A "CATCH-22" FOR MENTALLY-ILL MILITARY DEFENDANTS: PLEA-BARGAINING AWAY MENTAL HEALTH BENEFITS

VANESSA BAEHR-JONES*

In an accompanying article, Major Tiffany Chapman describes issues related to servicemembers administratively separated for acts of misconduct.[1] The instant article addresses separate issues facing servicemembers who have been administratively discharged in lieu of court-martial, whose numbers in the Army have amounted to 19,808, from the period shortly after the inception of the Global War on Terror through 23 July 2010.[2] Of these discharged veterans, statistics reveal that a good portion of them are likely to suffer from combat-related mental conditions—to a greater extent than other veterans—given the inescapable connection between mental illness and criminal behavior.[3] While veterans who receive Other Than Honorable (OTH) conditions discharges in lieu of court-martial may still be eligible for mental health treatment under limited exceptions to the law, sanity board results from

* Articles Editor, *UCLA Law Review*. Recent civilian positions include assignments at the Joint Intelligence Operations Center, U.S. Pacific Command (2008–2009; 2006–2007), the Joint Forces Command (2007), and the Defense Intelligence Agency (2004–2006).

[1] *See generally* Major Tiffany M. Chapman, *Leave No Soldier Behind: Ensuring Access to Health Care for PTSD-Afflicted Veterans*, 204 MIL. L. REV. 1 (2010).

[2] *See* E-mail from Homan Barzmehri, Mgmt. & Program Analyst, Office of the Clerk of Court, U.S. Army Court of Criminal Appeals, to Amy Atchison, Research Librarian, Univ. California, Los Angeles Law School (23 July 2010, 0754 EST) (summarizing statistics for the number of discharges in lieu of Court-Martial within the U.S. Army for the period 2002–2010). Between 2005 and 2 July 2010, the Navy separated 2326 personnel in lieu of court-martial. E-mail from Mike McLellan, External Media Manager, Navy Personnel Command, Public Affairs Office, to Amy Atchison, Research Librarian, Univ. California, Los Angeles Law School (28 July 2010, 1429 EST).

[3] Psychological studies show a strong connection between symptoms of PTSD and violence in veterans. A 1990 study of over 3000 Vietnam veterans, for instance, showed PTSD sufferers committed, on average, 13.3 acts of violence in a year compared to a rate of 3.5 for non-PTSD study participants. Almost half of the PTSD veterans also had been arrested or jailed at least once. RICHARD A. KULKA ET AL., NATIONAL VIETNAM VETERAN READJUSTMENT STUDY (1990). *See also* Thomas W. Freeman & Vincent Roca, *Gun Use, Attitudes Toward Violence, and Aggression Among Combat Veterans with Chronic Posttraumatic Stress Disorder*, 189 J. NERVOUS & MENTAL DISEASE 317 (2001) (showing a link between chronic PTSD and higher rates of self-reported aggression); Andrew Muskowitz, *Dissociation and Violence: A Review of the Literature*, 5 TRAUMA, VIOLENCE, & ABUSE 22 (2004) (concluding that dissociative symptoms can predict violence).

their military records, which are narrowly-tailored to purely criminal standards, can become the basis for the Veterans Administration's (VA) denials of veterans benefits. This article explores this unique problem in detail and recommends solutions.

The experiences of "K," a U.S. Soldier and Vietnam War veteran, highlight the dilemma faced by many mentally-ill servicemembers contemplating discharge in lieu of court-martial.[4] In 1967, K deployed to Vietnam, where he served in a combat platoon,[5] and then as a machine-gunner aboard small "Riverine" vessels.[6] In later interviews,[7] he recalled being haunted by experiences of watching as villagers—including women and children—were horribly burned by shrapnel.[8] K began compensating for the psychological effects of these events by using drugs, and alcohol.[9] Military records reveal that K attempted suicide while still in the military.[10] Upon returning from the deployment, he had increasing difficulty functioning,[11] periods of unauthorized absence, and was ultimately separated "for the good of the service" in lieu of trial by court-martial with an OTH discharge.[12] After leaving the military, K's situation worsened, as did the symptoms of his Posttraumatic Stress Disorder (PTSD).[13] The destructive behavior culminated in his 1982 conviction for second-degree murder, a crime K committed while intoxicated.[14]

