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On behalf of the
Ohio Psychiatric Physicians Association

Before Members of the
Senate Criminal Justice Committee

Proponent Testimony on S.B. 40
SMI and the Death Penalty

March 7, 2017

Chairman Bacon, Vice-Chairman Dolan, Ranking Member Thomas and members of the committee, thank you for the opportunity today to speak in support of S.B. 40, 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 grew up in Youngstown, Ohio, and moved to Cleveland in 2002 to begin medical school at Case Western Reserve University School of Medicine. After graduating from medical school, I completed residency training in psychiatry at University Hospitals of Cleveland, followed by specialty training in forensic psychiatry. I currently work in community re-entry, treating individuals with serious mental illness who are under the jurisdiction of the criminal justice system, and I provide consultation at Northcoast Behavioral Healthcare on issues such as Competence to Stand Trial, Criminal Insanity, and Conditional Release.

I am here today speaking on behalf of the Ohio Psychiatric Physicians Association, 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.

The OPPA is one of ten mental health advocacy organizations in support of S.B. 40 which represent thousands of Ohioans living with mental illness, family members, provider organizations and mental

health boards. The 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 and others who have testified before me, S.B. 40 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

Senate Bill 40 includes a very specific definition of Serious Mental Illness (SMI). Under S.B. 40, "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, 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 S.B. 40 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 S.B. 40 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 the 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 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. When mania ends, they crash into deep depression. They can also experience "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 interests, 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. Some people with Major Depressive Disorder do not improve with medications alone and require Electroconvulsant Therapy ("shock treatments") or experimental treatments such as 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.

During prior testimony, the following questions have been raised: 1) Why these five particular diagnoses – why were they selected; and 2) What about people with mental illness who stop taking their medications – why should they be spared any criminal punishment that could be imposed upon them should they commit murder in the context of not taking medications?

With regard to the first question, the five specific diagnoses included in the bill qualify as serious mental illnesses as defined by federal regulation, purely as a result of their diagnostic criteria. Federal regulations define "serious mental illness" as "a condition that affects persons aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder … that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities" such as maintaining interpersonal relationships, activities of daily living, self-care, employment, and recreation (Substance Abuse and Mental Health Services Administration). The federal definition of SMI includes many disorders not included in SB 40. These specific five disorders were chosen because they lead to impairment of thinking, planning, and decision-making, and thus can contribute to diminished capacity as defined in SB 40.

To answer the second question, it is necessary to discuss treatment of serious mental illness. As a treatment provider I would like to be able to tell this committee that there are effective, accessible medications available that alleviate all the symptoms of serious mental illness, and that if my patients simply see me regularly and take their medications as prescribed they will feel, think, and act as if they no longer suffer from their brain disorders. However, this is not how treatment of mental illness works. Many individuals with serious mental illness never recover from their illnesses, through no fault of their own. Many individuals with serious mental illness do not receive treatment because the very nature of their disorders causes them to be unable to recognize that they need help. Others avoid seeking help due to fear of societal stigma or fear of psychiatric treatment due to portrayals in the popular media (such as "*One Flew Over the Cuckoo's Nest*"). Others seek treatment but cannot access it due to inadequate resources or other systemic failures. Finally, if all of those barriers are overcome, there are many individuals who seek and receive treatment, but for whom treatment does not work or causes serious

side-effects (some examples would be diabetes, delirium, kidney failure or liver failure) that they cannot tolerate.

It has not been my experience as a psychiatrist to see people with mental illness find effective, tolerable treatments that resolve their symptoms, and then volitionally stop those medications. I do not see this, simply put, because nobody wants to be seriously mentally ill. Given the realities of the mental health treatment system that we have in this country, and the limitations of available treatments, individuals who are not taking medications at the time they commit crimes are not undeserving of consideration for exclusion from the death penalty.

As psychiatric physicians, the OPPA believes that individuals who, because of SMI, 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.

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