RIPSNEWS

RHODE ISLAND PSYCHIATRIC SOCIETY • *A District Branch of the American Psychiatric Association*

President's Message

Louis J. Marino, MD

As the year comes to an end, I'll take this opportunity to reflect on what we have accomplished and what we have to look forward to as a society. Six months into a two year term as president, I find that time is passing very quickly. I'm very grateful that Barry Wall solicited my input years ago so that the society could have an agenda that would span at least the four years of our terms. I'm also very grateful to the members who remain active participants in the society from those who take time out to socialize and learn with their old and new colleagues at the general membership meetings to those who make time to work more actively in the council or one of its committees.

The goals of the society continue to be organized around two central themes. The first concerns increasing member participation on all levels. This includes making all psychiatrists welcome in the society, and providing a place to support the professional needs of the members. The second theme concerns developing and maintaining relationships with organizations that can promote the needs of our members and our patients.

Many of the goals for the society come together in the general membership meetings. As financial and regulatory pressures mount, we all find ourselves becoming more efficient, but not necessarily more fulfilled. It is the goal of the general meeting to allow each of us to connect with one another socially and professionally – to break bread and enjoy a meal together, to re-connect with old friends, to make new friends, to hear about where our profession is going, to find out what challenges lie ahead, to talk about our plans to meet these challenges together, and to learn together. It is encouraging to meet the young psychiatrists, inspiring to meet the old ones. Attendance at these meetings has been excellent, and people have clearly been enjoying themselves. Ultimately, it is this connection to each other and our profession that will serve as a foundation for our psychiatric society. As long as we are actively involved with each other, we can create an environment that will benefit our patients and us.

There are also programs which serve to promote the involvement of groups which otherwise might feel overwhelmed by the majority membership. The Early Career Psychiatrists (ECP) program pioneered by Barry Wall continues to be enormously successful. About one third of our membership are in training or have recently finished training. In addition to encouraging participation at the general meetings, RIPS sponsors four ECP meetings each year geared specifically to the needs of this group. Attendance and enthusiasm have been great. More recently, we have begun a program to serve the needs of International Medical Graduates.The International Committee, under the guidance of Kazi Salahuddin, will continue to sponsor dinner meetings with the intent of addressing the unique needs of this group, which constitutes about a quarter of our membership. It is my hope that these dinners can facilitate attendance at the general meetings and more active participation in the society.

We are fortunate to have established a number of important relationships with outside organizations. *continued page 7*

December 2003

Volume 34, Number 3

Editorial

Anthony Jay Thornton, MD
Editor

No Room at the Inn

Many of you are probably already aware that periodically, and with increasing frequency over the last two years, psychiatry beds are filling up in the state. This causes back-ups similar to busy times at Logan Airport. Certified patients are stacked up in emergency rooms, sometimes for days, often with little to no treatment. Voluntary patients are put on waiting lists and can at least wait at home. This scenario is playing out across the country with at least half the states reporting similar problems. It has become very severe in Maryland and Minnesota where elaborate studies and reports have been commissioned to investigate the problem and suggest fixes. There have been meetings between various interested parties in Rhode Island, but at this stage it is mainly finger pointing with little coordinated problem solving. There was the Statewide Health Assessment Planning and Evaluation (SHAPE) study sponsored by BCBSRI. It told us demand for psychiatry beds would outstrip supply by 2006. This seems to be the case now (or at least the beginning stages). This has been an ongoing problem in child psychiatry, but now it has spread to adult psychiatry. What gives?

As usual, this seems to be a very complex, multifaceted problem with no easy answers. The simplest thing would seem to build more beds. As we speak, Rhode Island Hospital is expanding their number of psychiatric beds. It is true that according to the World Health Organization the US has many fewer psychiatry beds per population than Europe. No one seems to think this will ultimately solve the problem, but may be a temporary fix. The thought is that this option will turn out like the famous quote from the movie Field of Dreams…"If you build it…they will come." In a short matter of time we would likely be in the same predicament.

