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TECHNICAL MANUAL

MILITARY MENTAL HEALTH LAW

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HEADQUARTERS, DEPARTMENT OF THE ARMY
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HEADQUARTERS
DEPARTMENT OF THE ARMY
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MILITARY MENTAL HEALTH LAW

This manual will serve to acquaint medical officers with the problems concerning the interface between the law and mental health.

You can help improve this manual. If you find any mistakes or if you know a way to improve procedures, please let us know. Mail your memorandum or DA Form 2028 (Recommended Changes to Publications and Blank Forms) to: Walter Reed Army Medical Center, Forensic Psychiatry Service ATTN: HSHL-ROP, Washington, DC 20307-5001. A reply will be furnished to you.

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CHAPTER 1

INTRODUCTION

1-1. General Information

a. Value of the Clinician. With the expansion of mental health expertise has come increased exposure to the legal justice system. Difficult and confusing legal cases become more understandable when clinically evaluated. The clinician can play a valuable role by providing expert opinions to the military justice system. There are a number of diverse areas which the clinician stands to influence. This includes competency determinations and the ability of a trial to progress, responsibility assessments and the impact on criminal culpability, and even the severity of sentence following a guilty verdict. Quality forensic evaluations require familiarity with the United States military justice system and basic standards of the law relative to responsibility, competency, and certain civil issues.

b. Pragmatic Training Manual. This training manual on mental health law is first and foremost designed to be practical. Guidance and explanation of legal concepts and methods of evaluation are focused, as much as possible, on clinical concerns. Numerous clinical examples are provided to elucidate difficult concepts. A chapter devoted to the military justice system interprets the world the clinician will function within.

c. Not a Source of Legal Authority. The reader must clearly understand that the discussions relating to psychiatric tenets and opinions are not binding on anyone. This manual offers recommendations which must be tempered by the clinical material and unique local considerations. The clinical examples cited are for descriptive explanation only and should not be considered "typical" or "standard."

d. Determination of Legal Issues. The clinician is an adjunct to the military justice system's efforts to provide a fair dispensation of justice. The clinician should remember that the legal determination of sanity and other lesser degrees of mental impairment is primarily a question of fact that can only be resolved by the members of a courts-martial. By producing a thorough and impartial forensic evaluation, the clinician aids the difficult task of the fact finder in reaching a verdict.

1-2. References

All publications referenced in this manual are listed in appendix A.

1-3. Explanation of Abbreviations and Terms

The following abbreviations are used in this publication:

ADAPCP	Alcohol and Drug Abuse Prevention and Control Program
AWOL	away without official leave
BCD	bad conduct discharge
CID	Criminal Investigation Division
FTCA	Federal Tort Claims Act
IDF	installation detention facility
IDT	inactive duty training
JAG	Judge Advocate General
MCM	Manual for Courts-Martial
MP	Military Police
MRE	Military Rules of Evidence
MTF	medical treatment facility
PMR	partial mental responsibility
RCM	Rules for Court-Martial
SJA	Staff Judge Advocate
UCMJ	Uniformed Code of Military Justice

CHAPTER 2

THE MILITARY JUSTICE SYSTEM

2-1. Introduction

The military justice system serves the dual purposes of justice and discipline. It is complex and multifaceted. The brief overview of the system which follows is not exhaustive. It is designed to introduce clinicians, who may be unfamiliar with the system, to some of its important aspects. Among the topics discussed in this chapter are the sources of the military justice system, its background and development, the rationale for a separate system of justice, its jurisdiction, and the levels of the court.

2-2. Sources of the Military Justice System

a. The Constitution. The basic source for the separate system of criminal law which prevails in the military is the Constitution of the United States. Article I, Section 8, of that document provides that Congress shall have the power to "make Rules for the Government and Regulation of the land and naval Forces."

b. The Uniformed Code of Military Justice. In 1950, Congress used its constitutional powers to enact the Uniformed Code of Military Justice (UCMJ), which was substantially revised by the Military Justice Acts of 1968 and 1983. This statute provides a separate system of military criminal law for the armed services, much the same as the State of Michigan and the State of Maryland have separate systems of criminal justice to meet their societal needs.

c. The Manual for Courts-Martial. Like most other statutes, the UCMJ requires a detailed set of regulations to supplement and explain its various provisions. Article 36 of the Uniformed Code of Military Justice (UCMJ, Article 36) authorizes the President to issue regulations prescribing the procedure to be followed before military tribunals, including the rules of evidence. In addition, the UCMJ, Article 56, empowers the President to establish limits on punishment for most offenses. These regulations are issued in the form of an Executive Order by the President and are found in the Manual for Courts-Martial (MCM), 1984. Therefore, the MCM has the force and effect of law, and it must be complied with.

d. Army Regulations. In addition to the MCM, AR 27-10 (Military Justice) fine tunes the everyday administration of military justice. This regulation announces additional rules and procedures which must be followed. Furthermore, supplemental military justice regulations have been issued by many local commands. Commanders must also consult and comply with these regulations.

e. Court Decisions. While regulations supplement and explain the statute, the various courts involved with military criminal law interpret the statute and regulations. The Supreme Court of the United States and subordinate Federal courts hear cases involving military criminal law. These cases are usually limited to appeals based upon lack of jurisdiction and appeals based upon a denial of some constitutional right. The United States Court of Military Appeals is the highest appellate court within the military judicial structure. This court is composed of five civilian judges appointed by the President. Each of the Services has an intermediate appellate court of review consisting of military appellate judges. The decisions of these courts in interpreting statutes and regulations have the force of law and are binding upon commanders.

f. The Staff Judge Advocate. The sources of military criminal law are varied. To effectively address most military justice problems, one must refer to one or all of these sources. This is what the staff judge advocate (SJA) is trained to do. The SJA is the command's legal advisor. Just as corporations consult with their general counsel before making legal decisions, commanders and their subordinates should contact their SJA for advice in dealing with problems of military justice.

2-3. Background and Development

a. Background. The UCMJ had its beginnings early in our history. Regulations for the government of our Army have been in force since the time of the American Revolution, when the Army law consisted of the Articles of War. The first Articles of War were adopted by the Second Continental Congress on 30 June 1775, just three days before George Washington took command of the Continental Army. These Articles were patterned after the British Army Articles, which were derived from earlier European articles traceable to the Middle Ages. Our system of military justice is

e product of centuries of experience in many u: Do not think, however, that the present 3l. s an outmoded historical relic. On the ntrary, while retaining the substance of what s proved sound, Congress has periodically recon-lered and revised the military justice system to in accord with new knowledge, experiences, and anging law.

b. The Uniformed Code of Military Justice, 1950. significant revision in the military criminal law stem occurred with the adoption of the UCMJ. It nbined the laws formerly governing the Army, ıvy, and Air Force into one uniform code which verns all uniformed Services of the United ates.

:. The Military Justice Act of 1968. A major ision of the UCMJ and the MCM occurred with e Military Justice Act of 1968. The revised CMJ and MCM incorporated changes in the law ıce 1951 and made substantial modifications in e military justice system.

(1) Among the changes brought about by the 68 Act is a provision which gives soldiers the ht to a qualified lawyer at a special court-ırtial in all but the rarest of circumstances. The litary Justice Act of 1968, Article 27(c) provides ıt ıccused shall be afforded the representa-n qualified lawyer except where a lawyer ınot be obtained due to physical conditions or litary exigencies. AR 27–10, paragraph 5–5*a*, ıvides further guidance in this area, stating that *all* special courts-martial the accused must be ɔrded the opportunity to be represented by ally qualified counsel. This right to counsel is addition to the accused's right to hire a civilian ɣyer or request individual military counsel. If accused requests individual military counsel, vever, the detailed military counsel will nor-lly be excused by the detailing authority.

(2) Besides providing for legal counsel at spe-c courts-martial, the Military Justice Act of 68, as implemented by AR 27–10, provides that military judge be detailed to special courts-rtial whenever possible. In the event that the cial court-martial is empowered to adjudge a l conduct discharge, a military judge must be ailed. The Military Justice Act of 1968 also es an accused the right to request trial by a itary judge alone in all cases except those ich are referred to trial as capital cases. If the used elects trial by judge alone, the military ge determines the guilt or innocence of the ı ınd, if there is a finding of guilty, the ı . The Act also places a number of added ɔonsibilities upon the presiding officer of the rt-martial. The judge makes all legal and proce-dural rulings at the trial and cannot be overruled by a commander on these decisions.

d. New Developments in the System.

(1) *Changes to the UCMJ.*

(*a*) Since 1979, Congress has amended the UCMJ several times in order to increase the efficiency of our military criminal law system. In November 1979, Public Law 96–107 amended the UCMJ, Article 2, authorizing court-martial jurisdiction over service members entering the Armed Forces as a result of recruiter misconduct.

(*b*) The Military Justice Amendment of 1981 became effective in January 1982. One significant change is that the accused is no longer entitled to be represented by more than one military lawyer. If the accused requests individual military counsel and that counsel is reasonably available, detailed military counsel shall be excused at the detailing authority's discretion. Reasonable availability is defined by the Secretaries of the Services. A definition of reasonable availability can be found in AR 27–10, chapter 5.

(*c*) Another change resulting from the Military Justice Amendment allows the commander or convening authority to direct that excess leave may be used by individuals who have been convicted by court-martial and are awaiting appellate review. Previously, these individuals could only be placed on excess leave at their request.

(*d*) The Military Justice Act of 1983 substantially revised the UCMJ. In an effort to improve the efficiency and administration of our military justice system, several necessary changes have been made. The Act relieves commanders of the administrative burden connected with personally excusing court-members before trial, eliminates requirements that commanders make certain legal determinations, and alleviates many redundancies that existed in the system. The most significant revisions in the Act provide for direct review of court of military appeals decisions by the United States Supreme Court and authorize Government appeal of certain rulings by military judges at the trial level. This major revision was incorporated into the 1984 MCM and took effect on 1 August 1984.

(*e*) The Military Justice Amendments of 1986, signed on 14 November 1986, further refine the military justice system. The most significant change involves the expansion of court-martial jurisdiction to include jurisdiction over reserve component soldiers who commit offenses while in an inactive duty training (IDT) status. In addition, the Act authorizes, in limited circumstances, reserve component soldiers to be called to active

duty for the purpose of trial by court-martial, investigation under the UCMJ, Article 32, or nonjudicial punishment.

(2) *Changes in the Manual for Courts-Martial.* In 1980, the Joint Service Committee on Military Justice was given the monumental task of rewriting the MCM. This task was completed in May 1983 and copies of the revision were made available for public comment in the Federal Register. The MCM, 1984, took effect on 1 August 1984, and replaced the MCM, 1969.

e. The Trend. The trend in military justice legislation and court decisions is to increase the efficiency of our criminal justice system while at the same time balancing and protecting the rights of the accused.

2–4. A Separate System of Military Justice

a. One of the unique features of the United States military society is its separate system of criminal justice. Most justice problems involving military personnel are resolved within this separate military justice system and only infrequently reach civilian criminal courts. What justifies our separate justice system?

b. The first justification for our system is historical and political. The military did not create its own separate system of justice. Throughout our history, and in accordance with the Constitution, the Congress of the United States has recognized the need to provide a separate justice system for the military forces. Congress established the military justice system by duly-enacted legislation, from time to time modifies this legislation to adopt changing law, and continually oversees and reviews the system.

c. Numerous factors motivate the Congress to provide a separate military justice system. Many crimes in military society—away without official leave (AWOL), disobedience, disrespect, misbehavior before the enemy, malingering—have no counterpart in civilian criminal law. Military leadership requires command participation in the administration of criminal-law processes which impact on subordinates—both as a reinforcement for leadership and as a control over those factors which influence the fighting capacity of the force. Because of force deployment, military society requires world-wide application of its criminal prohibitions and jurisdictional reach—unlike civilian criminal systems which are usually localized. The environment and realities of military society are different from those of civilian life, and criminal justice must be administered and cases decided by people sensitive to those differences. Finally, there is doubt that the civilian justice system could meet these requirements of military society. Commenting on the relationship between civilian and military criminal jurisdiction, the Supreme Court observed in *Relford* v. *Commandant,* 401 US 355 (1971), "The distinct possibility exists that civil courts . . . will have less than complete interest, concern and capacity for all the cases that vindicate the military's disciplinary problems." In short, mission and location require a separate system.

d. For these reasons, Congress has granted the military a separate criminal law system. It is inevitable in a democratic society such as ours that the military justice system will be compared with the civilian court system. While there are differences, in almost every instance military accused receive rights and protections equal to or superior to those enjoyed by civilian defendants. Indeed, commanders are responsible for administering military justice with utmost fairness and efficiency. By doing so, the trust and confidence bestowed upon military leadership by the American people and the Congress will be preserved.

2–5. Jurisdiction of Courts-Martial

a. Active Duty Jurisdiction.

(1) On 25 June 1987, the Supreme Court decided the case of *Solorio* v. *United States,* 107 S.Ct. 2924 (1987). This case dramatically changed the rules concerning court-martial jurisdiction. The Court held that jurisdiction of a court-martial depends solely on the accused's status as a member of the Armed Forces, and not on whether the offense is service-connected. The case overruled the "service-connection test" established by the Court in *O'Callahan* v. *Parker,* 395 U.S. 258 (1969). Now jurisdiction will be established by simply showing that the accused is a member of the Armed Forces.

(2) *Solorio* creates a situation where both the military and civilian authorities may have jurisdiction over a soldier and his or her offense; e.g., an offense committed off post. This necessitates SJA coordination with the local civilian prosecutor. Such coordination will ensure that the exercise of UCMJ authority is prudent and consistent with good order and discipline.

(3) Civilians, including family members, are not tried before courts-martial. If they commit offenses on post, they may be tried in the local State or Federal court. Commanders consult with their SJA when issues arise involving misconduct by civilians.

b. Jurisdiction Over Reservists.

(1) As a part of the Military Justice Amendments of 1986, Congress amended the UCMJ,

Articles 2 and 3. The new amendments extend jurisdiction over reservists on all types of training; and, in short, if the reservist is training, he or she is subject to military jurisdiction for crimes committed during the training period. The most significant change is reflected in the UCMJ, Article 2(a)(3), which allows the military to exercise authority without any threshold over reservists who commit crimes while performing weekend drill in IDT status.

