

Trying to Remain Sane Trying an Insanity Case: *United States v. Captain Thomas S. Payne*¹

Major Jeff A. Bovarnick
Chief, Operational Law
XVIII Airborne Corps
Fort Bragg, North Carolina

Captain Jackie Thompson
Defense Counsel
101st Airborne Division (Air Assault)
Fort Campbell, Kentucky

Doctor (Expert in Forensic Psychiatry): Captain (CPT) Payne is a licensed dentist and, in addition to refusing to engage in any personal hygiene, he will not brush his teeth. It takes him forty to fifty seconds, sometimes minutes, to respond “Yes” or “No” to a simple question. We observe him through a monitor in his room and he will stand for hours staring at the wall, or he will swat at things that are not there.

Trial Counsel: How can you be certain CPT Payne is not malingering or faking this condition?

Doctor: For the past few weeks he has been on the maximum dosage of anti-psychotic medicine, and he is reacting very well. If you or I were to take that medication, it would knock us out. Captain Payne is not malingering—he is suffering from a severe mental disease.²

Introduction

A sanity board has just reported that an accused soldier is presently suffering from a mental disease or defect, and that the accused is not competent to stand trial. Whether you are a trial or defense counsel, your mission is to guide an insanity case through the legal battlefield. While a finding of “not guilty only by reason of insanity”³ is extremely rare in the military,⁴ it is not uncommon for military criminal law practitioners to face mental responsibility issues before and during trial. This article provides a suggested course of action based on the successful resolution of one such case, *United States v. Payne*.⁵ This article is not doctrine; rather, it proposes a model for practitioners to reference when faced with the complex task of trying an insanity case.

1. This article incorporates a fictional name for an actual insanity acquittee to protect his privacy. Locations, units, and other names have also been changed to guard against any unwarranted disclosure of personal information.

2. Interview with Dr. (Major) Evan Whitmore, Chief, Hospital Psychiatric Services, Lindberg Army Medical Center (LMC), Williams Air Force Base, Springfield (Feb. 16, 2000).

3. In the federal criminal system, the more familiar terminology for findings in an insanity case is: “Not guilty only by reason of insanity.” 18 U.S.C. § 4242(b)(3) (2000). At a court-martial, the terminology is: “Not guilty only by reason of lack of mental responsibility.” *MANUAL FOR COURTS-MARTIAL, UNITED STATES, R.C.M. 921(c)(4)* (2000) [hereinafter MCM].

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. Telephone Interview with Angela Dunbar, FBOP (May 8, 2000). Angela Dunbar, in her long tenure at the FBOP as the sole point of contact for coordinating transfers of military personnel to the FBOP for psychiatric treatment, had never done so as the result of a verdict until processing CPT Payne. *Id.*

Through the experience of the authors, whose background is similar to many military justice practitioners—both served tours as trial counsel, and one served additional tours as a defense counsel and a Chief of Military Justice, and through the authors’ discussions with numerous personnel involved in the military justice system, it is apparent that processing a mental responsibility case through completion is very rare. The authors polled the Criminal Law Division of The Judge Advocate General’s School of the Army, the Criminal Law Division of The Office of The Judge Advocate General, the Trial Counsel Assistance Program, military judges, senior judge advocates, and other Chiefs of Military Justice, and no one, at least as far as anyone could remember, had actually handled a case involving an accused that had to be committed.

5. Payne Record of Trial. The authors base other assertions and practice tips on their numerous experiences with sanity boards and mental responsibility issues.

The focus is twofold: (1) to explain to military legal practitioners how to get an insanity case to trial when a sanity board has determined an accused is incompetent to stand trial, and (2) to explain how to get an accused committed after a verdict of not guilty only by reason of lack of mental responsibility. This article does not focus on how to present or attack an insanity defense on the merits. Rather, it explores supporting efforts of such cases, which include the procedural hurdles facing the government and defense in those rare circumstances when an accused is not competent to stand trial (pretrial) or found not guilty by reason of insanity (post-trial). The first part of the article, *Trying to Remain Sane*, is a series of practice tips for counsel involved with an insanity case. The second part of the article, *Trying an Insanity Case*, details the authors' court-martial experience with *United States v. Payne*.

Part I: Trying to Remain Sane

Practice Tips

1. Processing the Sanity Board Request: RCM 706 Matters in Inquiry

When a credible accused pending trial tells his defense counsel or someone in his chain of command that he is depressed or suicidal, they usually initiate a sanity board.⁶ If that same soldier wakes up on time every day, dresses in a normal fashion, reports to formations, completes assigned tasks,

performs personal hygiene, and eats meals using appropriate utensils, the results of a sanity board inquiry should not be surprising. Although doctors may diagnose the accused with depression,⁷ the doctor's other sanity board findings will be the usual: the accused does not have a severe mental disease or defect, the accused was able to appreciate the nature and quality of the wrongfulness of the criminal misconduct, and the accused is able to understand the nature of the proceedings or cooperate intelligently in his defense.⁸

Sanity board requests under Rule for Courts-Martial (RCM) 706 may be forwarded by a number of parties before or after referral.⁹ Practitioners, however, will likely see the majority of RCM 706 requests initiated by the defense pre-referral. Defense counsel may serve the request directly on a commander; however, as a practical matter, the defense will usually serve it on the trial counsel. The trial counsel then coordinates a number of things: (1) the commander before whom the charges are pending must order an inquiry;¹⁰ (2) the doctor conducting the inquiry must receive all required documents;¹¹ and (3) the unit must ensure the accused's presence at all sessions of the inquiry, an especially burdensome task when the accused is in pretrial confinement. Additionally, the government must account for the inevitable delay caused by sanity boards. The convening authority should sign an RCM 707(c) delay in conjunction with the sanity board order to cover the period of the sanity board.¹²

6. See MCM, *supra* note 3, R.C.M. 706(a). Rule for Courts-Martial (RCM) 706(c)(2)(A)-(D), Matters in Inquiry, details the findings requested of a sanity board:

When a mental examination is ordered under this rule, the order shall contain the reasons for doubting the mental capacity or mental responsibility, or both, of the accused, or other reasons for requesting the examination. In addition to other requirements, the order shall require the board to make separate and distinct findings as to each of the following questions:

- (A) At the time of the alleged criminal conduct, did the accused have a severe mental disease or defect? . . .
- (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. R.C.M. 706(c)(2)(A)-(D).

7. This answer responds to Question B of RCM 706(c)(2). See *supra* note 6.

8. These answers respond to Questions A, C, and D of RCM 706(c)(2). See *supra* note 6.

9. "Referral is the order of a convening authority that charges against an accused will be tried by a specified court-martial." MCM, *supra* note 3, R.C.M. 601(a).

10. See *id.* R.C.M. 706(b). The commander who orders the RCM 706 inquiry must be a convening authority. *Id.* R.C.M. 706(b)(1). The trial counsel must be cognizant of the rank of the doctor who is the chief of the hospital section that will be conducting the inquiry. It may be awkward if an O-5 battalion commander orders an O-6 doctor to conduct this inquiry, and to do so in a timely fashion. Counsel should get the order signed by the special court-martial convening authority, usually an O-6 brigade commander. Although the defense may request completion of the inquiry before the Article 32 investigation, this is not mandatory.

11. The trial counsel must assemble a packet for the doctor conducting the sanity board. This packet should include, at a minimum, the sanity board order, the sanity board request, the charge sheet, and the pre-referral packet; that is, evidence supporting the charges. The unit escort should bring the accused's medical records to the doctor. Finally, the government should provide the doctors a copy of RCM 706.

12. See *United States v. Arab*, 55 M.J. 508 (Army Ct. Crim. App. 2001) (discussing speedy trial issues related to sanity boards). In *Arab*, the court found that the convening authority did not abuse his discretion when he granted an open-ended delay until the completion of the sanity board. Although the *Arab* court found that the 140-day delay for completing the accused's sanity board was unusually long, it determined the government displayed due diligence in processing the sanity board. *Id.* at 512.

2. *Processing the Sanity Board Results When an Accused Is Unfit to Stand Trial*

Trial and defense counsel anxiously await the results of the board, yet the report usually contains anti-climatic results declaring the accused sane at the time of the offense and fit to stand trial.¹³ This may cause trial counsel to view the sanity board process as another defense delay tactic; however, it may provide the defense with valuable expert testimony for the pre-sentencing phase of trial.¹⁴

What should counsel do when they receive that rare sanity board result stating that the accused has a severe mental disease or defect, and that he is not competent to stand trial?¹⁵ After re-reading the sanity board request to ensure it is correct, counsel should immediately call the doctor who compiled the report. Among many initial questions, the government and defense both need to know primarily what impact this result has on the accused: (1) whether he can be restored to competency, and if so, how long will it take; and (2) whether the accused can be released and treated on an out-patient basis or, if not, where the accused will be treated.

While the defense focuses on what is in the best interest of their client, the government must consider not only the needs of the accused, but also the needs of the Army and society. Trial counsel may have an uphill battle convincing their chief of criminal law and staff judge advocate, and more importantly, their commanders, to proceed to trial rather than a medical board or an administrative separation. In a violent crime with a true victim, the decision to go to trial should be simple. In a victimless crime, however, the decision is more difficult; under such circumstances, the best course of action for the accused may be commitment rather than punishment.

3. *Know the Rules*

Within the *Manual for Courts-Martial (MCM)*, the primary rules practitioners must familiarize themselves with are RCMs 706, Sanity Boards; 909, Capacity of accused to stand trial; 916(k), Defense of lack of mental responsibility;¹⁶ 921(c)(4), Not guilty only by reason of lack of mental responsibility; 1102A, Post-trial hearings; and UCMJ Article 76b, Lack of mental capacity or mental responsibility: commitment of accused for examination or treatment.¹⁷

The *MCM*, at RCM 909, and UCMJ Article 76b, refer practitioners to the applicable statutes within the federal criminal system: 18 U.S.C. §§ 4241-4246. Accused who are not competent to stand trial, or who are found not guilty only by reason of lack of mental responsibility, must be transferred to the federal system.¹⁸ Current military treatment facilities have no long-term in-patient psychiatric wards.¹⁹

The commanders and the staff judge advocate also need to know the administrative procedures for separating an accused diagnosed as suffering from a severe mental disease or defect.²⁰ The court-martial and commitment of a soldier to a federal psychiatric ward is time and resource intensive; however, this should not discourage counsel from proceeding with a court-martial if justice warrants such action. Up front, judge advocates and their commanders must know that eventually, after the federal psychiatric ward releases custody of a soldier, the only way to discharge the soldier is through the same administrative procedure that could have been implemented initially.²¹

4. *Requesting a Competency Hearing: Pre-Referral or Post-Referral?*

Rules for Courts-Martial 909(c) and 909(d) provide for pre-referral and post-referral inquiry into the mental capacity of the

13. See *supra* text accompanying notes 7-8.

14. In the pre-sentencing phase of a guilty plea when defense counsel have no intention of negating the pretrial agreement, they must clearly articulate their purpose in using mental capacity evidence in the form of extenuation or mitigation. See *MCM, supra* note 3, R.C.M. 1001(c). Military judges will not hesitate to re-open a providence inquiry when a doctor testifies the accused did not intend a certain result. See *id.* R.C.M. 916(k)(3)(B). This may cause defense counsel to refrain from presenting expert testimony which raises the issue of mental responsibility because the issue could negate the deal, even though the mental responsibility defense would fail if presented at trial.

15. If the report states that an accused was unable to appreciate the nature and quality of his acts at the time of the offenses, but that he is *not* currently suffering from a mental disease or defect and that he *is* competent to stand trial, then the mental responsibility issue will be litigated at trial. At this point in the article, the focus is on an accused determined to be suffering currently from a mental disease or defect such that he is not competent to stand trial. The requirement for competence to stand trial does not require that the accused's mental disease or defect be severe. *Id.* R.C.M. 909(a).