I would like to thank Elizabeth Earls, President/CEO of the Rhode Island Council of Community Mental Health Centers for providing much of the Rhode Island-specific information used in this editorial. She is involved in and is aware of activity in the state regarding this problem. There have been problems with getting people out of the hospital, especially the indigent. If the indigent do not fall within certain program

guidelines, there are really few to no community services for them. This creates the revolving door phenomenon. The "Butler bed," where MHRH pays Butler to care for indigent patients referred by local CMHCs, has nearly doubled in use. This has become such a problem that MHRH is requiring utilization review practices aimed at reducing the length of stay. This practice has been used in the private sector for years and has apparently not reaped great savings or benefit over time (except initially, when stays were reduced from one to two months to a few days). In fact, private insurers are more reluctant to deny admissions and use alternatives these days due to Department of Health regulatory actions.

Communication between inpatient and outpatient psychiatrists is often sited as an area where improvement is needed (both locally and nationally). Patients are sometimes released on medications and expected services they have no hope of being able to obtain outside the hospital. Outpatient psychiatrists sometimes do not communicate medication trials and treatments that have been attempted, causing inpatient psychiatrists to spin their wheels. We certainly do need to talk to each other more for the benefit of our patients and the system as a whole.

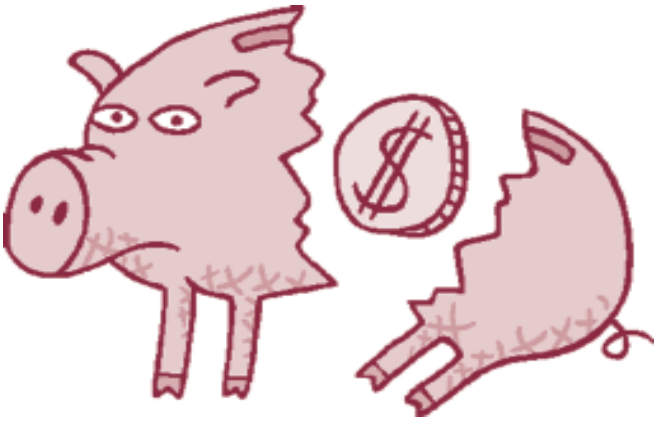
Are our campaigns to increase public awareness of mental health issues and treatment, and our crusade to lessen stigma finally paying off? Maybe so; there is an increasing demand for mental health care all across the country. In a Minnesota Hospital and Healthcare Partnership survey, demand for emergency or inpatient psychiatric services had risen 16–39% between 1997 and 2001.

A lack of detoxification and substance abuse treatment beds is another problem. Many patients are being diverted into mental health beds with dual diagnoses. The luxury of observing a patient for a month or more off drugs and alcohol in a controlled environment before medicating is largely gone. These complex patients seemed to have increased in numbers in recent years.

Inadequate funding is oft quoted as the culprit. Well, it is about to get worse. Financially strapped states are looking for ways to balance their budgets. There is a rumored 10% cut coming to MHRH and the CMHCs. Those in other states such as Massachusetts have seen draconian limitations in medications on formulary for Medicaid patients. This has not as yet impacted us as greatly in Rhode Island. However, those familiar with the CMAP program (providing psychiatric medications for the uninsured that meet certain criteria at CMHCs) know that it is tightening up to stem the flow of red ink. This on top of an already strained and inadequate system is a recipe for further disintegration of the system.

The Minnesota Psychiatric Society Task Force Report on the Shortage of psychiatrists and of Inpatient Bed Capacity came up with several recommendations. Here are a few:

- Increase reimbursement rates to reasonably reflect the true actuarial costs of inpatient care and comparable to other hospital based care.
- Establish monetary incentives for hospitals to create or increase psychiatry beds.
- Develop short stay facilities for crisis intervention, stabilization, assessment, and treatment plan development that divert people away from hospital emergency rooms.
- Expand and fund the role of Community Mental Health Centers as a community based resource to help patients stay out of the hospital.



- Encourage primary care clinics to more fully integrate mental health into services provided at the clinic including consulting psychiatrists.
- Integrate mental health and substance abuse funding and services.
- Eliminate behavioral health carve outs.