---

[4] *See* James C. May, *Hard Cases from Easy Cases Grow: In Defense of the Fact- and Law-Intensive Administrative Law Case*, 32 J. MARSHALL L. REV. 97 (1998) (describing the administrative case appealing the denial of K's veterans' benefits).
[5] *Id.* at 98.
[6] *Id.*
[7] In the process of appealing his case, the clinicians interviewed K extensively about his time in Vietnam. K also underwent interviews with a psychiatrist to determine the effects of the trauma on his mental health. *Id.* at 104.
[8] *Id.* at 106.
[9] *Id.* at 106–08.
[10] *Id.* at 105.
[11] *Id.* at 107.
[12] *Id.* at 97. This would be the equivalent of a Chapter 10 discharge, under the Army's current separation regulation. *See* U.S. DEP'T OF ARMY, REG. 635-200, ACTIVE DUTY ENLISTED SEPARATIONS (6 June 2005) [hereinafter AR 635-200].
[13] For a description of the historical development of the current diagnostic criteria for PTSD, see Chapman, *supra* note 1, at 6–16. Consistent with these criteria, during K's episodes, he would become violent and deranged, believing he was back in combat. May, *supra* note 4, at 107.
[14] *Id.*

In 1990, K began the lengthy legal fight to obtain veterans' disability benefits for PTSD.[15] His OTH discharge in lieu of court-martial, however, barred his eligibility.[16] Even though a psychiatric report showed K most likely suffered from PTSD during his service,[17] the Veterans' Affairs Board, on the first appeal, ruled that K would remain ineligible for benefits because of the nature of his discharge, necessitating no review of his mental health status.[18] K died from lung cancer[19] (related to his exposure to Agent Orange in Vietnam[20]) as his appeal continued. K's struggle to obtain treatment reveals the conundrum facing other mentally-ill servicemembers who have obtained discharges in lieu of courts-martial and who have been separated under OTH conditions.

In most cases, defense counsel request a sanity board when they suspect that an accused has some sort of mental defect.[21] When the

---

[15] The South Royalton Legal Clinic, a general clinic primarily providing legal aid-type services at the Vermont Law School, assisted with K's administrative case from 1990 to 1997. *Id.* at 88–115.

[16] *Id.* at 97.

[17] *Id.* at 105.

[18] *Id.* at 109–10.

[19] *Id.* at 110.

[20] Two months prior to his death, the VA acknowledged K's lung cancer as a service-connected disability based on a presumptive herbicide (Agent Orange) exposure, and awarded medical care benefits solely for cancer treatment. *Id.* at 110. The clinic continued to appeal the denial of disability benefits for K's PTSD on behalf of K's wife and child, eventually convincing the Board of Veterans Appeals in 1997 to rule in favor of granting accrued benefits to K's dependents. The Board acknowledged K suffered from PTSD at the time he went AWOL and, therefore, his Other Than Honorable Conditions (OTH) discharge did not bar him from receiving benefits. *Id.* at 115. Although K's appeals achieved a bittersweet conclusion for his family, the seven-year appeals process and extensive clinic resources devoted to the appeal are not realistic options for the majority of veterans who appeal their benefits cases pro se. *See* Michael P. Allen, *The United States Court of Appeals for Veterans Claims at Twenty: A Proposal for a Legislative Commission to Consider Its Future*, 58 CATH. U.L. REV. 361, 396 (2009) (noting that 53% of veterans appear in the U.S. Court of Appeals for Veterans Claims, pro se).

[21] *See* MANUAL FOR COURTS-MARTIAL, UNITED STATES, R.C.M. 706(a) (2008) [hereinafter MCM]:

> If it appears to . . . defense counsel . . . that there is reason to believe that the accused lacked mental responsibility for any offense charged or lacks capacity to stand trial, that fact and the basis of the belief or observation shall be transmitted through appropriate channels to the officer authorized to order an inquiry into the mental condition of the accused.

board finds that the accused was not insane at the time of the offense—which is routinely the case[22]—the accused confronts a dilemma. If he requests discharge in lieu of court-martial, supposing that the command would be receptive to it, the action will likely result in an OTH, as well as an uphill battle to regain eligibility for any sort of mental health treatment. This quagmire results from a provision in the Veterans' Benefits Code regulations that defines any OTH discharge obtained in lieu of court-martial as "under dishonorable conditions"—a complete bar to obtaining veterans' benefits.[23]

Following a finding of mental capacity during a sanity board, the accused essentially has the perverse incentive to plea-bargain away his veterans' disability benefits with an OTH discharge. Furthermore, the records indicating the competency of the accused will extinguish the only known exception in the Veterans' Benefits Code that permits treatment for OTH recipients.[24] In these cases, the accused ultimately faces a "Catch 22": He cannot receive benefits unless insane, but has little chance of being found insane.[25] This bar to benefits will usually stand,

---

See also United States v. Talley, 2007 CCA LEXIS 535, at *15 (A.F. Ct. Crim. App. Nov. 30, 2007) (unpublished) (describing defense counsel's duty to seek a sanity board inquiry and noting that RCM 706(a) "clearly establishes the duty of trial defense counsel to report sanity issues to an appropriate authority"). In fact, defense counsel have an incentive to request a sanity board in any case in which the accused shows signs of suffering from a mental health problem to prevent against a later claim of ineffective assistance of counsel. In a number of cases, appellants have raised such claims for failure to request a sanity board. *See, e.g.*, *id.*; United States v. Breese, 47 M.J. 5 (C.A.A.F. 1997); United States v. McClain, 1998 CCA LEXIS 549 (A.F. Ct. Crim. App. Apr. 29. 1998) (unpublished); United States v. Cote, 1991 CMR LEXIS 750 (C.M.R. Apr. 9, 1991) (unpublished).