16. See also UCMJ art. 50a (2000).

17. See *MCM, supra* note 3, R.C.M. 706, 909, 916(k), 921(c)(4), 1102A; UCMJ art. 76b; see also *Joint Service Committee on Military Justice Report, Analysis of the National Defense Authorization Act Fiscal Year 1996 Amendments to the Uniform Code of Military Justice*, ARMY LAW., Mar. 1996, at 143-46 (discussing the creation of the new Article 76b).

18. See *MCM, supra* note 3, R.C.M. 909(f), discussion; UCMJ art. 76b. The federal statutes referred to are 18 U.S.C. §§ 4241, Determination of mental competency to stand trial; 4242, Determination of the existence of insanity at the time of the offense; 4243, Hospitalization of a person found not guilty only by reason of insanity; 4244, Hospitalization of a convicted person suffering from mental disease or defect; 4245, Hospitalization of an imprisoned person suffering from mental disease or defect; and 4246, Hospitalization of a person due for release but suffering from mental disease or defect. See also Practice Tip #12—Coordination: Commitment of an Insanity Acquittee, *infra* page 21.

accused, respectively.²² Pre-referral, RCM 909(c) specifies the convening authority's ability to order an inquiry into the accused's mental capacity under RCM 706.²³ Post-referral, RCM 909(d) authorizes the military judge to order an inquiry sua sponte or at the request of either party. Furthermore, RCM 909(d) requires the military judge post-referral to conduct a competency hearing of an accused if that accused was determined mentally unfit to stand trial.²⁴ Although RCM 909(c) does not specifically authorize a military judge to preside over a competency hearing before referral, the rule does not prohibit the judge from conducting a hearing at this stage of the process, either.²⁵

Counsel should request a competency hearing before a military judge because of his ability to expedite the judicial process. When an accused found incompetent to stand trial is transferred to the custody of the FBOP, the military can lose significant control over the accused. If the government intends to dismiss the case, or processing time is not pressing, then this loss of control may not be an issue. If, however, the government intends to go to trial, or processing time is an essential factor, or both, then the involvement of the military judge can assist the command with control over the committed soldier. The federal commitment rules have strict timelines.²⁶ Although the FBOP doctors know and understand the importance of these rules, they cannot always meet the timelines. Because federal prisons work with court orders on a routine basis, the FBOP personnel are more likely to respond to a court order from a military judge than a convening authority.

For several reasons, counsel should make their request for a competency hearing before a military judge pre-referral. First, in general courts-martial, if the government proceeds with an Article 32 investigation without a declaration of competency, the defense will most likely move for a new investigation when the case comes before a military judge.²⁷ Second, if counsel wait until post-referral, they may never get the chance for a competency hearing before a military judge. If a sanity board finds an accused incompetent to stand trial, and the general court-martial convening authority agrees with this finding, then the accused "shall [be committed] to the custody of the Attorney General."²⁸ Defense counsel who concede their client's lack of competency, but intend to challenge their client's commitment, are out of luck. The decision to commit the accused under these circumstances is mandatory; it is not reviewable by a military judge.²⁹ Finally, neither party suffers prejudice from a pre-referral hearing. The transcript will be appended to the record of trial for the appellate courts to see the extraordinary effort the parties undertook to protect the accused's rights.³⁰

5. *Getting the Competency Hearing on the Docket*

Rule for Courts-Martial 909(e) is silent about the procedural requirements of the competency hearing, other than setting forth the burden of proof, the issue to be litigated, and a reference to the non-applicability of the rules of evidence.

The government or the defense can request a competency hearing using a document styled "Request for RCM 909(e) Competency Hearing."³¹ The request to the court should come

19. Telephone Interview with Dr. Evan Whitmore, Chief, Hospital Psychiatric Services, LMC, Williams AFB (Feb. 9, 2000) [hereinafter Whitmore Interview, Feb. 9, 2000]. According to Dr. Whitmore, only a small percentage of society suffers from a severe mental disease or defect, with an even smaller percentage in the military. Service members diagnosed as suffering from a severe mental disease or defect are usually separated via a medical board. The military does not have any long-term in-patient psychiatric treatment facilities because contracting these services to civilian facilities is more cost effective. *Id.*

20. See Practice Tip #14—Administrative Separation, *infra* page 23 (listing governing Army Regulations).

21. See Practice Tips #13—The Post-Trial Hearings, *infra* page 22, #14—Administrative Separation, *infra* page 23.

22. See MCM, *supra* note 3, R.C.M. 909(c)-(d).

23. *Id.* R.C.M. 909(c).

24. *Id.* R.C.M. 909(d).

25. See *id.* R.C.M. 909(c).

26. See 18 U.S.C. § 4241(d) (2000).

27. See *infra* note 136.

28. UCMJ art. 76b (2000).

29. See *United States v. Salahuddin*, 54 M.J. 918, 920 (A.F. Ct. Crim. App. 2001). In *Salahuddin*, the convening authority agreed with Salahuddin's sanity board that Salahuddin was not competent to stand trial, and subsequently committed Salahuddin to the Attorney General's custody. The defense argued against what it deemed an "involuntary commitment," arguing for a competency hearing before a military judge. Although the defense agreed Salahuddin was incompetent, it argued that Salahuddin did not require hospitalization. The AFCCA denied any relief, finding that the purpose of a competency hearing "is to determine the competency of an accused to stand trial, not to determine the propriety of commitment to the Attorney General." *Id.* at 920.

30. See Practice Tip #6—The Competency Hearing, *infra* page 17.

from the Special Court-Martial Convening Authority (SPC-MCA). If the defense submits the request, it should be served on the trial counsel for action by the SPCMCA. Or, if the government is requesting the hearing, the request should be drafted for the SPCMCA's signature. The signed document should be served on the court and opposing counsel.

The request should lay out the basic chronology and facts that led to the request, primarily an offer of proof that some expert is currently of the opinion that the accused is not competent to stand trial. If the other party has an expert who will testify to the contrary, the request should alert the judge of this fact as well. The request should note that the expert(s) will be produced by the government to testify at the hearing. Most importantly, it should clearly state what the moving party is seeking.

Because competency hearings are so rare in the military,³² no statistics state the positions commonly taken by the prosecution and defense. Based on his vast experience with competency hearings, primarily in the civilian sector, Dr. Evan Whitmore, Chief of Psychiatric Services at Williams Air Force Base, stated that in the majority of cases, the defense asserts an accused is incompetent to stand trial, the government opposes this position, and an actual finding of incompetence is rare. It is possible that when an accused's lack of mental responsibility is not contested, the government may move for a competency hearing. When the government makes such a request, it should spell out the course of action it would take based on the court's finding, as the government did in *United States v. Payne*:

If the court determines CPT Payne is not competent to stand trial at this time, then the government will comply with RCM 909(f) and remand CPT Payne to the custody of the Attorney General [under 18 U.S.C. § 4241(d)]. If the court determines CPT Payne is competent to assist in his defense, the SPCMCA will direct the Article 32 Investigating Officer to convene the hearing.³³

All documents will eventually become appellate exhibits to the Record of Trial. Enclosures to the request should include the Charge Sheet, the Request for Sanity Board, the Sanity Board Order, a short memorandum from the expert outlining

the preliminary opinion of the accused's competency, and the RCM 707(c) delay. At the competency hearing itself, since there is no record, the request and its enclosures will not be marked as appellate exhibits. They will be identified and referred to by their titles and maintained by the court reporter to hold as future exhibits should the case go to trial.

6. The Competency Hearing

At a pre-referral competency hearing, government counsel should begin making a record of the trial by using a court reporter to record the hearing, as one would record an Article 39(a) session,³⁴ and preserve a transcript of the hearing. If the case goes to trial, the transcript of the competency hearing will be appended to the record of trial as an appellate exhibit.

The official record of trial for a court-martial begins when the military judge calls the court to order at the initial Article 39(a) session for an accused's arraignment. Typically, the trial counsel follows with: "This court-martial is convened by Court-Martial Convening Order No. __, Headquarters, _____, dated ____, copies of which have been furnished the military judge, counsel, and the accused, and which will be inserted at this point in the record."³⁵ When a competency hearing is held pre-referral, however, the case has no convening order. To avoid the awkwardness presented by these extraordinary circumstances, counsel and the military judge should discuss the agenda for the competency hearing before entering the courtroom.³⁶

The competency hearing should begin with either the military judge or the trial counsel briefly outlining the chronology of events that lead to the convening of the hearing. Counsel should identify the memorandum or document laying out the request for the hearing along with its enclosures. Although the rule does not mandate any initial inquiry with an accused, such as an explanation of rights to counsel, giving such advice at the onset of the hearing is prudent.³⁷ Then, with the judge's permission, both sides may make brief statements outlining their positions.

Following these statements, the moving party should call its first witness, presumably the previously identified expert wit-

31. The competency hearing request in *Payne* is attached to this article at appendix A.

32. Authors' informal polling of fellow chiefs of justice, trial counsel, military judges, and other key personnel involved in the military justice system.

33. *Payne* Competency Hearing Request, *infra* app. A.

34. A competency hearing under these circumstances would not be an Article 39(a) session since the charges have not yet been referred. See UCMJ art. 39(a) (2000) (Article 39(a) sessions may be held "[a]t any time after the . . . charges . . . have been referred for trial").

35. U.S. DEP'T OF ARMY, PAM. 27-9, LEGAL SERVICES: MILITARY JUDGES' BENCHBOOK para. 2-1 (1 Apr. 2001) [hereinafter BENCHBOOK].

36. Similar to an Article 39(a) session, this conference would not be an RCM 802 conference because the case has not yet been referred. See MCM, *supra* note 3, R.C.M. 802(a) (allowing the military judge to order post-referral conferences sua sponte or at the request of either party).

37. See MCM, *supra* note 3, R.C.M. 909(e).

ness, to get to the heart of the matter—his opinion of the accused’s competency. After establishing the doctor’s credentials and offering him to the court as an expert witness, counsel should have the doctor establish his relationship with the accused, the treatment regimen, and ultimately his opinion on the accused’s mental status. To elicit expert testimony successfully, counsel must not only learn about the discipline of forensic psychiatry, but also educate their experts on what to expect in the courtroom. This includes counsel ensuring their experts are prepared to discuss their understanding of the standard for legal competency.³⁸

Trial counsel should be prepared to leave the courtroom when the defense counsel or military judge wants to inquire into specific events that may require the expert to discuss privileged communications with the accused. Although RCM 909(e) provides minimal guidance on the conduct of the hearing, the rule states that “the military judge is . . . bound by the rules of evidence . . . with respect to privileges.”³⁹

7. Know the Accused’s Current Mental Status

Counsel must have a firm understanding of the experts’ opinions of the accused’s mental status—past, present, and future. The sanity board’s answers to the questions posed by RCMs 706(c)(2)(A) and (D) provide an expert opinion for the accused’s past condition (his condition at the time of the offenses) and an opinion of the accused’s present status (whether the accused is currently mentally fit to stand trial), respectively.⁴⁰ The accused’s past and current mental status determine whether the accused will be committed, whether a competency hearing will be held, and ultimately how the case is tried, if at all. The following illustrates potential scenarios:

1. If the sanity board determines that the accused did not suffer from a severe mental disease or defect in the past and is currently able to stand trial, then the accused will not be committed. The defense may present lack of mental responsibility as an affirmative

defense at trial, which the government may rebut, typically resulting in a “battle of the experts.”