(2) Recognizing that IDT periods are brief, usually lasting only one weekend, the amendments to the UCMJ, Article 3, allow reservists to return home at the end of IDT drill without divesting the military of jurisdiction. As a result, nonjudicial punishment administered under the UCMJ, Article 15, may be handled during successive drill periods. Specifically, while punishment can be imposed during one drill period, it can be served during successive drill periods. In addition, under the UCMJ new Article 2(d), the Government can order to involuntary active duty those reservists who violate the UCMJ during a training period. Reservists can be involuntarily ordered to active duty for UCMJ, Article 32 investigations, courts-martial, and nonjudicial punishment.

2-6. Levels of Court

a. Summary Court-Martial.

(1) The summary court-martial is the lowest level trial court for disciplinary actions in the military legal system. A summary court-martial is designed for disposition of minor offenses under simple procedures. It is composed of one commissioned officer. The law specifies no particular grade for a summary court-martial officer, and the powers are the same regardless of the individual's grade. Ordinarily, the summary court-martial officer should be a senior captain or a field grade officer. A neutral judge advocate will be designated as the legal advisor for the summary court-martial officer.

(2) A summary court-martial is normally convened by a battalion commander. It may also be convened by anyone having authority to convene a special or general court-martial. The summary court-martial is detailed by personal direction of the convening authority.

(3) A summary court-martial may try only enlisted soldiers. The soldier may be tried by summary court-martial for any non-capital offense punishable under the UCMJ; that is, for any offense for which the punishment is something less than death. The summary court-martial should be limited to relatively minor military offenses, however, and is often used only after an accused has been offered and refused nonjudicial punishment for the offense.

(4) An accused may not be tried by summary court-martial over the accused's objection. If the accused objects to trial by summary court-martial, the summary court-martial officer will note the objection and return the charge sheet to the convening authority for disposition. If the accused consents to trial by summary court-martial, the summary court-martial officer will proceed with the trial.

(5) The punishment powers of the summary court-martial are very limited. For example, a summary court-martial may only confine enlisted soldiers who are serving in the rank of corporal or specialist or below.

(6) In a trial by summary court-martial, an accused is not entitled to representation by military counsel. If the accused desires to be represented by a civilian attorney (at no expense to the Government), or if the accused has secured the services of a reasonably available individual military counsel, the summary court-martial officer should allow such counsel to be present.

b. Special Court-Martial (Non-Bad Conduct Discharge).

(1) The special court-martial is the intermediate court in the system. It has more sentencing power than the summary court-martial, but less than the general court-martial. Unlike the UCMJ, Article 15, and the summary court-martial, an accused may not turn down a special or higher court-martial.

(2) The punishment powers of the non-bad conduct discharge (BCD) special court-martial includes 6 months confinement, forfeiture of two-thirds pay per month for 6 months, and reduction to private. A special court-martial may not confine an officer.

(3) The membership of a non-BCD special court-martial may take any one of three different forms. It may consist of at least three members; at least three members and a military judge; or solely a military judge if the accused so requests. Special courts-martial are not presently tried without military judges. In some instances, an accused's request for trial by military judge alone may be denied by the military judge; however, special courts-martial are tried by military judge alone in the vast majority of cases when requested. If an enlisted accused requests that the court have enlisted membership, at least one-third of the court members must be enlisted soldiers.

(4) The military judge of a special court-martial is detailed by the U.S. Army Trial Judiciary. AR 27-10, chapter 8, covers the detailing of military judges and their administrative and logistical support.

(5) Trial and defense counsel are detailed for each special court-martial. The trial counsel need not be a lawyer; however, the accused has a right to be represented at the trial by counsel who is a lawyer and certified by the Judge Advocate General (JAG). As a matter of practice, both counsel are lawyers. The administrative task of making counsel available is generally handled through the offices of the responsible SJA and senior defense counsel.

(6) A special court-martial may try anyone subject to the UCMJ for any non-capital offense made punishable by the UCMJ; that is, for any offense for which the maximum punishment is less than death.

c. BCD Special Court-Martial.

(1) The BCD special court-martial is basically the same type of court as the special court-martial outlined above except that this court-martial has the power to impose a BCD as punishment. There are certain requirements which must be met before such punishment may be imposed.

(2) In order for a special court-martial to have the authority to impose a BCD, a qualified defense counsel and a military judge must be detailed (unless a military judge could not be detailed because of physical conditions or military exigencies), and a verbatim record must be made. In addition, AR 27-10 provides that the military judge be assigned to the U.S. Army Legal Services Agency (Trial Judiciary) and that only a general court-martial convening authority may convene a BCD special court-martial. In practice, all Army special courts-martial will have a military judge detailed to them.

(3) The BCD special court-martial option provides a forum for those cases where a convening authority deems a punitive discharge warranted but does not feel that the charges are serious enough to warrant more than 6 months confinement. Where the discharge is warranted and the case is referred to a special rather than a general court, the effort that would have been expended by the UCMJ, Article 32 investigation process described below is saved.

d. General Court-Martial.

(1) The general court-martial is the highest level trial court in the military legal system and must be convened by a general court-martial convening authority upon the formal pretrial advice of the SJA. This court-martial tries military personnel for serious offenses.

(2) The punishment powers of the court are only limited by the maximum punishments for each offense found in Part IV of the MCM and can include confinement for life and even the death penalty.

(3) The general court-martial may take either of two possible forms. It may consist of a military judge and not less than five members, or solely of a military judge, if the accused so requests. The accused may elect trial by judge alone in all cases except those which are referred to trial as capital cases. In all cases a military judge must be detailed to the court. An enlisted soldier is also entitled to at least one-third enlisted membership upon request.

(4) Trial and defense counsel are detailed for each general court-martial. Both the trial counsel and defense counsel at a general court-martial must be lawyers certified by the JAG.

e. UCMJ, Article 32 Investigation.

(1) No charge may be referred to a general court-martial for trial until a thorough and impartial investigation has been made in accordance with the UCMJ, Article 32. The officer appointed to conduct this investigation should be a field grade officer or an officer with legal training and experience. The purposes of the investigation are to inquire into the truth of the matters set forth in the charge sheet, to determine the correctness of the form of the charges, and to secure information upon which to determine the proper disposition of the case. The perfecting of a case for the Government is not a purpose of the investigation. The UCMJ, Article 32 investigating officer performs a judicial function and must obtain legal advice from a source not involved in prosecution or defense functions.

(2) The investigation will be conducted with the accused present and represented by a defense counsel. The accused is entitled to present evidence and to cross-examine witnesses. Also, the accused is entitled to have witnesses produced when they are reasonably available. After the investigation, a report of investigation will be made to the officer directing the investigation. The recommendations of the UCMJ, Article 32 investigating officer are advisory only.

CHAPTER 3

MILITARY STANDARDS OF RESPONSIBILITY

3-1. Introduction

Military regulations define the structure of the forensic evaluation and provide the legal standard to which the clinical information is tested. Knowledge of the proper standard is critical to a reasoned analysis. Improper application of the wrong standard can serve as a ground for appeal and eventual retrial.

3-2. The Forensic Evaluation in the Military

a. Sanity Board Composition. When an active duty soldier is accused of an offense, and there is a question about the mental responsibility of the accused, a board of one or more medical officers may meet to examine the accused. This panel of medical officers is commonly referred to as a "Sanity Board." It consists of either physicians or psychologists. There must be at least one psychiatrist or psychologist on the Board that reports on the soldier's mental condition at the time of the offense charged as well as his/her mental capacity to stand trial. Thus, issues of mental responsibility (insanity) and competency are addressed.

b. Dissemination of the Board's Report. The report may be requested before, during, or after trial by a court-martial. A full copy of the report is given to defense counsel, and the conclusions alone are provided to the trial counsel. Not only does the report assist in determining the proper disposition of charges; it may also influence sentencing.

3-3. Mental Responsibility Standard

a. The Military Standard. There are a number of legal tests or standards for insanity. The current military standard dictates a person is not mentally responsible for a criminal offense if the accused can demonstrate by clear and convincing evidence that at the time of the offense, the accused, as a result of a severe mental disease or defect, was unable to appreciate the nature and quality or wrongfulness of his or her conduct. This standard for lack of mental responsibility is set forth in Rules for Court Martial (RCM) 916(k)(1).

b. The Questions Asked. The Sanity Board, which evaluates whether the accused lacked mental responsibility, is governed by RCM 706. Three specific questions are asked of the Sanity Board, based on the military mental responsibility standard:

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

(2) What is the clinical psychiatric diagnosis?

(3) 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?

c. Competency. The Sanity Board is also asked whether the accused has a sufficient mental capacity to understand the nature of the proceedings and to conduct or cooperate intelligently in the defense. Additional questions may be posed consistent with RCM 706.

3-4. Definition of Terms

a. Introduction. Although a standard for mental responsibility exists, no specific legal clarification for implementation has followed. Thus, a general vagueness and confusion results. Analyzing the mental responsibility standard discloses certain key words and phrases—"severe mental disease or defect," "unable to appreciate," and "nature and quality or wrongfulness." To apply the standard appropriately requires an understanding of the key concepts.

b. Severe Mental Disease or Defect. A severe mental disease or defect, by legal definition, excludes an abnormality manifested only by repeated criminal or otherwise antisocial conduct, or minor disorders such as nonpsychotic behavior disorders and personality defects. Still, a credible argument can be mounted that an individual who meets criteria for a borderline personality disorder or certain amnestic states, although nonpsychotic, may be quite severe. Although the term "severe" is generally applied to psychotic disorders, nonpsychotic behavior with severe impairment in social or occupational functioning might well qualify.

c. Wrongfulness. In addition to requiring a severe mental disease or defect, the mental responsibility test requires the accused be unable to appreciate the nature and quality or wrongfulness of his or her conduct.

(1) The officer performing the evaluation must ear in mind that the wrongfulness of conduct is determined by society. The appraisal of the act within the accused's private ethical system is not determinative.

(2) Simply determining whether the conduct was right or wrong or whether the accused understands in more general terms the difference between right and wrong is insufficient. It is not appropriate to use one's own value system as a yardstick by which the accused's behavior is measured. The evaluating officer should, in essence, specifically address the accused's state of mind with reference to the criminal conduct.

d. Collaborative Materials. Collaborating data describing the accused's behavior surrounding the time in question is helpful. Such behavior as flight, attempt to conceal commission of the act, statements of repentance, and voluntary surrender to civil or military authorities may suggest that the accused was aware of consequences attendant to the alleged criminal conduct.

e. Nature and Quality. The mental responsibility test requires the accused, because of severe mental disease or defect, be unable to appreciate "the nature and quality" or wrongfulness of his or er conduct. The phrase "nature and quality" ssentially restates the wrongfulness or harmfulness premise.

f. Appreciation. The accused's "ability to appreciate" the nature and quality of wrongfulness of his or her conduct must be addressed. The mere presence of a mental illness, even a severe mental illness, does not necessarily impair the ability to appreciate one's conduct as wrong. The nature of the behavior must be evaluated as a result caused by the mental disease or defect. The motivation for the behavior and the resultant gain must be explored. For example, an individual with a history of schizophrenia, poorly controlled, burglarizes a house and steals money and jewelry. The ill-gotten proceeds finance an expensive drug habit. During the burglary, which occurred at night, attempts were made to be furtive. This data suggests appreciation of the wrongfulness of the act.

g. Inability to Appreciate.

(1) Contrast this scenario with an individual who has a slowly evolving paranoid delusional disorder. As time progresses the individual is "convinced" that his immediate supervisor is spy- ng on him both at work and home. He believes at his supervisor then initiates a series of damaging rumors. At work, he thinks people talk behind his back. Every communication becomes threatening. In order to avoid confrontation, which the soldier feels is inevitable, he hides in his house with the blind closed, a club at the ready. Life becomes suffocating, all because of one individual. Finally, the individual perceives that his supervisor means to personally injure him. Fearing for his life, he preempts his supervisor and strikes first. The supervisor is mortally wounded; the accused awaits the police so he can present his case of self-defense.

(2) In this case, the soldier has a severe mental illness, a delusional disorder, paranoid type. The inability of the soldier to appreciate the wrongfulness of his behavior is considered in context with the mental disorder. In this elaborate delusional system, the soldier is convinced that while murder is wrong, to have done nothing would have been to forfeit his own life.

3-5. Assessing Criminal Responsibility

a. Assessing the Mental State. Assessing criminal responsibility requires close adherence to the prevailing mental responsibility standard. A retrospective analysis of mental state must then be performed. While it may seem an impossible task to determine a person's past mental state, this same exercise is performed by the jury/fact finder. As an expert on human behavior, the clinician provides guidance in understanding a prior mental state. The clinician's assessment of criminal responsibility is then best viewed as an adjunct to a lay decision-making process.

b. Accuracy Required. The opinion rendered by the clinician must be based on the "usual degree of medical certainty." In evaluating the accused's prior mental state then, the clinician is not held to an unreasonable standard. Where two competing hypotheses are present (was or was not the accused able to appreciate the wrongfulness of his or her behavior, for example), that argument with the most compelling data that simply tips the scales is sufficient to opine "within the limits of medical certainty"; "more probable than not"; or roughly 51% accuracy.

c. Components of the Responsibility Analysis. When the clinician assesses criminal responsibility, three basic inputs are required: collateral reports; a clinical evaluation, blending current mental status with a retrospective analysis; and the application of the mental responsibility standard. Collateral reports should be sought which describe the accused's behavior at or about the time of the alleged event(s). Evidence of disordered thinking is sought. The mental responsibility standard also requires an assessment be made of the accused's ability to appreciate the wrongfulness of his/her behavior. Clues are gathered from investi-

gative reports. To appreciate wrongfulness implies the ability to predict consequences. The accused who runs from the crime scene may be avoiding capture. An emotional expression, such as crying, remorse, or guilt suggests the accused was aware of his or her behavior, and this element should be explored. The need to confess is a powerful motivator of behavior. Any attempt to conceal aspects of the crime such as hiding a body or a weapon clearly indicates the accused was aware of the wrongfulness of his or her behavior. The manner in which the accused acted is also critical. Was the behavior purposeful, for example, or did it seem erratic? Could gain be predicted from the accused's action? The clinical evaluation also examines the investigative reports for any evidence consistent with a severe mental disorder. Witness statements can be particularly useful here. Any contradictions between the witness and the accused's versions of the alleged offense should be explored. The current mental state may also, by inference, be indicative of past mental functioning. The accused who displays the residual characteristics of a psychosis may have had an acute episode earlier. Current borderline personality dynamics may prompt an exploration, through retrospective analysis, of a brief reactive or atypical psychosis.

