

Thomas Barnard and James Ewing†

I. Introduction and Background

Preparing to defend a client suffering from a mental illness or injury presents many unique challenges. Defense counsel are faced with the unenviable reality that the client's conduct—for which he or she has been criminally charged—probably constituted a crime. However, if the client is suffering from a mental illness or injury, he or she may not have had the specific intent, or *mens rea*, required to be found guilty of a criminal offense.¹ This concept is complicated by several key realities. First, judges, jurors, and prosecutors tend to accept the reality of what they can see and prove remaining skeptical of explanations that depend on the internal functioning of the human brain, which are difficult to either prove or disprove. Second, most jurisdictions require a great deal procedurally from an accused presenting a defense of lack of mental responsibility. For example, in military courts-martial a defendant who pleads not guilty by reason of lack of mental responsibility has the burden of proving this by clear and convincing evidence.² Since these issues tend to arise as early as the first meeting with the client, defense counsel must be attuned to the unique challenges of representing a client suffering from a mental illness or injury from the

beginning of the representation. Accordingly, this article is focused on practical tips defense counsel should use *prior to trial* to set the stage for the best possible outcome, either at trial or through an alternative disposition prior to trial.³ This article will not directly address the inherent difficulties in representing mentally ill criminal defendants once the trial has started.

Successfully representing a client who is or may be suffering from a mental illness or injury requires good timing, creativity, and the willingness to approach the task in a manner that may defy the normal progress of a criminal case. The timing, structure, and process of the criminal trial lessen the opportunity for an appropriate result for a mentally ill client as the trial progresses. However, while defense counsel endeavors to achieve a specific result in a case, his approach to preparing the case must be disciplined, organized, and consistent in theme; the evidence and its presentation require the most forward-thinking, careful planning, and creative pre-trial negotiating of any case he will undertake.

This article offers five basic steps for preparing to represent a client with mental illness or injury. This structure comes from personal experience representing clients. While these recommendations were developed within the military court-martial system,⁴ the principles are applicable to

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† Thomas Barnard and James Ewing served together as judge advocates in the U.S. Army's Trial Defense Service for the National Capital Region, home to Walter Reed Army Medical Center, the Pentagon, and multiple other military installations and units, where they represented numerous soldiers with mental illnesses. Both graduated from the U.S. Military Academy at West Point, and both were selected out of line duty to attend law school and become judge advocates through the Army's Funded Legal Education Program.

¹ MANUAL FOR COURTS-MARTIAL, UNITED STATES, RULES FOR COURTS-MARTIAL 916(k)(1)-(3) (2008) [hereinafter MCM] (setting out the lack of mental responsibility defense in a court-martial).

² *Id.* (explaining that “[t]he accused is presumed to have been mentally responsible at the time of the alleged offense,” and that “[t]his presumption continues until the accused establishes, by clear and convincing evidence, that he or she was not mentally responsible at the time of the alleged offense”). There is a two-step process for a finding of lack of mental responsibility. In the first step, as in any other court-martial proceeding, at the close of the evidence the panel votes on whether the government has “proven the elements of the offense beyond a reasonable doubt.” *Id.* R.C.M. 921(c)(4). If two-thirds of the panel members vote guilty as to this question, in cases where the defense of lack of mental responsibility is raised, a second vote is taken. *Id.* If a majority of the panel votes that the defense has carried its burden of demonstrating “lack of mental responsibility by clear and convincing evidence, a finding of not guilty only by reason of lack of mental responsibility results.”

³ See generally Jeremy A. Ball, *Solving the Mystery of Insanity Law: Zealous Representation of Mentally Ill Servicemembers*, ARMY LAW., Dec. 2005, at 1 (providing a detailed discussion of the many legal aspects of mental health issues in the military).

⁴ In order to appreciate the context in which this article is written, it is important to have a basic understanding of how a case moves through the military justice system. There are no standing trial courts in the military; rather, each case must be independently referred to a court-martial trial by the appropriate level of commanding officer. Commanding officers administer the military justice system and are advised by their attorneys, Judge Advocates serving in a prosecutorial role. In a court-martial setting, the initial step is the preferral of charges, or official charging determination, against an accused. This preferral of charges is normally accomplished by the soldier's immediate commander with the prosecuting Judge Advocates drafting the charges for the commander. At each subsequent level of command, each commander has independent discretion to make recommendations as to the disposition of the charges and to potentially dispose of the charges at his or her level short of a formal trial. Prior to an accused standing trial at a General Court-Martial (the military's felony-level court), a pretrial hearing called an Article 32 investigation must also be held. 10 U.S.C. § 832 (2006). The Article 32 investigation may be thought of as the military's equivalent of a grand jury proceeding, with the exception that the accused and defense counsel have a right to be present and put on evidence. Additionally, the hearing is conducted by an Investigating Officer rather than a jury of officers or members. *Id.* § 832(b). After the charges have been through the various levels of command for recommendation without being disposed of, the General Court-Martial Convening Authority, normally a General or Flag officer, will determine whether to refer the case to a trial by court-martial. *Id.* § 834. Understanding this system is important in the context of raising a potential insanity defense because each level of command, reviewing commander,

representation of clients with mental illnesses in any forum. The basic steps to representing this type of client are: (1) identifying potential mental health issues; (2) determining the relevancy of the mental health issues to the proceedings; (3) understanding how the public and potential jurors view mental health defenses; (4) determining the appropriate *time* to raise the mental health issue; and (5) determining the appropriate *method* to raise the mental health issue. This article will discuss each of these five steps in turn.

II. Identifying Mental Health Issues

The first major step in any type of representation is the initial interview with the client. At this first interview, defense counsel may have little or no collateral information with which to evaluate the client, so the questions asked and the verbal and non-verbal responses will provide critical information about the client's awareness, state of mind, and memory of the relevant facts. The focus of the interview should begin with the general, non-controversial facts before moving on to more detailed facts about the allegation. For instance, begin by asking the client his name, facts about his service history, and details about some of his assignments. These details will indicate the strength of the client's long-term memory and may also indicate the client's combat experience or other assignments that may raise flags for traumatic brain injuries or posttraumatic stress disorder (PTSD). While conducting a client interview, counsel should pay particular attention to any aberrant or strange behavior by the client, such as the inability to form coherent sentences or comprehend concepts, the presence of body tics or inappropriate movements, or the general inability to interact normally with counsel. Counsel's personal observations may become vital in a subsequent request that a mental health expert be added to the defense team.

