OHIO PROSECUTING ATTORNEYS ASSOCIATION

196 EAST STATE STREET • SUITE 200 • COLUMBUS, OHIO 43215

TELEPHONE 614/221-1266 • FAX 614/221-0753 • WWW.OHIOPA.ORG

John E. Murphy
Executive Director

SB-40; Death penalty; mental illness
Opponent Testimony
March 7, 2017
Senate Judiciary Committee

SB-40 proposes to bar the imposition of the death penalty in cases where the defendant had a "serious mental illness" at the time of the offense.

The bill is unnecessary to address any legitimate concerns about application of the death penalty to the mentally ill or disabled. Ohio law and Federal precedent already protects the defendant suffering mental disorder in several ways:

a. a defendant who because of a mental disease or defect does not understand the nature of the proceedings against him or is incapable of assisting in his defense is incompetent to stand trial and may not be put on trial so long as that incompetence continues;

b. a defendant who is found to be not guilty by reasons of insanity cannot be subjected to criminal punishment;

c. a person who is insane to the extent that he does not understand the nature of the punishment or why it is being imposed on him cannot be executed, *Ford v. Wainwright*, 477 U.S. 399 (1986);

d. the death penalty may not be imposed on one who is mentally retarded, *Atkins v. Virginia*, 536 U.S. 304 (2002);

e. Ohio's death penalty statute includes an explicit mitigating factor that addresses the mental illness and disability issues. 2929.04(B)(3) reads: "Whether, at the time of committing the offense, the offender, because of a mental disease or defect, lacked substantial capacity to appreciate the criminality of the offender's conduct or to conform the offender's conduct to the requirements of the law."

This bill expands mental illness considerations far beyond what is necessary and will bar consideration of the death penalty in inappropriate circumstances.

The mental conditions are too broad and ill defined. While some include conditions that are quite serious, of course, they also include depression, thought disorders, lack of motivation, lack of ability to focus and concentrate, mood swings, feelings of sadness, anxiety, guilt, anger, isolation, hopelessness. While these issues could be raised as factors in mitigation, they are too

indefinite and amorphous to form the basis of a presumption against the death penalty. I attach a statement from A. Michael Ricciardi, Ph.D., who worked for fifteen years as a Psychology Supervisor at the Ohio Department of Rehabilitation and Corrections. This statement was submitted last year in response to SB-162. You will note that he cautions that the DSM categories and conditions are intended for clinical diagnoses and warns against their use for forensic purposes.

"When DSM-5 categories, criteria, and textual descriptions are employed for forensic purposes, there is a risk that diagnostic information will be misused or misunderstood. These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis. In most situations, the clinical diagnosis of a DSM-5 mental disorder...does not imply that an individual with such a condition meets legal criteria for the presence of a mental disorder...

"...S.B. 162 fails to address the very important issue of severity of symptoms, relying solely on whether or not an individual meets (even minimal) criteria listed in the DSM-5.

"It fails to consider the repeated admonitions of the authors, cautioning against misunderstanding or misuse of clinical diagnostic information when applied in forensic settings."

Dr. Ricciardi's second point quoted above is critical. The bill makes no distinction between severe, moderate, and minimal levels of the condition. Even the most minimal level will bar the death penalty unless refuted. That is an important reason why our current law is a more just way of dealing with the mental issue because the jury and judge can consider the level of severity of the condition and weigh it against other factors in the case.

Once the defendant shows a diagnosis, no matter how minimal, the burden shifts to the state to disprove the diagnosis or to show that it did not impair the defendant's capacity at the time of the offense. Note that the defendant is not required to show that the condition affected his capacity, he need only show the existence of the condition at the time of the offense. It is then presumed that the condition significantly impaired the person's capacity at the time of the offense, and unless successfully rebutted by the state, bars imposition of the death penalty. See lines 269 through 276. This relieves the defendant of any need to show that the condition affected his capacity and places on the state the necessity to prove that it did not. This is a particularly difficult undertaking, even by a preponderance standard, especially when it concerns something as indistinct and elusive as the defendant's state of mind at the time of the offense. These are matters within the defendant's own knowledge, and he should therefore bear the burden of proving them. And this problem is compounded in the post conviction scenario which could involve a case that is 10 or 15 years old.