What can we do? I believe we as individual psychiatrists and RIPS as a society need to stay involved and even increase our involvement in the political process where these issues are decided. Otherwise they will be decided for us by individuals with little understanding of the clinical implications of their actions. We have a unique role of being patient advocates, but also being a part and having an in-depth knowledge of the systems that provide care. ❖

Kleptomania: New Knowledge, New Treatments

Jon E. Grant, JD, MD, Director of the Impulse Control Disorders Clinic at Butler Hospital and Assistant Professor of Psychiatry at Brown Medical School, spoke to the RI Psychiatric Society on Monday evening October 20, 2003 at Spain restaurant on the topic of kleptomania. A leading researcher in the area of kleptomania, Dr. Grant detailed the history, clinical features, and treatment of this often ignored disorder.

Reports of kleptomania date back to the late 18th century. Largely ignored by current clinicians, kleptomania has intrigued both medical science and the popular imagination episodically through the years. Parisians during the 19th century worried about an "epidemic" of kleptomania, possible coming from Britain. Psychoanalysts in the early 20th century theorized about possible sexual psychopathology underlying the behavior.

A recent *Time* magazine story, which featured Dr. Grant, has kindled new interest in kleptomania. Regarded by many as a 'behavioral addiction' or an 'addiction without a drug,' kleptomania may share many features with disorders such as pathological gambling, compulsive shopping and compulsive sexual behavior. In fact, Dr. Grant has recently published a book on these disorders, *Stop Me Because I Can't Stop Myself: Taking Control of Impulse Behavior* (McGraw-Hill, 2002), which features numerous patient stories of their difficulties with these behaviors and suggestions for treatment.

The core feature of kleptomania appears to be an urge or craving to steal. Often unprovoked, this urge is usually experienced as intrusive and distracting. Patients report that stealing relieves the cravings, but then intense shame and embarrassment follow. Usually too ashamed to tell family members, patients may steal for years without telling anyone. They may seek treatment for the depression that often follows their behavior, but they may never tell their treating physicians about the stealing. Some patients even consider suicide as a means of stopping their behavior. In fact, levels of perceived stress in patients with kleptomania appear significantly higher than patients suffering from moderate to severe depression. Additionally, a quality of life study found that kleptomania patients report significantly lower quality of life than normal controls, with the majority reporting "low" or "very low" quality of life.

Comorbid depression is common in people with kleptomania, as are anxiety disorders and other impulse control disorders such as compulsive buying or compulsive sexual behavior. Interestingly, obsessive-compulsive disorder, antisocial personality disorder, and borderline personality disorder are not usually comorbid conditions.

Although perhaps 90% of the general population has stolen something at some time, usually as children or adolescents, the question remains as to why some people cannot control this behavior. Dr. Grant's research on the childhood development of patients with kleptomania suggests that a parental neglect hypothesis may underlie some of the behavior. When asked to recall parental behavior, patients with kleptomania tend to characterize their parents as not particularly loving or protective. Although childhood abuse is not overly represented in this patient population, there is a suggestion that some type of perceived neglect may contribute to some of this behavior.

In addition, family studies suggest that patients with kleptomania may have higher rates of substance use disorders among first-degree family members. Whether this suggests a genetic link among addictive behaviors or reflects the behavioral disinhibition often found in children of parents with substance use disorders is not clear at this point. It may, however, suggest a possible avenue for early recognition and intervention concerning stealing behavior.

A member of the California Bar Association and a former practicing attorney in San Francisco, Dr. Grant discussed the legal aspects of kleptomania and the current status of the 'irresistible impulse defense' in criminal law. Dr. Grant works with public defenders to recognize possible signs

of kleptomania and to direct these clients for treatment. Patients with kleptomania do not generally shoplift with others, they may report an inability to control their behavior, they may steal things that seem peculiar or make no sense to the person, and they often report amnesia for the actual theft, as dissociation may be pronounced in many patients.