The interviewer should conduct research regarding the client's educational and training background. Researched facts can later be compared with the personnel records received through discovery as well as the information the client provides in the client questionnaire. Furthermore, the client questionnaire will establish the level of the client's education, will further test the accuracy of client's memory, and will identify portions of the client's history that he may intentionally or inadvertently obscure or leave out altogether.

prosecuting Judge Advocate, and Article 32 Investigating Officer, represents a separate and distinct audience to which the defense counsel may choose to present the evidence of the accused's mental illness in the hopes of avoiding trial altogether. *See generally* James B. Roan & Cynthia Buxton, *The American Military Justice System in the New Millennium*, 52 A.F. L. REV. 185 (2002) (providing an overview of the Uniform Code of Military Justice (UCMJ)).

The interviewer should question the client about his relationships to identify family and friends and to obtain contact information for those people. The individuals with whom the client regularly associates may be potential points-of-contact to interview about the client. The inclusion of many contacts or friends, or the identification of none, may itself provide another indicator of a problem.⁵ With many of the traumatic-response or anxiety illnesses seclusion or isolation can be a symptom.⁶ Further, lack of social associates may be evidence that the client has been isolated by others as a result of anti-social behavior and erratic conduct.⁷

After these general background questions, the interviewer should begin asking questions about the occurrences that gave rise to the charges at issue. Again starting with general questions and moving to specific questions, counsel should compare the level of detail that the client reported before and after the incident to the level of detail about the incident itself, and the client's claimed ability or inability to remember details. Many clients will detail facts leading up to a particular action, like a fight. For example, consider a situation that started as a fight, but later led to a stabbing or a shooting. The client may describe where he was, what he was drinking, and what was said before the fight. However, when counsel asks him how the fight started or how it escalated, a client may be unable to explain or even remember the steps or actions as they occurred. This may be a sign that something happened in the initial events that altered the client's state of mind or ability to focus, like a traumatic head injury, which may impact his culpability for subsequent events.⁸

⁵ AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 468 (4th ed. 2000) [hereinafter DSM-IV] (noting that feelings of detachment or estrangement, as well as efforts to avoid associations, thoughts, or "conversations associated with the trauma" can be evidence of the "persistent avoidance" diagnostic criteria for PTSD). For a military member, everyone the soldier comes into contact with may remind him or her of the battlefield traumatic event. For example, after a combat tour soldiers may be given a school assignment as an instructor in an attempt to give that soldier a break from field duty, as well as let him share with students the lessons he learned. If this returning soldier is suffering from PTSD, he could essentially be asked to relive and talk about experiences on a daily basis. This may lead to poor performance, missing work, or not associating with other people at work.

⁶ *Id.*

⁷ The isolation factors alone are not enough to find that someone has PTSD. The fourth edition of the Diagnostic Statistical Manual (DSM-IV) covers diagnostic criteria for all the recognized mental illnesses and lays out requirements for the diagnostic criteria of each. *See id.* For instance, while isolation from others may point toward an anxiety disorder like PTSD, it may also point to a personality disorder, such as schizoid personality disorder. *Id.* at 308, 468. The implications and causes of both disorders differ greatly, and understanding that is critical to deciding the best use of a diagnosis at trial.

⁸ "Physical trauma to the head can cause a variety of cognitive problems, including memory loss, distractibility, trouble thinking abstractly, coordination problems, and difficulty learning new information." JAMES WHITNEY HICKS, 50 SIGNS OF MENTAL ILLNESS 190 (2005).

At the end of the initial interview, the defense attorney should obtain a signed release of medical and mental health information from the client.⁹ In some instances clients may have been previously diagnosed with mental health issues that they either seek to conceal or of which they simply do not understand the importance. The medical and mental health history may provide critical information and records of problems, and may also identify potential patterns of behaviors or prior diagnoses of mental health problems.

At the end of the first interview, attorneys should give their client a questionnaire to fill out at home and bring back to their next interview. Counsel should emphasize to the client the confidential nature of this questionnaire and the importance of being forthcoming when answering the questions. These questions should span all of the topics covered in the initial interview, but in more detail. Additionally, the questionnaire should include questions that were not asked in the interview that may elicit more personal information, such as prior psychiatric diagnoses or problems, family history of psychological disorders, hospitalizations, or prior criminal acts. Questions should also call for the client's personal assessment of his memory of the event and his personal assessment of his state of mental well-being. Not surprisingly, clients may include significant details on a written questionnaire that they would not provide in an oral interview. For instance, many soldiers will not want to admit prior in-patient psychological treatment or drug treatment. The presence of drug treatment in a soldier's record may itself be a sign of mental illness or brain injury because the use of drugs can be a common response to depression, and the desire for narcotic stimulus is a symptom of a possible frontal lobe injury.¹⁰

III. Determining the Relevancy of Mental Health Issues to the Proceedings

There are three ways mental health problems are relevant to a case: (1) problems may affect the client's mental responsibility at the time of the offense or offenses; (2) problems may affect the client's competency to stand trial; and (3) problems may constitute a defense on the merits for the *mens rea* element of the charge or that mitigate the client's criminal culpability and thus affect his sentence.

⁹ See, e.g., Authorization for the Disclosure of Medical or Dental Information (2003), available at <http://www.dtic.mil/whs/directives/infomgt/forms/eforms/dd2870.pdf>. A client can execute a standard release form, DD 2870. Other releases can include a simple memorandum, including the hospital or records center concerned, the nature of the records sought (clarifying that they include mental health), the identity of the person to whom records can be released, and a signature from the releaser.

¹⁰ See HICKS, *supra* note 8, at 190 (noting that head trauma can make people become more impulsive) "Addicting behaviors all involve impulses." *Id.* at 166 (describing the relationship between the inability to control impulses and different impulsive behaviors like drug use).

