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On behalf of the
Ohio Psychiatric Physicians Association

Before Members of the
House Criminal Justice Committee

Proponent Testimony on House Bill 136
Severe Mental Illness and the Death Penalty

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Chairman Lang, Vice-Chairman Plummer, Ranking Member Leland and members of the committee, thank you for the opportunity today to testify in support of H.B. 136, a bill which, if enacted, would exempt from the death penalty defendants who, at the time of the offense, had a serious mental illness (SMI) that significantly impaired their capacity to exercise rational judgment in relation to conduct, to conform their conduct to the requirements of law, or to appreciate the nature, consequences or wrongfulness of their conduct.

My name is Megan Testa, M.D. and I am a physician practicing forensic psychiatry in Cleveland, Ohio. I currently work in community re-entry, treating individuals with serious mental illness who are under the jurisdiction of the criminal justice system. I provide consultation for the State of Ohio and the City of Cleveland on issues such as Competence to Stand Trial, Criminal Insanity, Violence Risk Assessment and Conditional Release, at the state hospital and the municipal court.

I am here today speaking on behalf of the Ohio Psychiatric Physicians Association (OPPA), a statewide medical specialty organization whose more than 1,000 physician members specialize in the diagnosis, treatment and prevention of mental illness and substance use disorders.

I am also speaking on behalf of the Ohio Alliance on Mental Illness Exemption (OAMIE) of which the OPPA is one of ten mental health advocacy organizations in support of H.B. 136. These organizations represent thousands of Ohioans living with mental illness, family members, provider organizations and mental health boards. Several other organizations which make up the Ohio Alliance on the Mental Illness Exemption (OAMIE) include the National Alliance on Mental Illness of Ohio; Mental Health and

Addiction Advocacy Coalition; Ohio Psychological Association; Ohio Council of Behavioral Health & Family Services Providers; Ohio Association of County Behavioral Health Authorities and the Treatment Advocacy Center.

As you have already heard from the sponsor, H.B. 136 has been written to exclude a subset of individuals with mental illness – those with both serious mental illness *and* diminished culpability – from being subject to the ultimate penalty that the state of Ohio can impose, death.

Definitions of SMI

House Bill 136 includes a very specific definition of Serious Mental Illness (SMI). Under H.B. 136, "a defendant has a serious mental illness if he or she has been diagnosed with Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, Major Depressive Disorder, or Delusional Disorder and, at the time of the offense, the condition(s), while not meeting the standard to be found not guilty by reason of insanity (NGRI), nevertheless significantly impaired the person's capacity to appreciate the nature, consequences, or wrongfulness of his/her conduct; exercise rational judgment in relation to his/her conduct; or conform his/her conduct to the requirements of the law."

As a psychiatrist, looking at this definition of SMI, two things are apparent. First, given the very narrow list of qualifying diagnoses, only a fraction of individuals with mental illnesses in Ohio would qualify diagnostically. Second, because H.B. 136 does not create a categorical exemption, among those individuals who qualified diagnostically, an even smaller fraction would qualify functionally for exclusion based on diminished culpability.

The five psychiatric diagnoses included in the H.B. 136 definition of SMI are a narrow set of severe disorders that typically emerge in early adulthood and continue throughout life, either continuously or episodically. The disorders manifest with loss of touch with reality, cognitive impairment, compromised judgment, and/or executive dysfunction (a loss of ability to organize thinking and behavior).

Individuals living with these disorders also suffer with lack of insight into their illnesses, because the disorders themselves interfere with the individual's ability to recognize that what they think, and feel is not rational. These individuals have difficulty with education, employment, housing and relationships. They experience social stigma and isolation, and many times lack even minimal social support systems.

Allow me to describe the five diagnoses:

- **Schizophrenia** is a brain disorder that affects thinking and perception. It manifests with "positive" and "negative" symptoms of psychosis, as well as cognitive dysfunction, which can

resemble dementia. The positive symptoms of Schizophrenia include delusions, or fixed false beliefs, and hallucinations, which are unreal sensory experiences. The negative symptoms of Schizophrenia include blunted emotions, low motivation, low interests and inability to engage with others.

- **Bipolar Disorder** is a brain disorder that affects mood, impulse control, judgment, thinking and perception. Individuals with Bipolar I Disorder go through periods of mania, during which they experience elated mood, racing thoughts, inflated self-esteem, high energy and lack of need for sleep. When individuals are manic their heads are filled with ideas and the ideas all seem like great ideas. Thoughts move at lightning speed and individuals will engage in reckless behavior in pursuit of irrational goals. Individuals with Bipolar II Disorder experience periods of hypomania which include the symptoms of mania at a slightly lesser degree. When mania or hypomania ends, people with Bipolar Disorders crash into deep depression. They can also experience varying degrees of "Mixed States" during which they have co-occurring symptoms of mania and depression and are at high risk of suicide.

