Update on the Disposition of Military Insanity Acquittees

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There has been little study of the use of the insanity defense within the military judicial system, and aggregated data concerning such cases are not readily available when needed. Useful information is not consolidated in a central location, hindering potential research and the development of systemic improvements. One key area that would benefit from closer analysis is the process of the disposition of insanity acquittees. *The Manual for Courts-Martial* (2000 ed. Washington, DC: U.S. Government Printing Office) provides limited guidance in procedures to disposition, outlining the process in rather broad terms. The result is often a time-consuming and resource-draining process that can create significant burdens for both the military legal and health care systems. The need to address challenges within the system is discussed, and the creation of a centralized databank as a step toward improving this system is recommended.

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In 1990, Dr. R. G. Lande published an article titled, "Disposition of Insanity Acquittees in the United States Military" in *The Bulletin of the American Academy of Psychiatry and the Law.*[1] He found a paucity of available information regarding this topic and uncovered several systemic difficulties when dealing with the military insanity acquittee. Based on his research, he made recommendations and suggestions for improvement of the system. The following update reviews the subject, discusses some of the changes that have been implemented, and makes suggestions for improvements that are still needed.

History of the Insanity Defense Through the 19th Century

The insanity defense has a long and controversial history. Many different formulations of the defense have been proposed over the centuries, and the concept of criminal responsibility has been considered by many scholars throughout history. Aristotle stated, "A person is morally responsible if, with knowledge of the circumstances and in the absence of external compulsion, he deliberately chooses to commit a specific act."[2] In 13th century England, insanity was only a matter of mitigation and was not yet considered a valid defense. The concept evolved in the 14th century as "absolute madness," allowing for a complete defense. In the 17th century, sanity was based on whether the accused had at least the mentality of a 14-year-old. In 1723, Justice Tracey established "The Wild Beast Test" which became the standard in England for more than 75 years. The test stated that "to be exempted from punishment: it must be a man that is totally deprived of his understanding and memory, and doth not know what he is doing, no more than an infant, than a brute, or a wild beast, such a one is never the object of punishment" (Ref. 3, p 103).

Several landmark cases have contributed to the present requirements for the finding of not guilty by reason of insanity (NGRI) or a comparably titled adjudication addressing lack of criminal responsibility in different civilian jurisdictions and within the military judicial system. In 1843, the first major milestone in the modern history of the insanity defense came about with the establishment of the M'Naghten rule.[4] This standard followed a murder case in which a paranoid sailor by the name of Daniel M'Naghten shot and killed the secretary to Sir Robert Peel, the British Prime Minister, who was the

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intended victim. The instruction to the jury by Lord Chief Justice Trindal provided an option for a verdict of "not guilty on the ground of insanity." The resultant case law stated that

> . . . to establish a defense on the ground of insanity, it must be clearly proved that, at the time of committing the act, the party accused was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or, if he did know it that he did not know he was doing what was wrong [Ref. 5, p 73].

The *M'Naghten* case was the first appellate decision addressing the test for insanity. Almost all jurisdictions in the United States adopted this standard, but there were notable challenges to the rule. First, it did not establish a definition for "disease of the mind," so organic brain disease was the only disorder many courts would accept in an insanity defense. Second, the accused had to be totally devoid of mental responsibility—partial deficits were not an adequate defense. Finally, the rule only considered the cognition of the accused and ignored the volitional aspects involved in human behavior.[3] Whereas the cognitive element addresses whether the person had the mental capacity to distinguish between right and wrong, the volitional element explores whether the person had the ability to control his actions. At the end of the 19th century, a standard known as The Irresistible Impulse Test was added in an attempt to address this latter issue, stating that "if an accused's crime was committed as a result of an irresistible impulse, fostered by a mental disease, he should be acquitted because of insanity" (Ref. 3, p 104). Unfortunately, the addition was itself misleading, in that juries viewed it as only applicable to spontaneous acts and not those accompanied by brooding or reflection.