This burden shifting process was not recommended by the Supreme Court Task Force to Review the Administration of the Death Penalty.

Proponents argue that this process will apply only to a very few persons. We don't see it that way. We will not be surprised if every single inmate now on death row files a post conviction petition to be evaluated for mental illness so they can take advantage of this process to get off death row. Why wouldn't they? This bill slants everything in their favor. All they need do is get a diagnosis of one of these conditions, even at the most minimal level, and that will shift the burden to the state to prove that they did not have that condition or that the condition did not affect their conduct.

It would be a clear miscarriage of justice if a defendant who has been convicted beyond a reasonable doubt of a horrendous and vicious crime were to escape the death penalty that the jury and judge are otherwise ready to impose simply because of a diagnoses of one of these vague conditions. This could exclude from the death penalty even the worst offenders, and those who knew exactly what they were doing, fully intended to do it, and fully understood the nature of and the consequences of their acts.

It has been claimed that the Supreme Court Task Force to Review the Administration of the Death Penalty recommended an exclusion of the death penalty for those with a mental illness at the time of the crime. But the fact is that the recommendation was much more ambivalent than that, saying that the legislature should consider, among other things, "whether this issue is already adequately addressed by current law". The answer to that question is "Yes."

Current law by statute and court precedent clearly and reasonably provides a means for addressing legitimate mental illness and disability issues with respect to the death penalty. There is no need for this wholesale expansion of the definition of mental issues as contemplated here, or to create the one-sided processes envisioned by this bill.

For these reasons, we oppose the enactment of SB-40.

cc: Sen. Eklund

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A. Michael Ricciardi, Ph. D.
Licensed Psychologist
815 Centerville Trail
Aurora, Ohio 44202

February 22, 2016

To: Members of the Senate Criminal Justice Committee

My name is Michael Ricciardi. I have been practicing as a psychologist in Ohio since 1976. I have experience teaching at the college level; I have extensive clinical experience in hospital settings, in the correctional field, and in private practice. I am presently semi-retired, and work as a consulting psychologist for the Portage County Department of Adult Probation. Prior to my retirement from full-time employment in 2011, I had worked for 15 years as a Psychology Supervisor in the Ohio Department of Rehabilitation and Corrections. I am writing at the request of Victor Vigluicci, Prosecutor for Portage County, in regard to Senate Bill 162, which proposes changes in guidelines for the death penalty sentence. I will summarize some reasons why I believe the bill as written does not satisfactorily address mental health issues as related to sentencing.

Incorporated in the body of the proposed legislation are many references to the Fifth Edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, the DSM-5. I believe this is inappropriate, in that, like all preceding versions, the DSM-5 is intended for use by clinicians to assist them in making clinical decisions related to treatment of individuals with mental health problems. S.B. 162 would inappropriately apply it to decision-making quite separate from this intended use. In support of this assertion, I am providing some history and a brief look at the intended use of the manual. I am also including some specific caveats by the editors and other prominent members of the scientific Mental Health community with regard to its intended use.

I will end with some remarks about a few additional problems which I anticipate should the bill become law.

Section One:

The original version of the Diagnostic and Statistical Manual of the American Psychiatric Association, DSM-I, was published in 1952, and was a direct derivation of United States War Department Technical Bulletin 203, published in 1943. In the DSM-I, there were 106 psychiatric disorders listed.

The next revision to the DSM series was published in 1968. The DSM-II contained 182 disorders, an additional 76 compared to the original. Technical studies of its use among professionals revealed serious deficiencies, most significant of which was poor agreement among experts attempting to independently diagnose the same patients (Spitzer and Fleiss, 1974). That is, the DSM-II was an unreliable diagnostic tool.

There was a noteworthy editorial change in the 1974 printing of DSM-II. In response to pressure from activist groups, the diagnostic category of Homosexuality was deleted as a listed mental illness.

That year also marked the beginning of a concerted effort to upgrade psychiatric diagnosis to acceptable levels of reliability. The work of Robert Spitzer and other task force participants, culminated in the 1980 publication of the DSM-III, which featured a new look, the complex "Multiaxial" diagnostic system. The list of official diagnoses grew to 265.

In an attempt to address some of the problems with the DSM-III, a revision, the DSM-III-R was published in 1987. The list of disorders grew again, to 292.