Drawing upon his recent treatment research, Dr. Grant discussed treatment options for kleptomania. Having treated possibly the largest group of patients with kleptomania, Dr. Grant offered evidence for the pharmacological and psychotherapeutic management of this disorder. In particular, he spoke of the possible effectiveness of cognitive-behavioral therapy and family therapy. Citing his clinical work and some case reports, Dr. Grant discussed the usefulness of imaginal desensitization in combination with cognitive restructuring. Patients need to first understand that the urges to steal will go away and that stealing is not the only means by which the urges to steal can be reduced. In addition, taking patients through successful imaginative exposures to being in stores and not stealing provides them with a means by which they can respond to their urges in a healthier fashion. Dr. Grant also reported his open-label study using naltrexone in the treatment of kleptomania, the first pharmacological study of this disorder. Naltrexone, an opioid antagonist, was effective in reducing or eliminating the urges to steal, as well as the pleasure associated with stealing, in the majority of patients. A three-year follow-up study of Dr. Grant's clinic patients (not yet published) has also shown that the majority of treated patients improve and are able to control their stealing behavior.

In addition to his recent book written primarily for patients and their families, Dr. Grant has written numerous peer-reviewed scientific articles on kleptomania. In addition, he has developed a diagnostic instrument for clinicians to use when trying to determine if someone suffers from kleptomania. Dr. Grant will make the diagnostic tool and articles available upon request. For patients, Dr. Grant offers evaluation for anyone suspected of suffering from kleptomania, and will provide both pharmacological management and psychotherapy for those who suffer from kleptomania. For patient referrals, please call Dr. Grant at 401-455-6391. ❖

L–R: Luisa Skoble, MD; Tracy Kuniega-Pietrzak, MD; Giovanna Bouthiette, MD

L–R: Mickey Silver, MD; Kazi Salahuddin, MD; Carmen Monzon, MD

The Scene at the Cowesett Inn on a Terrifying Night

J. Clement Cicilline, MS
President/CEO
Newport County Community Mental Health Center

Editorial Note: Regarding last issue's editorial, it was J. Clement Cicilline, MS, President/CEO of Newport County Community Mental Health Center, who spearheaded the mental health response to the Station nightclub fire disaster (not Mayor David Cicilline, his nephew, who did make all needed Providence city services immediately available to West Warwick). Mr. Cicilline has provided an article of his first hand experience of the initial hours after the fire, with an update since that time.

On the morning of February 20, 2003, Mary Jane Creely, VP for Quality Improvement, Jean Darling, HR Administrator, and I met with Nicholas Logothets, Team Leader, Emergency Services, American Red Cross. The meeting was initiated by us because we wanted to develop a plan in the event of a disaster. The example we used was a possible fire at our group home. Nick advised us of what we needed to do and what Red Cross could provide. We were most pleased with the outcome of the meeting. Little did we expect that within 13 hours of that meeting, we would be called by Nick to provide mental health services at the scene of The Station Fire in West Warwick.

The first wave of responders from NCCMHC included Mary Jane Creely, Anna Harrison-Auld, Administrator of Adult Outpatient and Emergency Services, and me. Upon arrival, we went directly to the Cowesett Inn to provide assistance. Red Cross volunteers were already on the scene and welcomed our presence. The word "surreal" has been used a number of time to describe what was happening that night. It is an apt description. The Cowesett Inn was both a frenetic beehive of activity and a real haven for a whole range of individuals with markedly different roles and responsibilities. There were, of course, fire fighters and police personnel. There were family and friends of victims. There were survivors and volunteers – medical and mental health. There were members of the clergy and investigators from the Attorney General's office. There were Cowesett Inn employees. And there was one of The Station owners.

The atmosphere was understandably tense. Information was slow in coming. The fire fighters and police had their first-hand experiences in dealing with survivors and victims that would have an indelible effect on them. At once, they saw, heard, and smelled the worst of it all. They needed and received help in coping with the physically and emotionally devastating effects of the fire. At the same time, they had to be protected from an inquiring cadre of reporters who wanted to tease information from them to pass on to the general public.