2. If the sanity board determines that the accused did not suffer from a severe mental disease or defect at the time of the commission of the alleged offenses, but is currently incompetent to stand trial, the issue becomes whether the accused’s competency can be restored for trial. At a competency hearing, when a doctor opines that an accused presently suffers from a severe mental disease or defect rendering him mentally unfit to stand trial, the doctor must also render an opinion about the likelihood of the accused being restored to competency and the approximate time frame.⁴¹ If the accused’s competency cannot be restored, he will be committed to a federal institution, and no trial will be held.⁴² If the accused’s competency can be restored, he still faces commission, but can be brought to trial.⁴³

3. If the sanity board determines that the accused did suffer from a severe mental disease or defect at the time of the commission of the alleged offenses, but is now competent to stand trial, the accused will not be committed pending trial. At trial, when the defense raises the affirmative defense of lack of mental responsibility, the government may take two approaches. The government may rebut with their expert. Alternately, the government may choose to concede the issue. In the latter case, the accused will be found not guilty only by reason of insanity and will be committed post-trial.⁴⁴

4. Finally, if the sanity board determines that the accused was mentally incompetent at the time of the alleged offenses and is currently

38. See Practice Tip #10—The Mental Responsibility Evidence, *infra* page 20.

39. MCM, *supra* note 3, R.C.M. 909(e)(2).

40. See *id.* R.C.M. 706(c)(2)(A), (D); *supra* note 6.

41. See MCM, *supra* note 3, R.C.M. 909(e), 909(f) discussion.

42. See *id.* R.C.M. 909; 18 U.S.C. § 4246 (2000).

43. The provision governing commission of an accused under these circumstances varies with stage of the court-martial. See *id.* R.C.M. 909(c) (pre-referral), 909(d) (post-referral—this scenario envisions the convening authority disagreeing with the sanity board’s determination and the defense counsel subsequently requesting a competency hearing before a military judge); 18 U.S.C. § 4243(a) (post-trial).

44. See MCM, *supra* note 3, R.C.M. 1102A. An insanity acquittee will have a post-trial hearing covering commitment. See *id.* Article 76b(b)(1), UCMJ, provides that “[i]f a person is found by a court-martial not guilty only by reason of lack of mental responsibility, the person shall be committed to a suitable facility until the person is eligible for release in accordance with this section.” UCMJ art. 76(b)(1) (2000). See Practice Tip #10—The Mental Responsibility Evidence, *infra* page 20; see also *supra* note 42 and accompanying text.

incompetent, the issue again is whether the accused can be restored to competency to stand trial. If the accused can be restored to competency and the government chooses to bring the accused to trial, under these circumstances the government should concede the issue of mental responsibility, as described above.

8. *Commitment Before Trial*⁴⁵

Once the accused is transferred to the custody of the Attorney General and a suitable facility for psychiatric treatment, doctors will attempt to restore the accused to competency through medication.⁴⁶ An accused can continue to suffer from a severe mental disease or defect, yet be restored to legal competency through medication such that he can cooperate intelligently in his criminal defense.⁴⁷ The rules allow for four months of treatment and a reasonable, but not indefinite, extension of time.⁴⁸ Once the accused is restored to competency, the facility director will notify the Attorney General and the general court-martial convening authority, who must then take custody of the accused.⁴⁹ After the time period allowed for restoration of competency expires, if the federal psychiatric doctors determine the accused cannot be restored to a competency level at which he can stand trial, the government should dismiss the charges. The accused will then remain in the custody of the Attorney General and will eventually be released to his home state's psychiatric services.⁵⁰

9. *The Trial*

The Government's Case-in-Chief

The trial of a person with mental competency issues is no different than any other trial. The government must put on its case, and the defense may put on its case in rebuttal. The defense of lack of mental responsibility⁵¹ should never be a surprise to the government because of stringent notice requirements,⁵² the complexity of the issues, and the need for expert testimony. While the government may raise the issue of mental capacity in its case-in-chief for tactical reasons, to avoid confusion it may be prudent for the government to leave the issue for the defense to raise.

Once an accused is found fit to stand trial, and legitimate, if not conclusive, evidence establishes that the accused was not mentally responsible at the time of the offenses, then the government's purposes in going to trial must include getting the accused committed.⁵³ If the government wants an accused committed as a result of a trial verdict, the government must prove its case beyond a reasonable doubt.⁵⁴ If the government does not prove its case, then the result is simply an acquittal, and the accused soldier goes home.⁵⁵

The Defense's Case-in-Chief

While a straight acquittal is the defense's primary objective in every contested case, an insanity case raises an interesting issue. If the doctor's opinion is that the accused suffered from a mental disease or defect at the time of the offenses and was unable to appreciate the nature and quality or wrongfulness of his conduct, then government-funded professional psychiatric

45. The actual coordination required to transfer an accused to the custody of the attorney general is discussed in Practice Tip #12—Coordination: Commitment of an Insanity Acquittee, *infra* page 21.

46. See *United States v. Weston*, 255 F.3d 873 (D.C. Cir. 2001) (discussing forcible medication of a defendant to make him competent to stand trial). In *Weston*, the government sought a court order to medicate the defendant, diagnosed as a paranoid schizophrenic. The court ruled that the defendant could be administered anti-psychotic drugs to render him competent to stand trial. *Id.* at 873.

47. Payne Record of Trial, Transcript of 3 March 2000 Competency Hearing, Testimony of Dr. Evan Whitmore, at 38-39 [hereinafter Competency Hearing Transcript].

48. MCM, *supra* note 3, R.C.M. 909 discussion; 18 U.S.C. § 4241(d).

49. UCMJ art. 76b(a)(4) (2000).

50. MCM, *supra* note 3, R.C.M. 909(f) (2000), 18 U.S.C. § 4246.

51. MCM, *supra* note 3, R.C.M. 916(k).

52. *Id.* R.C.M. 701(b)(2).

53. In this situation, the government could have dismissed the charges before trial. "[I]f charges are dismissed solely due to the accused's mental condition, the accused is subject to hospitalization as provided in [18 U.S.C. § 4246]." *Id.* R.C.M. 909 discussion.

54. *Id.* R.C.M. 921(c)(4).

55. See Practice Tip #11—The Findings: Not Guilty Only by Reason of Lack of Mental Responsibility, *infra* page 21.

treatment is probably in the best interest of the accused. The means to this end is a finding of not guilty only by reason of lack of mental responsibility, and subsequent post-trial commitment.⁵⁶

After the government rests, the defense can raise the affirmative defense of lack of mental responsibility by presenting expert testimony.⁵⁷ The government must then contest or concede the accused's mental responsibility. If the government contests the issue, then it will probably rebut the defense evidence with an expert of its own, creating a "battle of the experts." If it concedes the issue, the government has no need to call an expert. Under these circumstances, the testimony of the defense expert is almost pro forma. The government may cross-examine the expert to highlight some points, but the main issue—whether the accused was insane at the time of the offenses—is not in doubt.

10. The Mental Responsibility Evidence

The Experts

An expert's presentation of mental responsibility evidence is a joint venture between the expert and counsel. The expert educates counsel on the medical significance of mental competency, and counsel ensures the expert knows how to apply his expertise to the criminal responsibility standards set forth in the *MCM*.

Well in advance of a competency hearing or trial, counsel must review questions and answers with their expert witnesses. The doctors likely can assist counsel with forming questions or, at least, provide key reference words counsel can incorporate in their questions to trigger responses on specific issues. In anticipation of a battle of the experts, the doctors need to know their opposition's opinion and its basis. Knowing this enables the experts to prepare better for their direct testimony, anticipate questions they will be asked on cross-examination, and to further assist their counsel's preparation for cross-examination of the opposing expert.

Counsel must also interview, with caution, the opposition's expert. Rules of confidentiality and privilege impose restric-

tions on what information appointed psychiatric members of the defense team can provide to government counsel.⁵⁸ What may also frustrate the government is that even their witness, the expert testifying that the accused could appreciate the nature and quality or wrongfulness of his conduct, cannot disclose comments the accused made during the course of the sanity board inquiry.⁵⁹

Similar to other affirmative defenses, when the government places too much emphasis on discrediting an accused's claim of lack of mental responsibility, the government not only gives some credibility to the defense, but may also confuse the trier of fact. Rather than anticipating the defense as part of the government's case-in-chief, cross-examination of defense witnesses and government rebuttal to the affirmative defense is a clear method for the government to proceed.

Lay Witnesses

In addition to expert testimony at a competency hearing, counsel for each side have a wealth of resources available to support their positions. Counsel should interview and potentially call as witnesses the soldiers who eat, sleep, and train on a daily basis with the accused. Facts about the accused's actions around fellow soldiers could sway a member's vote, especially when a panel is not receptive to complex medical testimony.

Defense counsel will want to elicit incidents of bizarre conduct, hopefully documented in counseling statements. Although these incidents may have been characterized as disrespect, disobedience, and failures to adapt to and learn military customs and courtesies, such occurrences may serve to bolster the expert's testimony. Conversely, testimony from an accused's peers that he regularly wakes up on time for formations, puts on the appropriate uniform, eats with the proper utensils, performs his job to standard, and carries on normal conversations can bolster expert testimony of the accused's sanity and help trial counsel place the defense theory in jeopardy.

56. See UCMJ art. 76b(b)(1) (2000).

57. *MCM*, *supra* note 3, R.C.M. 916(k).

58. *Id.* R.C.M. 706(c)(3)(C); MIL. R. EVID. 302, 513; *see also* United States v. Cole, 54 M.J. 572 (Army Ct. Crim. App. 2000). When the defense offers expert testimony concerning the mental condition of the accused, the government can request the full contents of any mental examination ordered under RCM 706. *MCM*, *supra* note 3, MIL. R. EVID. 302(c).

59. See *MCM*, *supra* note 3, R.C.M. 706(c)(5).

11. *The Findings: Not Guilty Only by Reason of Lack of Mental Responsibility*

Counsel must remember that a not guilty only by reason of lack of mental responsibility verdict is only possible after the government proves its case beyond a reasonable doubt.⁶⁰ The concept of the government proving its case seems obvious—the trier of fact must determine if the government has proven the elements of the offenses beyond a reasonable doubt.⁶¹ In a mental responsibility case, however, after an initial finding of guilty, the trier of fact must then determine whether the defense has proven lack of mental responsibility by clear and convincing evidence. If the affirmative defense succeeds, the finding is not guilty only by reason of lack of mental responsibility.⁶²

12. *Coordination: Commitment of an Insanity Acquittee*

Office of The Judge Advocate General Criminal Law Division

Counsel must coordinate with higher headquarters when transferring a military “prisoner” from the military corrections system to the federal corrections system. Whether the commitment is pre- or post-trial, the procedures and points of contact (POC) for coordination of the transfer of an accused to the custody of the Attorney General are the same. The mandatory

starting point is the Office of The Judge Advocate General (OTJAG) Criminal Law Division. The OTJAG Criminal Law Division current operations officer⁶³ assists government counsel by providing a POC at the Office of the Deputy Chief of Staff for Operations & Plans (ODCSOPS), the Army’s top law enforcement office, with whom OTJAG coordinates and works regularly. The officer at ODCSOPS, in turn, provides counsel with a POC at the Federal Bureau of Prisons (FBOP), whom counsel need to contact a committed soldier’s final destination—a federal psychiatric ward. These POCs can cut through the numerous levels of federal bureaucracy, thereby expediting the commitment process.⁶⁴

Office of the Deputy Chief of Staff—Operations & Plans

Within ODCSOPS, the POC will be in DAMO-ODL.⁶⁵ The POC needs the following identifying data on any individual transferred from the military to the custody of the FBOP: date of birth; race; height; weight; hair and eye color; and identifying marks, such as tattoos, birthmarks, and deformities. The POC forwards this information to the FBOP and informs government counsel within a few days who their FBOP POC will be.⁶⁶

60. See *id.* R.C.M. 921(c)(4).

61. *Id.* A military judge, or two-thirds of the members, must make a finding of guilty before deciding the mental responsibility issue. The vote must be unanimous in a death penalty case. *Id.*

62. *Id.* In a trial with members, a majority of the members present must find that the accused proved lack of mental responsibility. *Id.* As illustrated by the military judge in *United States v. Payne*, the findings would be announced as follows:

This court makes the following special findings: The government has proven the accused committed the following offenses beyond a reasonable doubt:

Attempted desertion in violation of Article 85; Failure to Repair in violation of Article 86; and Disorderly Conduct in violation of Article 134.

