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The Legal Regulation of Military Forensic Psychiatry in Enforcing Disciplinary Measures for Indonesian Army (TNI-AD) Soldiers

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ABSTRACT

Military discipline is a fundamental element of professionalism, command effectiveness, and operational readiness. However, disciplinary decisions become legally and clinically complex when alleged violations are associated with a soldier's mental condition. This study analyzed the legal regulations and implementation of military forensic psychiatry in supporting disciplinary enforcement within the Indonesian Army (Tentara Nasional Indonesia Angkatan Darat [TNI-AD]). The analysis was based on legal system theory, legal protection theory, and progressive legal perspectives. The findings indicated that Indonesia has established legal frameworks governing mental health services, expert testimony, military discipline, and military justice; however, these regulations remain fragmented and have not yet provided an integrated mechanism that connects forensic psychiatric assessment results with disciplinary decision-making processes.The implementation of military forensic psychiatry was influenced by several factors, including regulatory fragmentation, unclear referral authority, inter-institutional coordination challenges, professional capacity, medical confidentiality, stigma related to mental health, command-level understanding, and fitness-for-duty assessments. This study proposed a model of Military Discipline with Mental Health Safeguards, which provides a procedural mechanism requiring professional assessment when there is a reasonable indication that mental health conditions may be relevant to a soldier's behavior. The model differentiates between behaviors that are direct manifestations of mental disorders, behaviors partially influenced by mental health conditions, and intentional misconduct, while maintaining the authority of commanders and legal institutions in determining accountability. The proposed framework aims to strengthen legal certainty, fairness, mental health protection, and operational readiness without undermining the principles of military discipline.

INTRODUCTION

Military discipline is a fundamental element of professionalism, command effectiveness, and operational readiness. However, disciplinary decisions become legally and clinically complex when alleged violations are associated with a soldier's mental condition. This study analyzed the legal

regulations and implementation of military forensic psychiatry in supporting disciplinary enforcement within the Indonesian Army (Tentara Nasional Indonesia Angkatan Darat [TNI-AD]). The analysis was based on legal system theory, legal protection theory, and progressive legal perspectives. The findings indicated that Indonesia has established legal frameworks governing mental health services, expert testimony, military discipline, and military justice; however, these regulations remain fragmented and have not yet established an integrated mechanism that connects forensic psychiatric assessment results with disciplinary decision-making processes.

The implementation of military forensic psychiatry was influenced by several factors, including regulatory fragmentation, unclear referral authority, inter-institutional coordination challenges, professional capacity, medical confidentiality, mental health stigma, command-level understanding, and fitness-for-duty assessments. This study proposed a model of Military Discipline with Mental Health Safeguards, which provides a procedural mechanism requiring professional assessment when there is a reasonable indication that a mental health condition may be relevant to a soldier's behavior. The model distinguishes between behaviors that are direct manifestations of mental disorders, behaviors partially influenced by mental health conditions, and intentional misconduct while maintaining the authority of commanders and legal institutions in determining accountability. The proposed framework aims to strengthen legal certainty, fairness, mental health protection, and operational readiness without undermining the principles of military discipline.

The Indonesian National Armed Forces (Tentara Nasional Indonesia [TNI]) performs constitutional functions in the defense sector, requiring a highly disciplined command system, professional personnel, and continuous operational readiness. The legal character of military organizations does not eliminate the principle of the rule of law; rather, the exercise of command authority must remain grounded in legal provisions while ensuring legal certainty and protection of constitutional rights. The 1945 Constitution of the Republic of Indonesia establishes Indonesia as a state based on the rule of law, recognizes equality before the law, and guarantees the right to health. These principles apply to soldiers, although military service involves specific obligations and restrictions that differ from those applicable to civilians (Republic of Indonesia, 1945; Asshiddiqie, 2010). The legal framework governing the TNI, including amendments enacted in 2025, continues to emphasize professionalism, preparedness, and lawful execution of duties as fundamental characteristics of the defense institution (Republic of Indonesia, 2025a).

Military discipline has a distinct operational meaning compared with discipline in civilian workplaces. Disciplinary violations may affect unit cohesion, command effectiveness, safety, security, and mission success. Therefore, military organizations require timely and authoritative responses to disobedience, absenteeism, aggressive behavior, insubordination, substance abuse, and other actions that disrupt organizational order. Indonesian military discipline is regulated by Law Number 25 of 2014, which establishes a specific disciplinary system for soldiers and grants disciplinary authority within the chain of command (Republic of Indonesia, 2014). Although this special framework is justified by the unique functions of the armed forces, it should not be applied in a manner that disregards relevant medical considerations or fundamental procedural safeguards.

Legal complexities become more evident when behaviors perceived as misconduct are suspected to be associated with mental disorders. Soldiers may experience combat exposure, demanding deployments, chronic sleep disruption, family separation, traumatic events, organizational pressure, and other stressors that may affect psychological functioning. Mental health conditions can influence perception, judgment, impulse control, emotional regulation, decision-making capacity, or the ability to understand the consequences of actions. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) emphasizes that psychiatric diagnoses are established through professional clinical assessment based on significant patterns of cognition, emotional regulation, or behavior rather than

administrative assumptions (American Psychiatric Association, 2022). The World Health Organization also recognizes mental health as an essential component of overall health and functioning, rather than merely the absence of a diagnosed disorder (World Health Organization, 2025).

However, the presence of a psychiatric diagnosis does not automatically determine legal responsibility. Forensic psychiatry operates at the intersection of clinical assessment and legal decision-making. It provides professional evaluations regarding mental state at the relevant time, criminal responsibility, competency, fitness for legal proceedings, risk assessment, decision-making capacity, malingering, and the relationship between psychiatric symptoms and behavior (Rosner, 2017; Simon & Gold, 2019). Forensic psychiatrists do not replace the roles of commanders, investigators, prosecutors, or judges. Instead, psychiatrists provide scientific opinions regarding mental functioning, while legal authorities remain responsible for determining facts, applying legal standards, and establishing consequences. This distinction is particularly important within military environments because failure to separate clinical assessments from legal judgments may result in two problematic outcomes: excessive medicalization of disciplinary violations or punishment of behaviors that should have initially received appropriate mental health evaluation.