3–6. Clinical Examples

a. Malingering.

(1) An example of feigned mental illness is described first. The clinician received the investigative report on the accused who was charged with assault with intent to murder. The accused claimed a voice had ordered him to assault his first sergeant. A thorough review of the investigative reports and an exhaustive clinical evaluation concluded—

(*a*) There was no evidence of unusual behavior reported by witnesses.

(*b*) The accused fled the scene.

(*c*) There was no prior history of mental illness.

(*d*) The clinical evaluation was normal.

(2) It was concluded that no mental disorder was present. The accused later reported that "the voice" was made up. If the presence of a severe mental disease or defect is established, the next step is to examine the ability of the accused to appreciate the wrongfulness of his or her conduct. The mere presence of a severe mental disease or defect is not sufficient. Legally, a causal relationship between the severe mental disease or defect and the alleged criminal activity must be established.

b. Responsible Conduct and Severe Mental Illness.

(1) An example of an accused with a documented history of a severe mental illness that did not impair responsibility is discussed next. The accused had a long, documented history of schizophrenia, paranoid type. He also had a history of episodic violence. The accused was charged with assaulting a girlfriend. The accused cited mental confusion and hallucinations as causal. The forensic evaluation established—

(*a*) The accused did have a severe mental disorder but had just received his periodic intramuscular neuroleptic.

(*b*) Clinically, the accused exhibited no current signs of psychosis.

(*c*) The accused and his girlfriend had quarreled over money, and after assaulting her, he fled the scene.

(2) In this case, there is a severe mental disease, but it had no causal relationship with respect to the criminal behavior. The clinician must carefully explore the criminal behavior to determine if any such connection to the mental disease or defect exists.

c. Not Criminally Responsible.

(1) An example of a severe mental illness and lack of responsibility is suggested next. The accused was charged with murder. The facts indicate the accused reported to work on time, immediately went into his supervisor's office and stabbed him. The accused then sat down in the office, looking dazed and confused. The forensic evaluation disclosed—

(*a*) The witness statements described the accused as confused and talking illogically. He kept muttering about a "plot."

(*b*) The clinical evaluation found both current and past evidence of a psychosis. Specifically, delusional content centered around the accused's belief that his supervisor was plotting to kill him. The accused struck first when a voice told him that his supervisor had hired some "hit men."

(2) In this case, the presence of a severe mental disease, coupled with the markedly illogical reasoning, substantially impaired the accused's ability to appreciate the full context of his behavior. The mental disease or defect was intimately intertwined with the subsequent criminal behavior. There was no apparent goal other than "self-defense."

d. Somnambulism and Responsibility.

(1) A situation where responsibility for criminal conduct was affected involved a newly married sergeant who was being evaluated after assaulting his wife. The sergeant recalled falling asleep and

veral hours later awakening because of his f reams. The intervening period was a a. ıe wife provided the missing information. ıe was herself awakened when her husband arted yelling and then repeatedly struck her. ıe screamed; he finally "awakened" and was ofoundly upset at his behavior. Neighbors re-rted the incident to the police upon hearing the reams. There were no marital problems but cent job stresses had taken a toll. The sergeant as moody and irritable. Similar somnambulistic havior had occurred before.

(2) Since the facts of this case satisfy the quirements of the insanity defense, if referred r trial, the defense of insanity could prevail.

e. Amnesia and Responsibility.

(1) In a different case, an officer was charged ith attempted rape. The accused claimed amne-a. He could provide no details of his behavior fore, during, or after the attempted rape. Collat-al data disclosed the furtive behavior employed the accused to accost the victim. During the tack, he threatened harm if the victim screamed. fter the unsuccessful rape, the accused fled. linical evaluation discovered no mental illness.

(2) In this case, the court would probably find m ntally responsible for the crime because he t if he were doing something wrong. Amne-a ı, itself is insufficient to rebut the necessary ental state. In addition, even if amnesia resulted om a severe mental disorder, the causal relation-ıip must be proved.

–7. Partial Mental Responsibility

a. Impact on Criminal Culpability. Partial men-ıl responsibility (PMR) does not exonerate crimi-al conduct. PMR focuses on intent or that mental ıate whereby the person both knows and wishes ıat certain consequences will follow a certain ctivity. All criminal offenses have both a physical nd a cognitive component. The physical compo-ent, or the guilty deed itself, is the *actus reus*. In ıurder, for example, the *actus reus* is homicide. he cognitive element in criminal offenses, the vil or criminal mind, is referred to as the *mens ea*. In murder then, the *mens rea* is the malice forethought or desire to harm.

b. Degrees of Mens Rea. PMR lies exclusively ithin the domain of the emotional element of riminal offenses, or the *mens rea*. Different rimes have different *mens rea*, with the more evil or criminal mind" present, the greater the ıe s. Thus, premeditated murder, which may a. ıe death penalty, requires that the accused pecifically intend to kill the victim and consider he act of killing before committing the homicide. Unpremeditated murder requires an intent to kill or inflict great bodily harm, but does not require consideration of the killing act. Lesser forms of homicide, such as involuntary manslaughter and negligent homicide, require no intent to kill.

c. Mitigating and Extenuating Factors.

(1) PMR can negate the following special states of mind required for some crimes: specific intent, knowledge, willfulness, and premeditation. PMR will not, however, negate a general criminal intent. Where an offense requires specific intent, and no lesser included offenses requiring general criminal intent are raised by the evidence at trial, PMR will act as a complete defense.

(2) Factors that do not exonerate criminal behavior but instead may reduce the accused's sentence are referred to as mitigating circumstances. PMR is generally such a mitigating circumstance. The defense may argue, for example, that a mental disorder impaired the accused's ability to premeditate or deliberate due to the "fogging" effect of acute alcohol intoxication. Again, the evaluating officer must not peremptorily conclude that any mental disorder, including substance abuse, necessarily vacates higher cognitive functioning. The accused's behavior must be carefully studied, again using collateral data.

d. Intent. In some cases, the clinician is requested to provide opinions regarding specific and general intent. A general intent is an element of virtually all crimes. Specific intent, which is required for some offenses, encompasses general intent and further requires a singular state of mind. Some simple assaults are general intent crimes. Assault with intent to commit murder is a specific intent crime, requiring that the accused's assault on the victim be accompanied by the specific intent to murder. The presence of a mental disorder may, thus, negate the specific intent element, but the accused may nonetheless be guilty of a lesser included offense requiring only general intent (e.g., assault with a means likely to produce death or grievous bodily harm, a crime requiring no specific intent).

e. Clinical Example of PMR. An example of PMR, with its exclusive focus on mitigating the degree of *mens rea*, involves alcohol abuse. The accused was charged with premeditated murder after a barroom brawl left a former friend dead. During the trial, the accused's extensive alcohol abuse history was described. This information, along with recent marital and job stress, the unplanned nature of the murder, and the accused's grief after learning of the death, all lessened the "criminal mind" aspect and resulted in conviction for unpremeditated murder.

CHAPTER 4

COMPETENCY

4-1. Introduction

a. In the absence of evidence to the contrary, the law presumes that a person is competent to make decisions, conduct business, and stand trial if accused of a crime. The terms "competency" and "responsibility" are, at times, improperly used interchangeably. The major difference between competency and responsibility is a temporal one. The court is concerned with the accused's mental state at two points in time. The court needs an assessment to determine responsibility when the offense was committed. At the time of the trial, the court is concerned with the mental state of the accused to insure competency.

b. There are a number of legal areas where competency issues are raised. In the criminal setting, this includes the ability to stand trial, to make a confession, and, in capital sentencing cases, competency to be executed. The major difference between civil and criminal competency lies in meeting more stringent proof requirements for criminal proceedings. This is reflective of the more severe penalties and loss of life and liberty interests that a criminal trial may produce.

(1) *Affect on Trial Proceedings.* Once an issue of competency is raised and an evaluation ordered, the trial proceedings halt. The trial cannot continue until a judicial decision, based on expert opinion, is reached, concluding that the accused is competent to stand trial.

(2) *Competency to Stand Trial.* To ensure fairness in the judicial system, a defendant must be capable of participating in his/her own defense. If a mental disorder supervenes, the accused may not be able to logically pursue his/her defense. If the attorney working with the accused suspects a mental disorder is impairing cognitive functioning, the attorney must report the matter and relevant facts to the authority empowered to order a sanity evaluation. Although the concept of competency has been present since the earliest recorded history, an exact definition remained elusive. The controversy reached the Supreme Court in *Dusky* v. *United States* 362 U.S. 402 (1960). *Dusky* provides the guiding language for criminal competency. The opinion states that a competency test "must be whether he (the accused) has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he has a rational as well as factual understanding of the proceedings against him." In the U.S. Army this has been rephrased by RCM 909 to read—"Does the accused possess sufficient mental capacity to understand the nature of the proceedings against him/her and to conduct or cooperate intelligently in his/her defense?" The cause of the lack of mental capacity must be a mental disease or defect.

(3) *Two Parts of Competency.* In both standards a volitional and a cognitive element are present. The military volitional element of the competency standard requires the accused have the ability "to conduct or cooperate intelligently in his/her defense." The cognitive component requires that "the accused possess sufficient mental capacity to understand the nature of the proceedings against him/her." In other words, a clear mind and emotional stability are important, and disturbances in either can impair competency.

4-2. Conducting a Competency to Stand Trial Evaluation

a. The Competency Assessment.

(1) The competency evaluation will carefully evaluate the accused's present mental state. Particular emphasis will be placed on the cognitive and volitional elements necessary to traverse the justice system. The competency assessment should evaluate—

(*a*) The accused's understanding of available defenses.

(*b*) The risk of unmanagable conduct.

(*c*) The ability to relate to the attorney.

(*d*) The ability to develop legal strategies.

(*e*) Whether the accused has a basic understanding of the justice system.

(*f*) The accused's understanding of the charges with the possible sanctions.

(*g*) The ability to propose a possible outcome of the process.

(*h*) The ability to provide information to defense counsel.

(*i*) The ability to rebut Government claims.

(*j*) The ability to testify appropriately.

(*k*) The presence of significant self-defeating behavior.

(2) A determination of the degree of impairment is then made. Deficits should prompt further investigation. It must be remembered that any deficit must be causally related to a mental disorder. Apathy, indifference, and malingering do not impair competency.

b. Appraising Legal Defenses. The evaluation must determine how capable the accused is of aiding his or her own defense. Useful questions include—

(1) What is your understanding of the charges?

(2) How can you best help your attorney help you?

c. Unmanagable Conduct. Few things disturb courtroom decorum as much as the noisy, impulsive, uncontrolled client. The evaluation must determine if inappropriate behavior is the result of a mental disorder that interferes with the accused's competence. Some defendants are unruly and disruptive yet remain competent. The clinician's best service is in distinguishing those who cannot appreciate the proceedings or participate in their own defenses. Useful queries to assess this include—

(1) If you find something objectionable in the trial proceedings, how best can you express yourself?

(2) What effect will continued disruptive behavior have on your trial?

d. The Ability to Relate to the Attorney.

(1) Simple lack of confidence in the attorney is not sufficient. There must be a mental disorder present that impedes cooperative conduct. Useful questions include—

(*a*) Can you work with your attorney?

(*b*) Is your attorney doing his or her best?

(2) In assessing this aspect of competency, the ability of the accused to relate to the evaluating officer is a useful yardstick. An example of impairment would be the patient with a paranoid delusional disorder who can trust no one, save himself or herself. A severe lack of trust in anyone, including the accused's own lawyer, may so handicap cooperation that the legal defense is compromised. Medical treatment might be indicated before the accused could stand trial.

e. The Ability to Develop Legal Strategies.

(1) The attorney, in formulating the defense strategy, will often propose various options to the accused. The ability of the accused to consider this advice is important. Useful questions include—

(*a*) Would you accept an administrative separation with less than an honorable discharge (discharge for the good of the Service, AR 635-200, chapter 10) in lieu of a general court-martial, if offered?

(*b*) What will be your response if your attorney suggests you do not testify?

(2) Difficulties arise when the accused is resistant to any advice and rigidly pursues a course contrary to his or her best interests. The clinician's assessment will help establish whether such apparent behavior is the result of a mental disorder. Appropriate medical care will intervene if the condition warrants.

f. Basic Understanding of the Military Justice System. For the accused to effectively participate in his/her own defense, a minimal knowledge of the military justice system is needed. Areas of assessment might include—

(1) What are the roles of the trial counsel, defense counsel, military judge, and the function of the court members (jury)?

(2) Do you understand the basic sequence of trial proceedings, such as who performs the cross-examination, the purpose of this, who determines the sentence, and what avenues are available if a guilty verdict is reached?

(3) What will be the consequences if you are sentenced to confinement?

g. Understanding the Charges and Penalties. An appreciation of the seriousness of the charges and the range of possible penalties is important information to gather. A minimizing of the consequences, for example, could impair the accused's ability to effectively work in his or her own defense. Useful inquiries would include—

(1) What are you charged with?

(2) What would be a typical sentence should you be found guilty?

h. Assisting Defense Counsel and Rebutting Prosecution Claims. In the overall assessment of competency, the ability to discuss relevant issues and counter prosecution charges is paramount. In general, the clinician's detailed review of the accused's version of the alleged criminal activity may prove helpful in this assessment. The examination may include—

(1) Having the accused describe in detail the where, what, when, and how of the alleged criminal conduct.

(2) A careful mental status examination with special attention to potential memory deficits.

i. The Ability to Testify Appropriately. This particular element is best determined by the ability of the accused to render a logical account of his or her behavior and to respond appropriately to examination and cross-examination by counsel.

Clearly, the presence of a psychosis would exclude the ability to testify relevantly.

j. Self-Defeating Behavior. In some mental disorders, the drive for expiation is so great that no attempt is made to defend oneself. Instead, the accused eagerly anticipates, and desires, the most stringent punishment possible. This is to be contrasted with the truly repentant individual, who while acknowledging wrongdoing, does not wish an exaggerated punishment. Useful inquiries include—

(1) What punishment is sufficient for what you feel you have done?

(2) Will you accept a lesser penalty if your attorney can arrange it?

4–3. Clinical Examples of Criminal Competency

a. Incompetent. An example where the accused's mental state impaired competency is described first.