[22] *See* Major Jeff A. Bovarnick & Captain Jackie Thompson, *Trying to Remain Sane Trying an Insanity Case:* United States v. Captain Thomas S. Payne, ARMY LAW., June 2002, at 13 & 13 n.4 ("Of the thousands of courts-martial completed from 1998–2001, CPT Thomas Payne was the only military person committed to the custody of the Federal Bureau of Prisons (FBOP) resulting from a verdict of not guilty only by reason of lack of mental responsibility. Thus, the frequency of this verdict is quite low.").

[23] 38 C.F.R. 3.12(d)(4) (2010) specifies that any undesirable discharge accepted during plea-bargaining to escape court-martial is considered as "under dishonorable conditions." Under 38 U.S.C. § 101(2), any discharge under dishonorable conditions deprives the service member of veteran's status for the purpose of obtaining benefits under the Code.

[24] 38 U.S.C. § 5303(b) (2006).

[25] Although the process of veterans' claims remains a relatively obscure area of administrative law with little coverage in academic publications, the system itself impacted close to seventy-five million people as of 2007, who were potentially eligible to receive benefits from the U.S. Department of Veterans Affairs. *See* Allen, *supra* note 20, at 365.

even if the veteran can later show the mental illness was, in fact, service-connected.[26] The reality of this conundrum is highlighted in a number of veterans' benefits opinions.[27]

Part I of this article explores the peculiar function of the sanity board in precluding mentally-ill veterans from eligibility for exceptions to obtain treatment. It further highlights characteristics of sanity boards that severely limit or preempt the consideration of later, more detailed evaluations for veterans' benefits. Part II then proposes reforms that will better serve the interests of veterans facing court-martial who suffer from mental conditions.

I. Factors that Contribute to the Creation of a Catch-22 for Mentally-Ill Servicemembers Facing Court-Martial

A. Some Dilemmas inherent in Sanity Boards

An accused suffering from PTSD faces a particularly arduous challenge in demonstrating the existence of a qualifying condition for incapacity or insanity at a sanity board inquiry.[28] Even where the accused is shown to suffer from PTSD symptoms, a sanity board is unlikely to find that the condition deprived the accused of mental capacity at the time of the charged offenses.[29] For instance, in *United States v. Brasington*, the sanity board representative testified that, even

---

[26] *See, e.g.*, Stringham v. Brown, 8 Vet. App. 445, 449 (Vet. App. 1995) (finding service-connected PTSD did not qualify as insanity exception because he did not suffer from it at the time of offenses leading to OTH discharge); *see also* 38 C.F.R. § 4.1 (defining service-connected broadly as a "disability resulting from all types of diseases and injuries encountered as a result of or incident to military service").

[27] *See infra* notes 45–52.

[28] *See, e.g.*, May, *supra* note 4, at 114. *See also* United States v. Colvano, 2009 CCA LEXIS 95 (A.F. Ct. Crim. App. Mar. 17, 2009) (involving an unsuccessful appeal of a guilty plea after a sanity board ruling found the appellant did not suffer from PTSD, even though appellant underwent post-conviction treatment for PTSD); United States v. Brasington, 2009 CCA LEXIS 383 (A.F. Ct. Crim. App. Oct. 5, 2009) (unpublished) (describing a case where, during the original trial, a sanity board member testified the accused did not suffer from a stress disorder, even though the accused was undergoing psychological evaluation at the time of the offense, and had been diagnosed with an "acute stress disorder" prior to the offense).

[29] *See, e.g.*, United States v. Young, 43 M.J. 196, 198 (C.A.A.F. 1995) (describing how "few of the most common symptoms of PTSD could ever lead to a finding of lack of mental responsibility" in declining to find the accused's PTSD undermined his volition in his violent criminal episodes).

had the accused been suffering from an acute stress disorder, the condition would still not qualify as a "severe mental disease or defect."[30] Such results are attributable to a combination of five factors.