Indonesia already has several legal instruments that support the implementation of forensic psychiatric assessments. Law No. 17 of 2023 establishes the general framework for health services and recognizes mental health services as part of the national health system (Republic of Indonesia, 2023a). Minister of Health Regulation No. 77 of 2015 provides guidelines for mental health examinations conducted for legal purposes (Republic of Indonesia, 2015). Within the defense sector, Minister of Defense Regulation No. 23 of 2023 regulates health examinations within the Ministry of Defense and the Indonesian National Armed Forces (Tentara Nasional Indonesia [TNI]) (Republic of Indonesia, 2023b). Law No. 31 of 1997 concerning Military Justice recognizes expert testimony and expert documents as forms of evidence in military criminal proceedings (Republic of Indonesia, 1997). Furthermore, the general criminal procedure framework was updated through Law No. 20 of 2025, which came into effect on January 2, 2026, replacing the 1981 Criminal Procedure Code (Republic of Indonesia, 2025b). These legal provisions indicate that health services, expert evidence, disciplinary procedures, and military justice have been recognized within Indonesia's legal system.

The main challenge is not the complete absence of legal provisions but rather the lack of clear connecting mechanisms among existing regulations. The applicable provisions remain sector-specific: military disciplinary regulations govern authority and procedures; health regulations govern medical services and professional responsibilities; military justice regulations govern evidence and adjudication; defense health regulations govern medical examinations; and forensic psychiatric guidelines regulate assessments conducted for legal purposes. However, these regulations do not yet provide an integrated framework that clearly determines when soldiers suspected of violations should undergo forensic psychiatric assessment, who has the authority to initiate referrals at each stage, what assessment components are required, how evaluation results should be considered in disciplinary processes, and what follow-up measures should be implemented when significant clinical impairment is identified. This fragmentation creates a normative gap because each legal framework can function independently, while the coordination mechanism between these frameworks remains insufficiently defined.

This regulatory gap has practical implications. Commanders must be able to differentiate between disciplinary matters that require administrative responses and situations that require clinical or forensic clarification. Treating professionals need clear guidance regarding the distinction between therapeutic confidentiality and disclosure obligations in forensic assessments. Military investigators and legal authorities require procedures for obtaining expert evaluations without transferring legal decision-making authority to psychiatrists. Personnel administrators also require standards for temporary duty restrictions,

rehabilitation, and return-to-duty assessments. Soldiers need assurance that accessing mental health services does not automatically result in stigma, career limitations, or assumptions of legal incapacity. The literature on fitness-for-duty evaluations emphasizes that occupational psychiatric assessments should address specific functional capacities and provide graded conclusions, such as temporary unfitness, fitness with restrictions, or full fitness, rather than relying solely on a binary classification of fit or unfit (Anfang & Wall, 2006).

Comparative military systems demonstrate that disciplinary enforcement and mental health protection can operate simultaneously. In the United States, the military justice system has established procedures for assessing mental responsibility and competency, including structured mechanisms for mental evaluations in legally relevant cases (Schlueter, 2021). The United Kingdom incorporates expert evidence and mental capacity considerations within its service justice system under the Armed Forces Act 2006. Australia's Defence Force Discipline Act operates alongside military mental health policies, allowing mental health considerations to be addressed within both legal proceedings and personnel management systems (Commonwealth of Australia, 1982; Australian Government Department of Defence, 2018). Singapore also maintains a statutory military justice framework that incorporates medical evaluations within its armed forces personnel management system (Singapore, 1972). Although these systems differ in their legal structures, they demonstrate a common principle: mental health assessments should be integrated into disciplinary and personnel management processes rather than treated as separate mechanisms.

Previous legal and forensic studies provide important analytical foundations but have not fully addressed the integration of forensic psychiatry within the Indonesian Army's disciplinary system. Friedman's legal system theory explains that legal effectiveness depends on the interaction among legal substance, legal structure, and legal culture (Friedman, 1975). Hadjon's legal protection theory distinguishes preventive protection, which aims to prevent arbitrary or harmful decisions, from repressive or remedial protection applied after a violation occurs (Hadjon, 1987). Progressive legal thought emphasizes that law should pursue substantive justice and respond to social needs rather than remain limited to rigid formal procedures (Rahardjo, 2009). Within the context of military discipline, these perspectives demonstrate that protecting soldiers' access to professional mental health assessments can coexist with firm disciplinary enforcement when such protections are procedural, proportionate, and based on reasonable indications rather than being used as a means to avoid accountability.

This study addressed two interrelated questions: how military forensic psychiatry is regulated within the Indonesian military disciplinary system and how these regulatory arrangements can be effectively implemented in practice. The novelty of this research lies in the proposed Military Discipline with Mental Health Safeguards model. This model is not a clinical assessment instrument and does not assume that the presence of a psychiatric diagnosis automatically eliminates legal responsibility. Instead, it introduces a procedural checkpoint when there is a reasonable indication that a mental disorder may be relevant to an alleged violation. The model proposes differentiated legal responses: behaviors that are direct manifestations of severe mental disorders should primarily receive clinical intervention and rehabilitation; behaviors partially influenced by psychiatric conditions should receive proportionate and combined legal-medical responses; while intentional misconduct unrelated to mental disorders should continue to be processed through established disciplinary or criminal mechanisms. This study demonstrates that such safeguards can strengthen military discipline by improving the accuracy, fairness, and quality of personnel decisions while supporting operational readiness.

METHOD

This study employed a normative juridical method, also known as doctrinal legal research, to analyze the legal framework governing military forensic psychiatry and disciplinary enforcement. The

study did not collect primary clinical data, conduct interviews, or assess individual soldiers. The unit of analysis consisted of legal norms and institutional relationships among relevant regulations. This design was selected because the main research focus was regulatory coherence, particularly whether regulations related to military discipline, military justice, health services, mental health examinations, evidence, and personnel management had established an integrated mechanism for addressing violations potentially associated with mental disorders.

Three complementary approaches were applied in this study. First, a legislative approach was used to examine the 1945 Constitution of the Republic of Indonesia, regulations concerning the Indonesian National Armed Forces (Tentara Nasional Indonesia [TNI]), Law Number 25 of 2014 concerning Military Disciplinary Law, Law Number 31 of 1997 concerning Military Justice, Law Number 17 of 2023 concerning Health, Law Number 20 of 2025 concerning the Criminal Procedure Code, Regulation of the Minister of Defense Number 23 of 2023 concerning health examinations within the Ministry of Defense and the TNI, and Regulation of the Minister of Health Number 77 of 2015 concerning mental health examinations for legal purposes. These legal materials were analyzed functionally to identify not only the substance of each regulation but also the existence of referral mechanisms, authority arrangements, evidentiary provisions, confidentiality rules, and follow-up procedures relevant to forensic psychiatric assessments.