Will the accused and counsel please rise. Captain [Thomas S. Payne], this court finds you:

Of the Charges and Specifications: Not Guilty only by reason of lack of mental responsibility.

Have a seat please. In accordance with Article 76b, UCMJ, the accused will be committed to a suitable facility until such time that he is eligible for release.

Payne Record of Trial at 243-44.

63. During the author’s tenure as Chief, Criminal Law Division, Fort Swampy [hereinafter Chief, CLD, FS], the current operations officer was Major (MAJ) Peggy Baines. Major Baines was instrumental not only in the coordination for the commitment of the accused in *United States v. Payne*, but also in providing valuable information for other procedural steps in the case.

64. Telephone Interview with MAJ Peggy Baines, Operations Officer, OTJAG, Criminal Law Division (Feb. 21, 2000) [hereinafter Baines Interview]; Telephone Interview with Lieutenant Colonel David Hassenritter, Operations Officer, Department of the Army Office, Deputy Chief of Staff for Operations & Plans, Operations, Readiness and Mobilization Directorate, Security, Force Protection, and Law Enforcement Division (Feb. 22, 2000) [hereinafter Hassenritter Interview]. Another reason for counsel to contact OTJAG is that higher headquarters tracks transfers from military to federal corrections systems. Baines Interview, *supra*.

65. The acronym DAMO-ODL stands for Department of the Army Office, Deputy Chief of Staff for Operations and Plans (DAMO), Operations, Readiness and Mobilization Directorate (OD), Security, Force Protection, and Law Enforcement Division (L).

66. Hassenritter Interview, *supra* note 64.

The MCM and U.S. Code deem the Attorney General the custodian of mentally incompetent persons.⁶⁷ The FBOP is the Department of Justice agency that houses and treats such persons. Within the FBOP, the Psychology Services Branch oversees ten facilities that house and treat mentally incompetent patients.⁶⁸ Although government counsel may request a particular facility due to location, the POC at the FBOP will determine the location based on space availability. Counsel will have three POCs within the FBOP: (1) the initial FBOP POC received from DAMO-ODL, (2) the POC within the Psychology Services Branch, and (3) the POC at the actual institution. The POC at the institution will inform counsel which staff psychiatrist has been assigned to the accused, and more importantly, assist in the coordination for the transfer of the accused to the facility.⁶⁹

13. The Post-Trial Hearings

The rules require a hearing forty days after a not guilty by reason of insanity verdict.⁷⁰ Once an accused is committed to the custody of the FBOP, counsel and the military judge should tentatively docket the post-trial hearing around the forty-day mark. One critical witness for the hearing is the treating staff psychiatrist at the federal hospital. Production of this witness on the scheduled hearing date may not be within the trial counsel's control. Due to the staff psychiatrist's workload and the lengthy report that must be generated,⁷¹ the hearing could take place sixty to ninety days after the special verdict. One suggestion, pending approval by the military judge, is for counsel to schedule the post-trial hearing at the federal facility where the accused is being treated.

If the accused was committed post-trial, counsel will be working with a set of experts different than those who conducted the accused's pre-trial examinations. Before the actual hearing, communications with the staff psychiatrist likely will be telephonic. Counsel will probably not have an opportunity for a face-to-face interview with the expert until shortly before the hearing. Counsel must keep in mind that the doctor is likely unfamiliar with court-martial procedure, so counsel should prepare the witness for military formalities.

The main issue at the hearing will be to determine if the accused's release would create a "substantial risk of bodily injury to another person or serious damage to property of another due to a present mental disease or defect."⁷² The accused has the burden of proof, which varies according to his original offense. If the original offense involved bodily injury to another or serious damage to another's property, then the accused's burden of proof is by clear and convincing evidence. For all other offenses, the burden of proof is by a preponderance of the evidence.⁷³

If the hearing is convened at the hospital, government counsel must coordinate the logistics for this off-site hearing. No detail, from the judge's robe to the court reporter's equipment, is too small. Notably, government counsel should bring all documentation required to secure the accused's release, should that become necessary.⁷⁴ Because the facility is a federal prison, government counsel must send the facility an advance list of all attendees. All personnel on the roster must have two forms of identification to be admitted to the federal facility, and counsel should inform these witnesses they will be subject to a search.⁷⁵

This post-trial session will be on the record, just like any other post-trial Article 39(a) session.⁷⁶ The military judge will reconvene the court, account for the parties, and synopsize the events leading to the hearing. Next, the treating psychiatrist

67. See *supra* note 18 and accompanying text.

68. The FBOP has a total of ninety-six facilities. The following ten facilities fall under the Psychological Services Branch: Federal Correctional Institution, Butner, North Carolina; U.S. Penitentiary, Atlanta, Georgia; Federal Correctional Institution, Tallahassee, Florida; Federal Medical Center, Lexington, Kentucky; Federal Medical Center, Rochester, Minnesota; U.S. Medical Center for Federal Prisoners; Metropolitan Detention Center, Los Angeles, California; Federal Medical Center, Fort Worth, Texas; Federal Medical Center, Carswell, Texas; Federal Medical Center, Devens, Massachusetts. U.S. Dep't of Justice, Federal Bureau of Prisons, *Correctional Programs Division*, at <http://www.bop.gov/cpdpg> (last visited Apr. 25, 2002).

69. Hassenritter Interview, *supra* note 64.

70. 18 U.S.C. § 4243(c) (2000); MCM, *supra* note 3, R.C.M. 1102A(a).

71. See 18 U.S.C. §§ 4243(b), 4247(b)-(c).

72. MCM, *supra* note 3, R.C.M. 1102A(c)(3) (quoting 18 U.S.C. § 4243(d)).

73. *Id.* (implementing 18 U.S.C. § 4243(d)).

74. If the accused is to be released back to his unit, unit personnel should travel to the federal facility to act as escorts. If the accused is to be released on leave, all appropriate paperwork must be ready for the accused's signature.

75. Telephone Interview with Rendy Thomas, Butner Federal Correctional Institute, Butner, North Carolina (July 19, 2000).

76. See UCMJ art. 39(a) (2000).

will be called to elaborate on the previously submitted report.⁷⁷ If the doctor feels the acquittee is still a danger, then the acquittee will not be released, but if the doctor determines the acquittee is not a danger, then release is mandatory.⁷⁸ Based on the detail of the report, the result of the hearing should not be surprising.

14. Administrative Separation

Accused soldiers determined unfit to stand trial and incapable of being restored to competency, and insanity acquittees released after their post-trial hearings still face release from active duty. Army administrative regulations govern the rules for final separation from the military.⁷⁹

The insanity acquittee's current mental condition is the main factor considered when determining whether he is released. If the acquittee is still suffering from a mental disease, he must be administratively separated.⁸⁰ Rarely, if ever, will an expert forensic psychologist diagnose an accused with a mental disease such that the accused is unfit to stand trial, then determine the accused is "cured" within a few months such that he can return to normal military duties. Most likely, the acquittee's command will have to process him for separation.⁸¹

After release from a federal psychiatric ward, the acquittee's command should place him on voluntary excess leave pending future administrative separation.⁸² In coordination with the command, government counsel should begin the formal separation process for the acquittee following the detailed rules for an enlisted soldier or officer, respectively.⁸³

Part II: Trying an Insanity Case: *United States v. Payne*

The Facts of the Case

Springfield International Airport

Waiting for his departure flight at the Springfield International Airport on Friday, 4 February 2000, an off-duty Air Force Security Police (SP) sergeant looked up from his reading material and noticed a man in battle dress uniform (BDU) wearing a cap. The SP knew that a military individual indoors with a cap on meant that he could be armed.⁸⁴ Upon further inspection, the SP saw that the BDU cap with captain's rank was askew, and that the captain appeared disoriented. The captain's BDUs were badly wrinkled, and his bootlaces were untied and dangling out of his unpolished boots.

Captain Thomas Payne, an Army Dental Corps officer, approached a ticket counter in the airport terminal and asked for a ticket. His goal was to catch a connecting flight to Korea, where his mother lived. The ticket agent informed CPT Payne that she could not sell him a ticket because his credit card would not authorize the purchase. Captain Payne then asked bystanders if they could purchase a ticket for him. After receiving no response to his request, CPT Payne moved to the gate, where a flight attendant was boarding passengers. While the SP was watching, CPT Payne tried to walk past the flight attendant to board the plane. The stewardess politely informed CPT Payne that he could not board without a ticket. When the flight attendant, busy with other passengers, turned away from CPT Payne, he slipped by the attendant and began trotting down the runway toward the plane. Captain Payne ignored the flight attendant yelling for him to stop, but he immediately obeyed the SP's command for him to halt. The SP apprehended CPT Payne and turned him over to airport security, who then surrendered him to the Hazzard County police.

77. See 18 U.S.C. §§ 4243(b), 4247(b)-(c); *supra* text accompanying note 71.

78. 18 U.S.C. § 4246(e); MCM, *supra* note 3, R.C.M. 1102A(c)(4).

79. See U.S. DEP'T OF ARMY, REG. 600-8-24, OFFICER TRANSFERS AND DISCHARGES (21 July 1995) [hereinafter AR 600-8-24]; U.S. DEP'T OF ARMY, REG. 635-200, ENLISTED PERSONNEL (1 Nov. 2000) [hereinafter AR 635-200].

80. AR 600-8-24, *supra* note 79, para. 4-3, AR 635-200, *supra* note 79, paras. 1-32 to 33, 5-13.

81. See Competency Hearing Transcript, *supra* note 47, Testimony of Dr. Whitmore, at 39.

82. See generally U.S. DEP'T OF ARMY, REG. 600-8-10, LEAVE AND PASSES paras. 5-22 to 25 (1 July 1994). If necessary, the command can place the acquittee on involuntary excess leave. See *id.*

83. See *supra* note 80.

84. See U.S. DEP'T OF ARMY, REG. 670-1, WEAR AND APPEARANCE OF ARMY UNIFORMS AND INSIGNIA para. 1-10(i)(2) (1 Sept. 1992).

Captain Payne spent the weekend in the Hazzard County Jail in Springfield.⁸⁵ On Monday morning, after the government coordinated the transfer of jurisdiction of CPT Payne from the state to the military, CPT Payne was transported from the county lock-up to his military pretrial confinement hearing.⁸⁶ The company commander preferred charges against CPT Payne immediately before Payne's hearing. The charge was a violation of the UCMJ, article 133, Conduct Unbecoming an Officer and a Gentleman, with four specifications for the underlying offenses of Fraudulent Appointment, article 84; Attempted Desertion, article 85; Failure to go to appointed place of duty, article 86; and Disorderly Conduct, article 92.⁸⁷

Pretrial Confinement

At his pretrial confinement hearing, CPT Payne displayed signs of odd behavior. Captain Payne tried to walk out of the room several times without his officer escort; he stood with his face inches from a wall and stared straight ahead; and when he was asked basic questions by the military magistrate, it took him long periods of time to answer. To the layperson, CPT Payne appeared to be acting as if he were oblivious to what was going on rather than being defiant.⁸⁸ The military magistrate upheld the commander's pretrial confinement order,⁸⁹ and CPT Payne was transferred to the Williams Air Force Base (AFB) Regional Confinement Facility (RCF) in Springfield.⁹⁰

Captain Payne's mental health issues first came to the government's attention when CPT Payne in-processed into the Williams AFB RCF. The RCF guards cited Captain Payne, the only officer pretrial confinee at the RCF, as being disruptive and disrespectful. At times, CPT Payne simply would not follow orders, either being non-responsive to the guards' commands, or ignoring their commands altogether. Captain

Payne's responses to simple questions came only after long pauses. For example, in what was perceived as disrespect at that time, the RCF noncommissioned officer in charge (NCOIC) reported the following exchange:

Guard:	What is your name?
Payne:	<No response>
Guard:	Do you understand where your are?
Payne:	<No response>
Guard:	Do you understand why you are here?
Payne:	<No response>
Guard:	Move forward to the next line.
Payne:	<No response or movement>
Guard:	Do you understand that you have to follow my orders?
Payne:	<No response>
Guard:	Move forward to the next line.
Payne:	[Thomas Payne]. ⁹¹

85. Payne Record of Trial, Charge Sheet, secs. 8-9, [hereinafter Payne Charge Sheet]. The Hazzard County police detained CPT Payne in the Hazzard County Jail on Friday evening, 4 February 2000, to await arraignment the next Monday morning. Authorities notified Payne's company commander of Payne's absence sometime over the weekend, and the commander subsequently notified the trial counsel.