First, common PTSD symptoms that lead to violent behavior—mood liability and combat addiction—may be particularly difficult to identify, diagnose, and present as convincing evidence of a mental disorder within the military justice system.[31] Both of these symptoms could be confused for positive traits not reflective of a disorder due to the fact that many symptoms of combat addition are easily viewed as motivation and good-soldiering in military environments.[32] The Air Force Court of Criminal Appeals seemed to apply this kind of reasoning in *United States v. Curtis*, citing the accused's years of fighting in high-stress combat situations as evidence of his competency and dismissing the later finding of PTSD.[33]

Second, delayed-onset PTSD, a condition in which symptoms emerge long after exposure to the traumatic event,[34] or its co-occurrence with other mental health diagnoses, contributes to misdiagnosis among military members returning from combat.[35] Third, even if the sanity

---

[30] *Brasington*, 2009 CCA LEXIS 383, at *13.

[31] One study identified four psychological factors that can lead to violent behavior in those suffering from PTSD: flashback-associated violence, sleep disturbance-associated violence, mood liability-associated violence, and combat addiction violence. J. Silva et al., *A Classification of Psychological Factors Leading to Violent Behavior in Posttraumatic Stress Disorder*, 46 J. FORENSIC SCI. 309–16 (2001). Mood liability in military veterans can involve chronic irritability and hostility. Andrea Friel et al., *Posttraumatic Stress Disorder and Criminal Responsibility*, 19 J. FORENSIC PSYCHIATRY & PSYCHOL. 64 (2008). A 2001 study described a Vietnam combat veteran suffering from mood liability as chronically hostile and irritable, tending to "overreact even to quite minor provocation." *Id.* at 74. Combat addiction describes a person who "seeks to re-experience previous combat experiences by engaging in a repeated pattern of aggressive behavior." *Id*. Here, The patient will attempt to recreate the original trauma through "liv[ing] on the edge." *Id.*

[32] Quick demonstrations of hostility can also serve to positively distinguish a military member training for combat. *See, e.g.*, Lizette Alvarez, *Suicides of Soldiers Reach High of Nearly 3 Decades*, N.Y. TIMES, Jan. 29, 2009, at A19 (describing the "warrior culture" that discourages military members from seeking psychological treatment).

[33] United States v. Curtis, 2009 CCA LEXIS 11, at *15–17 (A.F. Ct. Crim. App. Jan. 6, 2009) (unpublished).

[34] *See, e.g.*, Chapman, *supra* note 1, at 12 (describing features of delayed-onset PTSD).

[35] Because of the sporadic and continuous symptoms of PTSD, the disorder can be especially difficult to correctly diagnose and treat in returning veterans. A twenty-year study of Israeli veterans showed how PTSD symptoms could vary greatly over time and lead to unpredictable diagnoses. The study found 22.6% of those who were diagnosed

board finds evidence of mental illness, because the symptoms of PTSD do not always negate the accused's volition,[36] the illness rarely serves as a complete affirmative defense based on a lack of mental capacity.[37]

Fourth, the structure of and rules governing sanity boards further limit the possibility of a finding of insanity. The sanity boards usually are comprised of only one individual,[38] and, in the case of multiple members, the board can include a supervisor and a subordinate, creating questions of fairness.[39] In addition, if the convening authority does not agree with the findings of the sanity board regarding mental competency, the Rules for Courts-Martial permit the convening authority to refer the charge to

---

with PTSD after year one no longer suffered from the disorder after year two. However, of that "recovered" sample, 36.8% were subsequently re-diagnosed with PTSD in year three of the study, suggesting that a number of veterans suffering from PTSD may be found "recovered" only to later suffer from recurring symptoms. In the context of diagnosing the disorder for the purposes of a court-martial, the sporadic onset of PTSD symptoms likely confound consistent diagnoses, increasing the difficulty of proving the disorder in court. Zahava Solomon & Mario Mikulinver, *Trajectories of PTSD: A 20-Year Longitudinal Study*, 163 AM. J. PSYCHIATRY 659, 659–66 (2006). Consider the example of K, which opened this article. Even though he attempted to commit suicide while in the military and suffered from substance abuse problems, military mental health evaluations did not diagnose his symptoms of PTSD. Consider also *Stringham v. Brown*, where the Veterans Board found that the veteran suffered from service-connected PTSD, but did not find evidence in his military mental health records to show he suffered from PTSD symptoms at the time of the offense. 8 Vet. App. 445 (1995).

[36] While the *Diagnostic and Statistical Manual of Mental Disorders* requires an objective evaluation of a causative traumatic stressor and requires symptoms of clinically significant distress or impairment in social, occupational, or other important area of functioning, only symptoms of unconsciousness and disassociation typically result in complete lack of volition in civilian criminal courts. Chapman, *supra* note 1, at 8–9; Major Timothy P. Hayes, Jr., *Post-Traumatic Stress Disorder on Trial*, 190 MIL. L. REV. 67, 78–79 (2006) (discussing civilian and military cases in which defendants asserted an insanity defense, claiming PTSD caused disassociation at the time of the offense); *see also* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 467–68 (text rev., 4th ed. 2000). However, PTSD rarely serves as a full affirmative insanity defense in the civilian criminal justice system. *See* Henry F. Fradella, *From Insanity to Beyond Diminished Capacity: Mental Illness and Criminal Excuse in the Post-Clark Era*, 18 U. FLA. J.L. & PUB. POL'Y 7, 52–53 (2007) (noting that only "extreme cases of Posttraumatic Stress Disorder (PTSD)" would qualify as an insanity defense in the majority of courts in the United States).