Second, a conceptual approach was applied to distinguish clinical psychiatry, forensic psychiatry, disciplinary liability, criminal liability, and fitness for service. Forensic psychiatric literature was used to clarify the scope of professional assessment and the distinction between clinical diagnosis and legal judgment (Rosner, 2017; Simon & Gold, 2019). The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) was used as a diagnostic reference framework rather than as a legal standard for determining liability (American Psychiatric Association, 2022). Fitness-for-duty literature was used to examine the functional implications of psychiatric conditions on military service (Anfang & Wall, 2006). The legal analysis was further interpreted through Friedman's legal system framework, Hadjon's legal protection theory, and progressive legal thought (Friedman, 1975; Hadjon, 1987; Rahardjo, 2009).

Third, a limited functional comparative approach was applied to examine relevant aspects of military justice and mental health systems in the United States, the United Kingdom, Australia, and Singapore. The comparison was not intended to directly adopt foreign legal systems but to identify institutional functions relevant to Indonesia, including mechanisms for mental health evaluations, expert involvement, fitness-for-service assessments, and integration between disciplinary and health services. Comparative legal analysis was used to identify potential reform options while considering differences in legal traditions, command structures, and institutional capacities (Zweigert & Kötz, 1998).

The analysis was conducted through four stages. First, the legal foundations were mapped and categorized into disciplinary, health, evidentiary, military justice, and personnel management functions. Second, normative gaps were identified by examining five operational aspects: when assessments should be considered, who may request assessments, what professional standards apply, how assessment results are incorporated into disciplinary or legal procedures, and what rehabilitation or service-status follow-up is required. Third, the implementation framework was analyzed through the dimensions of legal substance, legal structure, and legal culture. Fourth, the findings were synthesized into a proposed model of Military Discipline Based on Mental Health Protection. The analysis was qualitative and interpretive and was not intended to measure the prevalence of mental disorders, the frequency of disciplinary cases, or the performance of individual TNI units.

RESULTS AND DISCUSSION

Table 1. Functional Mapping of the Indonesian Legal Framework Relevant to Military Forensic Psychiatry

Legal instruments/domains	Main function	Relevance to forensic psychiatry	Identified integration issues
The 1945 Constitution of the Republic of Indonesia	Rule of law, legal certainty, right to health	Requires decisions that are lawful, fair, and sensitive to the health of soldiers.	Does not specify an operational referral mechanism
TNI Law as amended in 2025	Professional military organization, duties, and service	Supporting mental and physical readiness as an element of professionalism	There is no explicit link between forensic psychiatry and the discipline
Law No. 25/2014 concerning Military Disciplinary Law	Military discipline and order authority	Provides a disciplinary decision-making pathway	Has not yet comprehensively regulated mental disorder screening before decisions have serious consequences.
Law No. 31/1997 concerning Military Justice	Military criminal procedure law, evidence, expert involvement	Allows expert psychiatric evidence in legally relevant cases	Military forensic psychiatric examination procedures are not yet fully standardized.
Law No. 17/2023 concerning Health	Health rights, services, professional obligations	General legal basis for mental health services and professional standards	General health rules do not specify disciplinary consequences.
Minister of Health Regulation No. 77/2015	Mental health examinations for law enforcement purposes	Provides a specific framework for forensic mental health examinations	Not designed as a complete TNI discipline flow
Minister of Defense Regulation No. 23/2023	Health checks in the Ministry of Defense/TNI environment	Supporting health assessments related to official duties	Needs a clearer connection to legal and disciplinary questions
Law No. 20/2025 concerning the Criminal Procedure Code	The current general criminal procedure framework	Relevant as a background for expert evidence and due process outside of special military procedures	Needs to be functionally harmonized with the special military justice regime

Table 2. Comparative Functional Lessons for the Indonesian Military Forensic Psychiatry Framework

Jurisdiction	The main characters highlighted in the source research	Functional lessons	Direct transplant limits
United States of America	The military's formal mechanism for evaluating mental responsibility and competence	Establish clear procedural pathways for mental health evaluations when legally relevant	The military justice architecture and institutional resources differ
English	Expert evidence integrated into the service justice system	Using professional expertise without transferring legal decisions to clinicians	The structure of common law statutes and practices differ
Australia	Discipline is linked to mental health policy and military personnel	Linking discipline to early intervention, rehabilitation, and fitness for service	Defense health systems and organizational scales differ
Singapore	Legal regime of special armed forces with medical evaluation in personnel management	Standardizing command-medical-legal referral and information pathways	The size of institutional power and organization is smaller

Table 3. Military Discipline Based on Mental Health Protection: Proposed Decision Framework

Stage	Trigger/Question	Responsible function	Main output	Protection
1. Introduction	Is there any reasonable indication that a mental condition may be relevant?	Commander/Ankum, health officers, investigators	Documented trigger/no trigger decisions	Not every violation is automatically referred
2. Initial safety/triage	Is there an urgent risk or immediate clinical need?	Health services and command	Emergency stabilization or routine referral	Safety is prioritized over the time of the disciplinary process
3. Formal references	What legal or functional questions require expert assessment?	Authorized command/legal actor	Written reference questions	Does not ask for a predetermined conclusion of guilt/innocence
4. Forensic assessment	What are mental conditions and their functional relevance?	Competent psychiatrist, with psychological support if needed	Forensic psychiatric opinion/VER Psychiatricum	Independence, collateral data, explicit confidentiality boundaries

Stage	Trigger/Question	Responsible function	Main output	Protection
5. Functional classification	Direct manifestation, partial contribution, or no meaningful contribution?	Psychiatrists provide clinical-functional opinions	Structured functional conclusions	Diagnosis is not a legal conclusion
6. Legal/disciplinary decisions	What responsibilities and consequences follow from applicable law?	Commander/Ankum, investigator, auditor, or court	Disciplinary, criminal, administrative, or a combination of responses	Final legal authority remains with the legal institution/command
7. Rehabilitation and service review	What therapy, restrictions, monitoring, or return-to-duty plans are required?	Health systems and personnel with command input	Tiered therapy and eligibility plans	Periodic review; avoid permanent stigma based on diagnosis alone