(1) The accused had been recently charged with shoplifting. Prior to the arrest, his military career had been exemplary. In fact, a promotion awaited him. The articles taken were of little value, and the soldier had more than enough money on his person to pay for the items. When initially consulting with his attorney, the soldier appeared depressed, lethargic, and withdrawn. Questions posed by the attorney were answered monosyllabically. The accused did mention he felt he deserved the death penalty. A diagnosis of severe major depression was made.

(2) In performing the competency evaluation, the evaluating officer opined incompetence due to a mental disorder based on—

(*a*) The inability of the accused to relate to his attorney.

(*b*) The inability to develop a legal strategy.

(*c*) The inability to understand the reasonable punishment if found guilty.

(*d*) The inability to testify.

(*e*) The presence of significant self-defeating behavior.

b. Competent. A common example where competency is usually unaffected is the emotionally upset pre-trial detainee.

(1) A soldier was placed in detention after being AWOL while pending court-martial for drug possession and distribution. Once incarcerated, the soldier was found crying, anxious, and voicing vague suicidal ideations.

(2) The mental status and competency evaluations disclosed no cognitive or volitional impairment. The accused clearly understood his predicament and even posited viable defense strategies. His concern arose primarily from a fear of a possible guilty verdict. The accused was returned to pretrial detention with suicide precautions and mental health followup.

CHAPTER 5

THE CRIMINAL FORENSIC EVALUATION

5-1. Introduction

a. Special Defense of Insanity Plea. Under Federal law and the UCMJ, the insanity plea is considered an affirmative or special defense. As such, the accused does not deny the facts which give rise to the charge but instead provides evidence that will excuse criminal culpability. The accused has the burden of proving, by clear and convincing evidence, that he/she is not guilty by reason of insanity. Cooperation in the Sanity Board process must exist with either the accused, defense counsel, or both. If the Sanity Board finds such cooperation lacking with the accused, the presence of a mental disease or defect must first be explored. Lacking this explanation, counsel should be contacted and the situation discussed. In rare cases, the Sanity Board may be unable to render an opinion and should so state in writing.

b. Impact of Noncompliance. In one example, defense counsel requested a Sanity Board. The order for inquiry into the accused's mental state was prompted by his unusual behavior during commission of the offense. When instructing his client, counsel advised the accused not to discuss anything concerning the day in question. Although it was apparent the accused could provide vital information to the Sanity Board, he dutifully obeyed counsel's instructions. The Sanity Board was unable to render an opinion. A statement indicating that the order for inquiry into the mental state of the accused could not be accomplished, and the reasons were submitted to the convening authority. Subsequently, the defense counsel reversed course and instructed his client to cooperate fully. The Sanity Board eventually opined the presence of a severe mental disease or defect and a resultant inability of the accused to appreciate the nature and quality of his conduct.

5-2. Preparing for the Forensic Evaluation

a. Confidentiality. The accused must first be informed of the limits of confidentiality of communications. It is best to have the defense counsel advise the accused of limits of privilege. Subsequently, at the evaluation the psychiatrist can ask the accused what his or her understanding of the privilege is, and at that time the psychiatrist can reaffirm the limits. If pursued to trial, the accused must understand that the clinician may have to testify. As such, the accused's statements to the clinician may not be protected. The accused should further be advised that during the evaluation, notes will be taken, and anything the accused would prefer not to discuss is his/her right. However, lack of information may impede the ability of the Board to render a useful opinion. The accused must be instructed that at the conclusion of the evaluation, a written report will be generated. Prior to trial, certain safeguards exist so that the full report generally only goes to defense counsel. Only the Board's conclusions are seen by the trial counsel. The Fifth Amendment or UCMJ, Article 31 warning should not be given to the accused.

b. Limited Privilege. The Military Rule of Evidence (MRE) 302 establishes a privilege in favor of the accused. MRE 302 states:

> "(a) *General rule.* The accused has a privilege to prevent any statement made by the accused at a mental examination ordered under RCM 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."
>
> (b) *Exceptions.*
>
> (1) There is no privilege under this rule when the accused first introduces into evidence such statements of 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).

(c) *Release of evidence.* If the defense offers expert testimony concerning the mental condition of the accused, the military judge, upon motion, shall order the release to the prosecution of the full contents, other than any statements made by the accused, of any report prepared pursuant to RCM 706. If the defense offers statements made by the accused at such examination, the military judge may upon motion order the disclosure of such statements made by the accused and contained in the report as may be necessary in the interests of justice.

(d) *Noncompliance by the accused.* 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.

(e) *Procedure.* The privilege in this rule may be claimed by the accused only under the procedure set forth in MRE 304 for an objection or a motion to suppress. If the accused invokes the privilege at this court-martial, any direct statements made in the course of the sanity board evaluation may not be testified to at trials unless the door is opened by the accused or his defense team. This right exists regardless of whether the accused received Fifth Amendment or UCMJ, Article 31 warnings."

5-3. Conducting the Evaluation

a. General. A request for inquiry into the mental capacity and mental responsibility of the accused may be received before, during, or after a trial. That same request must specify the basis for the request. Since the legal system is not expert in determining impairment, a mental evaluation should be requested if the military justice system questions the presence of a mental disease or defect. The hypothesis correlating mental illness with the alleged criminal conduct or lack of competence to stand trial ideally should be described in the initial request.

b. Collateral Data.

(1) Collateral information is imperative. Generally, defense counsel is the source for these materials. At a minimum, the Board should receive—

(*a*) The charge sheet.

(*b*) Military Police (MP) records.

(*c*) Criminal Investigation Division (CID) report.

(*d*) Sworn statements.

(*e*) The UCMJ, Article 32 proceedings (if done).

(*f*) Selected military records.

(*g*) Blood alcohol test/drug testing results.

(*h*) Medical/Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) records.

(2) In addition, the Board may find it useful to interview commanders, co-workers, family members, and others who know the accused.

c. Responding When the Order Directs Specific Tests. The request itself may contain specific conditions. Issues such as discrete medical or psychological tests, composition and qualification of the Board members, and requests for recording the evaluation may be present. Any such requests must be evaluated in terms of existing rules as outlined in RCM 706c and proper medical care. For example, RCM 706c does not require: a forensic psychiatrist, a Board of three psychiatrists, specific medical tests, specific psychological tests, or audio/video recordings. In fact, RCM simply states that "Normally, one member of the Board shall either be a psychiatrist or a clinical psychologist." The tests that should be ordered are the proper province of the Sanity Board, not the legal system. The Board should explain that the diagnostic tests are not randomly ordered, are expensive, and time consuming. The mental status of the accused determines what, if any, tests are needed.

d. Speedy Trial Rules. The military has a strict requirement for a speedy trial, and violation of this rule can result in dismissal of charges. Rule 707 of the MCM in part, notes:

"The accused shall be brought to trial within 120 days after notice to the accused of preferral of charges or imposition of restraint when the accused is in pretrial . . . for the same or related charges. The following periods shall be excluded when determining whether the period of this rule has run, including (a) any examination into the mental capacity or responsibility of the accused; or (b) any hearing on the capacity of the accused to stand trial and any time during which the accused lacks capacity to stand trial. When the accused is in pretrial arrest or confinement, immediate steps shall be taken to bring the accused to trial. No accused shall be held in pretrial arrest or confinement in excess of 90 days for the same or related charges."

In a similar fashion, requests for recording or for the presence of the attorney during the evaluation should be discouraged. The Board must have the ability to conduct the evaluation as free from artificial distraction as possible.

e. Scheduling the Interview. The first appointment with the accused should be scheduled as soon as possible. This is usually coordinated with the trial counsel.

f. Reviewing the Order for Inquiry. The clinician should carefully review the request for inquiry into the mental capacity for mental responsibility of the accused. This outlines the specific questions that must be answered. The evaluation should be structured to gather the necessary information.

g. Components of the Clinical Interview. The basic interview consists of—

(1) The accused's statement, in detail, describing the offense. A discussion of behavior before, during, and after the offense should be examined. The role of substance abuse in the accused's mental state is reviewed.

(2) A thorough review of social/family history. The emphasis should be on relationships, school and work performance, past legal and psychiatric history. A sexual history also is done. All of this is reviewed to establish the presence of an enduring pattern of maladaptive behavior.

(3) The mental status examination.

h. The Medical Evaluation.

(1) The clinical interview also includes a medical evaluation. If a clinical psychologist is the only member of the Sanity Board, then a need exists to request the appropriate consultation from a competent medical authority. Accordingly, such an individual would have to be apprised of the nature of the request for consultation as well as informing the accused of the request. A detailed history of head injuries, convulsions, amnesia, headaches, and general health is taken. When medically indicated, perform—

(*a*) A physical exam (with a screening neurologic exam).

(*b*) Routine laboratory studies.

(*c*) A computerized tomogram scan or magnetic resonance imaging.

(*d*) An electroencephalogram.

(2) Other specialty examinations should be performed when warranted. Medical consultation should be requested when appropriate.

i. Psychological Testing. If psychological testing is indicated, the case may be reviewed with a clinical psychologist to help determine the tests best suited for clarification of the clinical diagnosis.

j. Hospitalization for Evaluation. If it will aid the examination and help avoid delays, the patient may be hospitalized in order to facilitate determining mental status. The accused should not routinely be admitted, but only when circumstances dictate. Some of the conditions warranting inpatient evaluation are if—

(1) The accused is mentally or physically ill and meets the usual criteria for admission.

(2) A large battery of testing is planned and an inpatient status would be more efficient. If the patient is admitted both defense counsel and trial counsel should be notified. Obtaining guards, when necessary, is coordinated through the trial counsel, unit commander, or detention facility.

k. Need for Expedited Evaluations. The MCM authorizes recesses or adjournments in the trial proceedings when necessary to determine the accused's mental state. In general, however, unnecessary delays should be avoided in conducting the examination. The accused is entitled to a speedy trial which, if violated, could result in dismissal of charges.

l. Responding to a Confession. If a confession to the alleged criminal conduct occurs during the evaluation, the evaluator should confer with the defense attorney. If the accused admits culpability for an uncharged offense (such as child abuse) in which the admission must be repeated officially, the evaluator should consult with the defense attorney and trial counsel if he or she reasonably believes that the events may have occurred.

CHAPTER 6

APPLICATION OF THE MENTAL RESPONSIBILITY STANDARD

6-1. General

This chapter provides clinical guidance for integrating the medical diagnosis with legal issues. Specific mental diseases or defects are reviewed with respect to the mental responsibility standard. Obviously, such a review can never be complete. Scientific advances require the clinician to consult authoritative periodicals. In addition, the complexities of human behavior and the variations that each accused's alleged crime present require flexibility. Furthermore, no specific mental disease or defect automatically equates with lack of mental responsibility. The presence of a severe mental disease or defect is only a portion of the data considered. The remainder concentrates on the impact of mental disease or defect on criminal behavior.

6-2. Substance Use Disorders

a. Voluntary Use of Intoxicants. Over half of all violent offenses are committed by an accused under the influence of drugs or alcohol. Property offenses (burglary, arson, fraud) have similar rates. Also important are arrests where substance use was the offense, such as drunkenness, disorderly conduct, driving under the influence, and drug abuse violations. Clearly, society is permeated by substance abuse. The line between substance use and disorder is based on clinical judgment. At a minimum, substance use must promote some degree of social or occupational dysfunction. Except under certain conditions, social or occupational impairment is not at the level of a severe mental disease or defect. With perhaps one exception, substance abuse will not esculpate. Intoxication may negate the specific intent requirement for UCMJ, Article 121 offenses of "larceny or wrongful appropriation." In the absence of this specific intent, voluntary intoxication may be a complete defense. The voluntary use of alcohol embodies the assumption that the drinker or drug-taker is aware of the risks entailed with excess consumption. Drinking beyond personal limits then becomes a matter of choice. Drug use has one potential difference. Illicit drugs may be produced with varying levels of quality control. Although voluntarily used, the exact composition of the substance could be a partial mystery. Still, the user assumes this risk.

b. Substance Use as a Mitigating Factor. Substance use then is not often legally advanced in hopes of attaining a non-responsibility acquittal. Instead, the substance use is offered as a mitigating factor on the intent element or in hopes of reducing the sentence. Defense counsel may assert that, secondary to the mind-altering effects of drugs or alcohol, specific intent could not be formulated. Thus, the crime of premeditated murder may be reduced to unpremeditated murder. It does not follow that substance use always removes the requisite knowledge or special state of mind required by law for premeditated acts. The amount of alcohol or drug used, the social setting, whether the accused had eaten, prior experience with the substance, the time interval between use and criminal act, the presence of purposeful goal-directed behavior such as flight or concealment, environmental factors related to behavioral expression, the relationship between accused and victim, and any potential gains from the criminal conduct must all be explored to determine the effects of substance use on cognitive abilities.

c. The Effects of Alcohol. Alcohol is a disinhibiting substance. Behavioral controls are relaxed with use. The normally nervous, shy individual may feel emboldened when certain psychological defenses are weakened. In a different fashion, some individuals "drink to forget" seeking the mind and body-numbing anesthetic-like properties of alcohol. As drinking continues, a complex interplay between alcohol, environment, and personality dynamics emerges. The individual, now generally aware of the intoxication, adopts a less socially motivated stance and turns instead to an "I don't care" attitude. Previous frustrations, not as firmly held in check by social or individual restraints, may now be vented. Thus, an individual prone to depression may become suicidal while the fundamentally angry person becomes the violent drunk.

d. Alcohol and Severe Mental Illness. Certain alcohol-induced conditions may relieve accountability for criminal behavior. Alcohol hallucinosis, alcohol withdrawal delirium, and dementia associated with alcoholism may qualify as severe mental

sorders. The clinical examiner must then determine if the alcohol-related mental disorder caused the accused to be unable to appreciate the wrongfulness of his or her conduct. Alcohol idiosyncratic intoxication, a pathological intoxication, is an unusual variation. In people who suffer from this rare disorder, ingestion of small amounts of alcohol may be associated with violent behavior. A pre-existent brain injury, such as trauma or infection, may be a predisposing factor. The accused is usually amnestic for the episode. This disorder might remove the *mens rea* or "criminal mind" producing a successful defense. The clinician must still be careful to elicit the full history since this diagnosis is subject to fabrication. In addition, if the accused knew the effect that alcohol created, the prosecution could argue that he or she should have refrained from its use. In this case, a defense based on alcohol is shallow and might not exonerate the accused or mitigate the circumstances.

e. Drug Use and Severe Mental Illness. When drug use induces a psychosis or delirium, as with alcohol, the necessary mental state required for criminal activity may be absent. A careful history of drug use should include—

(1) The types of drugs used.
(2) The quantity of drugs used.
(3) The drug cost and source of financing.
(4) The route(s) of administration.
(5) The social setting where use occurs.
(6) The relationship of accused to victim.
(7) How the accused treats "bad trips."

f. Criminal Case Involving Drug Abuse. A clinical example is a soldier who had been steadily increasing his consumption of amphetamines. His mental state correspondingly deteriorated into frank paranoia. While on board an aircraft enroute to a new assignment, the soldier became convinced that his life was in jeopardy. He sought to hijack the aircraft and avoid a certain deadly fate. The clinician who later evaluated the accused rendered a diagnosis of amphetamine delusional disorder. The soldier was unable to appreciate the wrongfulness of his behavior, the clinician opined. The jury agreed and the accused was declared not guilty by reason of insanity.

g. The Importance of External Information. Certain collateral data is helpful in determining the substance user's mental state. The military police report contains a section on the subject's behavior. Alcohol on the breath and behavioral observations uch as slurred speech are also noted. In such cases, a toxicology screen is finally performed at a local medical treatment facility (MTF) in some proximity to the arrest location. This information may not initially be included in the investigative reports since results will be pending. The clinician should make every effort to review these drug and alcohol reports.

