IN THE
INDIANA COURT OF APPEALS

Cause No. 49A02-1107-CR-00590

BEI BEI SHUAI, Appellant,	)	Interlocutory Appeal from the Marion Superior Court Criminal Division, Room Three
v.	)	Cause No. 49G03-1103-MR-014478
STATE OF INDIANA, Appellee.	)	Hon. Sheila Carlisle, Presiding

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BRIEF OF AMICUS CURIAE ORGANIZATIONS AND INDIVIDUALS COMMITTED TO EDUCATION ABOUT AND TREATMENT FOR PERINATAL PSYCHIATRIC ILLNESS IN SUPPORT OF APPELLANT

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BRIEF FOR POSTPARTUM SUPPORT INTERNATIONAL, DR. VIVIEN K. BURT, PROFESSOR MICHELLE OBERMAN & DR. MARGARET SPINELLI IN SUPPORT OF APPELLANT BEI BEI SHUAI

INTERESTS OF AMICI CURIAE

Amici are a not-for profit organization, an Associate Professor of Clinical Psychiatry at the College of Physicians and Surgeons of Columbia University and the Founding Director of the Women's Program in Psychiatry, a Professor Emeritus of Psychiatry and Director of The Women's Life Center of the Resnick UCLA Neuropsychiatric Hospital, and a Professor of Law at Santa Clara Law School. They are united in their concern that a punitive approach to women who have a psychiatric illness and are pregnant is unsound and that the implications of that approach may be significant not only for the women, families, and communities of Indiana but for this nation as a whole.

POSTPARTUM SUPPORT INTERNATIONAL is a non-profit organization whose mission is to promote worldwide awareness, prevention, and treatment of mental health issues related to childbearing. PSI envisions a world in which every woman and every family have access to information about, social support for, and informed professional care to treat mental health issues related to childbearing. PSI promotes its vision through advocacy and collaboration, and by educating and training the professional community and the public about the emotional changes that women experience during pregnancy and postpartum. Over its nearly 25 year existence, PSI has been committed to outreach efforts—from brochures, posters, and DVDs to evidence-based training programs—that educate the public and the professional community about appropriate and professional care for women with perinatal and postnatal psychiatric illnesses.

VIVIEN K. BURT, MD, PHD, is Professor Emeritus of Psychiatry in the Department of Psychiatry and Biobehavioral Sciences at The David Geffen School of Medicine at UCLA in Los Angeles, California. In addition, she is the Founder and Director of The Women's Life Center of the Resnick UCLA Neuropsychiatric Hospital. Dr. Burt has authored numerous articles and book chapters in the field of women's psychiatry, and she has coauthored *The Clinical Manual for Women's Mental Health*, published by the American Psychiatric Press in May 2005. She has been honored with the Outstanding House Staff Teaching Award from the UCLA Neuropsychiatric Institute, a President's Award of the Southern California Psychiatric Society, the Distinguished Service Award of the UCLA Neuropsychiatric Institute and Hospital, the 2008 Andre Boivin Professorship of the Motherisk Program of The Hospital for Sick Children in Toronto, Canada, and the 2010 Outstanding Achievement Award of the Southern California Psychiatric Society.

Her professional activities focus on projects in women's mental health with particular emphasis on psychiatric illnesses associated with reproductive transitions.

MICHELLE OBERMAN is a Professor of Law at Santa Clara Law in California. She is the leading scholar on the legal and ethical issues surrounding pregnancy and motherhood, and her work focuses on domestic and international issues at the intersection of health law and criminal law. Professor Oberman is active in the academic community. She frequently lectures to a wide variety of audiences, ranging from law school faculties to health care professionals to community-based interest groups, on issues relating to health law. Her recent book on legal and health issues affecting women during the postpartum period won the Outstanding Book Award from the Academy of Criminal Justice Sciences. Professor Oberman is a graduate of the University of Michigan Law School, the University of Michigan School of Public Health, and Cornell University.

MARGARET SPINELLI, MD is an Associate Professor of Clinical Psychiatry at the College of Physicians and Surgeons of Columbia University, the Director of the Maternal Mental Health Program at the New York State Psychiatric Institute, and the Founding Director of (and now Senior Consultant for) the Women's Program in Psychiatry at Columbia University. For over two decades, Dr. Spinelli's clinical, teaching, and research activities, as well as her publications, have focused on psychiatric disorders during pregnancy and the postpartum periods, and she has lectured to audiences all over the world about perinatal depression. She is the recipient of numerous awards, including research awards from the National Institutes of Mental Health to study depression and pregnancy, and the Manfred S. Guttmacher Award from the American Psychiatric Association and American Academy of Psychiatry and the Law for "outstanding literary contribution to psychiatry and the forensic sciences." Dr. Spinelli is graduate of St. Francis College and Cornell University's school of medicine, and she is board certified in both psychiatry and neurology.