Table 4. Suggested Implementation Domains and Evaluation Indicators

Domain	Minimum implementation requirements	Example of indicators
Legal substance	Written rules regarding triggers, referral authority, reporting standards, use as evidence, and follow-up	Percentage of cases relevant to referral decisions and documented legal basis
Institutional structure	Established points of contact between command, health, Military Police, prosecutors, personnel and the courts	Referral completion time; proportion of cases with complete handover
Professional capacity	Forensic psychiatry competencies and cross-sector training	Number/proportion of appointed professionals and trained commanders/investigators
Confidentiality/data	Role-based access and separation of clinical, forensic, and command information	Unauthorized access events; completeness of audit logs
Eligibility/rehabilitation	Procedures for temporary restrictions, review, rehabilitation and return to duty	Percentage of temporary restrictions reviewed as scheduled
Legal culture	Mental health literacy and a stigma-free help-seeking environment	Training coverage; results of periodic stigma/help-seeking surveys

Legal mapping shows that Indonesian law has sufficient normative support for both military discipline and mental health protection, but this support is dispersed across separate legal regimes. At the constitutional level, legal certainty, equal protection, and the right to health provide the general normative basis for any disciplinary mechanism involving soldiers whose mental condition is in question (Republic of Indonesia, 1945). At the military institutional level, regulations on the Indonesian National Armed Forces (TNI) provide the organizational basis for a professional armed forces, while Law No. 25 of 2014 establishes a specific disciplinary system (Republic of Indonesia, 2014; Republic of Indonesia, 2025a). In the health sector, Law No. 17 of 2023 regulates the right to health services and the responsibilities of health workers, while regulations in the defense and health sectors more specifically regulate medical examinations and mental health examinations for legal purposes (Republic of Indonesia, 2015, 2023a, 2023b). In the realm of adjudication, Law Number 31 of 1997 provides a procedural framework for military justice and recognizes the role of experts in matters requiring specialized knowledge (Republic of Indonesia, 1997). The existence of all these elements demonstrates that reform does not begin from a legal vacuum, but rather from the fragmented availability of law.

Fragmentation is evident when the legal system is tested through a sequence of decision-making processes. A soldier experiences a sudden change in behavior and commits an act that appears to be a disciplinary offense. The disciplinary regime informs the commander that order must be restored and provides a mechanism for discipline. The health regime requires medical personnel to assess and treat mental health conditions according to professional standards. The forensic regime provides a method for assessing the legal relevance of mental functioning. Military justice recognizes expert evidence. However, the legal system has not consistently defined thresholds for when disciplinary proceedings should be paused, supplemented, or informed by a professional psychiatric evaluation. This lack of transitional rules is at the heart of the normative gap identified by the research.

The distinction between clinical psychiatry and forensic psychiatry is crucial for addressing integration issues. Clinical psychiatry is primarily therapeutic: clinicians identify symptoms, establish diagnoses, formulate therapy, and maintain therapeutic relationships. Forensic psychiatry has a different primary goal. Evaluators are required to answer legally relevant questions and must clarify the limits of confidentiality, identify sources of information, assess the reliability of the interviewee's testimony, and relate clinical findings to functional or legal capacity without assuming final legal authority (Rosner, 2017; Simon & Gold, 2019). Military organizations that fail to differentiate between these two roles risk misusing confidential therapeutic information or expecting the treating psychiatrist to render legal conclusions outside the clinical relationship.

Forensic psychiatric reports can answer several questions relevant to military proceedings. They can reconstruct the mental state at the time of the alleged offense; assess the extent to which psychosis, severe mood disorders, cognitive impairment, intoxication, withdrawal, or other conditions affect the soldier's ability to understand or control behavior; assess the current ability to meaningfully engage in legal proceedings; identify risks to self or others; consider the possibility of malingering; and provide an opinion regarding the need for therapy. These questions are both scientific and functional. The legal system then determines the weight of the opinion and its consequences. Indonesian criminal law doctrine also distinguishes medical conditions from legal conclusions regarding responsibility (Hamzah, 2018). Therefore, the protections proposed in this article are built on a separation of expertise: the psychiatrist assesses mental function, while the competent legal or command authority determines responsibility.

The Visum et Repertum Psychiatricum (VER Psychiatricum) illustrates this distinction. In Indonesian legal practice, a forensic psychiatric report is a professional document prepared for legal purposes, not a standard therapy record. This document may include the basis for the request, the method, the psychiatric history, the mental status examination, relevant collateral information, the diagnosis, the

functional analysis, and the professional conclusion. Herkutanto (2001) emphasized the evidentiary function of the visum et repertum in criminal proceedings. In a military context, the report needs to be sufficiently standardized so that the commander, investigator, prosecutor, or judge understands what was examined, what questions were answered, and what limitations apply. A report that simply lists the diagnosis without explaining its functional relevance is inadequate for disciplinary decisions; conversely, a report that declares a soldier legally guilty or innocent goes beyond the psychiatrist's role.

The Military Justice Law provides legal space for expert involvement, but recognition of this category of evidence does not equate to the establishment of an operational forensic psychiatric system. Source texts identify ambiguities regarding referral authority, examination standards, the minimum form and content of psychiatric reports, the management of confidential clinical information, and coordination between military health facilities, the Military Police, the Military Auditorate, commanders, personnel supervisors, and military courts. Therefore, a practical framework needs to establish the steps. At the unit level, a reasonable indication should trigger medical screening or referral. At the investigation or adjudication stage, the request should be formulated as a legal question. In the assessment, psychiatrists use accepted professional methods. Reports are submitted only to authorized parties. Once a legal decision is made, clinical therapy and occupational follow-up should proceed through appropriate health and personnel channels.

Triggers for assessment are crucial because mental health protection should not become a routine escape from discipline. Not every violation requires a psychiatric evaluation. The appropriate threshold is a reasonable indication that a mental disorder may be relevant to the behavior, not simply a claim by the examined soldier or a general assumption due to stress. Indicators can include a marked and unexplained change in behavior from a prior condition, acute functional decline, disorientation, hallucinations, delusions, severe mood symptoms, suicidal behavior, unusual impulsivity, severe substance-related symptoms, a documented history of significant mental disorders, or observations by a healthcare professional that require further assessment. This threshold needs to be documented so that referral decisions can be reviewed and not manipulated to delay matters.