- **Schizoaffective Disorder** is a brain disorder that manifests as a hybrid of Schizophrenia and Bipolar Disorder or Major Depressive Disorder.

- **Major Depressive Disorder** is a brain disorder that affects less than seven percent (>7%) of the population per year. Because the term "depression" has become a lay term, some people when looking at this bill have been skeptical about whether Major Depressive Disorder is really a SMI. Major Depressive Disorder should not be equated with a lay understanding of "depression." It is not simply feeling down or slow or isolated for a period- of- time. A diagnosis of Major Depressive Disorder requires the persistent presence of profoundly depressed mood accompanied by a lack of interest, energy, motivation, concentration, and will to live. Major Depressive Disorder can be so severe that it leads to catatonia – a state of grave disability in which individuals cannot move, talk or eat. People with Major Depressive Disorder can develop pervasive feelings of worthlessness, delusional beliefs, and suicidality. Major Depressive Disorder can be difficult to treat. Many individuals that suffer from this SMI require multiple trials of antidepressant medications, as well as additional medications such as Lithium or antipsychotic medications, or require Electroconvulsant Therapy ("shock treatments") or experimental treatments such as Deep Brain Stimulation or Ketamine infusions. I have found that my patients with Bipolar Disorder are most afraid of the depressive phase of their illnesses.

- **Delusional Disorder** is a brain disorder in which a false belief becomes fixed in a person's mind and takes over his/her entire life. Individuals with Delusional Disorder often develop persecutory delusions and fear their safety or lives as a result. Individuals with Delusional Disorder are unable to accept that their beliefs are not true and go to great lengths to convince others that their delusions are true. They behave in accordance with their delusion rather than in accordance with reality.

With similar prior legislation, opponents have asserted that this legislation would "effectively end the death penalty." It has been said that everyone on death row will get themselves diagnosed with a mental illness. It has also been said that individuals who have suffered from "minimal levels" of mental illnesses, for example, those who have ever had "a mood swing" would be exempted under this bill. These statements are simply not true.

First, H.B. 136 requires that an individual be diagnosed by a Forensic Mental Health Evaluator with one of the five designated serious mental illnesses. Mental Health Evaluations that are done for the courts are very rigorous. Forensically-trained mental health professionals are experts not only at psychiatric diagnosis and treatment but also in the detection of malingering (i.e., faking or exaggerating mental illness). If a professional evaluator has diagnosed a person with SMI then they have found sufficient evidence through extensive record review, interviews, and mental status examination, to testify in a court of law to a reasonable degree of certainty that the person has exceeded the required threshold of symptoms required to meet that diagnosis, and they have ruled-out the possibility of malingering (ie: faking). An individual would have to first meet this requirement – formal diagnosis of one of five serious mental illnesses by a forensically-trained professional who can testify to the diagnosis in a court of law – to even proceed forward.

Second, remember that a diagnosis in and of itself is not enough. H.B. 136 is written explicitly to ensure that only those individuals whose SMI was in such a state of severity that it led to diminished capacity at the time of their crime. A Forensic Mental Health Evaluator would also assess the individual's capacity at the time of the crime and determine if their capacity was diminished by their SMI or not. The individual would qualify for exemption only if the evaluator concluded to a reasonable degree of professional certainty that they had diminished capacity at the time of the crime due to their SMI. Therefore, people who had well-controlled mental illness that did not diminish their capacity at the time of their crimes would not be exempted from execution. H.B. 136 does not even end the death penalty for everyone with mental illness, and certainly would not "effectively end the death penalty in Ohio."

Finally, concern has been raised that “sociopaths” could escape the death penalty if H.B. 136 became law. The terms “sociopath” and “psychopath” are terms that refer to individuals who violate laws, manipulate others, and lack empathy, guilt and remorse. The closest thing we have in the Diagnosis Statistical Manual of Mental Disorders (DSM-5) is Antisocial Personality Disorder, which is not covered in H.B. 136. This bill would not allow an individual who was purely a “sociopath” to escape execution.

In conclusion, individuals who, because of a serious mental illness, lacked the capacity to exercise rational judgment in relation to conduct, to conform his/her conduct to the requirements of law, or to appreciate the nature, consequences or wrongfulness of his/her conduct, at the time of commission of a crime, should not be put to death by the state of Ohio.

As stated in an opinion piece printed in the Akron Beacon Journal on April 28, “this isn’t a matter of somehow showing leniency for defendants. The alternative of life in prison without the option of parole amounts to a plenty severe punishment. This legislation goes to Ohioans defining themselves, ensuring the death penalty is conducted with thought and care, drawing clear distinctions about those the state puts to death.”

Thank you for your time and attention. I welcome the opportunity to respond to any questions you may have at this time.