The Insanity Defense in the U.S. Military

The 20th century saw individual jurisdictions in the United States adopting various standards and forms of the insanity defense. The evolution of the insanity defense in the military justice system was greatly affected by the outcome of the *M'Naghten* case. In 1921, a variation of the *M'Naghten* test was included in the U.S. Military's *Manual for Courts-Martial* (MCM),[6] but with slightly different wording in attempt to avoid similar challenges regarding the requirement for organic disease; however, the requirement for total deprivation of mental responsibility remained. In 1969, the President, based on the power to modify the Rules for Courts-Martial (RCM) granted via Article 36 of the Uniformed Code of Military Justice (UCMJ), incorporated the M'Naghten rule along with the irresistible impulse test into the MCM.[3] In 1977, following the case of *United States v. Frederick*,[7] the military adopted the American Law Institute (ALI) test in response to issues brought about in this landmark case.[4,7] The ALI test differed from the *M'Naghten* test in that it required that the accused lack only "substantial [not total] capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law." The second part of the ALI test better defined the terms mental disease and defect by establishing the exclusion of "any abnormality manifested only by repeated criminal or otherwise antisocial conduct."[3] The revised standard provided a more realistic view of the criminally insane, as few mentally ill people are totally deprived of either the ability to discern right from wrong or to conform their conduct to the mandates of society. The test did have weaknesses, one of the most problematic being the term "substantial capacity" which was ill-defined and left room for debate and interpretation.

In 1982, John Hinckley Jr. was found not guilty by reason of insanity in the attempted assassination of President Ronald Reagan. The jury found that the prosecution had failed to meet its burden of proving that Hinckley was sane beyond a reasonable doubt.[8] In response to the public outcry that followed, Congress adopted the Comprehensive Crime Control Act of 1984, and Title IV of the Act is known as the Insanity Defense Reform Act of 1984.[1,3,9] The Act differed from the ALI standard in that it required complete impairment with the accused being "unable to appreciate" the wrongfulness of his crime rather than just lacking "substantial capacity." The standard also required that the accused have a "severe" mental disease or defect; eliminated the volitional, or irresistible impulse, prong; and shifted the burden of proof from the prosecution to the defense, while decreasing the level of proof from beyond a reasonable doubt to clear and convincing evidence. The military adopted the Federal Insanity Defense Reform Act of 1984 through Congress's creation of Article 50a, UCMJ in 1986, known as the Military Justice Act of 1986.[10,11] The Act provides that (1) only severe mental disease or defects can form the basis for an insanity defense, which do not include

abnormalities manifested only by repeated criminal or otherwise antisocial conduct, or minor disorders such as nonpsychotic behavior disorders and personality defects; (2) the defendant must be totally unable to appreciate the nature and quality or the wrongfulness of his acts; and (3) the defense must prove insanity by a clear and convincing evidence standard.[3]

The 706 Board Process

Rule 706 of the *Manual for Courts-Martial* explains the process for inquiry into either the mental capacity or mental responsibility of the accused.[12] A request for evaluation may be initiated by the commander of the accused, investigating officer, trial counsel, defense counsel, military judge, or court martial panel member who questions the capacity of the accused to stand trial or his mental responsibility at the time of the offense. If such an examination is desired before the referral of charges, the request is submitted to the courts-martial convening authority, usually the senior-level commander. An examination request made after charges have been referred is directed toward the military judge. In either scenario, a board composed of clinicians is appointed to conduct the evaluation. The board, referred to as a "sanity board," must consist of one or more persons and each member must be either a physician or clinical psychologist, with at least one member usually being either a psychiatrist or clinical psychologist. The board will be tasked to answer at least four questions: (1) At the time of the alleged crime, did the accused have a severe mental disease or defect? (2) What is the psychiatric diagnosis? (3) At the time of the alleged crime was the accused unable to appreciate the nature and quality of his or her conduct due to this severe mental illness? (4) Does the accused presently have a mental disease or defect that renders him or her incapable of understanding the nature of the proceedings or to cooperate intelligently in the defense? Besides these four basic questions, the ordering official has the discretion to include other pertinent questions regarding the mental state of the accused at the time of the alleged offenses and the capacity of the accused to undergo the judicial process.

Unlike many civilian jurisdictions, two separate versions of the report are prepared as the level of disclosure is different for the defense and the trial (government) counsels. A full report to include pertinent statements by the accused is forwarded to the defense counsel while a brief report consisting solely of answers to the questions is provided to the commanding officer, the investigating officer, all counsel in the case, the convening authority and, after referral of charges, the military judge. Only the defense counsel or the accused may disclose actual statements made by the accused to the board. Additional examinations assessing the competency of the accused can be directed at any stage as deemed necessary. As in civilian jurisdictions, when an accused is assessed not to be competent to understand the proceedings and/or is unable to participate in his defense due to a mental illness, the judicial process is halted, and the accused is referred for treatment to restore competency.