INTRODUCTION AND SUMMARY OF THE ARGUMENT

Psychiatric illnesses[1] are serious medical conditions, and one disheartening but predictable aspect of many such illnesses is a suicide attempt. Pregnant women are not immune from these diseases or the ideations that may lead them to attempt to kill themselves. Because pregnant women share their anatomy and physiology with their developing fetus, a suicide attempt will necessarily affect the fetus. But punishing a woman for a behavior that is both legal and, in all likelihood, the result of a disease, is unsound. Just as it would defy logic, undermine legal principles, and ignore medical realities to punish a woman whose cancer metastasized to her fetus and caused its death after it was born, it makes little sense to punish a woman whose suicide attempt led to the same result.

ARGUMENT

I. Mental Illnesses Are Prevalent Medical Conditions That Carry Significant Costs, Including The Risk Of Suicide

Modern medicine recognizes mental illnesses as serious *medical* conditions. Like other medical conditions, their etiology has been traced to variances in neuroanatomy,[2] genetics,[3] and neurochemistry.[4] As a result, it is no longer valid to

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[1] This Brief uses the terms "psychiatric illness," "mental illness," and "mental disorder" as interchangeable, catch-all phrases that include affective, personality, and other mental disorders. For an overview of these disorders, *see* AMERICAN PSYCHIATRIC ASSOCIATION, DSM-IV-TR: DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed. 2000) (defining and categorizing mental disorders).

[2] *See, e.g.*, James Cole et al., *Hippocampal Atrophy in First Episode Depression: A Meta-Analysis of Magnetic Resonance Imaging Studies*, 134 J. AFFECTIVE DISORDERS 483 (2011) (discussing the loss of volume in the brain's hippocampus in first-episode depression and advocating for hippocampal volume loss as a potential

think of mental illness as a failure of will or something that an individual can just "snap out of" with a bit of effort.[5] Although mental illness has been and, to some extent, is still thought of as a moral failing, it is no more of a moral failure than any other disease.

These diseases are prevalent and costly. Recent reports estimate that nearly a quarter of the adult population in the United States suffers from a serious mental disorder.[6] These illnesses carry considerable costs. Annually, they may cost society

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neurobiomarker for the diagnosis of depression); Wi Hoon Jung et al., *Structural Brain Alternations in Individuals at Ultra-high Risk for Psychosis: A Review of Magnetic Resonance Imaging Studies and Future Directions*, 25 J. KOREAN MED. SCI. 1700 (2010) (describing neuroanatomical changes that precede psychosis).

[3] *See, e.g.*, Kathryn L. Ponder et al., *Maternal Depression and Anxiety are Associated with Altered Gene Expression in the Human Placenta Without Modification by Antidepressant Use: Implications for Fetal Programming*, ___ DEVELOPMENTAL PSYCHOBIOLOGY ___ (2011) (in press) (finding that maternal depression and anxiety affect the expression of a gene in the placenta); Katja Karg et al., *The Serotonin Transporter Promoter Variant (5-HTTLPR), Stress, and Depression Meta-analysis Revisited*, 68 ARCHIVES OF GEN. PSYCHIATRY 444 (2011) (finding "strong evidence" of support for the hypothesis that a particular part of the serotonin transporter gene moderates the relationship between stress and depression).

[4] *See, e.g.*, Woojae Myung et al., *Serotonin Transporter Gene Polymorphisms and Chronic Illness of Depression*, 25 J. KOREAN MED. SCI. 1824 (2010) (associating chronic depression with a genetic variant of the neurochemical serotonin); S. Brummelte & Liisa A.M. Galea, *Depression During Pregnancy and Postpartum: Contribution of Stress and Ovarian Hormones*, 34 PROGRESS IN NEURO-PSYCHOPHARMACOLOGY & BIOLOGICAL PSYCHIATRY 766, 767 (2010) (discussing the association between stress, glucocorticoids, and depression and noting that "[c]hanges in neurotransmitter levels and/or sensitivities play an important role in depression").

[5] Marek Fuchs, *Religion Journal; Finding the Place of Faith in Psychiatric Treatment*, N.Y. TIMES, Apr. 27, 2002.

[6] Ronald C. Kessler et al., *Prevalence, Severity, and Comorbidity of Twelve-Month DSM-IV Disorders in the National Comorbidity Survey Replication*, 62 GEN. PSYCHIATRY 617 (2005).