[37] *See, e.g.*, UCMJ art. 50a(a) (2008) (defining the affirmative insanity defense); United States v. Young, 43 M.J. 196, 198 (C.A.A.F. 1995).

[38] Hayes, *supra* note 36, at 83.

[39] United States v. Murphy, 67 M.J. 514 (A.C.C.A. 2008) (holding no conflict of interest where appellant claimed error based on supervisory relationship between sanity board members).

trial regardless of a finding that the accused lacks mental competency to stand trial.[40]

Finally, the military justice system also does not recognize a psychiatrist-patient privilege, which can discourage defense counsel from calling a psychiatrist to testify to the accused's mental state.[41] In *United States v. Mansfield*, the defense abandoned the planned lack of mental capacity defense because the accused made admissions to the defense psychiatrist that could indicate guilt on cross-examination.[42] Similarly, in *United States v. Toledo*, the prosecution used the psychiatrist on cross-examination as a witness to impeach the accused's credibility.[43] Thus, the current rules and procedures for sanity board evaluations create significant obstacles for introducing and proving evidence of the existence and extent of PTSD.

B. The Effects of Sanity Board Determinations on Disability Benefit Evaluations

Congress established an exception to the general rule barring benefits for veterans discharged with an OTH in lieu of court-martial. The existence of this exception recognizes the fact that such veterans may require treatment and be worthy of such care—notwithstanding their discharge characterization.[44] The Department of Veteran Affairs (VA)

---

[40] Hayes, *supra* note 36, at 83–84 (discussing RCM 909(c)).

[41] "There is no physician-patient or psychotherapist-patient privilege in federal law, including military law." United States v. Mansfield, 38 M.J. 415 (C.A.A.F. 1993), *cert. denied*, 511 U.S. 1052 (1994). A psychotherapist-patient privilege has been recognized, although not applied, in both the Second Circuit (*In re* Doe, 964 F.2d 1325 (2d Cir. 1992)) and Sixth Circuit (*In re* Zuniga, 714 F.2d 632 (6th Cir. 1983), *cert. denied*, 464 U.S. 983 (1983)). *But see* Loving v. United States, 64 M.J. 132, 164 (C.A.A.F. 2006) (recognizing the special privilege that attaches to a psychologist who is "part of defense team"). If, however, the mental health professional testifies, the Government can subject the expert to cross-examination.

[42] *Mansfield*, 38 M.J. 415.

[43] 25 M.J. 270 (C.M.A. 1987), *on reconsideration*, 26 M.J. 104 (C.M.A. 1988), *cert. denied*, 488 U.S. 889 (1988).

[44] This concept of worthiness is highlighted by Congress's intent to except "insane" veterans from treatment prohibitions, despite their characterization of discharge. Chapman, *supra* note 1, at 25. *Cf.* Donald E. Zeglin, *Character of Discharge: Legal Analysis*, *in* VETERANS' DISABILITY BENEFITS COMM'N, HONORING THE CALL TO DUTY: VETERANS' DISABILITY BENEFITS IN THE 21ST CENTURY 437–38 (2007), *available at* http://www.vetscommission.org/pdf/ExecutiveSummary_eV_9-27.pdf (discussing

standards define the characteristics of "insanity" that qualify for this exception. Although such standards are inconsistently applied by VA adjudicators—and ultimately the veterans boards and courts of appeal—PTSD could meet the insanity definition.[45] The problem is that, as Major Chapman recognizes, many VA adjudicators are applying a narrow "criminal-like" criterion, even though the framework is administrative, and not criminal.[46] Sanity board results are now used to deny the exception outright.[47] Ultimately, because VA standards still differ from the UCMJ's insanity criteria, the sanity board's evaluations serve to limit the evidence available to prove the insanity exception during later reviews.

In *Gardner v. Shinseki*, a sanity board found the accused competent to stand trial for absence without leave offenses and failure to obey a superior's order. He was sentenced to two years of hard labor and received a dishonorable discharge.[48] During his confinement, the servicemember showed signs of psychosis. After one year, he was ultimately transferred to a naval hospital where he was diagnosed with schizophrenia.[49] The military released Gardner from the remainder of his sentence and discharged him administratively under OTH conditions, notwithstanding the punitive discharge.[50] In reviewing Gardner's subsequent claims for service-connected disability benefits, the Board of Veterans' Appeals based its determination of the appellant's mental status on the UCMJ's definition used in his criminal case, still finding

---

Congress's intent in liberalizing the requirement for veterans' benefits to allow for OTH discharged veterans to receive benefits in 1944).