There are several potential outcomes that may result from a sanity board evaluation. The board may find that no mental illness existed at the time of the alleged offense and the service member is subsequently treated as any other defendant within the legal system. An alternative outcome is the sanity board may find that a severe mental illness did exist, but that the accused maintained the ability to appreciate the wrongfulness of his conduct. In this scenario, the command of the accused often decides to drop the charges and refer the service member for a disability evaluation, called a Medical Evaluation Board (MEB).[13] Should the command opt to pursue the charges despite a severe mental illness, the defense will probably use the mental illness as a mitigating factor in the sentencing phase of the courts martial if the accused is found guilty. If the sanity board finds that the accused had a severe mental disease or defect such that he was not mentally responsible for the crime charged, then a finding of Not Guilty by Reason of Lack of Mental Responsibility is rendered, creating a significant disposition issue.[12]

Insanity Acquittee Disposition Challenge

According to the findings of various civilian studies, the typical insanity acquittee is a white male carrying the diagnosis of a psychotic disorder (usually schizophrenia) and generally older than those convicted of similar crimes.[1] By contrast, those of lower socioeconomic status, nonwhite race, and age under 20 were least likely to have cases adjudicated not guilty by reason of insanity (NGRI) or by another jurisdiction-specific statute. Variables such as female gender and high level of education were often associated with outright acquittal. The profile of the in-

sanity acquittee included a prior arrest record, previous psychiatric hospitalizations, and the current charge usually involving a violent crime, often homicide.[14] Rehospitalization rates for these individuals range from about 50 to 66 percent and rates of criminal recidivism vary as well with rearrest rates ranging from 10 to 50 percent or more.[1]

Whatever the actual figure, clearly the risk of recidivism in individuals found NGRI in cases of a violent crime is an important social issue. To address this issue, several states have enacted measures that allow for the prompt disposition of the acquittee. For example, the states of Oregon, Connecticut, and Utah have formed Psychiatric Security Review Boards that serve the purpose of postadjudication management and treatment of insanity acquittees. In Connecticut, the NGRI registry has provided a wealth of data that has been used in research by the Law and Psychiatry Division at Yale University School of Medicine.[15,16] Such a database is lacking within the military as are studies pertaining to recidivism, perhaps due to the very infrequent nature of such acquittals within the military legal system. According to data provided by the Deputy Clerk of Courts for the Army Judiciary, from 1990 to present only six courts-martial cases have been adjudicated NGRI of 21,273 total courts-martial, making the percentage of cases resulting in an NGRI finding for each year less than 0.15 percent.[17]

Despite the infrequent occurrence, an NGRI finding is significant, as proper disposition can create great strains within the military behavioral health care system. Until 1996, there was no official policy within the military legal system guiding the disposition of the service member found not guilty by reason of lack of mental responsibility, often leading to debate over jurisdiction of the case between the federal government and the state in which the case was adjudicated.

The only solution available to resolve the dilemma of disposition was a creative process informally pursued between the involved medical and legal professionals.[3] In 1996, Article 76b was introduced as an amendment to the *Manual for Courts-Martial*. The purpose of the amendment was to address the problem of disposition of the military accused found not guilty by reason of lack of mental responsibility as well as those incompetent to stand trial. Article 76b states "the [acquittee] shall be committed to a suitable facility until the person is eligible for release."[18] The duty of the appointed facility is to conduct a psychiatric or psychological exam to assess the acquittee's current mental status and his or her likelihood of dangerousness upon release. Eligibility for release is then decided by a hearing that takes place not later than 40 days following this special verdict. At the posttrial hearing, the accused has the burden of proving that "his release would not create a substantial risk of bodily injury to another person or serious damage of property of another due to a present mental disease or defect," meaning that following trial the acquittee is involuntarily hospitalized, a dangerousness evaluation is completed, and then a posttrial hearing determines whether the acquittee will be released.

If the posttrial hearing determines that the military acquittee does not pose a significant threat to society, he or she is released from involuntary hospitalization and returned to his or her unit. In the vast majority of cases, the soldier has a medically disqualifying psychiatric condition and must undergo a Medical Evaluation Board, the Army's version of a disability assessment.[13] If the forensic assessment concludes that he or she represents a danger to society if released, then the court commits the person to the custody of the U.S. Attorney General. As per Section 4243 of Title 18:

> The Attorney General shall release the person to the appropriate official of the State in which the person is domiciled or was tried if such State will assume responsibility for his custody, care, and treatment. The Attorney General shall make all reasonable efforts to cause such a State to assume such responsibility. If, notwithstanding such efforts, neither such State will assume such responsibility, the Attorney General shall hospitalize the person for treatment in a suitable facility [Ref. 19, p 1].