$193.2 *billion* in lost earnings[7]—a staggering figure that may, in fact, be too conservative.[8] But perhaps most troublingly, these diseases are associated with a significant risk of both attempted and completed suicide.[9]

Suicide is not a rare occurrence. In 2006, the Centers for Disease Control ranked suicide as the eleventh leading cause of death in the United States.[10] In other words, that year, more than 33,000 people committed suicide. And for every completed suicide, there were an estimated 25 attempts.[11] Treatment of individuals who attempt suicide is, in fact, critical—they are "at high risk" of completing a subsequent suicide attempt.[12]

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[7] Ronald C. Kessler et al., *Individual and Societal Effects of Mental Disorders on Earnings in the United States: Results From the National Comorbidity Survey Replication*, 165 AM. J. PSYCHIATRY 703, 708 (2008).

[8] Kathleen Kingsbury, *Tallying Mental Illness' Costs*, TIME MAG., May 9, 2008, http://www.time.com/time/health/article/0,8599,1738804,00.html (reporting that Ronald Kessler, a Harvard professor of health care policy and the lead author of the aforementioned study, believes that the actual costs of serious mental illness to American society "are probably higher than what we have estimated").

[9] Keith Hawton & Kees van Heering, *Suicide*, 373 LANCET 1372 (2009) (remarking that "[m]ost people who die by suicide have psychiatric disorders, notably mood, substance-related, anxiety, psychotic, and personality disorders, with comorbidity being common").

[10] Centers for Disease Control and Prevention Suicide Data Sheet, http://www.cdc.gov/violenceprevention/pdf/suicide-datasheet-a.pdf.

[11] *Id.*

[12] José M. Bertolote et al., *Data from Emergency Care Setting in Five Culturally Different Low- and Middle-Income Countries Participating in the WHO SUPRE-MISS Study*, 31 CRISIS 194, 195 (2010) (noting that "[a]mong those who attempt suicide, up to 2% eventually die of suicide within the following year, up to 7% die of suicide within 10 years, and 15-23% receive treatment for a subsequent attempt within 1 year" and citing a dozen studies to support those findings).

II. Pregnant Women Are Not Immune From Mental Illness

Although pregnancy is generally perceived as a blissful time in a woman's life, psychiatric research suggests that is also a time of great vulnerability to mental illness, including depression.[13] As Dr. Shaila Misri, a leading reproductive psychiatrist, has explained, "The notion that pregnancy is a time of uninterrupted joy, happiness, and contentment has been challenged by evidence-based research showing that, to the contrary, many women are distressed by depressive disorders in pregnancy." In fact, "[t]he time of the highest risk for women to develop depression is during their childbearing years, a time when steroid and peptide hormones can fluctuate dramatically."[14] The American College of Obstetricians and Gynecologists (ACOG) has noted that "[d]epression is common during pregnancy—between 14 percent and 23 percent of pregnant women will experience depressive

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[13] Shaila Misri, *Suffering in Silence: the Burden of Perinatal Depression*, 52 CANADIAN J. PSYCHIATRY 477, 477 (2007). In 2010, Dr. Misri lectured at Community Medical Centers of the University of California at San Francisco and at Fresno on perinatal and postnatal depression and anxiety. The literature from that event, which is available at http://www.fresno.ucsf.edu/Misri326.pdf, offer this brief biography: "Shaila Misri, MD, FRCPC, is one of the leading reproductive psychiatrists in North America and is internationally recognized as a pioneer in women's mental health and reproductive issues. She is the founder and director of Reproductive Mental Health at both St. Paul's Hospital and BC Women's Hospital & Health Centre in Vancouver, and Clinical Professor of Psychiatry and Obstetrics and Gynecology at the University of British Columbia, Canada."

[14] S. Brummelte & Liisa A.M. Galea, *Depression During Pregnancy and Postpartum: Contribution of Stress and Ovarian Hormones*, 34 PROGRESS IN NEURO-PSYCHOPHARMACOLOGY & BIOLOGICAL PSYCHIATRY 766, 767 (2010). *See also* Salvatore Gentile, *Suicidal Mothers*, 3 J. INJ. VIOLENCE RES. 90, 90 (2011) (noting that "childbearing years are a time of increased vulnerability to the onset or recurrence of major depressive disorder, thus placing young women at risk of suffering from severe affective impairment during pregnancy").

symptoms while pregnant."[15] Women with a history of depression have twice the risk of developing minor and major depression during a pregnancy than women without that history,[16] and "a majority of women with bipolar disorder will experience a mood episode during pregnancy and the postpartum period."[17] Pregnancy is not a panacea for mental illness.