When this threshold is met, the disciplinary authority does not necessarily lose its disciplinary authority. Instead, the process should include professional clarification before any irreversible or consequential decisions are made. This aligns with preventive legal safeguards. Hadjon (1987) defines preventive safeguards as mechanisms to prevent unlawful or unjust consequences before they occur. In military discipline, forensic mental health checkpoints prevent two forms of error: mistaken exculpation, where violations are inappropriately attributed to illness, and mistaken assignment of guilt, where clinically significant functional impairments are overlooked and soldiers are treated solely as responsible without adequate assessment. Both are detrimental to discipline by undermining confidence in the fairness and accuracy of command decisions.

Research identifies three analytical categories of relationships between mental disorders and offenses. First, direct manifestation. In this category, behavior is substantially explained by an acute psychiatric condition that significantly impairs reality testing, behavioral control, or relevant functional capacity. Examples might include behavior arising from severe psychosis or a similar serious disorder, although legal consequences remain dependent on the facts and applicable law. The primary institutional response should emphasize safety, treatment, stabilization, and forensic clarification before disciplinary or criminal conclusions are reached. Second, partial or mixed contribution. In this category, the mental disorder contributes to impulsivity, emotional dysregulation, or judgment problems but does not completely diminish relevant capacity. A proportionate response may combine discipline with therapy, monitoring, task modification, and rehabilitation. Third, conscious misconduct. Soldiers may have a mental health diagnosis, but the condition has no meaningful connection to the specific offense. In such

situations, disciplinary or criminal liability proceeds normally. These three categories are not medical diagnoses, but rather decision-making frameworks for linking professional findings to legal analysis.

This distinction avoids the binary fallacy of deeming soldiers either fully healthy and responsible or mentally disturbed and completely irresponsible. Forensic psychiatry recognizes that psychiatric symptoms exist on a spectrum of severity and functional impact. The AAPL guidelines on forensic assessment emphasize the importance of formulating referral questions, using multiple sources of information, and separating clinical findings from legal standards (American Academy of Psychiatry and the Law, 2015). In the military context, similar rigor is required because the stakes include liberty, career status, operational safety, unit trust, and institutional legitimacy.

Fitness for duty presents a second functional-legal question that should not be confused with accountability for past actions. Soldiers may be fully responsible for an offense but then temporarily become unfit for duty due to a mental health condition. Conversely, soldiers whose behavior is affected by a treatable episode may recover and return to fitness for duty after therapy. Occupational psychiatric evaluations should therefore focus on functional demands, risks, treatment response, and the need for restrictions or monitoring (Anfang & Wall, 2006). A military policy that equates every psychiatric diagnosis with permanent incapacity will encourage concealment of problems and may unnecessarily eliminate experienced personnel. Conversely, a policy that ignores functional risks raises safety concerns. A tiered, reviewable fitness framework is more consistent with health protection and readiness.

Medical confidentiality is another implementation challenge. Therapy relies on trust, but military organizations also have legitimate needs for information related to safety, fitness, and mission risk. The solution is not unlimited disclosure. The safeguards model distinguishes between therapy records, forensic reports, and functional information for command. Treating clinicians disclose only information that is legally permitted and operationally necessary, while forensic evaluators must explain from the outset that examinations are not confidential like therapy and that reports will be provided to requesting authorities. Commanders generally require functional conclusions and necessary restrictions, not unfettered access to psychotherapy content. Clear information governance rules can reduce stigma and increase care seeking because soldiers can better predict how their information will be used.

Stigma and command culture are not simply psychological issues but are integral to the effectiveness of law. Friedman (1975) explained that legal culture influences whether formal rules are actually used. If soldiers believe that any contact with mental health services is automatically career-ending, they will tend to conceal symptoms until a crisis occurs. If commanders view seeking help as a weakness, formal referral channels may be discouraged. If health personnel fear that professional opinions will be ignored or misused, coordination will deteriorate. The legal culture necessary for effective military forensic psychiatry therefore includes mental health literacy, respect for professional boundaries, and an organizational narrative that distinguishes seeking help from disloyalty, while maintaining clear expectations for lawful behavior.

The structural dimension is equally important. Military forensic psychiatry is inherently cross-sectoral. The unit commander or superior with the authority to punish may first observe behavior; the unit physician or medical officer may conduct an initial screening; a psychiatrist may conduct a clinical or forensic assessment; a psychologist may provide supplemental examinations; the Military Police may conduct an investigation; the Military Auditor may assess evidence; the personnel supervisor determines service status; and the Military Court may adjudicate criminal liability. Without clear referral pathways and information, each institution may act according to its own mandate while the overall case remains fragmented. Therefore, the proposed model requires cross-sectoral standard operating procedures that define referral authority, timeframes, documentation, confidentiality, emergency exceptions, forensic inquiries, feedback to command, and handover for rehabilitation or legal proceedings.

The substantive dimension requires connecting regulations, not the creation of a comprehensive new codification. Indonesia already has general rules for each component. Practical reform could take the form of TNI or TNI AD regulations supported by technical guidelines and explicitly linking military discipline to mental health assessments. Such regulations should define military forensic psychiatry for disciplinary purposes; establish a threshold for reasonable indications; determine who can request evaluations at the unit, investigation, prosecution, and trial stages; differentiate clinical screening from forensic evaluation; establish minimum report elements; regulate data confidentiality and access; clarify that expert findings can inform but not dictate disciplinary decisions; and establish a pathway for rehabilitation and return to service. This approach harmonizes existing laws without unnecessarily duplicating them.

Updating the national criminal procedure framework is also relevant to the coherence of the legal system. Law No. 20 of 2025 replaced the old Criminal Procedure Code on January 2, 2026, as part of a broader national effort to strengthen procedural rights and modernize criminal justice (Republic of Indonesia, 2025b). Military criminal procedure continues to be regulated through the special regime of Law No. 31 of 1997, which is still in effect (Republic of Indonesia, 1997). The coexistence of the updated general criminal procedure code and the older specialized military procedure code raises the importance of systematic interpretation and future harmonization. Forensic psychiatric protections need to be designed to maintain military specificity, but fundamental procedural principles—professional evidence, fair treatment, and protection of rights—remain aligned with national legal developments.

Comparative systems provide functional lessons, not models that can be directly copied. In the United States, military justice provides a well-established mechanism for mental health evaluations when responsibility or competence are in question; Schlueter (2021) describes mental health and competence procedures as an integral part of military criminal practice. The practical lesson for Indonesia is that mental health issues should enter the legal process through clearly defined procedural channels, not simply through informal discretion. A defined mechanism also protects the military institution by establishing a track record that relevant clinical issues have been examined before responsibility is determined.