[45] The regulation implementing 38 U.S.C. § 5303(b) (2006) provides an exception permitting a veteran with an OTH discharge to obtain disability benefits when the claimant was insane at the time of the offense 38 C.F.R. § 3.12(b) (2010). For an exceptional case, in which the Veterans Court overturned the Board's denial of benefits based on reports that demonstrated the appellant suffered from schizophrenia at the time he committed the Absence Without Leave offenses, see Beck v. West, 13 Vet. App. 533, 541 (U.S. App. Vet. Cl. 2000).

[46] Chapman, *supra* note 1, at 29.

[47] The definition of insanity in 38 C.F.R § 3.354 also appears to provide a more expansive definition of insanity for evaluating the claimant's mental state at the time of the offense than does the UCMJ. *See* Zang v. Brown, 8 Vet. App. 246, 252–54 (1995) (observing that the existence of insanity, as defined in section 3.354(a), at time of commission of act, negates intent so as to preclude the act from constituting willful misconduct under section 3.1(n)).

[48] 22 Vet. App. at 417 (1995).

[49] *Id.*

[50] *Id.* at 417–18.

the appellant sane at the time of the offense and therefore denying benefits.[51]

Aside from varied and inconsistent standards for insanity, the veterans' benefits courts must also struggle with problems related to temporality—determining the time at which PTSD first emerged. In *Stringham v. Brown*, the Court of Appeals for Veterans Claims acknowledged that the claimant suffered from PTSD because of his service in Vietnam, but, nonetheless, denied his claim for service-connected benefits because there was no evidence showing he suffered from PTSD symptoms at the time of the offense resulting in his separation.[52] Both *Gardner* and *Stringham* demonstrate how the veteran's sanity board evaluations can easily disadvantage later attempts to secure mental health treatment by exception.[53]

III. Proposals: Expanding the Military Justice System's Capacity to Document and Consider VA Criteria for Insanity

To ensure that mentally-ill separated servicemembers retain access to health benefits, Major Chapman recommends revisions to the Veterans Code, which permit access to health care for all service-connected PTSD, regardless of the nature of a veteran's discharge.[54] Alternatively, she proposes explicit mention of PTSD within the Code's insanity exception.[55] This Part proposes other alternatives suited to the sanity board and administrative review process, which are not dependent on the Veterans Code. In this respect, reforms within the military criminal justice system will ensure that the accused has the opportunity to receive

---

[51] *Id.* at 420. *Mudge v. Nicholson* was also a decision in which the Veterans Court remanded because the lower court applied an incorrect standard. 2006 U.S. App. Vet. Claims LEXIS 1495 (U.S. App. Vet. Cl. Dec. 19, 2006) (remanding due to the Board's failure to apply the proper definition and its faulty reliance on whether the claimant could understand the consequences of his actions).

[52] Stringham v. Brown, 8 Vet. App. 445, 449 (1995).

[53] *See, e.g.*, Beck v. West, 13 Vet. App. 533, 540 (U.S. App. Vet. Cl. 2000) (upholding the Board's finding that "the only evidence of record indicating that the appellant was insane at the time he had committed the AWOL offenses are his own assertions of having had paranoid feelings"); Cropper v. Brown, 6 Vet. App. 450, 452 (1994) (upholding the Board's determination of "the lack of any evidence of insanity in the appellant's service medical files"). Bowles v. Brown, 1994 U.S. Vet. App. LEXIS 103 (Vet. App. Feb. 8, 1994).

[54] Chapman, *supra* note 1, at 39.

[55] *Id.*

an impartial mental health evaluation and a fair review of mental health evidence with an eye toward current and future treatment.

Because the Catch-22 identified in this article begins with the sanity board process, this article proposes the following two reforms to improve the fairness and comprehensiveness of sanity boards, and the quality of these evaluations.

A. Enlarge the Scope of Issues Considered by the Sanity Board to Address Veterans Benefits Standards, as well as Criminal Ones

As it now stands, the RCMs currently specify only four questions for sanity boards to consider.[56] Reforming sanity board procedures to address VA eligibility standards beyond the standard four military justice questions will assist an accused with an otherwise qualifying condition by preserving eligibility for excepted services. Even if it is not feasible to amend or modify RCM 706, defense and government counsel could submit additional questions to the sanity board or to the convening authority. Alternatively, convening authorities, who have been educated about this dilemma, could independently elect to include these questions in sanity board inquiries. Not only do the RCMs specifically permit fuller sanity board evaluations,[57] it is becoming more common to address

---

[56] MCM, *supra* note 21, R.C.M. 706(c)(2):

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

Id.