86. The Chief, CLD, FS coordinated with the Hazzard County District Attorney's Office for the release of CPT Payne from Hazzard County Jail to military authorities with an understanding that the military would prosecute CPT Payne for the state court offenses, and the district attorney would dismiss the state court offenses. Although double jeopardy would not apply, due to separate state and federal sovereigns, such an agreement was reached to save resources. Telephone Interview with Hazzard County Assistant District Attorney, Springfield (Feb. 7, 2000); see also Letter from CPT Jeff Bovarnick, Chief, CLD, FS, to Felony Intake Division, Hazzard County District Attorney's Office (Feb. 7, 2000) (copy on file with author); Motion to Dismiss/Order to Dismiss, State v. Thomas S. Payne (Feb. 7, 2000).

87. Payne Charge Sheet, *supra* note 85. After arraignment, the government dismissed the fraudulent appointment specification. See *infra* notes 142-44 and accompanying text.

88. It appeared to government counsel that CPT Payne was claiming mental problems to avoid repaying over \$65,000 for dental school he owed under his Army's Health Professions Scholarship Program contract. Captain Payne reported to his Officer Basic Course (OBC) one year after his original report date without giving the Army any reason for his delay. Authorities eventually tracked Payne down, and he agreed to serve out his active duty commitment. He reported for OBC where he began engaging in strange behavior. Based on his unusual conduct, the faculty initiated proceedings to separate him from the course. An Academic Relief Board convened, voted unanimously to separate him from OBC, and recommended rescinding Payne's commission and separating him from military service. The events at the airport occurred while CPT Payne was awaiting his separation board.

89. Military Magistrate's Conclusions (Feb. 8, 2000) (copy on file with author) [hereinafter Magistrate's Conclusions]. Payne's commander placed him in pretrial confinement because he was a flight risk. Commander's Checklist for Pretrial Confinement: Captain Thomas Payne (Feb. 8, 2000) (copy on file with author). Although the defense raised issues concerning CPT Payne's mental status, the magistrate based his decision on flight-risk factors. See Magistrate's Conclusions, *supra*.

90. Telephone Interview with Commandant, Williams AFB RCF, Springfield (Jan. 1999).

Frustrated with CPT Payne's noncompliance and their inability to process him into their facility, the guards, all non-commissioned officers, reported the situation to their commandant. After the commandant, a lieutenant colonel, failed to get CPT Payne to obey, he ordered CPT Payne's removal from the facility.⁹²

Pretrial Confinement Versus Mental Health Observation

After CPT Payne's confinement on Monday, 7 February 2000, Payne's defense counsel stated he would request a sanity board for Payne based on his observations of CPT Payne and his inability to communicate with his client. The government thus faced the prospect of coordinating CPT Payne's transfer to the RCF at Fort Sill, Oklahoma, with multiple returns to Fort Swampy, for his sanity board, Article 32 investigation, and trial, all with officer escorts.⁹³ This logistical burden made convincing Payne's command that prosecuting CPT Payne would serve the need for good order and discipline difficult, if not disingenuous.

After receiving the sanity board documents on 8 February 2000, the Chief of Behavioral Medicine at Sandler Army Medical Center (SAMC) recommended that the government check if the Lindberg Medical Center (LMC) at Williams AFB would admit CPT Payne into their in-patient ward for his sanity board.⁹⁴ Dr. Evan Whitmore, Chief of Hospital Psychiatric Services at LMC, agreed to admit CPT Payne temporarily during the sanity board process.⁹⁵ Although the government could accomplish the goal of keeping CPT Payne in the local area for his sanity board, the government still had to contend with the issue of his pretrial confinement status. Although Dr. Whitmore could tolerate CPT Payne's officer escorts on his ward

twenty-four hours per day, Payne's battalion commander had other thoughts about how she could use her officers. After one week of around the clock escorts and a very preliminary report from Dr. Whitmore that CPT Payne would require extensive treatment, the battalion commander ordered CPT Payne "released" from pretrial confinement.⁹⁶

Pretrial

The case involved victimless crimes. The government expert's opinion was that CPT Payne was currently suffering from a mental disease.⁹⁷ These major factors affected the government's recommendation to the command about how to dispose of the case, balancing what was most beneficial to the government and to CPT Payne.

If LMC simply released CPT Payne, he would return to his unit. The command was not willing to entertain this option. On numerous occasions before his attempted desertion, CPT Payne had sat down on the floor in his dental clinic, leaned against the wall, and fallen asleep in plain view of patients and initial-entry trainees. Captain Payne was an OBC student at this time, and the command could not assign him to another location. This presented the unit with a dilemma of what to do with CPT Payne.⁹⁸

After extensive discussions with doctors involved in the U.S. Army Physical Evaluation Board process, Payne's command determined that the shortest turn around for processing a PEB on CPT Payne would be months, even with high-level (Commanding General) emphasis to "push" CPT Payne through the system.⁹⁹ The regulations governing the administrative separation of an officer did not make the process any

91. Telephone Interview with NCOIC, Williams AFB RCF, Springfield (1600 hours, Feb. 8, 2000).

92. Telephone Interview with NCOIC, Williams AFB RCF, Springfield (2200 hours, Feb. 8, 2000). About 2100 on 8 February 2000, the RCF Commandant called the Chief, CLD, FS, and said he wanted CPT Payne out of his facility immediately. After some discussion, the commandant agreed to hold CPT Payne until the next morning. Telephone Interview with Commandant, Williams AFB RCF, Springfield (Feb. 8, 2000).

93. Captain Payne's company had two permanent party officers, the company commander (O-3) and his executive officer (O-2). All Army Medical Department OBC students are attached to a company-sized unit.

94. Telephone Interview with Chief, Behavioral Medicine, Williams Army Medical Center, Fort Swampy (Feb. 9, 2000).

95. Whitmore Interview, Feb. 9, 2000, *supra* note 19. Dr. Whitmore explained that if Air Force patients needed the beds, CPT Payne would have to leave. *Id.* Captain Payne was an in-patient in Ward 4D, LMC, from 8 February 2000 until his transfer to the Butner FCI, Mental Health Division, on 18 May 2000. Payne Record of Trial, Appellate Exhibit X, Forensic Evaluation (July 17, 2000) [hereinafter Payne Forensic Evaluation].

96. Interview with Battalion Commander, Fort Swampy (Feb. 15, 2000) [hereinafter Commander Interview]; Telephone Interview with Dr. Evan Whitmore, Chief, Hospital Psychiatric Services, LMC, Williams AFB (Feb. 15, 2000) [hereinafter Whitmore Interview, Feb. 15, 2000]. Ward 4D at LMC was a locked in-patient ward that patients were prohibited from leaving without an escort. Captain Payne had a single locked room that was under constant surveillance, and Dr. Whitmore would never allow CPT Payne to leave without a unit escort. Whitmore Interview, Feb. 15, 2000, *supra*. Based on these facts, the commander lifted the "pretrial confinement" order, Commander Interview, *supra*, alleviating the unit's responsibility of providing CPT Payne with a twenty-four hour per day escort. The government officially credited CPT Payne with day-for-day *Allen* credit for the entire time he was on the ward before his trial. In the battalion commander's release order, she informed CPT Payne and the defense that she would order CPT Payne back into pretrial confinement as soon as Dr. Whitmore finished his sanity board testing. *Id.* Because CPT Payne was held in Ward 4D until his trial and following his trial pending admittance to Butner, a subsequent pretrial confinement order or hearing was never held.

97. Payne Record of Trial, Sanity Board Findings, Hospital Psychiatric Services, LMC, Williams AFB (Mar. 3, 2000).

98. Commander Interview, *supra* note 96.

easier than a court-martial.¹⁰⁰ This course of action—pushing CPT Payne through the system—did not serve the needs of CPT Payne or the military. Discharging CPT Payne and sending him back to society while he was suffering a mental disease would not have benefited CPT Payne, or enhanced the image of the military taking care of its soldiers.¹⁰¹

Exhaustive communications with many agencies at Fort Swampy revealed that the military has no internal system to provide extensive long-term in-patient psychiatric treatment. The military does not provide long-term care for its infrequent psychotic patients.¹⁰² Realizing this, the drafters of the *MCM* adopted a procedure to use the federal criminal system in place for treating insane patients.¹⁰³

Trial counsel recognized that the only way to get CPT Payne the long-term treatment he needed was to get CPT Payne committed to a psychiatric ward.¹⁰⁴ Convinced that trial counsel's position was in CPT Payne's best interest, the command authorized trial counsel to pursue the best legal route to commit CPT Payne.¹⁰⁵ Based on this directive, government counsel no longer had the option of dismissing the charge against CPT Payne.

Going to Trial—Level of Disposition

When Payne's commander preferred charges against him, government counsel had no medical opinion on CPT Payne's mental capacity. Based on the serious nature of the main specifications—attempted desertion and fraudulent appointment—and that CPT Payne was an officer,¹⁰⁶ the company and battalion commanders initially recommended disposing the case at a general court-martial. On 8 February 2000, the SPCMCA appointed an Article 32 investigating officer and signed an order for a sanity board of CPT Payne.¹⁰⁷

On 11 February 2000, after observing CPT Payne on the ward for several days, Dr. Whitmore assessed CPT Payne as incompetent to stand trial. Based upon this initial assessment, Dr. Whitmore suggested to government counsel that they seek a competency hearing for CPT Payne. In Dr. Whitmore's opinion, as of 11 February 2000, "CPT Payne is suffering from a severe mental disease and . . . he cannot cooperate intelligently in his defense."¹⁰⁸ Depending on the date of the hearing and CPT Payne's reaction to anti-psychotic medicine, Dr. Whitmore's opinion would likely not change for a few months.¹⁰⁹

When the medical staff informed trial counsel that it might take "a few months" for CPT Payne to cooperate intelligently in his defense, the government faced a potential "speedy trial" issue. Stopping the clock was extremely important for the government because charges had been preferred and CPT Payne was under some form of restraint.¹¹⁰ Rule for Courts-Martial 707(c) specifically authorizes a delay for an accused hospitalized due to incompetence.¹¹¹ On 11 February 2000, the conven-

99. Interviews with Chief, Physical Evaluation Board (PEB), Fort Swampy (Apr. 2000) [hereinafter PEB Interviews].

100. See AR 600-8-24, *supra* note 79, para. 4-3.

101. PEB Interviews, *supra* note 99.

102. See *supra* notes 18-19 and accompanying text.

103. See *MCM*, *supra* note 3, R.C.M. 909(f), discussion; UCMJ art. 76b (2000); *supra* note 19.

104. See Practice Tip #8—Commitment Before Trial, *supra* page 19; Practice Tip #12—Coordination: Commitment of an Insanity Acquittee, *supra* page 21.