6-3. Intellectual Impairment (Mental Defect)

a. Intellectual Functioning. The complete forensic evaluation requires an assessment of intellectual functioning. Disturbances in cognitive and social skills may be either developmental as in mental retardation or occur later in life as a dementia. Regardless of etiology, the clinician should look for any significant changes in functioning. Severe mental retardation may render the accused not mentally responsible. Severe mental retardation is probably nonexistent in the active duty population. More likely, mild intellectual impairment may qualify as a mitigating factor.

b. Determining Mental Impairment. Appraisal of mental deficiency is a multidimensional analysis which combines assessments of general intellectual functioning and adaptive skills. The thorough clinical forensic evaluation of the accused allows for a rough estimate of intellectual functioning. The individual's social and work history is also important. The clinician should also review the General Technical scores from the Army Service Vocational Aptitude Battery. This test, which is taken by all enlisted soldiers, is a measure of math and English scores.

c. Standardized Tests. Psychological testing of intelligence is indicated when evidence of mental deficiency arises in the clinical forensic evaluation. The accused's case should be discussed with the psychologist and agreement reached on the most appropriate test battery.

d. Interpreting the Test Data. Care must be taken when relating mental deficiency to issues of responsibility. A man of 23 with a mental age of 8 is much more shrewd and sophisticated and has more worldly experience than a normal 8 year old. Conversely, the crime for which the accused is charged must be within his mental capabilities. The same man of 23 with a mental age of 8 would have difficulty committing computer espionage, for example.

6-4. Amnesia and Altered States of Consciousness

a. Dissociative Disorders. The dissociative disorders represent disturbances in identity, memory, or consciousness. The onset and duration is variable. The accused who appears to meet criteria for multiple personality, psychogenic amnesia, somnambulism, or fugue presents a real clinical challenge. The clinical evaluation will be exhaustive,

to eliminate as much as possible the fabricated dissociative event. Most cases of dissociation are preceded by a significant psychosocial stressor. A history of prior episodes is typical. The *de novo* appearance of a dissociative disorder following illegal activity is highly self-serving. Personality dynamics and psychological testing will aid diagnosis.

b. Amnesia and Criminal Culpability. The law has generally concluded that the accused who experiences amnesia based on a dissociative disorder after commission of an offense is not relieved from criminal responsibility. In addition, the accused is NOT unable to stand trial simply because he cannot recall the facts surrounding the offense or antedating its occurrence.

c. Evaluating the Role of Amnesia. As usual, the nature of the offense should be examined closely. Note any personal gain, evidence of premeditation, relationship between accused and victim, and witness statements characterizing the accused's behavior. This will help establish the link between the mental disorder and any causal role played in the alleged criminal activity.

d. Substance Use and Memory Loss. Blackouts and periods of amnesia are very common in alcoholism. Many drugs, however, including barbiturates and benzodiazepines, also impair the ability to register and retain new information. With alcohol, amnesia of varying degrees may be a symptom but it does not relieve criminal responsibility. A more complex issue involves an idiosyncratic response to a legal prescription drug. In some cases, intoxication which is the unexpected result of a substance taken pursuant to medical advice or a legal prescription is characterized as "involuntary," and the accused is relieved of criminal responsibility for his or her acts while intoxicated.

6–5. Seizure Disorders

The accused may not be held legally responsible for an act consequent to a seizure. An exception would occur if the accused knew, or should have known, of the likelihood that the seizure would occur. Noncompliance with medication is an example. The clinician must establish that necessary link between seizure and resultant act. The mere history of a seizure is insufficient without this causal connection. In addition, the clinician should be suspicious of any trance state which developed for the first time in the context of criminal behavior. The diagnosis of a seizure disorder is often based on a history of repeated episodes. One would expect to find that prior episodes antedated the offense. An electroencephalogram and neurologic evaluation may be required in some cases.

6–6. Organic Mental Disorders

There are many medical conditions that may cause acute or chronic impairment in brain function. Trauma, metabolic states, toxins, cerebral vascular injuries, and drugs are a few. Various symptoms suggestive of cognitive impairment may occur such as defects in judgment, memory, and attention. The ability to formulate plans may be compromised.

6–7. Impulse Control Disorders

a. Characteristics. The impulse control disorders represent the failure to resist an impulse, drive, or temptation. A pattern of tension before with relief after the act is characteristic. This category includes the intermittent explosive disorder, kleptomania, pyromania, and pathological gambling. All have significant legal complications. With the possible exception of intermittent explosive disorder, these disorders generally will not exonerate. The defense attorney may offer the mental disease or defect as a mitigating factor, however. The primary reason such disorders will fail is the elimination of the volitional element in the revised insanity defense. In the military, the inability to control conduct, when due to a mental disorder such as pyromania, will no longer vacate responsibility.

b. Intermittent Explosive Disorder. An accused may relate symptoms required for a diagnosis of intermittent explosive disorder for self-serving purposes. The clinician should carefully exclude personality disorders and substance abuse. The possibility of an organic basis for the disturbance should likewise be explored. Typically, the violence seen in this disorder is totally out of proportion to the provocation. There should be a history of prior episodes if the diagnosis is valid. The nature of the attack, the mental state of the accused, and the behavior immediately afterwards will help decide the issue of responsibility.

6–8. Personality Disorders

a. Definition. In the mental non-responsibility standard, 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 behavior disorders and personality defects. The attempt is to specifically disallow a defensive strategy that concentrates solely on a pattern of misconduct and which lacks any evidence of significant mental illness.

b. Differences of Opinion. The medical and legal professions view character in different ways. Personality disorders are considered a mental illness, with significant subjective distress and functional impairment, by the medical community. Elaborate theories have been advanced to explain characterological development. Since, in most cases, the personality structure does not diminish the cognitive ability to appreciate wrongfulness, the personality disorder will not meet the military test for insanity. The blaming, rationalizing, prevaricating defenses only strengthen this supposition. When the clinician does assert that mental responsibility or intent is affected by personality dynamics, the well-prepared clinician will anticipate the need to explain the opinion in detail.

c. Personality and Responsibility. In assessing the impact a personality disorder may have on culpability, the clinician must remember that the real question is not one of classification but of effect. It is prejudicial to rigidly assume that individuals with personality disorders in all circumstances are fully responsible for their behavior. There may be rare occasions when a particularly severe character defect may impair the accused's ability to form the required mental state and remove the ability to appreciate the wrongfulness of behavior. This would most likely occur in the cluster A disorders of paranoid, schizoid, and schizotypal, where cognition is already distorted. Actual psychotic regression may accompany certain personality disorders also. The clinician must make sure that such distinctions are based on specific data. Attacks of frenzy and violent temper frequently punctuate the careers of individuals with severe personality disorders and should not be mistaken for a psychosis.

d. Personality and Intent. Sometimes personality disorders will be so severe that they could destroy the required mental state. In those cases, a clear, well-reasoned forensic report that is not based on psychological theory is expected. Personality disorders may also be of such severity as to impair the accused's ability to entertain a specific intent and thus raise the issue of partial mental responsibility. As usual, the mere finding of a personality disorder is insufficient in determining whether the required state of mind was present. How the presence of the personality disorder shaped the actual offense, thus affecting the accused's mental processes, must be explained.

6-9. Sexual Disorders

a. Importance of Objectivity. Many of the sexual disorders never come to the attention of the mental health system until the offender is arrested. Frequently this results in tension between the medical and legal system. With emphasis on treatment, the medical community may clash with the legal system's interest in punishment and safety. Sexual crimes often arouse much moral indignation and potentially bias the clinician's evaluation. The clinician, however, should introduce a note of objectivity to ensure a fair forensic review. Of particular importance in this area is child sexual abuse. The emotionality and outrage generated in these cases markedly impact all the participants in the justice system. The profound affect associated with these types of cases, especially upon reaching the trial stage, tends to overshadow the known scientific aspects of these disorders.

b. Focus of Evaluation. In evaluating the accused charged with a sexual crime, the focus should not be exclusively on the sexual aspects. Personality dynamics, mental deficiency, and psychosis must be considered. The existence of sexual misconduct alone will not relieve responsibility. Of unique relevance in such cases is the potential for successful treatment and rehabilitation of the offender, the victim, and the family involved (if any).

c. Sexual Disorders and Responsibility. In most sexual disorders, except where psychosis or other more severe illness supervenes, the accused knows the particular act is wrong. This is shown by the fact that the accused sought to perform the act in private, or under calculated or clandestine circumstances. All this suggests a knowledge of wrongfulness. If the offense occurs only under the influence of drugs or alcohol, criminal responsibility is still not affected.

d. Sexual Crimes and the UCMJ. Certain crimes have a sexual element as a component. Rape and murder, for example, do not require that the offender be tried only on the sexual issue. The accused may be accused of both rape and murder. Certain sexual behavior (voyeurism, exhibitionism) is not specifically condemned in the UCMJ, but an offender may be brought to trial under Articles 133 (conduct unbecoming an officer and a gentleman) or 134 (general article).

e. Structure of the Sexual History. The clinician who assesses the sexual offender should consider whether—

(1) The sexual behavior, particularly the paraphilias, are a source of gratification.

(2) The behavior is covert and furtive.

(3) The behavior is repetitive.

(4) The individual is distressed about the sexual impulses.

(5) Family dynamics are present which are suggestive of certain offenses, such as with incest.

(6) Child abuse is present in the accused's developmental history.

(7) There are problems in relationships with parents, women, sexual orientation conflicts, and employment or financial difficulties.

(8) Pornographic materials have been used by the accused.

(9) In pedophilia, coercion, threats, and other inducements were used to overcome a victim's resistance. This is characteristic of the ability to plan and premeditate the pedophilia and thereby minimize detection.

(10) Sexual sadism, as contrasted to other forms of sexual assault, is present. This is distinctive in the degree of violence which exceeds that required to gain compliance. Arousal is purely secondary to inflicting pain.

f. The Evaluation of Children. In forensically evaluating children who are the apparent victims of abuse, the clinician should be skilled in those unique interviewing techniques required. If not, appropriate consultation with a specifically skilled clinician is in the best interests of the child and the legal system.

6-10. Psychosis

Psychosis, a very specific mental state, is characterized by disturbances in perception and cognition. In terms of the mental responsibility standard, the clinician should consider a psychosis as "a severe mental disorder." The details of the offense and witness statements describing the accused in proximity to the offense are needed. Sheer brutality or bizarreness of a crime does not, by itself, provide proof of psychosis. Defense counsel sometimes takes the position that "no sane man would have done a thing like this"—a declaration the clinician cannot accept. To do otherwise implies that anyone can get away with murder by making it seem particularly senseless. In a similar manner, a history of, or even a currently diagnosed psychosis, does not permit an *ipse dixit* proclamation of non-responsibility. The usual criterion for establishing the necessary mental state, the inability to appreciate the nature or quality or wrongfulness of behavior, is still required.

6-11. Malingering

a. Definition. Malingering is not a mental illness. Malingering is the purposeful simulation or exaggeration of physical or psychological symptoms. The goal is avoidance of unpleasantries such as certain military duties or legal sanctions. The accused who faces criminal charges may be tempted to fabricate a mental disorder. The clinician performing the forensic evaluation must consider malingering in the differential diagnosis. Detection of malingering, however, is an inexact art. Certain strategies and techniques can aid the search for deception. To have considered malingering, analyzed the subject in a methodical manner, and then concluded otherwise, adds significant credibility to the forensic evaluation.

b. Detecting Malingering.

(1) The accused feigning an illness must initially overcome his or her own anxiety about possible detection. Attempts by the accused to control his or her posture, voice, and motor activity may product a rigid bearing or tightly modulated emotions. For example, "leakage" occurs when, despite attempts to control behavior, the anxiety "slips" out. The accused who smiles, yet has an angry voice or denies nervousness while constantly tapping his or her feet, gives mixed signals. This should provide a clue for the clinician to investigate further.

(2) When deception is suspected, the clinician should concentrate on verbal and behavioral clues. Visual cues are mostly distractions and are the most easily manipulated.

(3) The latency and length of response to questions can provide clues to deception. Long pauses before answering allow time to structure the response. Excessively long or perfunctory answers, particularly if characteristic of the entire evaluation, may be evasive techniques.

(4) The accused who is malingering may exaggerate symptoms. An imprecise knowledge of mental illness produces contradictions.

(5) The degree of cooperation may be used to control the content of the interview. The angry accused who takes repeated and unnecessary umbrage effectively limits the evaluation.

(6) The accused may assume that a simple *ipse dixit* assertion, "I hear voices," for example, is a subjective experience incapable of objective verification. In some respects this is true, but accumulated clinical experience has identified certain fairly constant attributes of psychiatric symptoms. For instance, auditory hallucinations are the most common perceptual disturbance. Visual hallucinations, however, predominate in psychotic disorders with a toxic or physical cause. Psychotic hallucinations typically originate "outside the head," can be differentiated by the sex of the voice, occur regardless of the presence of other people, and are clear and distinct. The clinician's experience in mental illness allows the use of discriminating diagnostic details such as these.

(7) Additional techniques for detecting deception include the use of—

(*a*) Open-ended questions which require the accused to proceed without benefit of the clinician's structured interrogatory.

(*b*) Leading questions—while seeking inconsistencies.