In 1994, the DSM-IV was published, and an additional 5 diagnoses were added, bringing the count to 297. Just a few years later, in 2000, a new edition was published to address some minor problems. This was the DSM-IV-TR (for Text Revision).

In the Introduction to the DSM-IV and the DSM-IV-TR, the editor noted that "no definition adequately specifies precise boundaries for the concept of 'mental disorder'... different situations call for different definitions". Additionally, "there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders or from no mental disorder" (APA, 1994 and 2000).

In a 2003 position paper, Spitzer and DSM-IV editor Michael First, stated that the DSM was generally viewed as clinically useful by practicing professionals, but that it was *too complicated* [my emphasis] for primary care physicians. In the same report, these two fathers of the modern DSM system stated that, while many DSM diagnoses might apply to a single patient, it would be "total speculation" to assign a single diagnosis to an individual patient.

Interestingly, though DSM-III had been praised as "revolutionary or transformative" for psychiatric medicine, Spitzer, in a 2007 interview reflected that "the DSM [series] led to the medicalization of 20% to 30% of the population ***who may not have had any serious mental problems***." [my emphasis] He stated that the DSM, by operationalizing (manualizing) the definitions of mental disorders while paying little attention to the *context* [my emphasis] in which the symptoms occur, may have medicalized ***the normal human experience*** [again, my emphasis] of a significant number of people.

This brings us to the current edition, the DSM-5. It has been controversial even before its publication date in 2013. Thomas R. Insel, M.D., then Director of the NIMH, stated in a 2013 article:

<u>**Transforming Diagnosis**</u> *by Thomas Insel, on April 29, 2013*

"In a few weeks, the American Psychiatric Association will release its new edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) ...The goal of this new manual, as with all previous editions, is to provide a common language for describing psychopathology. While DSM has been described as a "Bible" for the field, *it is, at best, a dictionary*, [my emphasis] creating a set of labels and defining each. The strength of each of the editions of DSM has been "reliability" – each edition has ensured that clinicians use the same terms in the same ways. *The weakness is its lack of validity.* [my emphasis] Unlike our definitions of ischemic heart disease, lymphoma, or AIDS, the DSM diagnoses are based on a consensus about clusters of clinical symptoms, not any objective laboratory measure. In the rest of medicine, this would be equivalent to creating diagnostic systems based on the nature of chest pain or the quality of fever. Indeed, symptom-based diagnosis, once common in other areas of medicine, has been largely replaced in the past half century as we have understood that symptoms alone rarely indicate the best choice of treatment. Patients with mental disorders deserve better..."

The DSM-5 makes a few significant changes in diagnostic categories, with the most noteworthy for purposes here being the deletion of the subtypes of Schizophrenia: Paranoid, Disorganized, Catatonic, Undifferentiated, and Residual.

In summary, the history of the American psychiatric diagnostic and classification system has involved a number of very sophisticated efforts to solve significant problems in this field. The series of Diagnostic and Statistical Manuals – seven since 1942 – have attempted to address the essential issues of reliability and validity. As past NIMH Director Dr. Thomas Insel has pointed out, success has been elusive. He was generous in describing "reliability" as a strength. The research reveals

that, even though clinicians may be using "the same terms in the same ways", they still do not agree completely when attempting to diagnose the same patient: "Field trials of DSM-5 brought the debate of reliability back into the limelight as some disorders showed poor reliability. For example, Major Depressive Disorder, a common mental illness, had a poor reliability *kappa* statistic of 0.28, indicating that clinicians frequently disagreed on this diagnosis in the same patients. The most reliable diagnosis was Major Neurocognitive Disorder with a *kappa* of 0.78."(from Freedman, et al, January, 2013).

There have been seven changes in the basic diagnostic manual between its first publication in 1952, and the current edition in 2013. Future changes are planned to occur more frequently: the APA has revised the numbering system from Roman to Arabic numerals, so that future updates will be identified with decimals (5.1, etc.). The APA has expressed the intent to respond more quickly with updates to the manual to reflect the quickening pace of development in the field. Inasmuch as the publishers of the DSM-5 are already planning changes, it is inappropriate – or at the least, problematic – to base an amendment to the Ohio Revised Code on this frequently-changing instrument.