105. Interview with Battalion Commander, Fort Swampy (Apr. 15, 2000).

106. An officer can only receive a dismissal from a general court-martial. Compare *MCM*, *supra* note 3, R.C.M. 201(f)(1)(A), with *id.* R.C.M. 201(f)(2)(B)(i).

107. Memorandum for SPCMCA, Fort Swampy, subject: Investigation of Court-Martial Charges Against Captain Thomas S. Payne (Feb. 8, 2000).

108. Telephone Interview with Dr. Evan Whitmore, Chief, Hospital Psychiatric Services, LMC, Williams AFB (Feb. 11, 2000). Based on his extensive experience with competency hearings in the civilian sector, Dr. Whitmore considered this opinion, which answers Question D of RCM 706(c)(2), as addressing the only relevant issue for a competency hearing. Dr. Whitmore, a moderator and lead lecturer in sanity board roundtable discussions, pointed out that the other questions posed to a sanity board by RCM 706(c)(2) pertain to an insanity defense, and therefore are only relevant, if ever, after resolution of Question D. *Id.*

109. *Id.*

110. See *MCM*, *supra* note 3, R.C.M. 304(a)(2)-(4), 707.

111. *Id.* R.C.M. 707(c). This rule also excludes delay for when an accused is in the custody of the Attorney General. See *id.*; see also *id.* R.C.M. 909(g) (excluding delay for a committed accused).

ing authority approved such a delay requested by government counsel.¹¹²

The Competency Hearing—Before or After Referral?

Before researching the substantive issues of CPT Payne's competency to stand trial, government counsel had to figure out the logistics and prerequisites to getting a competency hearing. Some of the issues included whether a competency hearing before a military judge could take place before referral and, if so, if the hearing would be "on the record." What type of record is there if the case has not yet been referred?

Rule for Courts-Martial 909—The Capacity of CPT Payne to Stand Trial

The starting point for government counsel's review of the competency hearing process was RCM 909. This rule explains the procedure, the burden of proof, and the potential outcomes.¹¹³

An accused is presumed competent to stand trial.¹¹⁴ The determination by CPT Payne's sanity board that he presently suffered from a mental disease rendering him unable to cooperate intelligently in his defense overcame this presumption. After reading RCM 909(a), it was clear to the government that CPT Payne was not going to trial unless some stringent requirements were met.

Since the sanity board came to its conclusion pre-referral, RCM 909(c) controlled this case. If the determination had been made post-referral, RCM 909(d) would have controlled. Under either rule, the convening authority determines how the case is handled. Since CPT Payne could only go to trial after being found competent to do so, the sanity board's determinations presented the convening authority with two options: (1) disagree with the board's determination and dispose of the case,

including referral to trial; or (2) agree with the determination and commit CPT Payne to the custody of the Attorney General.¹¹⁵

The First Competency Hearing

On 15 February 2000, the government requested a competency hearing.¹¹⁶ The military judge granted the hearing, and it was held on 3 March 2000 in the Fort Swampy courtroom. The unit escorts were tasked to pick up CPT Payne from Ward 4D, the LMC psychiatric ward, and get him into his Class A uniform for the hearing. When the escort officer asked CPT Payne where he lived, CPT Payne responded, "Near a tree."¹¹⁷ After discussing CPT Payne's response with the doctors, and realizing CPT Payne was not joking, the unit escort tried to impress upon him the importance of securing his uniform before going before the military judge. After a long pause, CPT Payne responded, "Near a tree, on a hill."¹¹⁸ The military judge permitted CPT Payne to sit through the hearing in BDUs.¹¹⁹

At the hearing, Dr. Whitmore testified that CPT Payne currently was not competent to stand trial. Dr. Whitmore further testified that it could take close to six months of treatment, medication, and close evaluation before CPT Payne "might" be restored to a level of competency where he could stand trial.¹²⁰ It was obvious to all parties, except CPT Payne, that he was not competent to stand trial.¹²¹

The military judge, in various exchanges with counsel before the hearing and during a recess, made it clear to the government that he was unhappy with the prospect of remanding CPT Payne to the custody of the Attorney General. If he did so, the military could completely lose control over CPT Payne after he was processed into the federal system. The government counsel could not alleviate the court's concern. When the military judge asked Dr. Whitmore if LMC had the resources to provide short-term treatment for CPT Payne, Dr. Whitmore responded that it did.¹²² Later in the proceeding, the military

112. Payne Record of Trial, RCM 707(c) Delay, Brigade Commander, Fort Swampy (Feb. 11, 2000).

113. See MCM, *supra* note 3, R.C.M. 909.

114. *Id.* R.C.M. 909(b).

115. *Id.* R.C.M. 909(c). Ultimately, the convening authority referred Payne's case to a special court-martial. See *infra* note 136 and accompanying text.

116. Payne Competency Hearing Request, *infra* app. A; see Practice Tip #6—The Competency Hearing, *supra* page 17.

117. Interview with Company Executive Officer (Mar. 3, 2000). The executive officer described his conversation with CPT Payne to government counsel after arriving at the courtroom with CPT Payne still in his BDUs. *Id.*

118. *Id.*

119. *Id.*

120. See Competency Hearing Transcript, *supra* note 47, Testimony of Dr. Whitmore, at 47.

121. See *infra* text accompanying notes 128-30.

judge recalled Dr. Whitmore to determine if his staff could provide the necessary treatment to restore CPT Payne to competency. Dr. Whitmore testified that while it could take three to four months to restore CPT Payne to competency, the main issue was that he needed authorization from the hospital commander to house CPT Payne indefinitely at the Air Force facility.¹²³

After Dr. Whitmore's testimony, CPT Payne told his defense counsel he wanted to be heard.¹²⁴ Despite the sanity board's determination and Dr. Whitmore's opinion, CPT Payne did not think he was ill. Captain Payne had previously expressed to his doctors and defense counsel that he just wanted to go home.¹²⁵ To this point in the hearing, the defense had not contested the competency issue. Captain Payne put his defense counsel on the spot to advocate that CPT Payne was competent.

Captain Payne was sworn in and took the stand. After eliciting from CPT Payne that they had not prepared any questions, the defense counsel asked CPT Payne about the court process. Captain Payne understood what an oath was, and he knew what it meant to be prosecuted. Aside from the long pauses between questions and answers, CPT Payne articulated fairly well the potential verdicts and the differences between a judge alone and jury trial.¹²⁶ When the government counsel stood to cross-examine CPT Payne, the military judge promptly ended what would have been an interesting cross-examination.¹²⁷

Next, the court asked CPT Payne simple questions about the roles of counsel. Captain Payne's responses negated his earlier, somewhat coherent, testimony. Between pauses and stuttering, CPT Payne seemed to switch the roles of counsel, stating that the prosecutor wanted him to be found competent and the defense did not.¹²⁸ When asked if the defense counsel sitting next to him was present to assist him, CPT Payne responded, "I guess so."¹²⁹ The court questioned this response and, after a

few more questions, he asked CPT Payne to return to his seat, and called for a recess.¹³⁰

In chambers, with both sides present, the court asked government counsel what course of action the government would take if he ruled CPT Payne incompetent to stand trial. The government preferred keeping CPT Payne in the local area at LMC because this was most beneficial to CPT Payne and the command. If CPT Payne could not remain at LMC until he was restored to competency, however, government counsel informed the court that RCM 909(e)(3) required the convening authority to commit CPT Payne to the custody of the Attorney General.

The court decided to defer ruling on CPT Payne's competency until Dr. Whitmore informed the court whether CPT Payne could remain at LMC. Additionally, if CPT Payne were to remain at LMC, the military judge directed that the government, through Dr. Whitmore, provide the court with periodic updates on CPT Payne's progress.¹³¹

The Referral Decision

The psychiatry staff at LMC subsequently received authorization to treat CPT Payne on an in-patient basis. On 1 April 2000, Dr. Whitmore reported that little had changed since the hearing, and he still predicted it would be several months before he could state anything definitively. Captain Payne was responding to treatment, but he was not close to the point at which he could cooperate intelligently in his defense.¹³²

On 17 April 2000, Dr. Whitmore informed government counsel that CPT Payne had a relapse and was getting worse. Dr. Whitmore wanted to change the anti-psychotic medication, but currently, he predicted it would be a long time before CPT Payne could be restored to competency. Dr. Whitmore strongly

122. Competency Hearing Transcript, *supra* note 47, Testimony of Dr. Whitmore, at 47.

123. *Id.* at 64-68.

124. *Id.* at 50.

125. *Id.* at 48.

126. *Id.* at 50-57.

127. *See id.* at 57.

128. *See id.* at 58. According to Dr. Whitmore, prosecutors and defense normally take these positions—prosecutors arguing for competency, and defense counsel arguing lack thereof. Interview with Dr. Evan Whitmore, Chief, Hospital Psychiatric Services, LMC, Williams AFB (Mar. 3, 2000).

129. *Id.* at 57-60.

130. *Id.*

131. Despite the court's action, the convening authority still had the power to remand CPT Payne to the custody of the Attorney General. *See* MCM, *supra* note 3, R.C.M. 909(e)(3). The government, however, had previously foregone this course of action. *See id.* R.C.M. 909(c).

132. Telephone Interview with Dr. Evan Whitmore, Chief, Hospital Psychiatric Services, LMC, Williams AFB (Apr. 1, 2000).

suggested that the government move to get CPT Payne committed to the custody of the Attorney General for long-term mental health treatment.¹³³

At this point, still pre-referral, the government could have simply requested that the convening authority direct CPT Payne's commitment under RCM 909(c).¹³⁴ But, since the government had already involved a military judge, the government decided to continue pursuing its goal through the judicial process. The government's intention was to have a post-referral competency hearing at which the military judge would find CPT Payne incompetent to stand trial and have CPT Payne committed. Post-referral, everything would be "on the record."¹³⁵

The government now had to reconsider what level of court to recommend to the command. The government's goal was to get CPT Payne long-term psychiatric care, not jail time, a dismissal, or even a conviction. Therefore, on 19 April 2000, the convening authority referred the case to a "straight" special court-martial.¹³⁶ The military judge docketed the case for arraignment and a competency hearing on 28 April 2000.

The Arraignment and Second Competency Hearing

Initially, the 28 April 2000 Article 39(a) session appeared to be a mere formality in having CPT Payne committed. The day before the hearing, however, Dr. Whitmore shocked government counsel with the revelation that CPT Payne's capacity had improved such that Dr. Whitmore would testify that CPT Payne was now competent to stand trial. Dr. Whitmore explained that CPT Payne was reacting well to the new medication. He emphasized that CPT Payne still suffered from a severe mental disease, but that under the maximum dosage of his current medication, he was presently competent to stand trial.¹³⁷

Captain Payne was arraigned, and the government proceeded with its motion to have him committed under RCMs 909(d) and (e). Combating the government's motion, Dr. Vince Carlson, a resident psychiatrist working with Dr. Whitmore, testified that CPT Payne was competent. Additionally, the psychiatrist acknowledged that CPT Payne would not take his medication voluntarily because he did not think he was ill. Dr. Carlson conceded, however, that CPT Payne could not be released from a twenty-four hour facility because he would not take his medication voluntarily, and without it he would have another severe relapse.¹³⁸

After Dr. Carlson's testimony, CPT Payne agreed to answer questions from the military judge. Although he misunderstood a few of the finer points of law,¹³⁹ CPT Payne demonstrated that he generally understood the nature of the proceedings and the roles of the parties to the trial.

The government was left to argue why, despite uncontested expert testimony that CPT Payne was competent to stand trial, the court should rule to the contrary and allow CPT Payne to be committed. In a detailed ruling, the court denied the government's motion to commit CPT Payne to the custody of the Attorney General, and the court found CPT Payne competent to stand trial.