The UK offers a different lesson. The Armed Forces Act 2006 consolidated service justice within a single statutory framework and allowed for the use of expert evidence in matters requiring specialist knowledge (United Kingdom, 2006). The crucial functional point is not that the UK has a separate law on forensic psychiatry, but rather that military justice can utilize general professional expertise while retaining the authority of service courts. Indonesia also does not need to create a separate 'military forensic psychiatry law'; what is needed are sufficiently clear procedural rules to link expert mental health assessments to the military's disciplinary and adjudication system.

Australia illustrates the personnel management dimension. The Defence Force Discipline Act 1982 provides a disciplinary framework, while the defence mental health strategy positions psychological health as part of force readiness and organizational responsibility (Australian Government Department of Defence, 2018; Commonwealth of Australia, 1982). The lesson learned is the importance of linking the disciplinary process to prevention, early intervention, rehabilitation, and fitness-for-service decisions. A case should not end with a disciplinary decision; if a mental health condition is found, there must be a clear pathway for treatment, review, and reintegration.

Singapore offers another example of a relatively compact military system operating under a special armed forces law (Singapore, 1972). Its relevance for Indonesia lies in the possibility of integrating command, medical, and legal functions without obscuring the distinctions between them. Smaller systems can more easily standardize referral and decision-making pathways, but the basic principle can be applied on a larger scale: each actor must know the authorized questions to be asked, the information they are permitted to receive, and the decisions they are competent to make. The larger and more geographically

dispersed Indonesian National Armed Forces (TNI) requires more robust documentation and digital reference support to achieve similar consistency.

Comparative studies support reform based on functional integration, not copying foreign institutions. The Indonesian model must work within the constitutional role of the Indonesian National Armed Forces (TNI), the authority of the superior judicial authority (Ankum), the military justice system, and the national health legal framework. The model must also be realistic regarding the availability of forensic psychiatrists. A rule requiring a full forensic psychiatric examination for every behavioral problem is impractical and potentially overburdens specialist services. Therefore, a multistep approach is more appropriate: initial observation and screening, clinical triage, and then formal forensic evaluation only when legal questions and reasonable indications warrant it.

The Mental Health Protection-Based Military Discipline Model consists of seven interconnected stages. The first stage is recognition: the commander, medical officer, investigator, or other authorized actor identifies reasonable indications that a mental disorder may be relevant. The second stage is initial screening: urgent safety and medical needs are addressed, and the matter is then differentiated from ordinary misconduct without delaying necessary emergency control. The third stage is referral: a formal, authorized request identifies legal or occupational questions requiring professional assessment. The fourth stage is assessment: an independent psychiatrist examines the soldier using accepted clinical and forensic methods and appropriate collateral information. The fifth stage is classification: professional findings are translated into functional conclusions of direct manifestation, partial contribution, or no significant psychiatric contribution. The sixth stage is decision: the appropriate command or legal authority determines disciplinary action, criminal proceedings, administrative measures, or a combination of responses. The seventh stage is follow-up: treatment, rehabilitation, duty restrictions, periodic reviews, and return-to-service planning are implemented when clinically indicated.

This model intentionally requires that referral requests contain questions, not desired answers. Commanders should not require psychiatrists to declare soldiers guilty, not guilty, or deserving of punishment. Requests can inquire about whether a mental disorder exists, the soldier's mental state at the relevant time, whether the condition reasonably impairs understanding or behavioral control, whether the soldier is currently capable of participating in the examination, and whether there are any safety or fitness-for-duty considerations. This protects psychiatric independence and reduces the risk of confirmation bias. Reports also become more useful to legal authorities because opinions are structured around functions, not labels.

Classification steps should also be interpreted with caution. 'Direct manifestation' does not automatically imply legal inaction, as applicable legal standards may require a specific threshold. 'Partial contribution' does not stipulate a specific reduction in sanctions, as proportionality depends on the seriousness of the act, the degree of impairment, prior history, safety risks, and other legal factors. 'Conscious violation' does not necessarily exclude a diagnosed soldier from treatment. A person can remain responsible for the offense and still be entitled to mental health services. Therefore, the purpose of these categories is procedural differentiation: ensuring that institutions do not conflate diagnosis, causality, responsibility, and treatment.

Progressive legal thought supports a differentiated approach because rigid formalism can result in decisions that contradict the substantive purpose of discipline. Discipline aims to maintain a professional, effective, and operationally ready force. Punishing soldiers experiencing acute psychiatric conditions without evaluation can worsen the condition, reduce opportunities for rehabilitation, and create preventable risks. Conversely, exonerating conscious violations simply because of a diagnosis can undermine command authority and the sense of justice for other soldiers. Professional protection seeks a

practical middle ground: ensuring factual accuracy before imposing consequences. In Rahardjo's (2009) perspective, law must be responsive to human and social realities while adhering to institutional goals.

Legal protections also have operational value. Soldiers who trust that disclosures of mental health issues will be handled fairly are more likely to seek help before a crisis. Early intervention can reduce the likelihood of symptoms escalating into serious behavioral incidents. Therefore, protections have a preventative function that extends beyond individual cases. The model encourages commanders to prioritize mental health literacy as part of risk management and preparedness. At the same time, the model does not turn commanders into amateur diagnosticians. Their role is to recognize warning signs, maintain safety, initiate legitimate referrals, and exercise professional judgment within the bounds of legal authority.

Cross-sector standard operating procedures must contain at least eight technical elements: triggering criteria; authorized officials requesting the examination; emergency pathways; distinction between clinical and forensic evaluations; minimum documentation; consent and notification regarding the purpose and limits of confidentiality; communication of results; and post-assessment follow-up. SOPs should also establish timelines, as excessive delays can be detrimental to both the disciplinary process and the soldier's clinical condition. Cases with acute risks should be immediately submitted through the emergency health pathway, while non-urgent forensic assessments are prioritized according to the legal process schedule.

Information governance requires special attention in hierarchical organizations. The legal and operational need for information should be determined by role. A unit commander may need to know that a soldier is temporarily prohibited from carrying weapons, driving, handling classified materials, or performing assigned duties, but not detailed psychotherapy notes. Investigators may require an official forensic report, not the entire therapy history. Personnel supervisors may require a functional fitness conclusion and review date. Courts may require expert opinions as evidence. A role-based approach to information can protect privacy while ensuring safety and due process. It also clarifies the distinction between medical confidentiality and legal privilege, two concepts often mistakenly treated as synonymous.