Similarly, pregnancy is not protective against suicide. The prevalence of suicidal ideation during pregnancy is relatively high,[18] and, in this country, suicide has been ranked as the fifth-leading cause of death among pregnant women.[19] Importantly, a pregnant woman who attempts suicide does not necessarily aim to express malice toward her fetus. Suicidal ideations are not necessarily tied to thoughts about the fetus, and a suicide attempt cannot be assumed to be an attempt to terminate a pregnancy. Moreover, suicidal thoughts must be viewed in the

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[15] American College of Obstetric and Gynecologists News Release, *Depression During Pregnancy: Treatment Recommendations, A Joint Report from APA and ACOG*, August 21, 2009.

[16] Susanna Banti et al., *From the Third Month of Pregnancy to 1 Year Postpartum. Prevalence, Incidence, Recurrence, and New Onsent of Depression. Results from the Perinatal Depression-Research & Screening Unit Study*, 52 COMPREHENSIVE PSYCHIATRY 343 (2011).

[17] Cheryl Ann Chessick & Sona Dimidjian, *Screening for Bipolar Disorder During Pregnancy and the Postpartum Period*, 13 ARCH. WOMENS MENTAL HEALTH 233, 233 (2010).

[18] Salvatore Gentile, *Suicidal Mothers*, 3 J. INJ. VIOLENCE RES. 90 (2011); *see also* Margaret Oates, *Perinatal Psychiatric Disorders: A Leading Cause of Maternal Morbidity and Mortality*, 67 BRITISH MED. BULLETIN 219 (2003) (also stating that in the United Kingdom, psychiatric disorder, and suicide in particular, "is the leading cause of maternal death").

[19] Jennifer L. Melville et al., *Depressive Disorders During Pregnancy: Prevalence and Risk Factors in a Large Urban Sample*, 116 OBSTETRICS & GYNECOLOGY 1064 (2010).

context of the disease. Violent thoughts may be emblematic of the illness itself and not an example of clear-headed, intentional thinking.

III. Perinatal Mental Illness Requires Treatment, And A Punitive Approach To A Suicide Attempt May Dissuade The Pregnant Patient From Seeking—Or Accepting—Treatment

Medical experts concur that the treatment of perinatal mental illness—that is, mental illness that occurs during pregnancy—is critical. Various treatments may be effective for different mental disorders.[20] Importantly, *untreated mental illness has serious consequences.* Untreated maternal mood symptoms have been associated with an increase in the rate of pregnancy complications, like pre-eclampsia, premature delivery, impaired fetoplacental function, and low fetal growth, as well as other perinatal problems.[21] Untreated illness may negatively impact both the pregnant woman and her fetus.

Untreated mental illness also impacts children. Depressed women are at risk of "impaired interaction with their infant" during a critical developmental period, which "may lead to poorer cognitive functioning and compromised social adaptation during childhood, adolescence and young adulthood.[22] In fact, untreated mood

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[20] Susanna Banti et al., *From the Third Month of Pregnancy to 1 Year Postpartum. Prevalence, Incidence, Recurrence, and New Onsent of Depression. Results from the Perinatal Depression-Research & Screening Unit Study*, 52 COMPREHENSIVE PSYCHIATRY 343 (2011) (suggesting that "casting a multiprofessional network around women in need of support" during the perinatal period may be potentially useful for reducing the effects of depression on the mother and the newborn child).
[21] Salvatore Gentile, *Suicidal mothers*, 3 J. INJ. VIOLENCE RES. 90, 91 (2011); *see also* Lori Bonari, *Perinatal Risks of Untreated Depression During Pregnancy*, 49 CANADIAN J. PSYCHIATRY 726, 727-731 (2004) (noting that untreated depression during pregnancy has been associated with various adverse effects).
[22] Salvatore Gentile, *Suicidal mothers*, 3 J. INJ. VIOLENCE RES. 90, 91 (2011).

disorders can also disrupt an entire family system, "inhibiting the woman's ability to perform daily activities, to bond with her infant, and to relate to the infant's father."[23] Because psychiatric illness "can have dire consequences for the mother, the baby, and the entire family," "nothing is more critical than sustaining maternal emotional well-being during pregnancy."[24]

However, many pregnant women do not receive the medical treatment they need. Some scholars believe that "many women may be afraid or embarrassed to disclose that they are suffering from depression."[25] Indeed, stigma is a "significant impediment" to the receipt of treatment.[26] Punishment—and even the threat of punishment—by the state for behavior that stems from mental illness intensifies that stigma and deters women from seeking medical care that will benefit them, the developing fetus, and the child once born. As a legal and policy matter, the state should *encourage*, not discourage, care and treatment for perinatal mental illness.