After the court entered its ruling, the defense requested an immediate trial date and indicated the accused would elect a judge alone forum. Defense counsel understood their client's competency may be fleeting, and the likely result would be not guilty only by reason of lack of mental responsibility. With no possibility of a discharge or jail time, the defense had two possible outcomes: a full acquittal, or commitment as the result of a not guilty only by reason of lack of mental responsibility verdict.¹⁴⁰ The court set the trial date for one week later, 5 May 2000.¹⁴¹

133. Telephone Interview with Dr. Evan Whitmore, Chief, Hospital Psychiatric Services, LMC, Williams AFB (Apr. 17, 2000).

134. See MCM, *supra* note 3, R.C.M. 909(c).

135. See UCMJ art. 39(a) (2000).

136. See Payne Charge Sheet, *supra* note 85. Because the government did not seek confinement or a dismissal for CPT Payne, a special-court martial appropriately limited the punishment that CPT Payne could receive. See MCM, *supra* note 3, R.C.M. 909(e)(3), 1003(c)(2)(A)(ii) and (iv). "Only a general court-martial may sentence a commissioned . . . officer . . . to confinement . . . [or] to be separated from the service with a . . . dismissal." *Id.* R.C.M. 1003(c)(2)(A)(iv). Furthermore, given CPT Payne's lack of competency to assist with his own defense, convening an Article 32 hearing, as required of a case referred to a general court-martial, UCMJ art. 32(a), would be problematic. Even if the defense waived the Article 32 hearing, eventually the court would inquire if CPT Payne knowingly and voluntarily waived this right. See BENCHBOOK, *supra* note 35, para. 2-1-1 (requiring military judge to inquire whether Article 32 investigation waived knowingly and voluntarily).

137. Interview with Dr. Evan Whitmore, Chief, Hospital Psychiatric Services, LMC, Williams AFB (Apr. 28, 2000)

138. Physicians initially treated CPT Payne with the anti-psychotic medication Seroquel, but when CPT Payne relapsed, they changed his medication to Risperdal. Dr. Carlson also testified that CPT Payne had eaten breakfast, regurgitated, and then consumed his regurgitation at the breakfast table. See also *United States v. Weston*, 255 F.3d 873 (D.C. Cir. 2001) (concerning involuntary medication issues, discussed *supra* note 46).

139. For example, CPT Payne mistakenly thought he could be discharged from the service as a possible consequence.

The Government's Case-in-Chief

The government proceeded with *Payne* just like any other criminal case—calling witnesses to prove each element of the charged offenses beyond a reasonable doubt. Similar to a guilty plea in which, for all practical purposes, the parties know what the verdict will be, there was little doubt as to the verdict in CPT Payne's case. To avoid confusion, the government chose not to address CPT Payne's mental competency during its case-in-chief; rather, it let the defense raise the uncontested affirmative defense of lack of mental responsibility.

To prove the disorderly conduct offense, the government called three witnesses from the Springfield International Airport to testify about CPT Payne's actions on 4 February 2000. On cross-examination, the defense focused on the witnesses' observations of the accused's behavior. One flight attendant testified that CPT Payne appeared "[s]ort of blank, like there was no emotion, like I could run my hand across his face and he wouldn't even blink." For the military offenses of attempted desertion and failure to report, the government called the company commander, executive officer, and first sergeant.

While the testimony of the first six witnesses went quickly, the fraudulent appointment charge became the subject of extended litigation. Despite lengthy testimony, voluminous exhibits, and a couple of Article 39(a) sessions to argue about the fraudulent appointment, the government ultimately moved to dismiss this specification.

The facts surrounding the fraudulent appointment specification raised some interesting issues and could have exacerbated an already complex case if CPT Payne was convicted of this offense. While in dental school under a Health Professions Scholarship Program contract, a physician treated CPT Payne for a bi-polar depression disorder. Captain Payne's contract required him to disclose this treatment to program administrators.¹⁴² The government charged Payne's failure to disclose his treatment as fraudulent appointment under a breach of contract theory.¹⁴³

Dr. Whitmore's opinion was that CPT Payne was not suffering from the severe mental disease at the time he was appointed as a commissioned officer—27 June 1999. He testified CPT Payne's civilian doctor diagnosed CPT Payne with bi-polar depression disorder in May 1998, and that condition developed into the severe mental disease CPT Payne suffered at the Springfield Airport on 4 February 2000. With no evidence contradicting Dr. Whitmore's opinion, the affirmative defense of lack of mental responsibility would not apply to the fraudulent appointment specification, potentially resulting in mixed findings.¹⁴⁴ Due to evidentiary burdens, namely voluminous records and lengthy testimony from multiple out-of-state witnesses to authenticate such records, and the government's goal of getting CPT Payne the treatment he needed, the government dismissed the fraudulent appointment specification.

Although not raised by *Payne*, mixed findings driven by the mental responsibility of an accused raises a currently unresolved issue. If a court-martial finds an accused guilty on one charge and sentences him to confinement, but also finds the accused not guilty only by reason of lack of mental responsibility,

140. Dr. Whitmore would later testify that CPT Payne was not mentally responsible for the events at the airport, but that he was mentally responsible for the fraudulent appointment that occurred eight months earlier. Potentially, CPT Payne could be found guilty of one specification and not guilty only by reason of lack of mental responsibility for the other three specifications. Because of the sentence limitations facing the government at a special court-martial of an officer, *see supra* note 136 and accompanying text, the fact that CPT Payne could be found guilty of one offense was inconsequential.

141. With no merits witnesses present, the only way the government could have immediately proceeded to trial was to enter into a stipulation of fact with the defense covering the events surrounding the charged offenses. Although the defense agreed to enter into such a stipulation, the court set the date one week out.

142. Payne Record of Trial, Department of the Army Service Agreement, F. Edward Hebert Armed Forces Health Professions Scholarship Program Contract (June 6, 1995).

143. Specification 2 of the Charge in violation of UCMJ article 133 read as follows:

In that Thomas S. Payne, U.S. Army, on active duty, did, on or about 27 June 1999, by means of deliberate concealment of the fact that the said accused was diagnosed with bipolar depression on 19 May 1998, which the said accused had a continuing duty to disclose pursuant to paragraph 13 of his Edward Hebert Armed Forces Health Professions Scholarship Program (HPSP) Contract, to wit: "I understand that I must immediately notify (the) Office of the Surgeon General of any administrative or medically related problem I might incur while a participant in the program," procure himself to be appointed as a commissioned officer in the United States Army, and did thereafter, at Fort Swampy, receive pay and allowances under the appointment so procured.

Payne Charge Sheet, *supra* note 85.

144. Captain Payne could be found guilty of the fraudulent appointment specification, and found not guilty by reason of lack of mental responsibility for the remaining specifications.

ity on other charges, does the accused serve his jail term first or get committed first?

Sections 4245 and 4246 of 18 U.S.C. suggest that the accused would begin serving his sentence to confinement first. If, after a competency hearing, he is found to be suffering from a severe mental disease, he can then be transferred and hospitalized for psychiatric treatment for a period not to exceed his original sentence to confinement.¹⁴⁵ If a subsequent competency hearing determines the accused has recovered, he will be re-imprisoned to serve the remainder of his sentence. If the accused is found competent and his sentence has expired, he will be released.¹⁴⁶ If the accused's sentence has expired, but the court determines the accused still suffers from a mental disease *and* his release would create a substantial risk of bodily injury or property damage to another, then the Attorney General must make all reasonable efforts to transfer the accused to the appropriate officials in the accused's home state.¹⁴⁷

The Defense Case: The Affirmative Defense of Lack of Mental Responsibility

Although the government called the psychiatric experts in the two prior competency hearings, the government did not call them in their case-in-chief. Therefore, by necessity, the defense had to call an expert to present their affirmative defense. For expediency and based on the complexity of the issues raised by this defense, the accused elected a judge alone trial.

The defense laid the foundation for CPT Payne's mental disease by showing how his behavior rapidly deteriorated during his Officer Basic Course. Captain Payne had been through an academic board a few months before his court-martial.¹⁴⁸ The defense called the officer who served as the recorder on the academic board:

DC: [S]ir what were the specific symptoms that Captain [Payne] exhibited which caused you to think that he might have a mental condition [at the academic board]?

Witness: He had difficulty speaking at times, would have a facial tick, and then he would start grunting.

DC: And what do you mean by

grunting, sir?

Witness: We would be sitting in the board and he would start going hrr, hrr, hrr.

Next, Dr. Whitmore testified for the defense. The defense elicited Dr. Whitmore's opinion on CPT Payne's mental status at the time of the alleged conduct:

DC: Do you have an opinion about whether Captain Payne on the fourth of February suffered from a severe mental disease or defect?

Dr. Whitmore: Yes, I do.

DC: And what is your opinion?

Dr. Whitmore: That he did suffer from a severe mental disease.

DC: And what was that severe mental disease?

Dr. Whitmore: Schizophrenia.

Dr. Whitmore discussed the differences between a severe mental disease and defect, as opposed to a mental disease or defect that was not severe. Dr. Whitmore further testified that his diagnosis of the accused fell within the *MCM*'s standards for a severe mental disease. The following is an excerpt of his testimony concerning his observations of CPT Payne at the LMC psychiatric ward:

I was called to see him on the Monday after he was put in jail. He was transferred to the confinement facility at Williams AFB and he was having trouble there just following rules and responding appropriately, and so they sent him to the emergency room and we evaluated him then.

The same things were consistent—with hallucinations, with long periods of time without moving. When he would talk, it might be a single word; it would never be a sentence or even a phrase. He appeared to be having hallucinations.

145. See 18 U.S.C. §§ 4245-4246 (2000).

146. See *id.* § 4245(e) (plain language of rule implying that sentence continues to run while accused is hospitalized).

147. *Id.* § 4246(d).

148. Faculty Board Meeting concerning CPT Thomas S. Payne, Medical Officer Basic Course, Nov. 9 and Dec. 6, 1999 (transcripts on file with author).

At times he would start talking to something that wasn't there, and at other times he would be hitting out at things. He would stand or sit in his room for hours staring at the wall or talking to the wall. He wouldn't do any of his personal hygiene. He's a dentist and he wouldn't brush his teeth, he wouldn't shower. He would have to be forced to try, and a lot of times, he wouldn't. When you tried to ask him a simple question, you either wouldn't get an answer or, in hallucination, he might give you a "no" or just stare for hours.

Because we had him in an environment where we could observe him twenty-four hours, seven days a week, his behavior was all—it was consistent. It wasn't just when I was interviewing him, which I have seen in people that malingering mental illness. It was a constant, and that's what you will see in people that have schizophrenia.

After presenting expert testimony, the defense called lay witnesses, including classmates and members of Payne's chain of command, to paint a picture of a dentist who displayed very abnormal behavior, especially in small day-to-day activities. For example, the accused's company commander testified that while working at the dental clinic, CPT Payne repeatedly wore a disheveled uniform and fell asleep in front of enlisted students. After removing CPT Payne from the clinic, the commander assigned CPT Payne simple tasks in the orderly room. One task included alphabetizing leave and earning statements. Captain Payne, the valedictorian of his high school class, with a 4.0 grade-point average graduate from Johns Hopkins, would put the A's before the B's, but within the A's would put Anderson before Adams.

The government did not present rebuttal evidence. The court then allowed counsel to present bifurcated closing arguments. The initial arguments dealt solely with the facts of the crimes. The government focused on proving the remaining three specifications beyond a reasonable doubt. The defense argued for a straight acquittal. The next portion of the closing

argument focused on the defense of lack of mental responsibility. The defense had the burden and presented their argument. With no evidence to the contrary, the government did not rebut this portion of the defense closing.

The Verdict

The military judge found that the government had proven that CPT Payne committed the underlying lesser-included offenses of Attempted Desertion, Failure to Repair, and Disorderly Conduct. He further found CPT Payne not guilty only by reason of lack of mental responsibility of the charge and its specifications.