Professional capacity is another prerequisite. Military psychiatrists performing forensic work require competency not only in diagnosis but also in forensic interviewing, report preparation, legal standards, malingering assessment, violence and suicide risk, court testimony, and military occupational demands. General psychiatrists can perform many of these tasks with appropriate training, but institutional policies need to recognize that forensic evaluation is not synonymous with routine therapy. AAPL guidelines emphasize the need for objectivity, collateral information, careful documentation, and explicit boundaries of opinion (American Academy of Psychiatry and the Law, 2015). Similar competencies can be adapted to continuing education and military credentials.

Capacity building should also include non-psychiatric actors. Military Police investigators need to be able to recognize when psychiatric questions are relevant without attempting to establish a diagnosis. Military prosecutors and judges need to understand the strengths and limitations of forensic psychiatric evidence. Commanders and personnel supervisors need mental health literacy and an understanding of temporary restrictions and rehabilitation. Unit health personnel need clear referral criteria. Psychologists need to understand when psychological examinations contribute to forensic questions. Joint training modules can reduce role confusion and increase inter-agency trust.

Rehabilitation and reintegration should be the final component of legal design. A system that assesses mental illness solely to determine liability is incomplete, as military service is also a matter of duty and readiness. If a soldier can be treated and regains function, the system should allow for a gradual return to service with appropriate restrictions and review. If a soldier is permanently unable to perform essential military functions, administrative decisions should be based on documented medical and

occupational criteria, not stigma. The fitness for duty literature supports evaluations that address specific job demands and risks, not diagnosis alone (Anfang & Wall, 2006).

A safeguards model can also reduce litigation and reputational risks for the institution. Decisions supported by documented professional assessments are more easily accounted for and reviewed than those based solely on informal impressions. Documenting the reasons for whether or not a psychiatric assessment was requested can demonstrate procedural fairness. Standardized reporting can improve consistency across regions. Clear confidentiality rules can reduce disputes over unauthorized disclosure. Most importantly, an integrated process can protect the legitimacy of military discipline by demonstrating that strict accountability is compatible with scientific evidence and legal rights.

The proposed model does not require every mental health issue to be brought to the military justice system. Most mental health services should remain clinical and preventative in nature. The forensic pathway should only be used in cases where legal, disciplinary, or service status questions make mental functioning directly relevant. This boundary prevents unnecessary judicialization of regular services. It also protects the therapy system from being perceived primarily as a disciplinary instrument. Soldiers should continue to have access to routine mental health services without the assumption that every consultation will result in a forensic report.

The model also requires safeguards against potential abuse by the examined soldier. Claims of mental illness following a violation should not automatically halt the process indefinitely. Referring authorities can use objective indicators and available medical information to determine whether the evaluation threshold is met. Forensic psychiatrists can assess inconsistencies and the possibility of malingering using clinical judgment and collateral data. If the evaluation concludes there is no relevant impairment, the disciplinary process can proceed with greater confidence. Thus, safeguards simultaneously enhance protection and accountability.

From a legal substance perspective, the most pressing reform is binding internal rules that explicitly establish reference points. From a legal structure perspective, the priority is a coordinated pathway connecting command, health services, personnel development, Military Police, Military Prosecutors, and military courts. From a legal culture perspective, the priority is to shift from the perception that mental health assessments are a sign of weakness or disciplinary lapses to an understanding that accurate assessments are part of professional decision-making. These three reforms are interdependent. New rules without trained actors will be ineffective; trained actors without clear rules will result in diverse practices; and both will fail if organizational culture inhibits the use of these mechanisms (Friedman, 1975).

The principle of proportionality in the model is crucial. While military law emphasizes order and obedience, legal certainty also requires that consequences be linked to relevant facts and capacities. A combined response may be appropriate when a soldier still bears substantial responsibility, but a treatable impairment contributed to the incident. Such a response could include proportionate disciplinary action combined with mandatory therapy, temporary duty modification, and follow-up. This approach avoids two extremes: medicalizing every violation and ignoring clinically significant functional impairments. Proportionality thus provides a practical link between discipline and health protection.

Mental health protection also needs to be incorporated into command education. Commanders do not need diagnostic competency, but they do need sufficient literacy to recognize warning signs, understand the referral process, and interpret functional limitations. Education should explain that psychosis, major mood disorders, severe anxiety, trauma-related symptoms, substance-related syndromes, and cognitive conditions can manifest through behavior, not always through subjective reports. Education should also explain that ordinary stress, frustration, or conflict do not automatically indicate a mental disorder. Balanced literacy supports appropriate referrals without encouraging over-referrals.

The role of the disciplinary superior (Ankum) must be clarified, as disciplinary authority is a key feature of the military system. A safeguards model should maintain the statutory authority of the Ankum while establishing a procedural obligation to seek professional input when thresholds are met. In this design, professional assessments are treated like other expert information used by commanders: providing consideration but not supplanting authority. Commanders remain responsible for final disciplinary decisions and should be able to explain how psychiatric findings are considered when materially relevant.

During the investigation phase, Military Police should have the authority to request or recommend a forensic psychiatric evaluation when the mental state is relevant to the alleged offense. The request should include the alleged offense, relevant timeframe, observed symptoms, and specific forensic questions. Investigators should avoid providing unnecessary or overly prejudicial material that could bias the evaluator, but should still provide sufficient collateral information to verify the testimony of the interviewee. Psychiatrists should be able to request additional documents or interviews if necessary. The resulting report should identify the source of the data and distinguish facts provided by others from clinical observations.

At the prosecution and trial stage, forensic psychiatric evidence should be examined like any other expert evidence. Experts can be questioned about their qualifications, methods, diagnostic reasoning, alternative explanations, and the relationship between symptoms and functional capacity. Judges remain free to evaluate these opinions alongside other evidence. This approach aligns with the principle that expert evidence assists, not binds, the court (Republic of Indonesia, 1997; Simon & Gold, 2019). Therefore, standardization should increase the transparency of expert reasoning, not transform psychiatric opinions into automatic legal formulas.

In personnel administrative decisions, the evaluation question changes. The focus shifts from accountability for past events to the current ability to perform essential functions safely and reliably. Return-to-duty assessments should identify current symptoms, treatment adherence, cognitive and emotional functioning, medication effects, if relevant, risk factors, job demands, available supervision, and the proposed length of the restriction. Periodic reviews should be part of any temporary restriction. Soldiers should not be permanently discharged simply because of a diagnostic label in the medical record; the decision must be linked to actual military function and risk (Anfang & Wall, 2006).