If placement in a state forensic facility is not feasible, arrangements are made for transfer to a federal forensic facility; however, in the interim, the acquittee may be placed in the local military treatment facility. Such a disposition places significant strain on both the patient and the staff of the appointed "suitable facility" because most military treatment facilities are not accustomed to handling forensic cases. Although Article 76b of the *Manual for Courts-Martial* addresses the gaps in policy related to disposition of insanity acquittees, logistical issues still exist within the system.

A Clinical Case Demonstrating Difficulties With Disposition

Several issues related to the insanity defense are of great importance despite the infrequent occurrence of a not guilty by reason of lack of mental responsibility adjudication within the military. A recent case demonstrated some of the challenges that can arise for the military behavioral health system when confronted with such a disposition.

The service member in this case was charged with indecent sexual assault and conduct unbecoming a member of the military. Based on several clinical interviews with the accused; review of medical records and case file; and multiple collateral interviews with family members, witnesses, and fellow soldiers, the 706 Board diagnosed the service member with bipolar disorder. The Board also concluded that, at the time of the offenses, the accused was in a florid manic state and could not appreciate the nature and quality or wrongfulness of the acts because of a severe mental disease. As a result of these findings, the service member was adjudicated not guilty by reason of lack of mental responsibility by the military court and required disposition as per Rule 76b of the *Manual for Courts-Martial*. Upon order of the military judge, the service member was involuntarily admitted to an inpatient psychiatry ward at a military treatment facility for an evaluation to determine potential for dangerousness due to a psychiatric disorder, consistent with Rule 76b. Within one week, the examining psychiatrists concluded that the service member continued to be at risk of becoming dangerous due to mental illness and therefore required continued psychiatric hospitalization. In addition, a Medical Evaluation Board was performed and submitted for processing. Because this case occurred in a remote location, the "suitable facility" in which the service member was involuntarily admitted was not a forensic psychiatric hospital but a military treatment facility with an acute psychiatric ward. The acquittee continued to be held involuntarily on the inpatient psychiatric ward, awaiting a hearing that would allow transfer to an appropriate forensic facility; however, the presiding judge was away at that time and not available to hear the case, ultimately resulting in the acquittee's being hospitalized for over 45 days.

Initially, the service member was fully engaged in his treatment plan, but over the course of hospitalization he grew increasingly eager for transfer and became medically noncompliant. The extended stay in a "holding pattern" was frustrating to both the acquittee and the ward staff, as a long-term forensic treatment plan could not be initiated on the acute ward. The service member eventually began to refuse medications and did not engage readily in the milieu. On completion of the requisite administrative process, the service member was transferred to a federal forensic facility farther from the acquittee's home of record than the facility that was originally identified.

Discussion

The dilemma in addressing disposition difficulties is compounded by the lack of accessible data related to the military insanity defense. As described by Lande, "A world-wide court-martial system, a frequent turnover of key personnel, and a lack of centralized data collection have created barriers to information retrieval" (Ref. 1, p 303). At present, there is no official procedure in place to track insanity pleas or 706 Boards, an issue not unique to the military. In a 1991 study, Callahan and Steadman concluded, after a very complex process of identifying insanity defense pleas in eight states, that data on insanity pleas are not centrally or systematically maintained.[20] This expensive and extremely time-consuming process involved the hand searching of county court dockets to identify those cases involving the insanity defense. They also found that although most states have a centralized information system for persons adjudicated NGRI, case records on NGRIs committed to state mental health systems are not necessarily maintained in one location. In a 1995 follow-up study, Cirincione *et al.*[14] again found a lack of statewide data on insanity pleas.