[57] *See, e.g.*, *Brasington*, 2009 CCA LEXIS 383 (involving competing testimony from a sanity board member and another military mental health expert who had conducted extensive psychiatric testing on the accused).

VA standards. For example, the active components have spearheaded recent efforts to synchronize VA standards with their own disability evaluations in recognition of active military members' needs after separation.[58]

The Veterans Code regulations define the insanity exception broadly, considering whether the veteran "interferes with the peace of society" or "lacks the ability to make further adjustments to the social customs."[59] A psychiatric evaluation that included testing for mental health disorders would provide the accused with the basis for requesting an insanity exception post-separation.[60] It would also create a record during military service of mental health problems, which could assist in reclassifying the discharge.[61]

---

[58] *See, e.g.*, Editorial, *U.S. Department of Veterans Affairs; VA Announces Expansion of Disability Evaluation System Pilot*, L. & HEALTH WKLY., Nov. 29, 2008, at 2160 (describing a program intended for "19 military installations, representing all military departments," which consolidates active duty and VA disability evaluations into a single process, instead of forcing the veteran to undergo separate evaluations).

[59] 38 C.F.R. § 3.354(a) (2010):

> Definition of insanity. An insane person is one who, while not mentally defective or constitutionally psychopathic, except when a psychosis has been engrafted upon such basic condition, exhibits, due to disease, a more or less prolonged deviation from his normal method of behavior; or who interferes with the peace of society; or who has so departed (become antisocial) from the accepted standards of the community to which by birth and education he belongs as to lack the adaptability to make further adjustment to the social customs of the community in which he resides.

[60] For example, with regard to PTSD, psychologists use several different diagnostic tools to evaluate a patient and identify PTSD, the most common being a structured diagnostic interview known as the Clinician-Administered PTSD Scale. Friel et al., *supra* note 31, at 67–68. However, according to the testimony of a sanity board doctor, psychological or psychiatric testing is not routinely conducted for sanity boards. *Brasington*, 2009 CCA LEXIS 383, at *12.

[61] *See infra* notes 64–69 and accompanying text describing the process of reclassifying discharges.

B. Broaden the Sanity Board Evaluation to Include Recommendations for Treatment

If the sanity board considered a broader set of questions in evaluating the accused, to include recommended treatment, the military justice system could potentially consider alternatives to court-martial, such as funded treatment programs.[62] A full evaluation of the accused, comprehensive psychiatric testing, treatment recommendations, and predictions of the efficacy of treatment on the accused's behavior would greatly expand the material the convening authority, judge, and court-martial members could consider during negotiations and in sentencing. Although formal adoption of this change would require revision of the RCMs,[63] such standards could be enforced through particularized requests by the military judge or convening authority. A fuller evaluation during pretrial negotiations and sentencing would not require any legislative change to the rules; rather, it would require a change in perspective within the military justice system, prioritizing long-term healthcare and societal welfare among veteran populations in addition to current exigencies.[64]

---

[62] There are strong policy reasons for assisting servicemembers through preventative care, such as mental health treatment and substance abuse treatment. In absence of this kind of care, numerous social problems can result from an untreated mentally ill veteran population, including an increase in crime. Studies and news reports have identified an increase in the crime rate of veterans, noting possible links to lack of treatment. *See* R. Jeffrey Smith, *Crime Rate of Veterans in Colorado Unit Cited*, WASH. POST, July 28, 2009 (reporting on accounts of members of the Army's Fourth Infantry Division's Fourth Brigade that the Army's failure to provide proper treatment for stress was partially the cause for the increased homicide rate in returning veterans); Thomas L. Hafemeister & Nicle A. Stockey, *Last Stand? The Criminal Responsibility of War Veterans Returning from Iraq and Afghanistan with Posttraumatic Stress Disorder*, 85 IND. L.J. 87, 102 (2010) (discussing studies linking veterans suffering from PTSD to a high rate of criminal behavior, and noting "in 2004, state prisons held 127,500 veterans, accounting for approximately 10% of the entire prison population"). The civilian criminal justice system has created new approaches to help veteran criminal defendants, in order to prevent future crime by providing treatment options. *See, e.g.*, Captain Evan R. Seamone, *Attorneys as First-Responders: Recognizing the Destructive Nature of Posttraumatic Stress Disorder on the Combat Veteran's Legal Decision-Making Process*, 202 MIL. L. REV. 144, 159–62 (2009) (exploring the emergence of numerous veterans treatment courts and statutes in Minnesota and California that have recognized the importance of diversion programs in the criminal justice system to help veterans obtain treatment).