A. Diminished Mental Health As an Affirmative Defense

Evidence of a mental disease or defect that would be relevant to the affirmative defense of lack of mental responsibility essentially comes in two forms: evidence showing the client had an altered perception of reality at the time of the offense, or evidence showing the client's mental processes were inhibited in some way. For either of these to be considered a possible defense, the client's mental disease or defect must be severe.¹¹ The test of whether a mental disease or defect is severe depends on the nature of the illness itself and the frequency and scope of the diagnostic symptoms.¹² A reasonable test, prior to getting an expert opinion, is to look at whether the illness impacts a person's daily functioning in a significant way.¹³ This may be evaluated by observing the client's on-the-job performance including notable drops in efficiency reports. In addition, demonstration of erratic behavior, sudden increases in minor misconduct, obvious changes in the client's personal life and relationships, or evidence of alcohol or drug abuse may all be signs that there is a problem severely impacting the client's life.¹⁴ Laying these events on a timeline may assist counsel in making the connection between these behaviors and a traumatic event in the client's life, such as combat service, a severe automobile accident, or being the victim of a crime. These sorts of drastic changes may be good circumstantial evidence of the severity of the disease. However, the dispositive evidence of whether a mental disease or defect is severe must come from a mental health expert.¹⁵

¹¹ See generally Ball, *supra* note 3, at 16-23 (discussing the elements of the defense of lack of mental responsibility). An important starting point in the case evaluation is the presumption of mental responsibility and competency. See MCM, *supra* note 1, R.C.M. 916(k)(3), 909(b). Furthermore, the issue of mental competency is a question of law for the judge often resolved before the trial on the merits begins, and the preponderance of the evidence burden is lower than the mental responsibility requirement. *Id.* R.C.M. 909(e).

¹² What constitutes *severe* is not specifically defined in the Rules for Courts-Martial (R.C.M.) or in the UCMJ, but there is some guidance in R.C.M. 706(c)(2)(A) and in the *Military Judges' Benchbook*. U.S. DEP'T OF ARMY, PAM. 27-9, MILITARY JUDGES' BENCHBOOK 817, para. 6-2 (2002) ("The standard of proof on [the issue of mental capacity at the time of trial] is whether the accused is presently suffering from a mental disease or defect rendering him/her mentally incompetent to the extent that he/she is unable to understand the nature of the proceedings or to cooperate intelligently in the defense of the case."), available at <http://www.jag.navy.mil/documents/MJBenchbook.pdf>; see also Ball, *supra* note 3, at 17-18 (discussing the definition of severity).

¹³ See, e.g., PTSD support.net, PTSD & the Global Assessment of Functioning (GAF) Scale, http://www.ptsdsupport.net/ptsd_gafscores.html (last visited May 15, 2009). The impact on daily life is often measured on a sliding scale of evaluation known as the Global Assessment of Functioning, or GAF. After an individual assessment, a number between 1 and 100 indicates the impact of PTSD on a person's functioning.

¹⁴ See *id.*

¹⁵ Unlike other affirmative defenses, the military judge has a sua sponte obligation to order an inquiry into the mental health of the accused if it appears that it is an unresolved question. In other words, the question of a lack of mental responsibility is not left up to the judge or the parties—if it is

The second prong to a defense of lack of mental responsibility is often difficult to establish. While different jurisdictions employ different “tests” for this prong, the majority of jurisdictions, including the military, utilize some form of the following test: assuming the severe mental disease or defect existed at the time of the offense, was the client able to determine right from wrong?¹⁶ Stated differently, the test asks whether the accused “was unable to appreciate the nature and quality or the wrongfulness of his . . . acts.”¹⁷ This is a substantial burden that, as noted above, defense counsel will be required to prove by clear and convincing evidence.¹⁸ Many clients may have a severe mental disease or defect but still know right from wrong. For example, a person who develops a substance addiction secondary to a mental disease may know that the conduct is wrong, but he may not be able to stop himself or may not care.

B. Competency to Stand Trial

The issue of mental competency is directly tied to a person’s right to a fair trial and representation because a person must be able to understand the proceedings and be able to participate in his own defense.¹⁹ Defense counsel should review with the client the basic rights advisement covering the nature of the potential court-martial, the rights of representation, the rights pertaining to a jury trial, and the nature of the charges. After going over the charges, defense counsel should have the client explain back some of the issues. The client’s comprehension of these initial matters may be a good indicator of competency. At a minimum this step may provide warning signals if there is a problem, such as a learning disability.²⁰ Reviewing the client’s testing

at issue, it must be addressed by a mental health professional. *See, e.g.,* United States v. Shaw, 64 M.J. 460, 465 (C.A.A.F. 2007); *see also* Learning Disabilities Association of America, Screening for Adults with Learning Disabilities, <http://www.ldanatl.org/aboutld/adults/assessment/screening.asp> (last visited May 15, 2009) [hereinafter Screening for Adults with Learning Disabilities] (explaining that with regard to learning disabilities a “formal assessment is carried out by a professionally-trained educational diagnostician, counselor, psychiatrist or psychologist . . .”). *See generally* MCM, *supra* note 1, R.C.M. 706 (noting that the evaluation board shall include either a “psychiatrist or a clinical psychologist”).

¹⁶ *See* Ball, *supra* note 3, at 16-23 (discussing the elements of the defense of lack of mental responsibility).

¹⁷ MCM, *supra* note 1, R.C.M. 916(k)(1).

¹⁸ *Id.* R.C.M. 921(c)(4).

¹⁹ *See* Ball, *supra* note 3, at 1-2 (discussing the elements of the defense of lack of mental competency).

²⁰ Screening for Adults with Learning Disabilities, *supra* note 15.

The following behaviors may indicate the possibility of a learning disability if observed over a considerable period of time: Difficulty absorbing major ideas from an oral presentations (instructions, lectures, discussions); information must be repeated and reviewed before understanding is achieved; problems with following directions; difficulty

records, job performance records, and academic history may also indicate problems with intelligence.²¹ Counsel’s personal observations of the client’s demeanor and ability to focus during conversations are critical to an evaluation of competency. For example, defense counsel may be going over rights and procedures, and the client may be looking around the room, may be staring blankly, or may be simply nodding along with what is said. The client may repeatedly indicate to counsel that he understands, but in order to determine whether the client truly understands what is being explained, counsel’s questions during the interviews should be non-leading. After a few interviews, counsel may also test the client by troubleshooting his explanation of events. The client’s reaction to defense counsel’s confrontation, or the client’s reaction to being asked to explain things from his supervisor’s perspective, may also reveal indicators of deeper problems. For instance, a soldier charged with disorderly conduct or disrespect may have a very different perspective of what happened; he may even believe that he was attacked, contrary to the testimony of eye witnesses. After pressing the client on this issue, he may have a very aggressive or violent reaction showing that even minor confrontations lead him to act irrationally. This may be an indicator of a mental disorder that could seriously inhibit his ability to make rational decisions at trial, to make informed selections with regard to forum, or to even maintain composure in the courtroom.²²

C. Mental Incompetency as a Defense on the Merits or as a Mitigating Factor

If a client’s mental disease or defect does not rise to the level of proof by clear and convincing evidence that the client did not know right from wrong at the time of the offense, the matter still may be relevant regarding the *mens rea* element of the offense. This is commonly known as the quasi-mental health defense.²³ Additionally, evidence that an

retaining information without excessive rehearsal and practice; cannot recall familiar facts on command, yet can do so at other times.