(*c*) An extended evaluation session during which malingering becomes more difficult. Inpatient observation is a form of extended evaluation

(*d*) Collateral data.

(*e*) Psychological testing. Certain formal psychological instruments contains subscales designed to assess an individual's attempt to consciously appear "bad" from the standpoint of pathology. The clinician again is cautioned to appreciate the validity of the scale used to address the issue of malingering.

CHAPTER 7

PREPARING THE FORENSIC REPORT

7-1. Introduction

a. Target Audience. At the completion of the forensic evaluation, a complete written report must be generated. It must be remembered that the target audience for the forensic report is not composed of clinicians, but of laymen lawyers, commanders, and jury members with varying degrees of medical sophistication. As such, the report should be written clearly with as little technical jargon as possible. Complicated terms which are essential to the text should be explained.

b. Objective. Every effort should be made to make the report objective. Except when answering the questions raised by the order for the Sanity Board, opinions should be absent. Judgmental or prejudicial statements only detract from the credibility of the report and thus should be absent. The very manner in which the report is written can convey a certain attitude. Comments such as "I feel" or "I believe" convey less certainty of position than "In my opinion." The former should be avoided. Persuasive remarks such as "It is clear" or "It is obvious" as a prologue to a position are rarely convincing.

c. Specific Language. The precise meaning, in legal terms, of the words "possible" and "probable" is a useful distinction. "Possible" implies an almost virtual certainty, i.e., "Anything is possible." "More likely than not" as a definition of "probably," however, is more specific and indicates there is at least a 51% chance that a given act will occur.

d. Completeness. In general, a more complete forensic report results in fewer subsequent requests for clarification.

7-2. Structure of the Forensic Report

a. Suggested Subheadings. The written report should be organized by topical content. The key issue is relevance. In preparing the report, the patient/client should be referred to as the defendant, the accused, or by name and rank. The report should contain data which ultimately supports the conclusions. Extraneous data should be omitted. Suggested subheadings for the report include—

(1) Identifying Information.
(2) History of the Offense.
(3) Past Legal History.
(4) Past Psychiatric History.
(5) Past Medical History.
(6) Military Record.
(7) Social and Family History.
(8) Mental Status Examination.
(9) Drug and Alcohol Use.
(10) Physical Evaluation and Laboratory Studies.
(11) Psychological Testing.
(12) Diagnoses.
(13) Opinions.

b. Identifying Information. The identifying information segment of the forensic report should contain several elements. In addition to listing the typical medical demographic data, the specific charge for which the defendant stands accused is listed. The reason for the referral is that which is outlined in the order for mental inquiry. The source of the referral is noted, also. The actual time expended in conducting the evaluation is noted. If more than one interview was performed, so indicate. A very important aspect of the forensic report is describing the information the clinician reviewed. The date and times the accused was evaluated, the documents that were reviewed, whether psychological testing was done, and other collateral contacts should be listed. This section should conclude with a statement indicating that the accused was apprised of the nature and purpose of the evaluation along with the limits of confidentiality as previously discussed.

c. History of the Offense. This section should begin with a synopsis of the investigative report, followed by the accused's version of the offense. In preparing the forensic report, quotations from the accused are more enlightening than the clinician's inferences drawn from such statements. Any inconsistencies between the investigative report and the accused's statement should be noted. The use of psychoactive drugs or alcohol at or near the time of the offense is included. The relationship, if any, between the accused and the victim is also noted in the report. This portion of the forensic psychiatric report must be logical and inclusive. The data concerning the charged acts that the clinician uses to form opinions must be present here.

d. Past Legal History. The adult and juvenile criminal history of the accused must be explored. If any doubts persist regarding the adult criminal history, the appropriate arrest records should be sought. At times it maybe necessary to inquire directly regarding certain offenses such as driving under the influence, speeding tickets, and non-support of a spouse. The military record, including any adverse criminal (court-martial or nonjudicial punishment) or administrative action (discharge, letter of reprimand, reduction, etc.), should be noted. The general tenor of counseling statements is often a neglected area.

e. Past Psychiatric History. A careful review of past mental diseases or defects, including substance abuse and treatment, is included in the forensic report.

f. Past Medical History. Any condition, such as a severe head injury, which might impact on current mental functioning, is particularly important to include.

g. Military Record. A list of assignments, awards, and trend of efficiency or evaluation reports should be included as relevant. The reason for joining the military is also listed.

h. Social and Family History. This is an important area of the forensic psychiatric report because the evidence of many mental diseases or defects which require a longitudinal history may be revealed here. Emphasis is placed on relationships throughout life, school performance, character of peer groups, and substance abuse patterns. An opportunity to explore familiar authority structure, and the accused's early response is gleaned by inquiring into the typical rewards and punishments administered in the family. Further information in this area can be elucidated by asking, "What is the best and worst thing you did when growing up?" Any collateral contacts with the family, which at times are essential, should be described.

i. Mental Status Examination. The mental status examination should be thoroughly documented. Direct responses, with the clinician's assessment following, are far more useful than a conclusory comment such as, "Judgment was impaired." It is far more compelling to list the accused's response to the hypothetical question "What would you do if there was fire in a theater?" as "I would quickly leave" as opposed to a summary comment "Judgment was good." The presence or absence of suicidal or homicidal ideation is indicated. The organic screening component is presented in detail.

j. Drug and Alcohol Use. A thorough history of the patterns of drug and alcohol use must be outlined both in the accused and his family. The clinician should explore all potential drugs of abuse with attention to routes of administration: track marks, for example, may be hidden by clothing.

k. Physical Evaluation and Laboratory Studies. A review of the medical records may suffice if current. Otherwise, appropriate aspects of the physical exam and lab work must be performed.

l. Psychological Testing. If psychometric tests were administered, a summary of the tests performed and their results is included. If testing was desired but not able to be performed for a specific reason, this should be indicated in the report. However, it is possible that this may weaken some of the conclusions drawn in the final report. It would be wise for the clinician to suggest to the court that an adequate evaluation should include such additional inquiry and for the court to seek out suitable and qualified psychologists accordingly.

m. Diagnoses. The diagnoses should be listed in accordance with current nomenclature, using the Diagnostic and Statistical Manual of Mental Disorders multi-axial system. The report up to this point should provide enough data necessary to sustain the diagnoses.

n. Opinions. The Sanity Board is asked to respond to specific questions. Answers should reference each query directly. In addition to standard questions, the Sanity Board may be asked other questions. If any of these are unclear, written clarification should be received. When responding to the question of responsibility, the exact legal language in the mental responsibility standard should be cited. In other words, if the clinician opines responsible conduct, the response could be: "The accused was *able* to appreciate the nature and quality of wrongfulness of his or her conduct." An explanation, buttressed by the forensic report, should follow. All opinions should be qualified by noting, "The opinion set forth is based on 'reasonable medical certainty'." This is a legal term addressing the reliability of the opinion. For example, if two competing hypotheses could be proposed, the one tipping the balance more persuasively would be an opinion considered reliable to within a "degree of medical certainty." The clinician is not expected to render a conclusory statement indicating whether the accused is sane or not. At times it is not possible to formulate an opinion. This may be due to lack of information and should be so indicated. The clinician must remember that all opinions must focus on the presence or absence of a mental disease or defect. There are times when no mental disease or defect

is found in a service member accused of a heinous crime. Prefacing opinions with the proviso "No specific symptoms of a mental disease or defect are currently present" will indicate that not all crimes are committed by individuals who are mad. Instead, the accused may simply be "bad." The Sanity Board may have been requested to evaluate the capacity of the accused to form that necessary mental state of crime or simply criminal intent. Conclusions about capacity for intent are given in the opinion section. Here is an opportunity, when appropriate, for the clinician to discuss mental illness as a mitigating circumstance. While not exonerating the accused, it may affect the sentence. Finally, as much as possible, avoid using theories of behavior to rationalize criminal activity or buttress clinical opinions.

7–3. Submission of the Report

a. Abridged Report. The Sanity Board releases only the final conclusions to the trial counsel. The order requesting the Sanity Board may also direct this same report be sent to the officer ordering the evaluation, the accused's commanding officer, the UCMJ, Article 32 investigating officer, the convening authority, and, after referral, to the military judge.

b. The Full Report. Unless otherwise authorized in the order, the full report may be released only to other medical personnel for medical purposes, the defense counsel, and upon request, the accused's commanding officer.

c. Unauthorized Disclosure. Disclosure to the trial counsel of any statement made by the accused to the Board, or any evidence derived from that statement to the trial counsel, is prohibited. Releasing the report to inappropriate personnel, even if done inadvertently, can seriously compromise the military justice system's ability to justly and effectively resolve the accused's case.

CHAPTER 8

EXPERT TESTIMONY

8-1. Introduction

a. The opportunity to testify is usually greeted with trepidation by the clinician. The adversarial nature of court proceedings is quite different from the clinician's usual collegial surroundings. Rarely is the clinician's judgment challenged as it may be in the courtroom. In a public forum, the clinician explains his/her reasoning and discloses the means by which an opinion was reached. Such exposure is not comfortable. It is important for the expert to understand his/her role in the courtroom. This knowledge, along with certain strategies, will prepare the expert for testifying.

b. There are various types of witnesses, all of whom give evidence under oath. The expert witness is a special category. Because the expert possesses knowledge not normally held by the average person, the expert may be qualified to so testify. In the purest sense, the expert is invited into the courtroom to educate the trier of fact. As such, the expert is not bound to comment only on facts directly observed. The expert is allowed to testify regarding an opinion. This opinion is based on professional knowledge and experience, in light of information gathered both directly and indirectly about the accused.

8-2. Courtroom Procedure

The usual method of eliciting testimony is by question and answer. A strict procedure is followed. The lawyer for the party calling the witness asks the first questions. This procedure is called direct examination. Cross-examination follows and allows the opposing attorney an opportunity to ask questions. The military judge ensures the process progresses smoothly and fairly. In addition, any disputes regarding admissibility of certain aspects of the expert's testimony are resolved by the military judge. A court reporter will take a verbatim account of the expert testimony. When not testifying, the expert witness may or may not, at the discretion of the military judge, be allowed to sit in the audience. Attorneys often desire the expert to be present to comment on facts or opinions offered by the opposing case. This expands the role of the expert witness to that of an on-site consultant. Such an expectation by the lawyer should, of course, be clarified before the actual trial.

8-3. The Mechanics of Expert Testimony

a. Pretrial Preparation.

(1) The overall effectiveness of the expert's testimony is directly proportional to the degree of preparation. It is the attorney's responsibility to ensure that his or her witness is prepared. Aside from the thorough forensic evaluation itself, a pretrial conference with the attorney is essential. This meeting should clarify several issues such as—

(*a*) The exact content of direct testimony.

(*b*) The potential cross-examination questions and likely responses.

(*c*) Any special requirements such as the attorney's request that the expert be present in the courtroom.

(2) The clinician, as initially stated, must be thoroughly familiar with the case. The expert is better prepared if he or she can testify entirely from memory. However, whenever there exists psychological test data from a wide array of instrumentation, a written report of findings should be constructed. This is advised even if it potentiates opposing counsel's access to the data.

(3) It is very useful to rehearse the questions and answers for the direct testimony. The initial part of the direct testimony involves a procedure known as "qualifying the expert." Before the expert can testify, the clinician must be certified by the military judge as particularly knowledgeable in the subject area. This generally involves questioning the proposed expert about professional training, a complete investigation of his or her experience, and may include questions related to certification, research and publications. For clinicians, this public display of accomplishments may be embarrassing but, in the legal system, it serves to establish credibility. The clinician should practice qualifying with his or her attorney. It is also advisable to have on hand a current, updated *curriculum vitae* which, during the qualification phase of the courtroom proceedings, becomes an exhibit.

(4) Prior to trial, the expert should be reasonably available for interview by the opposing counsel. The expert should answer questions truthfully and frankly, keeping in mind the MRE 302 privileges and restrictions upon releasing information (RCM 706) discussed earlier.

(5) The proper uniform to wear when testifying varies and should be clarified in pretrial meetings. The clinician can discuss the possibility of bringing notes when testifying. In general, however, the expert presents more forcefully if not fumbling around looking for notes.

b. Presenting Effective Testimony.

(1) The most effective expert witness is thoroughly familiar with the material and then presents it to the jury clearly. The expert must keep in mind the role of an educator. The extensive use of jargon will cause confusion. The clinician should reduce opinions to plain language. Substitute "mood" or "emotions" for the term "affect," for example. Words like "psychosis" need to be defined. Complicated theories of human behavior should be avoided. An important point to remember is that once under oath, every effort should be made to be non-partisan. There is a natural tendency to become emotionally invested a long, difficult case. To portray this, however, is to erode credibility. In the final analysis, the clinician is rendering only an opinion. The trier of fact determines the verdict. Even if the clinician answers a question that would hurt counsel's case, this must be done. In the course of testifying, the expert may be interrupted by an objection of opposing counsel. The witness should remain silent until the military judge rules on the objection. Also, the expert witness cannot be limited to simple yes or no answers unless such an answer is sufficient to respond to the question. If a more thorough answer would enlighten the court, the expert witness can request to fully explain the answer.

(2) Another important aspect of effective presentation is to maintain good eye contact with the jury. Once a question has been asked by counsel, the expert witness should provide the answer to the jury. The witness should never joke, argue, or be afraid to indicate a lack of knowledge. Any written materials counsel refers to, or directs questions from, should be requested for review. In addition, texts and journals should not be cited by the expert witness because it is the opinion of the expert concerning the specific case that the court wants to hear. The expert is not a conduit of written science. In addition, the door is opened for a cross-examination on the merits of the literature cited. If the expert does not understand a question, a simple request for clarification is in order. At the conclusion of testimony, unless arranged differently, the expert witness should immediately leave the courtroom. It is proper for the clinician to request to be permanently excused by the military judge where there are other pressing duties and neither counsel has initiated such a request. A normal feeling after testifying is the sense that the testimony was incomplete. None the less, an objective, disinterested and impartial forensic evaluation and an honest, dispassionate, complete, and clear presentation will be sufficient.

c. Cross-Examination.

(1) A good cross-examination will explore in depth the clinician's thoroughness. The expert witness should remember that credibility as a witness is being measured by total demeanor, not just intellectual capacity. Emotional displays such as anger, arguments, joking, and arrogance detract from the witness' credibility. Alternately, compassion, concern, and appropriate indignation may enhance credibility. The attorney is obligated to make searching inquiries into the methods and techniques employed by the clinician. It is the witness' obligation to make this information understandable to the court. It is wise to consider the attorney an expert at his or her craft. The attorney is in control in the courtroom. Much of the frustration clinicians feel results from their diminished control.

