Ohio Prosecuting Attorneys Association

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Senate Bill 54
Opponent Testimony
July 17, 2019

Chairman Eklund, Vice-Chair Manning, Ranking Member Thomas and members of the Senate Judiciary Committee, thank you for the opportunity to provide opponent testimony today on Senate Bill 54. I am Vic Viguicci, the Portage County Prosecuting Attorney and President of the Ohio Prosecuting Attorneys Association. Senate Bill 54 is the most recent iteration of a bill that our Association has consistently opposed over the last several General Assemblies and a bill for which a variety of concerns have gone unaddressed.

Ohio prosecutors are very concerned with the impact that this legislation will have on the enforceability of Ohio's death penalty law, the impact that it will have on the families of victims whose offenders have already been sentenced to death, and the great time and expense that will be required to re-litigate the sentences of those who are currently on death row. While the changes that have been made to this legislation over the past year are an improvement, it remains our position that this bill is not necessary to address any legitimate problems with the application of the death penalty in Ohio and that it will leave Ohio's death penalty unenforceable in all but the narrowest circumstances.

To be clear, Ohio is not executing the severely mentally ill. Revised Code section 2901.01(A)(14) states that "A person is "not guilty by reason of insanity" relative to a charge of an offense" if "at the time of the commission of the offense, the person did not know, as a result of a severe mental disease or defect, the wrongfulness of the person's acts." 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). A defendant who does not understand the nature of the proceedings against him or is incapable of assisting in his defense is incompetent to stand trial. This legislation excludes some other group. It excludes those who did appreciate the wrongfulness of their conduct.

Additionally, mental disease or defect may be raised as a mitigating factor during the sentencing phase of a death penalty trial. Proponents have put forth that this legislation is necessary because juries cannot be trusted to treat serious mental illness as a mitigating factor and that they often treat it as an aggravating factor. Yet it has been stated in the same proponent testimony that "by a 2 to 1 margin Americans want to

prevent those with a serious mental illness from being subject to a death sentence." Jurors, of course, are selected from the same pool of people who make up this 2 to 1 margin. They are selected by both the prosecution and the defense. It is contradictory for proponents to assert that two thirds of Americans wish to prevent those with a serious mental illness from being subject to a death sentence but that the same group of Americans overwhelmingly treat serious mental illness as an aggravating factor once they are on a jury. If two thirds of the public wish to prevent those with serious mental illness from being subject to a death sentence, then the defense should have no trouble seating jurors who disfavor such a sentence, and even less trouble creating reasonable doubt in the mind of a single juror – which is all that it takes to prevent a sentence of death.

Beyond the lack of need for this legislation, the bill still provides the opportunity for those currently on death row to file a motion for post-conviction relief based on a claim that they had a serious mental illness when they committed their crime. This is a provision that we have consistently asked to have removed from the bill over the last several years. It is unclear how someone who committed an offense 10, 15, or even 20 years ago will demonstrate that they had a mental illness at the time of their crime and that the illness impacted their ability to exercise rational judgment in relation to the act. Proponents have argued that they believe only a few people on death row would "qualify" for relief. But that is a different question than whether they are "eligible" to file for that relief. It is likely that every single person on death row would file such a motion. This would create even more litigation just to confirm that the person was properly sentenced 10, 15 or 20 years ago. It also creates more uncertainty for the families of victims of Ohio's most heinous crimes and allows the offender yet another opportunity to cause victim's families more pain. The handful who "qualify" should instead seek to have their sentence commuted and save the state the time and expense of re-litigating the sentences of everyone on death row. We urge the removal of this provision.

The bill also still lists four undefined mental illnesses for which a person may seek to be excluded from the death penalty. Prosecutors remain concerned with the lack of definition. Because the illnesses are not defined it will be necessary to rely on the Diagnostic and Statistical Manual of Mental Disorders (DSM), a delegation of legislative authority to American Psychiatric Association who authors the manual. There will be no legislative oversight. The DSM is also intended for use by clinicians in making decisions about treatment. It was not designed for forensic use. I have attached to my testimony a document authored by Dr. A. Michael Ricciardi that was written for a previous version of this legislation. In it, Dr. Ricciardi notes a couple of things that are important for the committee to consider. First, he discusses concerns expressed by the DSM-5 authors regarding the potential inappropriate use of the manual in forensic applications. The authors state that 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 the 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." (Emphasis added).

Finally, there is the issue of the illnesses listed in Senate Bill 54. There is no question that they can be severe. But they can also vary in degree from mild to severe and may enter periods of partial or even full remission. The legislation has no nuance regarding the severity of symptoms. A person who meets even minimal criteria could be excluded from the death penalty under this bill even though they appreciated the wrongfulness of their conduct and were able to control that conduct. This is precisely why juries are in the best position to consider mental illness and weigh it as a mitigating factor. They can make the individualized assessment about the seriousness of the illness, how that illness expressed itself for that particular individual, and how, if at all, it impacted the person's ability to control their behavior and appreciate the wrongfulness of their conduct. At a minimum, if the bill is to pass, the legislature should better define these illnesses

Ohio prosecutors continue to believe that this legislation is unnecessary and that it should not be adopted by the General Assembly. If the bill is to be reported out of committee, however, we urge you to make it a better bill. A bill without the post-conviction relief provision is a better bill. A bill with better defined illnesses is a better bill. And a bill that allows for victim impact evidence and evidence of a defendant's violent criminal record to be considered in the penalty phase as aggravating factors is a better bill. These changes make the legislation more balanced in terms of fairness for the State and justice for both the victim and the accused.

Thank you again for the opportunity to testify. I would be happy to answer any questions.

A. Michael Ricciardi, Ph. D.
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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:

Transforming Diagnosis 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 <u>context</u> 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 <u>recovery</u> from severe mental illness, the so-called Recovery Movement. (<u>Recovery From Schizophrenia: With Views of Psychiatrists, Psychologists, and Others Diagnosed With This Disorder, Schizophrenia Bulletin,</u> 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 <u>Criterion for Clinical Significance</u>, 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.
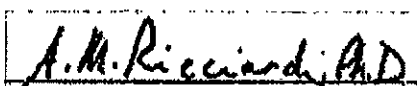
It fails to address changes, as evidenced by the seven iterations of the Diagnostic and Statistical Manual in the diagnostic criteria over time — and changes already projected for the future.

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,

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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.