Id.

²¹ *See id.* (“[T]he information-gathering process can include . . . reviews of school, medical, and employment records (wherein patterns of problems may be evident and should be noted) . . .”).

²² *See* ELIZABETH BRONDOLO & ZAVIER AMADOR, BREAK THE BIPOLAR CYCLE: A DAY BY DAY GUIDE TO LIVING WITH BIPOLAR DISORDER 11-18 (2008). Symptoms of bipolar disorders include mania symptoms, such as “abnormally and persistently elevated, expansive or irritable mood[s].” DSM-IV, *supra* note 5, at 357. This can include “hallucinations or delusions,” and a person “may have difficulty distinguishing dreams from reality” in progressed manias. BRONDOLO & AMADOR, *supra* at 11, 13.

²³ The term “quasi-mental health defense” refers to a situation in which an accused is charged with a specific-intent crime, and while there is evidence that the accused has mental health issues, this evidence does not rise to the level of a successful affirmative defense of a lack of mental responsibility. *See supra* Section III.A. In this situation, rather than mount an affirmative defense of lack of mental responsibility, defense counsel can utilize the “quasi-mental health” defense to attack the government’s ability to prove

accused has mental health issues is often highly relevant during the sentencing portion of a trial. These uses are the most common applications of mental health issues in the courtroom, and they should not be overlooked by defense counsel. Because the evidentiary burden for these uses is unique and heavy on the defense, defense counsel should avoid taking on evidentiary burdens in a criminal trial unless absolutely necessary. The quasi-mental health defense undermines the government's proof of *mens rea* and allows the defense to present expert mental health evidence while keeping the burden on the government to prove its case.²⁴ By using the quasi-mental health defense, counsel may also avoid difficult jury instructions that highlight the burden on the defense to establish the elements of lack of mental responsibility.²⁵

Mitigation in the sentencing phase of trial is another very common use of this type of evidence by the defense. Many clients will have issues or problems in their lives, some may even have been diagnosed with mental health problems, which may be a rationale or reason for certain actions. Take, for instance, a person charged with drunk driving. This client may have PTSD or another combat-related stress syndrome, which may cause both nightmares and flashbacks that the person has learned to suppress through the use of alcohol or other drugs.²⁶ While this does not excuse the behavior, it is something that many potential panel members can relate to as the average panel member typically has a significant amount of experience in the military²⁷ and has probably encountered a person with a

beyond a reasonable doubt that the accused had the requisite *mens rea*, or specific intent, to commit the offense in question. In this way, evidence of the accused's mental health issues—presented on the merits—is no different than any other defense evidence presented in an attempt to undermine the government's proof of an element of the offense at issue.

²⁴ See MCM, *supra* note 1, R.C.M. 916(k)(2), discussion. See generally, Ball, *supra* note 3, at 23, 27, 31 (discussing *mens rea* and the mental health defense).

²⁵ Ball, *supra* note 3, at 27.

²⁶ “The longer someone has PTSD, the more likely he’ll develop drug or alcohol abuse” Marilyn Elias, *Post-traumatic Stress Is a War Within for Military and Civilians*, U.S.A. TODAY, Oct. 27, 2008, at 7D. This article also cites a RAND study which found that only “about half of recent veterans with PTSD symptoms” have sought treatment. *Id.* The tendency to use drugs or alcohol can be explained by looking at the type of symptoms associated with PTSD. Symptoms like re-experiencing the trauma and hyper-vigilance can be disturbing and may cause the person to be unable to function in their daily lives. See LAURIE B. SLONE & MATTHEW J. FRIEDMAN, *AFTER THE WAR ZONE: A PRACTICAL GUIDE FOR RETURNING TROOPS AND THEIR FAMILIES* 152-53 (2008). To cope with the discomfort associated with these symptoms, individuals may use “drugs or alcohol to numb out the difficult thoughts, feelings, and memories,” especially since these seem to offer a quick fix as an alternative to the more difficult process of working through the underlying problems. *Id.* at 175-76. Furthermore, troops returning from a war zone where no alcohol is available are likely to see the availability of alcohol as an appropriate outlet. *Id.* at 177.

²⁷ See 10 U.S.C. § 825(d)(2) (2006) (mandating that convening authorities shall detail court members who are “best qualified for the duty by reason of age, education, training, experience, length of service, and judicial temperament”).

similar problem on more than one occasion in their career.²⁸ This empathy may potentially contribute to mitigation at sentencing.

IV. Understanding How the Public and Potential Jurors View Mental Health Defenses

Historically, the general public has not embraced lack of mental health responsibility defenses as legitimate excuses for otherwise criminal behavior.²⁹ This public opinion was most evident in the aftermath of the assassination attempt of President Reagan and criminal trial of John Hinckley.³⁰ After he was acquitted based on his lack of mental responsibility, Congress responded with the modern framework for mental health as a defense, placing a substantial burden on the defense in criminal cases.³¹

²⁸ “About one out of seven service members have returned from deployments with symptoms of PTSD.” Elias, *supra* note 26, at 7D. As a result, most military members have worked with or met someone suffering from PTSD while serving in the military.

²⁹ See, e.g., John P. Martin, *The Insanity Defense: A Closer Look*, WASH. POST, Feb. 27, 1998, available at <http://www.washingtonpost.com/wp-srv/local/longterm/aron/qa227.htm> (tracing the history of the insanity defense back to the *M'Naughten* case in England in 1843 and noting the consistent public opinion that the defense is unfair or overused).