The protection model also has implications for the architecture of data records. Therapy clinical records, occupational fitness assessments, and forensic psychiatric reports should not be stored or circulated as if they were the same document. Access should be segmented. The military health system may store complete clinical records; forensic reports are distributed to legally authorized recipients; and command systems receive only operationally necessary conclusions. This segmentation can be supported by digital access controls and audit logs. Transparent policies should clarify to soldiers who can access each category of information and for what purposes.

The study also found a need for harmonization of terminology. Indonesian regulations may use the terms mental health examination, psychiatric examination, medical examination, expert testimony, visum et repertum, fitness, disability, and disciplinary accountability in different contexts. Without clear definitions, similar terms can conceal different legal functions. Therefore, future technical regulations need to define at least clinical psychiatric examination, forensic psychiatric examination, psychiatric VER (Verifikasi Verifikasi Psikotrikum), mental health screening, fitness for service, temporary incapacity, permanent incapacity, therapeutic confidentiality, and forensic disclosure. Precise definitions reduce disputes over authority and evidence.

Legal reform needs to be accompanied by planning for service delivery. The Indonesian National Armed Forces (TNI) operates across a vast archipelago, and forensic psychiatric expertise will not be evenly available at all locations. A referral system could utilize a hub-and-spoke structure, with specific military hospitals or regional health commands providing specialist forensic assessments, while unit

health services provide initial screening and emergency treatment. Telepsychiatry consultations can support triage and case preparation where appropriate, although high-risk forensic opinions should still adhere to professional standards regarding identity verification, privacy, data records, and examination adequacy. The source text does not provide empirical data on the current distribution of specialists, so appropriate network design requires further institutional study.

Implementation should be evaluated through legal and operational indicators. Legal indicators might include the proportion of high-impact disciplinary cases that have documented mental health screening when there is a reasonable indication, clarity of referral authority, adherence to reporting standards, and documented consideration of expert findings. Health indicators might include time to assessment, connection to therapy, safety incidents, and continuity of follow-up. Organizational indicators might include commander training, stigma measures, inter-unit consistency, and the proportion of temporary restrictions reviewed on schedule. These indicators should not be used to pressure clinicians into reaching specific conclusions; the goal is to assess whether the process is working as designed.

The research's primary theoretical contribution is reframing mental health assessments from exceptions to discipline to mechanisms for disciplinary quality control. In this view, safeguards do not challenge military authority, but rather improve the factual basis for its use. Command decisions are strengthened when they demonstrate that relevant medical information has been considered through a legitimate and professionally independent process. This logic aligns with the principle of the rule of law, as authority becomes more predictable, reviewable, and proportional (Asshiddiqie, 2010; Hadjon, 1987).

This model also clarifies the human rights dimension without simply transferring the civilian employment model to the armed forces. Soldiers assume special obligations, risks, and restrictions. However, this special status does not eliminate the right to health or the obligation for state power to be exercised in accordance with the law. Protection still respects military interests by allowing for emergency control measures and maintaining command authority. At the same time, institutions are obliged to examine credible evidence of mental disorders before imposing serious consequences that presuppose complete behavioral control. In this sense, legal protection and operational readiness are mutually reinforcing, not competing.

The study has several limitations. It is normative and did not measure how frequently mental health conditions arise in disciplinary practice, how commanders currently make referral decisions, or the number of forensic psychiatrists available within the Indonesian National Armed Forces (TNI) health system. The comparative analysis is functional and selective, not comprehensive. The proposed three-category model has not been empirically validated as a decision-making tool and should not be used as a diagnostic instrument. Future research should include interviews with commanders, military health personnel, Military Police investigators, Military Auditors, personnel supervisors, and military judges; review of anonymized case files; map specialist capacity; and pilot the referral protocol. Such research would allow the procedural model to be tested for feasibility, speed, fairness, and unintended consequences.

Despite these limitations, normative analysis is sufficient to identify regulatory integration issues and formulate structured solutions. The legal framework that informs this research already contains key institutional components: disciplinary authority, military justice, health services, psychiatric expertise, and professional standards. The challenge for reform is to connect these components through clear triggers, referral pathways, expert roles, decision rules, confidentiality regimes, and rehabilitation processes. The Mental Health Protection-Based Military Discipline Model provides this connecting architecture while maintaining the core principle that psychiatric expertise informs, but does not supersede, military legal authority.

CONCLUSION

Military forensic psychiatry within the Indonesian Army (Tentara Nasional Indonesia Angkatan Darat [TNI-AD]) is supported by several legal foundations, including constitutional guarantees, military disciplinary regulations, military justice provisions, health legislation, defense health regulations, mental health examination guidelines, and forensic professional standards. However, the primary challenge remains regulatory fragmentation, as the current legal framework has not yet established an explicit mechanism that connects reasonable indications of mental disorders, professional forensic psychiatric assessments, the use of assessment results in decision-making processes, disciplinary measures, and subsequent rehabilitation or review of service status.

This regulatory gap creates uncertainty regarding referral authority, assessment standards, confidentiality requirements, inter-institutional coordination, and the legal interpretation of psychiatric findings. This study proposes a Military Discipline-Based Mental Health Protection model as a procedural framework. When there is a reasonable indication that a mental disorder may be relevant to an alleged violation, the responsible authority should initiate an independent professional assessment before significant disciplinary, criminal, or administrative decisions are finalized. The assessment should differentiate between behaviors that are direct manifestations of mental disorders, behaviors partially influenced by mental health conditions, and intentional misconduct, without considering a psychiatric diagnosis as an automatic basis for eliminating legal responsibility.

Commanders and legal institutions should retain final decision-making authority, while psychiatrists provide professional opinions regarding clinical and functional aspects of mental health conditions. Effective implementation requires harmonized internal regulations, cross-sectoral standard operating procedures (SOPs), professional training, role-based confidentiality mechanisms, structured fitness-for-duty evaluations, rehabilitation and reintegration pathways, and organizational strategies to reduce mental health stigma. When properly designed, these safeguards do not weaken military discipline; rather, they strengthen legal certainty, proportionality, personnel protection, and operational readiness by ensuring that disciplinary decisions are based on accurate facts and appropriate professional evidence.

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