A punitive approach to perinatal mental illness is troubling. It is clear that, "for the pregnant or postpartum woman with depression, exposure [of the fetus] always occurs, either to untreated illness and its ramifications for mother and child,

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[23] Susanna Banti et al., *From the Third Month of Pregnancy to 1 Year Postpartum. Prevalence, Incidence, Recurrence, and New Onsent of Depression. Results from the Perinatal Depression-Research & Screening Unit Study*, 52 COMPREHENSIVE PSYCHIATRY 343 (2011).
[24] Lee S. Cohen et al., *Treatment of Mood Disorders During Pregnancy and Postpartum*, 33 PSYCHIATRY CLINICS OF N. AM. 273, 274 (2010).
[25] *Id.*
[26] Healther A. O'Mahen et al., *Stigma and Depressing During Pregnancy: Does Race Matter?*, 199 J. NERVOUS & MENTAL DISEASE 257 (2011).

or to the medication itself.[27] Under the precedent that the prosecution of Ms. Shuai threatens, is a pregnant woman with a mental disease whose *treatment* may affect the fetus also at risk for criminal prosecution? What about a pregnant woman with a mental disease whose disease, if left *untreated*, may affect the fetus?[28] Consider the pregnant woman who is diagnosed with cancer during her pregnancy and whose cancer metastasizes to her fetus. If, after its birth, the child dies from that cancer, should its mother be prosecuted for killing her baby? If not, why should predictable sequela of mental illness receive dissimilar treatment under the criminal law? What about a pregnant woman whose cancer *treatment* harms the fetus? And should an HIV positive woman who transmits HIV to her baby be prosecuted for a crime?[29] Decisions about treatment for mental illnesses during the perinatal period are challenging to both clinicians and patients. Criminal law has no place here.

CONCLUSION

Over the past two hundred years, the common law has abandoned the notion that suicide is both a crime against the state and a moral failing. Today, the medical community understands that mental illness is a disease that requires

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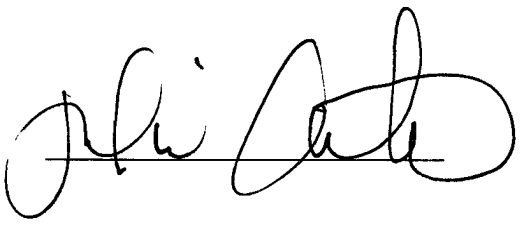
[27] Emily C. Dossett, *Perinatal Depression*, 35 OBSTETRICS & GYNECOLOGY CLINICS OF N. AM. 419, 430 (2008).

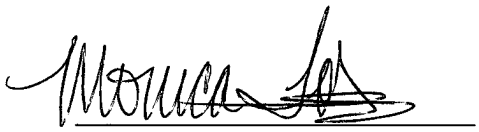
[28] *See, e.g.*, Johann Guillemot et al., *Could Maternal Perinatal Atypical Antipsychotic Treatments Program Later Metabolic Diseases in the Offspring?*, ___ EUROPEAN J. PHARMACOLOGY ___ (2011) (in press) (explaining that the risk of perinatal exposure to second generation antipsychotic medications "must be weighed against the growing evidence that maternal psychiatric illness poses risks to the fetus/newborn as well as for long-term susceptibility to diseases").

[29] André A. Panossian, Vahé Panossian, & Nancy P. Doumanian, *Criminalization of Perinatal HIV Transmission*, 19 J. LEGAL MED. 223 (1998) (arguing for a criminal approach to women who transmit HIV to their offspring during pregnancy).

treatment. A suicide attempt is a sad but predictable aspect of mental illness, and, unfortunately, pregnant women are not immune from such diseases. Because treatment is so critical for the pregnant patient, her fetus, and her family, *amici* support an approach that sees suicide and attempted suicide as a medical issue, not a criminal one—a stance that is consistent with the position of the Indiana Department of Health[30] and the Indiana legislature, which decided not to criminalize attempted suicide. Adding punishment to a suicide attempt makes a tragedy all the more macabre. *Amici* respectfully request that the Court consider perinatal psychiatric disease as an illness in the current appeal.

Respectfully submitted,





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[30] INDIANA DEPARTMENT OF HEALTH, SUICIDE IN INDIANA 2001-2005 (2007), http://www.in.gov/isdh/files/SuicidePaper_9-5-07.pdf (explaining that "[t]he objective of this report was to take the initial step of the public health approach: to define the problem [of suicide], both in the U.S. and Indiana").

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a copy of the foregoing has been served upon the following by U.S. First Class Mail, postage prepaid, this 17th day of October, 2011:

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