³⁰ The case of John Hinckley is perhaps the most well known case of an insanity defense in the United States in the last fifty years. On March 31, 1981, John Hinckley shot President Ronald Reagan in the chest outside of the Washington Hilton Hotel in Washington, D.C. See, e.g., Howell Raines, *Reagan Wounded in Chest by Gunman; Outlook 'Good' After 2-Hour Surgery; Aide and 2 Guards Shot; Suspect Held*, N.Y. TIMES, Mar. 31, 1981, at A1. Hinckley fired six shots, which hit four people, including President Reagan and his press secretary James Brady. See Douglas Linder, *The Trial of John Hinckley*, The University of Missouri/Kansas City Faculty Project 2002, <http://www.law.umkc.edu/faculty/projects/ftrials/hinckley/hinckleyaccount.html> (last visited May 15, 2009) (providing an exhaustive account of the ensuing trial). At trial, a “battle of the experts” ensued, with the defense experts claiming that Hinckley was insane and government experts claiming that he was competent at the time of the shootings. *Id.* Importantly, reflecting the state of the law at the time of the trial, at the close of the evidence, the trial judge instructed the jury that in order to convict Hinckley the government had to prove “beyond a reasonable doubt” that he was *not* insane. *Id.*; see Martin *supra* note 29. Hinckley was subsequently found not guilty by reason of insanity on June 21, 1982. Stuart Taylor, *Hinckley Is Cleared but Is Held Insane in Reagan Attack*, N.Y. TIMES, June 22, 1982, at A1. The Linder study of the case cites to an ABC News poll conducted the day after the case which found that 83% of respondents believed that “justice was not done.” Linder, *supra*. This public backlash formed the impetus for Congress to pass the Insanity Defense Reform Act of 1984. See generally 18 U.S.C. § 17 (2006).

³¹ A major structural change of the Insanity Defense Reform Act of 1984, was to transform the insanity defense from a defense which, when raised by “some evidence,” must be disproved by the government beyond a reasonable doubt to an “affirmative defense” in which the burden is on the defense to raise the issue. 18 U.S.C. § 17(a). The Insanity Defense Reform Act sets a high bar for defendants wishing to raise this defense—namely that they must prove the existence of the defense by “clear and convincing evidence.” See *id.* § 17(b). The timing of this change to the federal law as well as numerous state laws regarding the insanity defense can be directly linked to the Hinckley verdict. See Linder, *supra* note 30 (“Within three years after the Hinckley verdict, two-thirds of the states placed the burden on the defense to prove insanity, while eight states adopted a separate

In the last decade, however, mental health issues have become important to the public in several areas. First, mental health evidence has become increasingly important to sentencing in capital murder cases.³² A second major area that has developed over the last few years is the increased attention to combat-related mental illnesses and traumatic brain injuries.³³ However, since interest in this area has been primarily one of compassion, a general misunderstanding about the nature of these illnesses still exists.³⁴ This distinction is significant when assessing how to bring mental health issues to a jury. The case may require defense counsel to debunk myths and to educate jury members on the aspects of the illness that are critical to the arguments the defense is putting forth. However, given confusion about the nature of mental illness and the difficult burdens of proof regarding lack of responsibility as an affirmative defense,³⁵ counsel has to plan the incorporation of this evidence carefully, especially in determining when to bring it to the court's attention.

V. Determining the Appropriate Time to Raise the Mental Health Issue

Once defense counsel has identified information or evidence that shows a client has a mental illness, the next difficult step is deciding when the best time is to alert the government or the court to the potential issues. Since there are many levels of decision-makers involved in getting a case to court-martial, the answer to this question is probably unique to the military justice system: the earlier the better.³⁶

verdict of 'guilty but mentally ill' and one state (Utah) abolished the defense altogether.”).

³² See, e.g., *United States v. Kreutzer*, 59 M.J. 773, 776 (A. Ct. Crim. App. 2004); see also Ball, *supra* note 3, at 36 (“The message from *Kreutzer* is fairly clear. In a capital case, defense counsel has a heightened duty to present mitigating evidence of mental illness”); HARRY HENDERSON, CAPITAL PUNISHMENT 43, 81-82, 99 (3d ed. 2006) (discussing the role of mental health in capital punishment and the unwillingness to sanction execution of the mentally ill).

³³ See, e.g., Deborah Sontag & Lizette Alvarez, *In More Cases, Combat Trauma Takes the Stand*, N.Y. TIMES, Jan. 27, 2008, at A1 (reporting on a murder trial in South Dakota in which the accused had recently returned from Iraq and had been diagnosed with severe PTSD; the article is part of a larger series by the New York Times on the topic of veterans of the Iraq and Afghanistan wars who have been charged with killings upon returning home to the United States); Associated Press, *Pentagon Totals Rise for Stress Disorder*, N.Y. TIMES, May 28, 2008, at A18 (reporting over 40,000 military personnel have been diagnosed with PTSD since 2003).

³⁴ “Despite all the public attention, myths about PTSD abound.” Elias, *supra* note 25, at 7D (quoting Farris Tuma, Chief of the Traumatic Stress Program at the National Institute of Mental Health).

³⁵ See generally Ball, *supra* note 3, at 16-23 (discussing the elements of the defense of lack of mental responsibility).

³⁶ The military justice system is managed primarily by a system of key decision-makers known as convening authorities. In the standard model, there are three levels of convening authorities: Summary Court-Martial Convening Authority, Special Court-Martial Convening Authority, and General Court-Martial Convening Authority. See generally 10 U.S.C. §§

In the military, defense counsel should identify the issue to trial counsel early by requesting a mental health evaluation pursuant to R.C.M. 706.³⁷ This request should be made if defense counsel has any evidence that raises questions about either the competency or the mental responsibility of the defendant.³⁸ Failure to explore this question has been grounds for claims of ineffective assistance of counsel and even for reversal.³⁹ The rationale for these concerns is clear. If an issue of lack of mental responsibility for an offense goes unexplored by defense counsel and is therefore unresolved, it is unclear how the client could either (1) properly plead guilty to an offense at trial and attain the benefit of a plea agreement, or (2) properly mount a competent defense in a contested trial on the merits. Furthermore, in light of the liberty interest of the client, the assistance of a medical expert at no financial cost to the government should be completed when a question has been raised.