Post-Trial

Coordination for the Commitment

The military judge remanded CPT Payne to the custody of the Attorney General on 5 May 2000. The FBOP assigned CPT Payne to the psychiatric unit of the Federal Correctional Institute (FCI) at Butner, North Carolina.¹⁴⁹ Captain Payne arrived at Butner FCI on 18 May 2000.¹⁵⁰

The Butner FCI staff psychiatrist was aware of his statutory requirement to complete his examination and report on CPT Payne within forty days of Payne's arrival.¹⁵¹ Due to his workload and the complexity and length of the required report,¹⁵² the doctor could not meet this deadline.¹⁵³ Government counsel, with the consent of the defense, obtained an extension from the military judge.

The staff psychiatrist completed his report on 17 July 2000, and the Butner FCI warden forwarded it to the military judge on 19 July 2000.¹⁵⁴ The report made it clear that CPT Payne was not a danger, and that he would have to be ordered released by the judge.¹⁵⁵ The judge then docketed a post-trial "dangerousness" hearing for 28 July 2000 at Butner FCI. The government requested to hold the hearing at Butner to reduce several burdens: (1) on CPT Payne's unit, who would have to provide unit escorts for CPT Payne's travel; and (2) on the Butner FCI doctors, who would have to travel to an off-site hearing. Govern-

149. See also Practice Tip #12—Coordination: Commitment of an Insanity Acquittee, *supra* page 21.

150. Between 5 May 2000, the date of the trial and the military judge's commitment order, and his 18 May 2000 arrival at Butner FCI, CPT Payne remained on Ward 4D at LMC under Dr. Whitmore's care. Interview with Dr. Evan Whitmore, Chief, Hospital Psychiatric Services, LMC, Williams AFB (May 18, 2000).

151. See MCM, *supra* note 3, R.C.M. 1102A(b) (requiring military judge to obtain psychiatric report before mandatory post-trial hearing of accused found not guilty only be reason of lack of mental responsibility).

152. See *supra* note 71 and accompanying text.

153. Telephone Interview with Staff Psychiatrist, Butner FCI, North Carolina (June 15, 2000).

154. See Letter from Warden, Butner FCI, to Military Judge (July 19, 2000) (on file with author).

155. Payne Forensic Evaluation, *supra* note 95, at 13-14.

ment counsel subsequently coordinated with the Butner FCI hospital staff for the admittance of all parties to the federal prison, and secured all other items necessary to transform a federal prison conference room into a military courtroom, to include the appropriate flags and a judge's robe.¹⁵⁶

The Hearing

The Butner FCI staff psychiatric team conducted a detailed forensic evaluation of CPT Payne to determine his eligibility for release.¹⁵⁷ The doctors found that CPT Payne was “not suffer[ing] from a severe mental disease or defect the result of which his release to the community would create a substantial risk of bodily injury to another [or] serious damage to the property of another.”¹⁵⁸

The government did not present any rebuttal evidence. The defense called the Butner FCI psychiatrist, qualified him as an expert, laid the foundation for his opinion, and then elicited the mental capacity standards for release, his findings on CPT Payne, and his expert opinion on the paramount issue—whether CPT Payne's release would create a substantial risk of bodily injury to another or serious damage to another's property.¹⁵⁹

DC: Would you describe . . . your interviews and the testing that was done by your forensic team?

Doctor: The psychologists conducted a number of tests of cognitive functioning, intellectual functioning and personality assessment.

DC: Based on your study . . . do you have an opinion as to whether CPT Payne presently suffers from a mental disease?

Doctor: Yes, I do.

DC: And what is that opinion?

Doctor : That he does suffer from a

severe mental disease.

DC: And what's the diagnosis?

Doctor: I have diagnosed him as schizophrenia, paranoid type.

DC: Based on your study of CPT Payne do you have an opinion as to whether—if he were released from this institution—whether that release would pose a substantial risk of bodily injury to another person or to property?

Doctor: At this time—and, again, you have to keep in mind that prediction of dangerousness is a very, very difficult—in the immediate future, I don't see him as being a danger to himself, or the property of others, or to other people.¹⁶⁰

The government did not present any evidence. After closing the evidence, the military judge issued his written opinion and release order to the confinement facility.¹⁶¹ After out-processing, CPT Payne was released to the custody of his brother, and he returned home on voluntary excess leave, where he remained until completion of his separation from the military. Captain Payne received follow-up mental health treatment at a local military hospital, and he was referred to his home state's mental health system after his release from active duty.

Administrative Separation

After CPT Payne's return to his home state, he remained on his company's personnel roster. In the fall of 2000, the command initiated an officer elimination proceeding.¹⁶² CPT Payne waived his presence before a Board of Officers, but his detailed defense counsel appeared at the 6 December 2000 proceedings.¹⁶³ The defense argued for CPT Payne's retention on active

156. See generally Practice Tip #13—The Post-Trial Hearings, *supra* page 22.

157. See 10 U.S.C. § 876b (2000) (outlining conditions for release).

158. Payne Forensic Evaluation, *supra* note 95, at 13.

159. See 18 U.S.C. § 4243(e). The hearing was conducted according to 18 U.S.C. § 4247(d). See *id.* § 4243(c); Practice Tip #13—The Post Trial Hearings, *supra* page 22.

160. Although the psychiatrist testified that CPT Payne was not a danger to *himself*, the statutory standard is whether the person's “release would create a substantial risk of bodily injury to *another*.” 18 U.S.C. § 4247(c)(4)(C) (emphasis added).

161. Payne Record of Trial, Post-Trial Competency Hearing Findings and Release Order (July 28, 2000).

162. See AR 600-8-24, *supra* note 79, paras. 4-2 to 4-3.

duty in hopes of avoiding a recoupment action of about \$41,300 for CPT Payne's dental education under Payne's HPSP Contract.¹⁶⁴

The board of officers voted to separate CPT Payne with an honorable discharge.¹⁶⁵ On 12 April 2001, fourteen months after his offenses at the Springfield Airport, the Department of the Army finally released CPT Payne from active duty.¹⁶⁶

Conclusion

When a sanity board diagnoses an accused soldier as being incompetent to stand trial due to a severe mental disease or defect, opponents on the legal battlefield may share the objective of getting the accused the professional medical treatment he requires.

In the pretrial phase, the *MCM* and the U.S. Code lay out the axis of advance practitioners must follow to get an accused committed to the custody of the Attorney General.¹⁶⁷ If the accused is restored to competency, the government has a decision point—whether to go forward with an administrative separation or a court-martial. This decision will likely hinge on the nature of the offenses. Once the government commits to a trial, it must bear in mind the high probability of a finding of not guilty only by reason of insanity. In the post-trial phase, the *MCM* and U.S. Code also lay out the framework to commit an insanity acquittee and further provisions for his ultimate release.¹⁶⁸

Throughout the process, practitioners must focus on two key pieces of intelligence: what is the likelihood that medical personnel can restore the accused to competency, and what is in the best interests of the accused, the Army, and society. Once those issues are resolved, it is only a matter of trying an insanity case and not going insane.

163. Board proceedings on file with the Criminal Law Division, FS (Dec. 6, 2000) [hereinafter Payne Officer Elimination Board]. The trial counsel in Payne's criminal case appeared as a government witness to provide the board with a chronology of events surrounding CPT Payne's offenses, court-martial, commitment to the FBOP, and subsequent release.

164. *See id.*; *see also* Memorandum, Office of the Surgeon General, U.S. Army, to Commander, U.S. Army Medical Command, subject: Entitlements Paid Under the Health Professions Scholarship Program, RE: Payne, Thomas (11 Feb. 2000) (on file with author). "Captain Payne received HPSP entitlements totaling \$66,577.62 (\$41,344.47 in educational costs and \$25,243.15 in stipend payments) . . . \$41,334.47 may be eligible for recoupment under [10 U.S.C. § 2005(a)]." *Id.* para. 4.

165. Payne Officer Elimination Board, *supra* note 163.

166. Message, 141213Z May 2001, Personnel Command, subject: Separation (Probationary). The Department of the Army message sent to the Commander, U.S. Army Garrison, Fort Swampy, also called for a prorated recoupment amount of \$38,586.32. *Id.* para. 4.

167. *See MCM, supra* note 3, R.C.M. 909; 18 U.S.C. § 4241(d) (2000).

168. *See MCM, supra* note 3, R.C.M. 1102A; 18 U.S.C. § 4246.

Appendix A

UNITED STATES)
)
v.)
)
PAYNE, Thomas S.)
Captain; XXX-XXX-XXXX)
)
Fort Swampy)

REQUEST FOR RCM 909(e) COMPETENCY HEARING

15 February 2000

Through the Special Court-Martial Convening Authority, the government respectfully requests this court to conduct a Competency Hearing IAW Rule for Court-Martial (RCM) 909(e).

I. FACTS

1. On 8 Feb 00, charges were preferred against the accused (Encl 1) and the accused was ordered into pretrial confinement. The accused was placed into pretrial confinement at the Williams AFB, Regional Confinement Facility (RCF) that evening. Based on his disruptive behavior and failure to follow the orders of the guards, the RCF Commander asked this command to remove the accused from his Air Force facility. An agreement was made for the accused to spend the evening at the RCF while coordination was made for his transfer to the Army RCF at Fort Sill, OK.
2. On 8 Feb 00, the Defense requested (Encl 2), and the Special Court-Martial Convening Authority (SPCMCA) ordered, pursuant to RCM 706(b)(1), an inquiry into the mental capacity and responsibility of the accused in accordance with Rule for Courts-Martial 706 (Encl 3). Based on the accused's removal from the Williams AFB RCF and the Sanity Board order, the government counsel and doctors coordinated a plan for the accused to be transferred from the RCF to Ward 4D of Lindberg Medical Center (LMC), Williams AFB. Ward 4D is a "lock-down" psychiatric ward at LMC. Dr. Evan Whitmore, Chief, In-Patient Mental Health, was directed to conduct the accused's Sanity Board.
3. On 15 Feb 00, both government and defense counsel received notice from Dr. Whitmore (Encl 4), the accused's attending psychiatrist, that the answer to the question posed in RCM 706(c)(2)(D) is that the accused is currently suffering from a mental disease or defect rendering him unable to understand the nature of the proceedings against him or to conduct or cooperate intelligently in his defense. Dr. Whitmore is continuing his examination to provide the answers to the other questions listed in RCM 706(c)(2).
4. On 8 Feb 00, in addition to directing a RCM 706 Sanity Board, the SPCMCA also directed an Article 32b Investigation. Further on 11 Feb 00, the SPCMCA delayed the Article 32 IAW RCM 707c until the Sanity Board was complete based on medical recommendations (Encl 5). To date, the Article 32b Investigation has not been conducted, thus the accused's charges are still before the SPCMCA for disposition and have not been forwarded to the general court-martial convening authority.

United States v. CPT Thomas S. Payne; Request for Competency Hearing

5. The SPCMCA respectfully asks the court to conduct a competency hearing IAW RCM 909(e) to answer the questions set forth therein.
6. If the court determines the accused is not competent to stand trial at this time, then the government will comply with RCM 909(f) and remand the accused to the custody of the Attorney General IAW Title 18 United States Code section 4241(d). If the court determines the accused is competent to assist in his defense, the SPCMCA will direct the Article 32 Investigating Officer to convene the hearing.
7. The government will produce Dr. Whitmore and his associate psychiatrist to testify before the court and any other witnesses ordered by the court necessary for the requested determination.

- 5 Encls
1. Charge Sheet
 2. Defense Request for Sanity Board
 3. Sanity Board Order
 4. Dr. Whitmore Memo
 5. RCM 707c Delay

THEODORE M. D' COSTA
LTC, MS
Acting Commander