[63] 10 U.S.C. § 836 (2006). Article 36 gives the President power to amend the rules implementing trial procedures in military courts-martial.

[64] For one example of the social science literature examining the links between veterans with psychiatric problems and increased crime, see, e.g., Brent B. Benda et al., *Crime*

C. Utilize the Discharge Review Boards Invigorated Review Standards to Thoroughly Evaluate Veterans' Claims and Include Additional Analysis of VA Standards for Further VA Review, Even Where There is Insufficient Evidence to Warrant an Upgraded Discharge

Discharge Review Boards (DRBs) provide a potential forum to address discharges in lieu of court-martial resulting in a denial of benefits to servicemembers with PTSD.[65] The Boards give discharged servicemembers the opportunity to present evidence of injustice or unfairness in their discharge, in order to reclassify the discharge. In 2009, Congress amended the act governing the DRBs with the specific purpose of providing more thorough review for veterans with PTSD and traumatic brain injury (TBI). The new sections require the DRB to include a physician, clinical psychologist, or psychiatrist in cases where the former servicemember was diagnosed with PTSD or TBI following a deployment in support of a contingency operation.[66] Congress also now requires the Secretary to expedite applications for relief from those servicemembers.[67] These amendments would benefit servicemembers separated in lieu of court-martial, who were found competent or sane by a sanity board, but who may still have suffered from documented symptoms of PTSD or TBI during their service.

Even with these amendments in place, however, the DRB review process presents a former servicemember with a challenging up-hill battle. The boards review a vast number of cases with only brief time to consider each claim.[68] The review standard is also extremely deferential

---

Among Homeless Military Veterans Who Abuse Substances, 26 PSYCHIATRIC REHABILITATION J. 332 (2003); sources cited *supra* note 3.

[65] Each service has its own DRB, as well as Board for Correction of Military Records (BCMR) which typically reviews claims the DRB has already denied. The DRB is comprised of five military officers empowered to review and, if necessary, reclassify discharges awarded other than by general court-martial. Its actions are subject to the review of the secretary of each service. 10 U.S.C. § 1553(a)–(b). The BCMR is made up of civilian personnel from each of the service departments and can change a servicemember's records where "necessary to correct an error or remove an injustice." *See id.* § 1552(a).

[66] *Id.* § 1553(d)(1).

[67] *Id.* § 1553(d)(2).

[68] According to one practitioner's FOIA request, the Army BCMR members spend an average of 3.75 minutes deciding each application, while the Navy BCMR members spend an average of 1.6 minutes. Aside from the Air Force, the services do not require the board members to review applications and supporting evidence before deciding the claims. *See* RAYMOND J. TONEY, MILITARY RECORD CORRECTION BOARDS AND THEIR JUDICIAL REVIEW, MILITARY LAW SECTIONS PROGRAM 3 (June 11, 2010), *available at*

and requires a showing of injustice or legal error to change the discharge.[69] The boards, in fact, start from the "presumption of regularity in the conduct of governmental affairs," placing the burden on the veteran to provide "substantial credible evidence."[70] Thus, for those servicemembers who willingly accepted an OTH discharge in lieu of trial, the review may not provide a realistic chance of reclassifying the discharge.

These new reforms, however, suggest that Congress intended the DRB to spend more time considering each application. The requirement in 10 U.S.C. § 1553(d)(1) to include a physician, psychiatrist, or psychologist during the review implies these reviews involve some evaluation of the medical or mental health records. Assuming that the newly-composed DRBs were permitted to spend additional time evaluating claims in which veterans presented additional information besides the singular sanity board evaluation in their sparse files, DRBs would be ideally and uniquely positioned to clarify the record, address some of the VA eligibility criteria, and provide the veteran with a new opportunity to obtain treatment—even if the veteran failed to meet the criteria for a discharge upgrade.

Consequently, the DRBs provide a second opportunity for servicemembers who may have some record of mental health problems, but who are not found insane during the sanity board.

IV. Conclusion

This article identified a Catch-22 in which mentally-ill servicemembers will lose their eligibility for service-related benefits primarily based on the results of extremely limited sanity board evaluations. Aside from recommendations to revise the Veterans' Benefits Code, this article recommended simple measures that could be accomplished within the military. In line with the sacrifices made by many of these veterans, the implementation of these measures can address their problems long after their departure from the armed services.

---

http://www.texasbar.com/flashdrive/materials/military_law/MilitaryLaw_Toney_MilitaryRecord_FinalArticle.pdf (last visited July 18, 2010).

[69] VETERANS FOR AMERICA, THE AMERICAN VETERANS AND SERVICE MEMBERS SURVIVAL GUIDE 329 (2009), *available at* http://www.veteransforamerica.org/wp-content/uploads/2008/11/15-Discharge-Upgrades.pdf (last visited July 18, 2010).

[70] *Id.*