When this issue is raised with trial counsel, defense counsel should take the time to explain the process to the various commanders and to interview them and other unit leaders about the behavior, personality, and habits of the client. Getting a feel early on for their opinions of his conduct and behavior can be important in deciding when to bring mental health evidence at trial. For instance, witness testimony indicating the client exhibited irregular behavior,

822-24 (2006). Each of these convening authorities has a different and distinct authority, and they have different appropriate courses of action to take upon considering any one particular case. Compare MCM, *supra* note 1, R.C.M. 403, and MCM, *supra* note 1, R.C.M. 404, with MCM, *supra* note 1, R.C.M. 407. Each level is required to exercise independent discretion on a particular case. 10 U.S.C. § 837(a) (stating the statutory underpinning for the prohibition on unlawful command influence).

³⁷ MCM, *supra* note 1, R.C.M. 706. If it appears to defense counsel “that there is reason to believe that the accused lacked mental responsibility for any offense charged or lacks capacity to stand trial,” this section requires that defense counsel *shall* transmit the reasons for that belief to an officer “authorized to order an inquiry.” *Id.* R.C.M. 706(a). Prior to the referral of charges, that officer is “the convening authority before whom the charges are pending.” *Id.* R.C.M. 706(b)(1). After referral, that officer is typically the military judge with some minor exceptions. *Id.* R.C.M. 706(b)(2). The military judge can order an inquiry regardless of any previous decision by a convening authority. *Id.* The inquiry is conducted by a board “consisting of one or more persons,” at least one of which is a psychiatrist or clinical psychologist. *Id.* R.C.M. 706(c)(1). Every member must be either a physician or clinical psychologist. *Id.*

³⁸ See MCM, *supra* note 1, R.C.M. 706(a) (placing an affirmative obligation on defense counsel to report, through the appropriate channels, the belief that an accused lacks mental responsibility or competency to stand trial).

³⁹ Defense counsel has a duty to diligently explore matters in mitigation which might tend to lessen their client's culpability; this includes adequate investigation into the client's mental health. In *Wiggins v. Smith*, the U.S. Supreme Court found ineffective assistance of counsel in a case where “[c]ounsel's investigation into Wiggins' background [to include his mental health] did not reflect reasonable professional judgment.” *Wiggins v. Smith*, 539 U.S. 510, 534 (2003); see also *United States v. Kreutzer*, 59 M.J. 773, 784 (A. Ct. Crim. App. 2004) (finding ineffective assistance of counsel despite a completed R.C.M. 706 evaluation because “[d]efense counsel's investigation into appellant's mental health background fell short of reasonable professional standards”).

talked to himself, or had periodic seizures may add merit to an expert request or defense. On the other hand, testimony that the client was intelligent, deliberative, or thoughtful at work may weaken a defense in the eyes of a potential judge or jury. Jurors will want to know how the defendant acts on a daily basis at work to put his behavior in a context they can understand and with which they are comfortable.

Early discussions with the command will also commit command leaders later to their early opinions and behavior assessments. If command opinions change later, defense counsel could raise new discovery questions concerning the basis for command's opinion change, providing possible basis for a claim of unlawful command influence.⁴⁰ At the least, such a change in command opinion would be fertile ground for cross-examination.⁴¹ Further, early discussions help build a theme for the client and force discussions to be more about his potential illness and defense than about his underlying potential misconduct. This is the discussion and the climate that defense counsel must create to get the best possible outcome for the client. This issue is forced by presenting the case to each and every level of command or convening authority.

⁴⁰ It is a bedrock foundation of military life that commanders of higher ranks give orders to commanders of lower ranks on all types of issues, both in peacetime and in combat. These orders carry the force of law. However, in regards to the administration of military justice, this arrangement changes. At each level of command, each commander is required to utilize his or her best judgment in the handling and disposition of a particular case, and it is *unlawful* for a superior commander to order a subordinate commander to dispose of a particular case in a particular way. This arrangement recognizes the "quasi-judicial" role of commanders in the military justice setting. Commanders who violate this maxim give rise to defendant's claim of "unlawful command influence." The concept of unlawful command influence has been called the "mortal enemy of military justice." See *United States v. Gore*, 60 M.J. 178, 178 (C.A.A.F. 2004) (quoting *United States v. Thomas*, 22 M.J. 388, 393 (C.M.A. 1986)). "Where [unlawful command influence] is found to exist, judicial authorities must take those steps necessary to preserve both the actual and apparent fairness of the criminal proceeding." *United States v. Lewis*, 63 M.J. 405, 407 (C.A.A.F. 2006) (citing *United States v. Rivers*, 49 M.J. 434, 443 (C.A.A.F. 1998)); see *United States v. Sullivan*, 26 M.J. 442, 444 (C.A.A.F. 1988). Where the mental competency of an accused is at issue, and a commander later changes his or her position on the issue of mental competency or his or her evaluation of the accused's mental state, it is important for defense counsel to ascertain whether the commander had engaged in any communications with a superior commander on the topic.

⁴¹ MCM, *supra* note 1, MIL. R. EVID. 608(c) makes it clear that cross-examination of witnesses is always relevant and allowable to demonstrate a motive to misrepresent or a bias against a particular individual. Where a commander initially gives a favorable response to defense counsel regarding a potential defense of lack of mental responsibility and later changes that position, it is prudent to pursue whether this change was the product of personal bias against the client or a motive to "get rid of" an individual the commander likely deems a "problem soldier" in his or her unit.

The defendant's lack of mental responsibility should be pressed at the Article 32 hearing, or equivalent civilian pretrial hearing because a favorable recommendation from the Article 32 officer could have an impact on the convening authority.⁴² Further, if defense counsel has legitimate concerns about an accused's competence to stand trial, defense counsel should have the same concerns about the accused's competence to stand at a pretrial hearing, whether it is an Article 32 investigation or an equivalent civilian pretrial proceeding. In the military system, the impact of the Article 32 officer's recommendation could be limited by the communication between the convening authority and Staff Judge Advocate under Article 34 of the Uniform Code of Military Justice (UCMJ).⁴³ However, defense counsel is entitled through discovery to know what Article 34 advice was given to the convening authority.⁴⁴

VI. Methods for Using Evidence of Mental Illness

There are several methods for presenting the client's case to commanders. In Article 32 hearings, most attorneys will have access to the client's medical records. The client may have been subject to a command referral for a mental health evaluation,⁴⁵ may have already seen a mental health specialist on a self referral,⁴⁶ or may have even been

⁴² After the Article 32 proceeding, the convening authority is advised by the Staff Judge Advocate pursuant to Article 34 as to whether the specifications properly allege offenses under the UCMJ, whether the specifications are warranted by the evidence, and whether a court-martial has jurisdiction over the accused. 10 U.S.C. § 834(a)(1), (3) (2006). This advice should include the results of the Article 32 investigation and the recommendation of the Article 32 Investigating Officer to the convening authority regarding the disposition of the case. *Id.* § 834(b)(1)-(2). A case cannot be referred to a trial by general court-martial without this Article 34 advice from the Staff Judge Advocate. *Id.*

⁴³ Compare M.C.M., *supra* note 1, R.C.M. 405(j), with *id.* R.C.M. 406.