As previously noted, the U.S. Army keeps track of the number of insanity acquittees through the Clerk of Courts, U.S. Army Judiciary, and was able to provide these data as well as the total number of courts martial per year since 1990. However, obtaining statistical data and case-specific knowledge concerning 706 Boards continues to be a difficult endeavor. What remains abundantly clear is that the sanity board evaluation along with the MEB process can be both lengthy and costly. Taking the case presented as an example, the average cost for one day of hospitalization on the military psychiatric ward that housed the service member was approximately $2,500, translating into a total expenditure of approximately $120,000 for the extended hospitalization.[17] More

thorough analysis of the disposition process beginning at the time of adjudication would make for a more efficient and cost-effective transition, allowing the acquittee a more timely entrance into the forensic system. A consolidated database tracking both 706 Boards and service members adjudicated not guilty by reason of lack of mental responsibility throughout the uniformed services in addition to a link to individual state tracking systems would aid in timely disposition of insanity acquittees.

Another important resource that should be taken into account is manpower. Article 76b requires that those who are acquitted via a finding of not guilty by reason of lack of mental responsibility be evaluated at (i.e., admitted to) the nearest "suitable facility" for further evaluation, most likely a military medical treatment facility equipped with limited behavioral health resources, a staff not trained to treat forensic patients, and an inpatient milieu not designed for extended hospitalizations. Because the finding of not guilty by reason of lack of mental responsibility occurs so infrequently, the strain on hospital staff may at first appear minimal; however, the manpower burden created may actually be quite significant if a long hospitalization is required. In the case discussed, evaluation of the service member was completed by hospital day four, yet an additional six weeks of custodial care were required before the patient could be transferred to a forensic facility.

Perhaps even more pertinent is determining the effect that the current process has on those requiring long-term forensic hospitalization. The case presented an example of how prolonged hospitalization in an acute-care facility delayed the establishment of a comprehensive forensic treatment plan. The treatment challenges that emerged most likely could have been avoided through a shorter hospitalization with a more streamlined disposition process. The establishment of a composite database could serve as the first step in identifying systemic problems and finding potential solutions.

A centralized database containing detailed information of all 706 Boards performed to include cases adjudicated not guilty by reason of lack of mental responsibility would aid both the military medical and legal systems. Such a database would provide valuable information on the rate of 706 Boards that result in cases' being adjudicated not guilty by lack of mental responsibility in addition to previously unknown metrics such as length of time and total cost of the RCM Article 76b disposition process; total postadjudication period within the military medical system with notation of time exclusively awaiting transfer to a nonmilitary facility; and percentage of cases that progress through the military medical disability system. In addition, previously unreported pertinent 706 data such as diagnosis, evaluation completion time, and correlation of diagnosis to evaluation length would be valuable to the military in planning and scheduling judicial proceedings. From the military medical perspective, the rate of cases in which charges are dropped before trial due to a 706 Board finding of mental disease or defect along with the percentage of such cases referred to the Army medical disability system is very valuable information due to the military's unique dual role of potentially prosecuting alleged criminal acts and then granting medical disability to the same individual.

Summary

The insanity defense has a long, tenuous history, a rare occurrence in both military and civilian jurisdictions. Article 76b of the Uniform Code of Military Justice has aided in giving guidance in the disposition process but still lacking is an effective policy to decrease the excessive time, money, and manpower utilized for each case adjudicated not guilty by reason of lack of mental responsibility. Military treatment facilities are not structured to serve as forensic hospitals, and the acquittee must transition after adjudication from the military to the civilian system.

To better analyze the limitations of the system, individual cases involving a 706 Board should be reviewed leading to creation of a centralized database containing information such as the number of sanity boards completed per year, charge(s), findings (presence/absence of serious mental illness, specific psychiatric diagnosis, past psychiatric history, and criminal record), disposition of cases (charges dismissed, MEB, incarceration, commitment to a forensic facility), timeline of the entire process, and demographics of defendants. A corollary database highlighting the not guilty by reason of lack of mental responsibility dispositions could also be developed and compared with the much larger 706 information pool. Such a database would assist in identifying challenges in the system involving the adjudication and disposition of military insanity acquittees and contribute to stream-

lining the process of transitioning the service member from the military to the civilian forensic system.

Successful insanity defenses are quite uncommon in the military judicial system but such cases impose a significant burden on the military behavioral health care system in terms of time, money, and resources. Enhanced communication between the military legal and medical systems would aid in getting service members through the judicial process expeditiously. An improved process of transitioning into the civilian forensic system of the service member both adjudicated not guilty by reason of lack of mental responsibility and assessed to be dangerous under Article 76b of the UCMJ is essential not only to conserve resources but also to avoid delay in establishment of a forensic treatment plan. Development of both a comprehensive 706 Board database and not guilty by reason of lack of mental responsibility information tool would identify opportunities for improvement to streamline the process.

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