(2) Certain techniques are useful in helping the witness to testify effectively. First and foremost, the witness is an expert in his clinical field. The clinician has undergone years of training and clinical experience. The attorney who attempts to challenge the expert in this area has entered the expert's domain. Usually then, this area is ceded to the witness. This leaves attempts to impeach the credibility of the expert as the dominant tactic. A typical question is, "How many times have you testified for the prosecution as opposed to the defense (or vice versa)?" This attempt is to imply that the expert is a "hired gun" for one side. It might also serve to show inexperience. One can usually preempt such inquiries by discussing the issues on direct examination. Generally, the expert should not quote or seek authority from the medical literature. Instead, all opinions should be buttressed by the expert's training, experience, and data generated from the specific case. The exception to the rule is the Diagnostic and Statistical Manual. This is the standard authority of psychiatric nomenclature. A tactic of rapid fire questions is best countered with a pause, and then a thoughtful response. The witness can also request clarification or repetition of questions. The

expert must never exaggerate positions, sometimes a consequence of a pushing, zealous cross-examination. The expert can indicate limits of knowledge, a situation that does not display ignorance, but rather honesty. Conversely, a pretentious witness may be challenged in a number of areas and be led to cite books or journals, without adequate familiarity with them. No one is acquainted with every written reference. The cross-examining attorney typically asks narrowly focused questions. In addition, the attorney may ask leading questions. Remember, this is not an aimless interrogatory but is intended to lead in a certain direction.

(3) The expert can analogize cross-examination to a chess game; responses must always be planned one or two moves ahead. Self-contradiction is a most effective means of impeaching credibility. The good attorney preparing for cross-examination takes good notes during direct examination. Weakness will be exploited in cross-examination. Approach such a situation with honesty and humility tempered with firmness.

d. Hypothetical Questions. Generally, hypothetical questions can only be asked of an expert witness. Hypothetical questions permit the expert to form conclusions based on a variety of alleged facts. The court determines which set of facts is true. In framing the hypothetical question, the attorney furnishes the clinician with a scenario, always on evidence presented in the case. The witness provides an expert opinion in response to questions asked about issues raised by the "hypothetical" scenario. If any facts are in dispute, each opposing attorney will adjust the hypothetical question. It is not required that an expert opinion be elicited by hypothetical questions. It may be used by an attorney to cause the expert to agree with part of his/her argument, which may in turn diminish the impact of an expert's testimony. Hypothetical questions can also help clarify the expert witness' testimony and indicate the assumptions upon which it is based.

e. Limitations of Expert Witnesses. The expert psychiatric witness is not allowed to express opinions of law. The expert cannot declare the accused "sane" or "insane." The expert's opinion must be framed in terms of the prevailing mental responsibility standard. Psychiatrists, non-psychiatric physicians, and non-medical professionals such as psychologists and others may, depending on the jurisdictions and the issues involved, be qualified by the court as experts on human behavior. The degree of specialized training or experience in human behavior affects the weight of the testimony provided. The opinion is usually based on personal observation unless a hypothetical question is posed. In some cases, a narrowly defined focus of testimony does not require a personal examination of the accused. In some special cases, the clinician may be called upon to educate the court regarding certain mental health issues. For example, testimony may be sought clarifying diagnostic terminology, theories of human behavior, and other similar issues. In such cases, the expert witness need not have performed a clinical evaluation or even a review of the evidence in a case.

CHAPTER 9

DISPOSITION OF THE MENTALLY ILL ACCUSED

9-1. General

Currently, no regulation provides guidance on the disposition of cases where the mental state of the accused has resulted in dismissal of charges or actual acquittal at the court-martial. Consequently, close cooperation between legal, medical, and administrative personnel is required to achieve a disposition which is appropriate to a given case.

9-2. Notification of Release

a. AR 40-3, paragraph 6-15, deals specifically with the release of mentally incompetent service members who have a history of involvement in major crimes or antisocial behavior and who are considered to have a significant potential for recurrence of such behavior. The concern addressed is the potentially dangerous patient. Such an individual, when medically stable, is reported by the Medical Activity/Medical Center to Headquarters, Department of the Army, Office of the Surgeon General in Washington, DC. Included in the report are the following documents:

(1) Applicable CID, MP or civilian police investigations.

(2) Investigations under the provisions of the UCMJ, Article 32(f).

(3) SJA's advice to the general court-martial.

(4) Record of trial.

(5) Sanity Board proceedings.

(6) Medical Board proceeding, including narrative summary.

(7) Indictments, complaints, other investigative files, and court orders.

(8) Proposed date, place, and basis of individual's release from the Army MTF including identification of receiving facility.

b. It must be noted that this regulation serves only notification purposes and offers no guidance regarding the mechanics of disposition. All documents must be forwarded to HQDA no later than 72 hours prior to actual disposition.

9-3. Disposition of the Insanity Acquittee

There are two issues involved in the disposition of the insanity acquittee: the presence or absence of current mental illness, and whether the acquittee is dangerous as a result of concurrent mental illness. The acquittee who remains severely mentally ill usually receives a Medical Board, is medically retired, and transferred to a veterans' medical facility for extended treatment. The acquittee who is not currently mentally ill may also be medically retired but may not need post-service hospitalization. This individual will be released as any other medical retiree. In all cases, the discharge planning should include a review of Federal and State Government resources. Hospitals for the criminally insane in both jurisdictions can be avenues of disposition. Again, close cooperation between the medical, legal, and administrative sections is required in formulating these individualized dispositions.

9-4. Disposition of the Service Member Found Incompetent to Stand Trial

If an accused, by virtue of mental illness, is declared incompetent to stand trial, the proceedings will halt. The accused is remanded to medical authority for treatment. Once medically stabilized, the accused is returned to the court-martial. It is not common for an accused to become despondent when charged with criminal activity. Frank suicidal ideation or even gestures may occur. Proper clinical intervention in concert with unit and detention facility awareness should be sufficient emotional support for the service member. In such an instance, a speedy return to court is the norm. In other cases, the mental disorder may not remit quickly. Where treatment either may not restore competency or may require months or years, the court should be so instructed. Again, protracted incompetency may require medical retirement and eventual transfer to a veterans' medical facility. The fate of the legal charges will be determined judicially. The medical care of the accused is the first concern.

CHAPTER 10

DANGEROUSNESS

10-1. Introduction

a. Introduction. Assessing the dangerous patient is an important skill, given the emphasis placed on accurate prognostication of future violence. There are a number of circumstances which require that the clinician evaluate dangerousness. Routine release of a patient from inpatient psychiatric wards, violence threatened by an inpatient, and disposition of the insanity acquittee are common examples. An opinion about an accused's future dangerousness may also be elicited during the pre-sentencing stage of a court-martial. Accurate evaluation can also be of use in crisis management where astute sensitivity to escalating behavior may forestall a serious incident.

b. Landmark Legal Decision. Medical responsibility for the dangerous patient was the issue in the 1974 case of *Tarasoff* v. *Regents of the University of California,* S29 P2d 553 CAL (1974). In this unfortunate incident, a student of the University of California came to the attention of the mental health clinic. The student subsequently verbalized fantasies of injuring a girlfriend who had spurned his advances. The campus police were notified, the student denied any intent to harm his girlfriend, and the issue was dropped. Two months later, the student killed his girlfriend. From the ensuing charge of negligence in not notifying the potential victim, subsequent litigation, and statutory action, the State of California adopted a rule requiring " . . . reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency." Actually, any act will suffice which lessens the imminent dangerousness. The clinician can use commitment, adjust medication, seek consultation, notify command for active duty personnel, or hospitalize a voluntary person. Although State law in this area remains unsettled, some cases expanding the scope of liability and other cases dismissing liability, the California rule is a good working model for the therapist.

c. The Dangerous Military Patient. In the U.S. Army, the dangerous patient raises unique considerations given the worldwide deployment of troops as well as access to weapons and dangerous equipment, and the variety of local laws and social supports available. In general, to prevent potential violence, either containment or treatment or a mixture of both should quell immediate concerns. The first consideration by the clinician must be the evaluation of the mental status. The presence of a severe mental illness contributing to present instability would suggest the need for hospitalization. The lack of any mental disorder in the violent individual would argue for containment, either at the unit level or possibly at the installation detention facility (IDF). The latter opinion is especially appropriate if there is a risk of the individual going AWOL or not showing up for trial, or if there is a high risk of violence. Recommendations for restriction at the unit level should be discussed with the company commander. If the IDF is considered, consultation with both the company commander and the local JAG office should occur.

d. Dangerousness in the Non-Military Population. The more difficult situation occurs when the dangerous patient is either a dependent or a civilian for which the avenues of containment for the active duty service member may not be available. Again, however, if a mental illness is present, hospitalization is appropriate. If voluntary admission to the local MTF is refused, civil commitment must be considered. The military police should be involved to ensure a smooth transition from military to civilian control. They should contact local civilian authorities. The procedure will vary by jurisdiction and when in doubt, the local JAG's office should be consulted. This is particularly difficult overseas where civilian commitment may be inappropriate. Close consultation with the local JAG's office and the hospital command is necessary. Strong consideration should be given to writing a standard operating procedure addressing this issue in advance to prevent confusion.

10-2. Assessing the Dangerous Patient

a. Reliability. Evaluating the potential for violence requires a multifactorial analysis. No single variable has enough reliability to predict either imminent or future dangerousness. In this regard, a distinction should be made. Imminent dangerousness, that behavior which, if not immediately modified, will probably result in an overt act of violence to self or other, is generally a more

liable clinical prediction. The farther in the future the forecast reaches, the less reliable prediction becomes.

b. Demographics of the Dangerous Patient. The typical statistical profile of the violent individual is a non-white male less than 30 years of age who comes from a lower socioeconomic background and has a past history of violence. The best statistical correlate is a history of prior violence. Apparently, once the threshold is surpassed between controlled verbal anger and physical expression of violence, a barrier falls and promotes occurrence in the future. In addition, violence is often reinforced in the environment where control and submission in victims is equated by the aggressor with a sense of power. Even so, caution should be expressed in using the past as a sole indicator as to future violence or dangerousness. To date, the use of formal psychological instruments and methods to predict violent behavior are replete with methodological problems. Yet, there continues to develop a body of research designed to provide more useful and reliable procedures.

c. Substance Abuse. The capacity for drugs/alcohol to distort cognition and judgment cannot be minimized. The effects of both are to diminish internal restraint mechanisms. If an individual is marginally compensating an aggressive drive, the effects of drugs and alcohol may result in the release of violent behavior. Expression of violence may be increased. The evaluation of dangerousness must include an assessment of the patient's alcohol and drug use. Attention must be directed towards the specific effects of certain drugs, such as agitation and delusions induced by amphetamines or cocaine. In addition, withdrawal states associated with substance abuse may increase psychological and physiological distress.

d. Mental Illness. The role of mental illness in the dangerous patient is a complex one. The individual who is paranoid, distrustful, suspicious, and defensive should be carefully evaluated. With psychosis, the content of the delusions and hallucinations will provide some guidance in assessing dangerousness. Command hallucinations require special attention. Medical conditions contributing to mental instability such as dementia, delirium, organic personality disorder, and other organic syndromes hold the potential for reversibility in ongoing states of irritable, aggressive behavior.

e. Signs of Impending Violence. Imminent violence is often telegraphed by certain behavioral attributes. The clinician should be alert to changes in the patient's speech, posture, motor activity, and degree of startle response. The picture of a patient sitting on the edge of a chair, often tense and rigid, whose speech volume starts increasing is suggesting impending loss of control over aggressive drives. The patient who refuses to sit and paces about nervously cannot fully control his or her anxiety and may require little further provocation. An easily evoked startle response is also an important clue to potential violence.

10-3. Management of the Dangerous Patient

a. Conduct of the Evaluation. Management of the dangerous patient is an exercise in crisis intervention. Again, many variables are important in bringing the crisis to a safe resolution. The stance of the interviewer is an important first step towards stabilization. If the patient is already in a threatening posture, minimizing eye contact, lowering one's voice, and being firm but not confrontational will help. There is debate concerning the position of the clinician when interviewing the dangerous patient. Some suggest that the patient be nearest the door to allow a quick egress. There are advantages for the clinician being nearest the door. Such a position allows the clinician to leave and summon assistance. A potential hostage situation is also averted. Where possible, back-up should be available.

b. Impact of the Clinician's Behavior. The overall conduct of the clinician also will affect the crisis outcome. Obviously, no attempt should be made to disarm a dangerous patient. Similarly, the clinician should avoid the defensive reaction of becoming confrontational or argumentative with the patient. This may only increase the dangerous patient's anxiety.

c. Advance Preparation. If the clinician receives advance information indicating a patient may be dangerous, a plan of action should be developed. This includes notifying other staff about the patient, having restraints and appropriate medications available, and even having a designated code word the clinician can telephonically transmit to alert his or her staff to intervene.

d. Hospitalization. Once a determination is made to hospitalize the dangerous patient, an escort must be provided at all times to prevent elopement. The patient will often begin bargaining at this point, requesting to leave to go home, for example, to pick up a few things. If the patient is to be admitted, this should not be allowed. If emergency commitment is considered, the receiving physician should be notified. All paperwork for emergency commitment must be carefully annotated to indicate the presence of imminent dangerousness and a mental disorder.

CHAPTER 11

TORT LIABILITY

11-1. General

It is useful for the clinician who performs mental evaluations, admits patients to psychiatric facilities, and administers somatic treatments to understand certain legal issues which are connected with medical care. Society imposes certain expectations that essentially regulate types of interpersonal contacts, such as the clinician-patient relationship. These rules have evolved as a complex compromise to maximize good medical care, privacy considerations, and public safety. Transgressing such established rules invites patient dissatisfaction at a minimum. Administrative and legal inquiry follow more serious infractions. Breaches which cause a person injury are known as torts and lead to liability, for which the aggrieved party, or plaintiff, may seek redress. This is a continuously evolving area in the law. Only the most basic concepts are presented in this chapter. The goal is to facilitate the clinician's movement through this difficult and complex subject. Specific issues, detailed discussions, and current legal developments fall within the purview of the local SJA's office.