⁴⁴ The defense is entitled to copy and inspect "[a]ny paper which accompanied the charges when they were referred to the court-martial . . ." MCM, *supra* note 1, R.C.M. 701(a)(1)(A). For a general court-martial, these papers would include the Staff Judge Advocate's Article 34 advice. 10 U.S.C. § 834(b). If the Article 34 advice does not reference the recommendation from the Article 32 Investigating Officer or if it misstates this advice, this could be grounds for a motion for an improper referral of charges to the court-martial. *Id.* § 834(c).

⁴⁵ Department of Defense Directive 6490.1 (DoD Directive) is the specific Directive which governs referrals for mental health evaluations. DEP'T OF DEF., DIRECTIVE NO. 6490.1, MENTAL HEALTH EVALUATIONS OF MEMBERS OF THE ARMED FORCES (1997) [hereinafter DoD DIRECTIVE 6490.1]. The regulation is the source of authority for the procedure and protections afforded to a service member who is referred for evaluation. *Id.* para. 1.

⁴⁶ The DoD Directive specifically states that the procedure does not apply to self-referrals and evaluations under R.C.M. 706. *Id.* para. 4.3.5. Self-referrals for treatment are privileged psychotherapist-patient communication. MCM, *supra* note 1, MIL. R. EVID. 513. Further, the DoD Directive "does not modify any authorities or responsibilities about the . . . prosecution of offenses under the UCMJ . . ." DoD DIRECTIVE 6490.1, *supra* note 45, para. 4.9. As discussed earlier, issues concerning the mental responsibility or competency of an individual pending charges are required to be reported to an appropriate officer. MCM, *supra* note 1, R.C.M.

hospitalized in one of the Army Medical Centers. These records should be easily obtained through a medical release from the client and a request to the appropriate location. This request should not be funneled through the command or through trial counsel unless they already have the records because of a command referral. Mental health records are not open to command or law enforcement review absent one of the various exceptions to the privileges. Law enforcement officials may not know this, and the individuals working at the clinic may not be sure of whether they have to give those records to law enforcement.⁴⁷ However, absent notice to the court of an expert or the intent to introduce mental health evidence, that information should not be disclosed. Furthermore, with regard to the reports generated under R.C.M. 706, information need not be provided to government counsel until information is actually presented at trial.⁴⁸ As a precautionary measure, when defense counsel

706(a). Defense counsel should be mindful of efforts by a commander to bypass the R.C.M. 706 procedures by using a command directed evaluation. Evaluations done pursuant to the DoD Directive lack procedural and other protections provided under Rule 302 of the Military Rules of Evidence and will provide more information to the command, and by necessity, the prosecution.

⁴⁷ See U.S. DEP'T OF ARMY, REG. 40-66, MEDICAL RECORD ADMINISTRATION AND HEALTHCARE DOCUMENTATION 4, para. 2-2 (2008) (setting forth penalties for improper dissemination of military members' medical records, including mental health records, and also delineating the limited ways that information from records may be released to law enforcement officials for identification purposes). The regulation sets forth the following:

Disclose PHI [protected health information] to a law enforcement official if the employee is a victim of a crime and provided that the PHI is about a suspected perpetrator of the criminal act and is only limited to identification information. In response to law enforcement requests for limited information for identification and location purposes, the MTF may disclose only items listed in (a) through (h) below. (Note: PHI for the purpose of identification or location does not include DNA or DNA analysis, dental records or typing, samples or analysis of body fluids or tissue (see DOD 6025.18-R, para C.7.6.2.2).)

- (a) Name and address.
- (b) Date and place of birth.
- (c) Social Security number.
- (d) ABO blood type and Rh factor.
- (e) Type of injury.
- (f) Date and time of treatment.
- (g) Date and time of death, if applicable.

(h) A description of distinguishing physical characteristics, including height, weight, gender, race, and eye color; presence or absence of facial hair (beard or mustache); scars; and tattoos.

Id. para. 2-2(g)(5).

⁴⁸ MCM, *supra* note 1, R.C.M. 706(c)(5) ("No person, other than the defense counsel, accused, or, after referral of charges, the military judge may disclose to trial counsel any statement made by the accused to the board or any evidence derived from such statement."). Any statement made by the accused under R.C.M. 706 is privileged, as is any derivative evidence from that statement. See *id.* MIL. R. EVID. 302(a). However, this privilege is waived if the accused introduces these statements. See *id.* MIL. R. EVID. 302(b)(1). Additionally, if the accused offers expert testimony

requests the records, counsel should also include a brief letter to the clinic as a reminder of the obligation not to disclose any information absent a release from the client or a court order.

The R.C.M. 706 report may be the most significant piece of evidence the defense will have. The report comes in two forms, a short and a long form, both of which answer the necessary questions to determine if competency and mental responsibility are at issue.⁴⁹ The government will only get the short form, which contains a diagnosis and discrete answers in the affirmative or negative to the questions regarding mental health.⁵⁰ The long form contains the same information as well as information indicating the tests that were performed, the information relied on in making the findings, and the statements of the accused. The long form usually informs defense counsel about the strengths and weaknesses of any potential defense.⁵¹ It is imperative that the medical professionals performing the evaluation on the client understand the confidentiality requirements of a government-ordered mental health examination such as R.C.M. 706 or the civilian equivalent.

concerning his mental health, "the military judge, upon motion, shall order the release to the prosecution of the full contents, other than any statements made by the accused, of any report prepared pursuant to R.C.M. 706." *Id.* MIL. R. EVID. 302(c). It is important to note from this rule, that the right to move for disclosure comes after the evidence is actually offered, not upon notice to bring an expert witness. The government, therefore, will have to either request a continuance or recess to review the report and consult with their expert witness. Both are often unappealing choices, especially with a military panel waiting. Knowing that such an event will occur, defense counsel should have a copy of the report prepared with all the statements of the accused redacted ahead of time. That way, when the judge grants the government motion to produce the report, defense counsel can give a copy of the original and the redacted version for the judge for an *in camera* review, and he will then provide the redacted copy to trial counsel. Note that if defense counsel, either through the accused or an expert, introduces statements by the accused that he made during the R.C.M. 706 examination, then the government will be entitled to an unredacted report. See *id.* R.C.M. 706(c)(3)(B).

