURRENT DIAGNOSIS (At the Time of Evaluation):

Axis I:  
Axis II:  
Axis III:  
Axis IV:  
Axis V: GAF=xx (Current)

25. FORENSIC OPINION / COMPETENCY TO STAND TRIAL:

As noted R.C.M. 706(c)(2)(D) asks:

Is the accused presently suffering from mental disease or defect rendering the accused unable to understand the nature of the proceedings against him (trial by courts-martial) and to conduct or cooperate intelligently in the defense?

On this basis, SPC SS is found to be competent to stand trial at the time of this evaluation based on an opinion that is being offered to a reasonable degree of psychological certainty.

26. FORENSIC OPINION / CLINICAL DIAGNOSIS:

As noted RCM 706(c)(2)(B) asks:

What is the clinical psychiatric diagnosis?

Axis I:

Axis II:

Axis III:

27. FORENSIC OPINION / LACK OF MENTAL RESPONSIBILITY:

RCM 706(c)(2)(A) asks:

At the time of the alleged criminal conduct as set out in the alleged charges, did the accused have a severe mental disease or defect? (The term "severe mental disease or defect" does not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct, or minor disorders such as non-psychotic disorders and personality defects).

RMC 706(c)(2)(C) asks:

Was the accused, at the time of the alleged criminal conduct and as a result of such severe mental disease or defect, unable to understand the nature and quality or wrongfulness of his conduct? If so what is the degree of impairment of this capacity?

28. LIMITS ON CONCLUSIONS REACHED AND INTERPRETATION OF DATA:

This report is based on a large amount of information obtained from multiple sources. I believe that all information contained herein is accurate and provides an adequate basis to form both clinical and forensic opinions to a reasonable degree of psychological certainty. However, if any information is substantially inaccurate, I would appreciate it if this were immediately called to my attention. In addition, should we learn of any additional new information which casts substantial doubt upon either our clinical or forensic opinions, we will immediately notify the offices of Trial Counsel and Defense Counsel, and write an addendum to this report.

29. Questions regarding this case can be directed to xxxx.

Name  
Title  
Signature