In this section, I have attempted to demonstrate the fact that diagnosis in Mental Health is an evolving field and that despite sophisticated attempts to improve precision in diagnosis, it remains a rather intractable task. Although the courts understandably would like everything cut and dried and precisely defined, case-by-case evaluation by clinical experts appears to be an unavoidable necessity. A simplistic approach – "Does the accused have one of the listed diagnoses?" – while attractive, is simply inadequate. We must keep in mind Spitzer's admonition that context must be given consideration when making a clinical diagnosis.

Finally, in this section, I would like to point out the particular concerns expressed by the DSM-5 authors regarding the potential inappropriate use of the manual in Forensic applications: "...the use of DSM-5 should be informed by an awareness of the risks and limitations of its use in forensic settings. When DSM-5 categories, criteria, and textual descriptions are employed for forensic purposes, there is a risk that diagnostic information will be misused or misunderstood. These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis. In most situations, the clinical diagnosis of a DSM-5 mental disorder ...does not imply that an individual with such a condition meets legal criteria for the presence of a mental disorder or a specified legal standard (e.g., for competence, criminal responsibility, or disability). ... It is precisely because impairments, abilities, and disabilities vary widely within each diagnostic category that assignment of a particular diagnosis does not imply a specific level of impairment or disability. ... Even when diminished control over one's behavior is a feature of the disorder, having the diagnosis in itself does not demonstrate that a particular individual is (or was) unable to control his or her behavior at a particular time."(DSM-5, 2013, p. 25)

Section Two

Senate Bill 162 stipulates that an individual, who has, *at any time* been diagnosed with one of the listed mental disorders, shall not be sentenced to the death penalty. This appears to be based on *a priori* dismissal of any likelihood of improvement. Consider that an ongoing and exciting current topic in mental health is recovery from severe mental illness, the so-called Recovery Movement. (Recovery From Schizophrenia: With Views of Psychiatrists, Psychologists, and Others Diagnosed With This Disorder, Schizophrenia Bulletin, March, 2009; 35(2): 370–380. Frederick J. Frese, III, Edward L. Knight, and Elyn Saks).

Also consider the issue of symptom severity as it interacts with diagnostic categorization. In a section of the introduction to use of the DSM-5 titled Criterion for Clinical Significance, the authors point out that "in the absence of clear biological markers or clinically useful measurements of severity for many

mental disorders, it has not been possible to completely separate normal and pathological symptom expressions contained in diagnostic criteria. This gap in information is particularly problematic in clinical situations in which the patient's symptom presentation by itself (particularly in mild forms) is not inherently pathological and may be encountered in individuals for whom a diagnosis of "mental disorder" would be inappropriate."

The S.B. 162 fails to address the very important issue of severity of symptoms, relying solely on whether or not an individual meets (even minimal) criteria listed in the DSM-5.

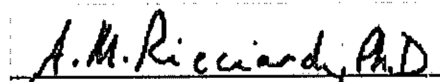
It fails to address changes, as evidenced by the seven iterations of the Diagnostic and Statistical Manual in the diagnostic criteria over time – and changes already projected for the future.

It fails to consider the repeated admonitions of the authors, cautioning against misunderstanding or misuse of clinical diagnostic information when applied in forensic settings.

Finally, remember the caveat that **context** is important for making an accurate diagnosis. Because diagnosis is usually based upon an interview, a properly motivated individual has ample opportunity to influence the examiner's conclusions. And every inmate potentially has access to the DSM-V.

For these reasons, I believe that Senate Bill 162, as written, is a flawed document.

Respectfully submitted,



A. Michael Ricciardi, Ph. D.
Clinical Psychologist
Ohio Psychology License # 2384

Note: **Reliability** is a measure of repeatability. It addresses the question: "If the same test or measurement procedure is applied twice to the same individual or situation, does one obtain the same result? Do two individuals using the same yardstick and measuring the same thing get the same result?

Validity is a measure which addresses the question of whether we are truly measuring what we are intending to assess. For example, if I were polling American households to assess the likelihood that a political candidate would be elected, and I chose my sample from the phone directory, I would miss everyone who did not have a home phone number listed, as well as those who were not at home or not answering their phones at the time I called. Rather than measuring who might be elected, I would be based on the responses of phone owners listed in the phone directory who were actually answering their calls, thereby neglecting the substantial numbers of people who screen their calls or who use cell phones exclusively.