⁴⁹ After an R.C.M. 706 inquiry is completed, the board produces two reports. One report, commonly referred to as the "short form," is provided only to the officer ordering the examination and other specific officials, and it will answer only the specific questions outlined in R.C.M. 706(c)(2). See *id.* R.C.M. 706(c)(3)(A). A full report, commonly referred to as the "long form," will be provided to defense counsel and typically requires an order from a military judge to be released to anyone else. *Id.* R.C.M. 706(c)(3)(C). The contents of the full report are protected by a unique military rule of evidence, M.R.E. 302. *Id.* MIL. R. EVID. 302(c). However, as described later in this article, defense counsel does have the ability to release all or portions of the report as part of a litigation plan. *Id.* R.C.M. 706(c)(5). While some of the information in the long report may be harmful or incriminating to a client, portions may also be relevant background to help trial counsel, Staff Judge Advocate, or Convening Authority understand the nature and cause of a client's problem.

⁵⁰ *Id.* R.C.M. 706(c)(3)(A).

⁵¹ *Id.* R.C.M. 706(c)(3)(B)-(C).

Once defense counsel gets this report, he or she is in a position to determine if a request for an expert consultant in the area of mental health is justified.⁵² This request should explain the need for the expert and, if a report is going to be included with the request, defense counsel should only include the short form. Defense counsel can be confident that the government will not be able to summarily disapprove a request in these circumstances. If the expert is a government expert, available at no cost to the government, it is probably in the government's interest to approve the request to avoid litigating the request at a hearing and to keep the case moving. When determining whether to request an expert or how to proceed after receiving the results of the R.C.M. 706 evaluation, it is incumbent on defense counsel to become educated, to the extent possible, on the issues raised by the R.C.M. 706 or government mental evaluation of the client. This self-education can come from consulting the DSM-IV, internet sources, or through informal consultations with other medical professionals (other than the individuals who performed the government directed evaluation).⁵³ This self-education is important for a number of reasons. First, knowledge of different types of mental evaluations and diagnoses can assist counsel in recognizing inconsistencies in the government's report.⁵⁴ Second, it is important to note which tests the government did or did not perform during the evaluation, as this can be addressed in both the request for an independent defense mental health expert consultant and potentially in discrediting the government's findings that the client is of sound mental health.⁵⁵ For example, this would be problematic where defense counsel suspects that the client may have suffered a traumatic brain injury, but an

MRI of the client's brain was not conducted as a part of the government's evaluation. Third, knowledge of the underlying diagnoses and of the language of mental health professionals will be invaluable to defense counsel when, either at trial or in a pretrial proceeding, they cross-examine the government's mental health professional or conduct direct examination of the defense expert.⁵⁶ As in any area of litigation, counsel must strive to become as competent as possible in the nuts and bolts of their client's mental health diagnosis and in understanding what the diagnosis means. If counsel is not comfortable with the meaning of the diagnosis and its ultimate effect on the client's behavior, he will not be able to effectively articulate this to a judge or jury at trial.

Circumstantial evidence is another key source of evidence. This evidence may include demonstrated changes in a person's behavior. Circumstantial evidence can be used to show how a significant event, like an accident or injury in combat or some other traumatic event, impacts the before-and-after picture of the person's performance. For instance, some soldiers may be predictable, calm, and disciplined prior to a combat tour. However, after their return, they may have drug or alcohol problems, attendance issues, domestic disputes, and anger management problems. This sort of before-and-after image may indicate a clear intervening action and may show a change in behavior that is not consistent with an intentional change.

VII. Conclusion

These various notes on preparing a defense for a mentally ill patient are certainly not exclusive, nor do they explain how to conduct the litigation itself. However, these logical steps help ensure that defense counsel takes advantage of every possible chance to get an equitable result for his or her client. The best chance for success is available prior to going to trial. If that approach is unsuccessful, organized preparation will ensure a better defense at the trial itself.

⁵² United States v. Gonzalez, 39 M.J. 459, 461 (C.M.A. 1994) (citing United States v. Garries, 22 M.J. 288, 291 (C.M.A. 1986)) (discussing the right to expert assistance and the conceptual framework for requesting an expert for the defense in a military court-martial). The *Gonzalez* court set out three questions that defense counsel must answer in order to demonstrate the need for a defense expert: (1) Why is the expert needed?; (2) What would the expert accomplish for the accused?; and (3) Why is defense counsel unable to gather or present the evidence without the assistance of this expert? *Id.*

⁵³ *Id.* Prong three of the *Gonzalez* standard for requesting expert assistance asks why defense counsel cannot gather and present the evidence without the assistance of an expert. In the realm of mental responsibility defenses, unless defense counsel is also a qualified psychiatrist or psychologist, it is doubtful that any level of self-education would completely obviate the need for a defense expert, especially in cases where the government has its own mental health professional. Additionally, even in the unlikely event that defense counsel is also a qualified mental health professional, it would still be difficult to "present" the evidence, as detailed defense counsel cannot serve as a witness in a trial proceeding. However, self-education—to the extent possible—is still vital in order to demonstrate to the court due diligence in addressing prong three of the *Gonzalez* test for expert assistance, as well as for general knowledge of the accused's mental condition.

⁵⁴ See generally DEMOSTHENES LORRANDOS AND TERENCE W. CAMPBELL, CROSS EXAMINING EXPERTS IN BEHAVIORAL SCIENCES §§ 5-1 to -61 (2001) (providing model transcripts for challenging diagnostic classifications and other relevant explanations). A table of contents to this two-volume set is available at <http://www.psychlaw.net/CrossExaminingExpertsTOC.pdf>.

⁵⁵ *Id.*

⁵⁶ See generally *id.* §§ 6-1 to 7-95 (explaining potential psychological tests used by expert witnesses and providing a model transcript for cross-examination); DSM-IV, *supra* note 5.