11-2. The Basics of Tort Law

a. Definition. A tort is a private civil wrong which can result in an award for damages. In most cases, tort law does not include either criminal or contract issues. Tort liability may be imposed for either intentional or negligent acts. For negligent acts, the military practitioner's liability is subsumed by the Federal Government under the Federal Tort Claims Act (FTCA).

b. Negligent Torts. A negligent tort is conduct (acts of omissions) where a failure to exercise that degree of care established by law to protect other persons against unreasonable risk of harm has been breached, and the other person has been injured.

(1) In bringing legal action for medical negligence, the plaintiff must prove, by a preponderance of the evidence, that the physician had a "duty" to conform to a specific "standard of care" to protect his or her patient from unreasonable risk of foreseeable harm ("foreseeable" is often more broadly interpreted than many physicians or other health care providers may realize); that the physician "breached the duty"; that the patient suffered "damage" or harm (that was "foreseeable"); and that the breach of duty "proximately caused" the patient's injury. The first element the plaintiff must prove is the existence of a clinician-patient relationship from which flows certain expectations, or duties. "Breach" of a "duty" occurs when the practitioner does not meet the requisite standard of care. The standard of care is determined by comparing the care rendered the injured patient to care which a reasonable practitioner in good standing and in the same or similar circumstances would provide. The psychiatrist, for example, with specialized medical and human behavior expertise, will generally be held to a higher standard than a family physician when rendering care to a mentally ill patient. An exception would be a family practitioner, for example, who holds himself or herself out as one who has special knowledge and skill regarding mental disorders and treats patients who seek his or her care with the understanding that he or she possesses special knowledge. The family practitioner would be required to render care in this case in accordance with the same standard as a psychiatrist. In practical terms, the standard of care is attested to through expert witness testimony. In psychiatric negligence, the plaintiff will offer expert psychiatric testimony claiming that the defendant did not meet the required standard of care. Based on the testimony, the judge or jury decides if the actions of the defendant were reasonable given the particular circumstances.

(2) The plaintiff must prove that he suffered "damage," what the damages are, and that the damages were *proximately caused* (often called "proximate causation"). "Proximate causation" is a legal mechanism for limiting liability of a defendant to certain acts or omissions rather than holding the defendant liable for all injuries "actually" caused by him/her such as those which were "unforeseeable" or "unusual." (*Caveat*: Each case is decided on its own merits within the context of statutory, regulatory, and case law bearing on the issues raised in a case.) In order for an act (or omission) to have proximately caused an injury, the act must be the "cause in fact" of the injury and the injury must be the "direct result"

of the act, or the result of the act and foreseeable 'intervening forces" which are normal incidents of, and within the increased risk caused by, the act. "Caused in fact" generally means that, "but for" the act, the injury would not have happened; or, that the act was a "substantial factor" in producing the injury. "Direct result" means that there is an unbroken chain of events between the negligent act and the injury, within limits. But the clinician can also be responsible even if the chain was broken in certain circumstances such as medical malpractice of subsequent treaters, or subsequent disease or accident produced by a patient's weakened condition, for example.

c. Intentional Torts. An intentional tort involves a volitional act along with the goal of bringing about the consequences of the act (specific intent), or a volitional act along with the substantially certain knowledge that certain consequences will result (general intent). The act invades the interests of the other party illegally.

(1) In general, a person is presumed to intend the reasonably foreseeable consequences of his or her behavior. Unlike negligent torts in which actual harm or injury to the plaintiff's person or property must be proved, damage in intentional orts is presumed by law. Furthermore, the person /ho commits an intentional tort may be liable for an unintended injury which results from an act or acts which form(s) the basis of the harm. For example, if A pushes B and B falls, breaking his or her leg, A will be responsible for the harm even if A did not "intend" that B break a leg. The intent of A to push B forms the basis of the tort (battery in this example). In most cases, the act need only be a "substantial factor" (not the only factor) in bringing about the harm. "Motive" is different from "intent" in that motive is what moves a person to act to achieve a result whereas intent is the selection of a particular means to bring about the result desired. For instance, Dr. A may have a "motive" to protect a suicidal patient from injury. Dr. A causes the patient to be restrained in an isolated room, a result that Dr. A "intended" as a means of protecting the patient. Unless certain laws and factual circumstances exist, such an act violates the patient's liberty interests (and possibly other interests) and constitutes the intentional tort of false imprisonment. (The latter tort does not apply to active duty members but DOES apply to retired service members and their dependents as well as to dependents active duty personnel.)

(2) The clinician who touches, examines, or conducts a procedure upon a patient without the patient's consent is subject to assault and battery charges. The only defense is an emergency (high likelihood of death or grave bodily harm) which precluded consent. In emergency cases, consent is implied through the notion that had the patient been able, he or she would surely have consented to a life or limb-saving treatment.

(3) The assessment of liability for an intentional tort is different from negligence. The standard of care need not be debated. No expert witness testimony is needed. The potential sanctions for some intentional torts such as battery may be criminal as well as civil. The clinician should be able to avoid liability for battery or false imprisonment by obtaining adequate informed consent.

11–3. Minimizing the Risk of Tort Liability

a. Evaluations. The clinician should always be diligent and careful in clinical evaluations. Thoroughness in patient assessments, careful evaluation of suicide and homicide potential, and the use of appropriate diagnostic tests are critical.

b. Maintenance of Knowledge and Skill. Medical education is an ongoing process. The clinician's actions will be compared to the most recent, accepted developments.

c. Good Records. The clinician should maintain good treatment records which fully document the diagnosis and treatment. The clinician is not expected to achieve perfection in care. Bad outcomes can result from the best of medical care and treatment. The best defense in this case, and all malpractice suits, is the treatment record. Without adequate substantiation of the clinician's logic, the final judgment is suspect.

d. Consultation. The clinician must know his or her own professional limits. This forms the foundation for appropriate consultation. Consultation for complex organic disorders or second opinions in refractory treatment cases may be necessary. Thorough documentation of such consultation helps rebut negligence charges.

e. Report. The clinician must be sensitive to the climate of patient relationships. A lack of rapport obviously increases patient dissatisfaction. Any consequent problems in care enhance the prospect of legal action.

f. Consent. In order to avoid battery, informed consent should be obtained (also see para 11–4 below). Psychiatric admission and electroconvulsive therapy both require that proper documents be completed. With respect to medications and other therapies/procedures, a peer-developed checklist defining areas requiring informed consent is helpful.

11-4. Informed Consent

a. Definition. Informed consent is permission *voluntarily* granted to a clinician by a competent patient (or legal substitute) to conduct an evaluation, procedure, treatment program, change of treatment, etc., after the patient has been made adequately *knowledgeable* of the risks, benefits, alternatives, and consequences of proposed actions, including the risks/consequences of no care at all.

b. Competency. This requires the absence of any mental disorder of such a nature as to impair the cognitive task of weighing options and selecting one in a thoughtful, reasoned manner. That a patient chooses a treatment not in concert with the clinician's wishes does not mean a patient is incompetent. The severely demented patient, however, totally unable to integrate new information, could not render informed consent. The issue of competency in psychiatric patients is complex. Consultation with colleagues is often appropriate.

c. Making the Patient Knowledgeable. Informed consent is a classic example of a legally imposed duty without clearly articulated guidelines for compliance, except in a few jurisdictions. A major dilemma is determining the risks to disclose to the patient. To disclose too much information, particularly rare complications, may unduly frighten the patient and preclude worthy treatment. Yet should the rare event occur, a claim or suits could follow alleging damage from failure to obtain informed consent. Because there are several legal standards for disclosure, the clinician should consult with the local JAG's office for guidance regarding the rule in the jurisdiction of practice. For example, under one of the standards, the judge will decide whether a reasonable person in the plaintiff's position would have consented given suitable communication. In general, however, liability is assessed on the basis of whether the patient would have consented to the treatment given the knowledge of the complication. Ideally, the clinician-patient interaction represents an active dialogue with exchange of information.

11-5. Federal Tort Claims Act

a. General. Sovereign immunity precludes an individual from suing the Government for injury resulting from negligent acts or omissions of the sovereign's agents. The FTCA waives this sovereign immunity in certain circumstances. Since 1946, any claim resulting from the negligence of a Government employee, operating within the scope of employment, falls within the jurisdiction of the United States District Courts. The FTCA has a number of exclusions such as injuries received during military conflict. For military health care professionals, intentional torts are not covered. However, the Justice Department will examine the case and might provide a legal defense. Theoretically then, battery charges could be brought against the clinician as an individual. Circumstances of each case can vary so much that specific guidance should be sought from the local SJA as far as liability exposure for the individual clinician.

b. Landmark Legal Decision. Feres v. *United States* is a 1950 United States Supreme Court decision that barred soldiers from suing the Government or military personnel under the FTCA for injuries incident to service. The complexities arise in determining what is "incident to service." The rationale for preventing such lawsuits primarily rests on the extensive compensation package available to those injured. Another consideration is the deleterious effect on military discipline should civil action be allowed against military supervisors.

c. The Gonzales Act. Public Law 94-464, the so-called Gonzales Act, protects the Federal health care provider from personal liability for medical malpractice which occurs in the scope of employment. Under the law, the Department of Defense health care practitioner cannot be sued as an individual for malpractice by any military health care beneficiary. The clinician's care, however, may be the subject of a quality assurance review, administrative sanctions, or even lead to a court-martial. The practitioner should not be lulled by what appears to be blanket coverage. There are significant exemptions to this liability coverage. The clinician is not protected from intentional tort liability and may be sued personally. For example, clinicians engaging in sexual activities with a patient are not considered to be acting within the scope of employment. Military dependents, retired military, and civilians may properly pursue a malpractice claim. Finally, the FTCA does not extend to foreign assignments although the Military Claims Act provides similar protection. Because this is an area of law which is in a state of flux, clinicians should keep apprised of new developments.

d. Claims Procedure. All eligible claims are processed through the local JAG's office. If a settlement cannot be reached, the claimant has 6 months, from receipt of notice from the JAG's office of denial of the claim or of an unacceptable settlement and offer, to bring suit in Federal district court. A claimant may also file suit if no action has been taken on his/her claim within 6 months of filing.

11-6. Confidentiality/Privilege

a. General. Confidential communications are private exchanges which are given with the understanding that they will not be disclosed to third parties who are not authorized by law to have access to the communications, without permission of the original parties. Military health care involves confidential communications. However, clinicians should be aware of current military regulations which authorize third party access to patient communications without specific permission of the patient. The JAG and patient administration divisions of MTF's are sources of guidance. *Privileged communications* are confidential communications which are protected from disclosure even in legal proceedings unless an exception arises in the law. By acting as a shield to disclosure, the privilege facilitates the free flow of information and protects relationships valued by society. Husband-wife, lawyer-client and in some jurisdictions, doctor-patient or therapist-patient enjoy such privilege. In the clinical realm, it is the patient—not the clinician—who owns or holds the privilege (which can be waived voluntarily by a competent patient).

b. Privilege in the Military. In the U. S. Army here is no recognized doctor-patient privilege. The MCM, in fact, specifically denies the privilege. There is also no recognized psychotherapist-patient privilege. With a few exceptions then, the therapist can be compelled to testify regarding patient care.

c. Protected Communications. There are three areas where communications do receive some protection. MRE 302 provides partial protection for an accused undergoing the forensic evaluation. Statements made by the accused during Sanity Board proceedings are not disclosed unless: the material is released by the defense; or the issue of insanity is raised at trial, and the defense first presents the accused's statements. Another area where all communication is considered privileged is when a clinician agrees to become part of the defense team. This requires the clinician be formally involved, usually by special order. The protection extended is actually under the attorney-client privilege. One final area where a certain privilege exists is outlined in AR 600-85, the Alcohol and Drug Abuse Prevention and Control Program (ADAPCP). Recognizing the importance of confidentiality in this treatment area, AR 600-85 defines a limited therapist-patient privilege. No judicial action or adverse administrative action is allowed based on information derived from the clinical evaluation, after enrollment in ADAPCP. This same protection extends to emergency medical care for drug and alcohol abuse, if not preceded by an apprehension. There are three exceptions: when criminal conduct occurs while under the influence of drugs or alcohol; if drug use persists after enrollment; and when non-disclosure could negatively impact national security or the health and welfare of others.

11-7. Specific Problem Areas

a. Involuntary Detention on Mental Wards. AR 600-20, paragraph 5-4, defines those circumstances where the soldier is required to submit to necessary procedures, including psychiatric hospitalization. If treatment is advised and a soldier steadfastly refuses appropriate treatment, a Medical Board is convened. If the Board concludes that a specific treatment is indicated, and the soldier persists in refusing, a report of the Medical Board is submitted to the Surgeon General. If the soldier does not accept the Surgeon General's recommendation, the matter is referred to the appropriate commander who will order the treatment if deemed appropriate. Finally, administrative actions or UCMJ discipline can be imposed for failure to obey an order. The reader, however, is strongly advised to remain current on the literature and legislative language relevant to the issues of involuntary treatment and/or hospitalization. The whole matter is in a state of flux.

b. Consent by Non-military Patients. AR 40-3 does not permit non-military individuals to receive medical treatment without their consent or consent from a person authorized to give such. Consent for admission to a psychiatric ward or procedures such as electroconvulsive therapy require that informed consent be obtained and a consent form (SF 522 (Medical Record—Request for Administration of Anesthesia and for Performance of Operations and Other Procedures) or equivalent) be completed. SF 522 is available through normal publications channels. In cases where the non-military patient is dangerous, the civil commitment procedures of the local jurisdiction must be utilized.

APPENDIX A

REFERENCES

A-1. Army Regulations

AR 27-10	Military Justice
AR 40-3	Medical, Dental, and Veterinary Care
AR 40-66	Medical Record Administration
AR 40-501	Standards of Medical Fitness
AR 600-20	Army Command Policy
AR 600-85	Alcohol and Drug Abuse Prevention and Control Program
AR 635-200	Enlisted Personnel

A-2. Other Publications

Diagnostic and Statistical Manual of Mental Disorders III-R, American Psychiatric Association, Washington, DC.

Manual for Courts-Martial, U.S., 1984, Superintendent of Documents, U.S. Government Printing Office, Washington, DC.

Monahan, J. *The Clinical Prediction of Violent Behavior*, National Institute of Mental Health, 1981.

Reisner, R., and Slobogin, C. *Law and the Mental Health System*, 2nd Edition, American Casebook Series, West Publishing Co.

Sourcebook of Criminal Justice Statistics, U.S. Department of Justice, Bureau of Justice Statistics.

A-3. Forms

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