Then there were family members and friends who gathered at tables and around the bar and, often, at the television sets, hungry and anxious for news – really goods news that never seemed to come. They drank coffee and soda. They paced and prayed and later ate scrambled eggs provided by the Cowesett Inn at around 4 o'clock. They talked more among themselves than with others, but were appreciative of the numerous offers of help.

There were some survivors there as well, including one guy from Portsmouth and another from Tiverton. They were grateful to be alive, but there was nothing happy about their tone. They wanted to leave more than talk, but couldn't access their car. Then, there was the band leader. He said he was lucky to be alive and he gave me a hug when I asked how he was doing. Conversations were mostly brief; most ending with heavy silence. We got to know the names and occupations of the people lost in the fire, but there seemed to be a reticence about saying much more. The air was thick with uncertainty and sadness. Support came in the form of an arm over their shoulders.

Hope got pushed around by confusion, so, at times, firefighters, family members, survivors, and volunteers didn't really know what was going on. The dim lighting in the place seemed to be an eerie metaphor for the thinking and feeling of everyone around. But, there was always a sense of support permeating the scene – and there was an unspoken understanding and determination that everything possible would be done. Then, we left for the Crowne Plaza where a much larger operation was being established. The response from the mental health provider community was awesome - and that continues to the present. Correspondingly, the State of Rhode Island has opened its hearts,

doors, and resources in a dimension beyond measure, as if realizing that we all lost something dear that night.

P.S. – It's been many months since The Station fire and since the above article was written. For sure, a significant number of people continue to struggle with the effects of that devastating fire. Survivors, family members, friends, and rescue personnel have been going through a whole range of reactions that will still play out over more months and then years.

Whatever good that such a catastrophic event like this yields can be seen in the many precautionary measures that have been put into place. We see more stringent enforcement of existing fire codes and the enactment of new procedures that will increase public safety.

In addition, we are seeing the special training and mobilization of behavioral healthcare workers who will be much more helpful in such tragedies. NCCM-HC got thrust into such a circumstance following the crash of Egypt Air Flight 990 in October, 2000. Then, the terrorist attacks of September 11, 2001, gave us all a jolt, resulting in the need for behavioral healthcare workers to become more prepared to assist people in such crises. Working in chaotic situations is not easy. But, because they keep occurring, we seem to be getting better at it. And, that is something to ponder. ❖

Member Notes

Congratulations to **JANE EISEN, MD**, who has been named the new Training Director, Brown Medical School, General Psychiatry.

MINDY ROSENBLOOM, MD, has a new office location effective January 1, 2004: 26 Bosworth Street, Suite 5, Barrington, Rhode Island 02806.

Our Website Is Up and Running!

The RIPS website has been launched. The address is psychri.org. You will find information on upcoming meetings and Grand Rounds, the most recent newsletter, and more. Visit the site!

President's Message continued

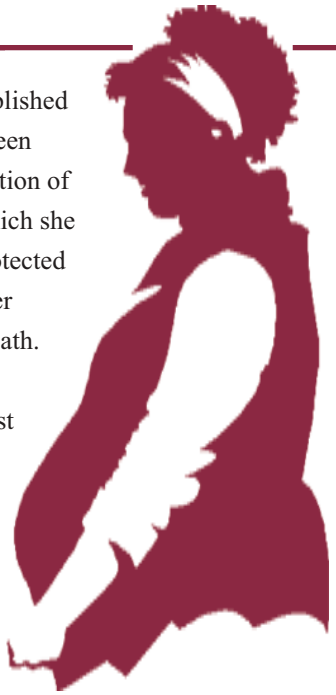
With the Eleanor Slater Award we have an opportunity to recognize community leaders who have advocated for our patients. We have developed a relationship with NAMI that allows for free communication and mutual support. We have assumed an active role in the Rhode Island Medical Society's mission to improve reimbursement from Blue Cross, and we remain actively involved in their council. Our general meetings are frequently used to connect state and national leaders to our members. It is critically important that all of the relationships be in place in anticipation of any one of a number of challenges that can suddenly erupt. These alliances give us a voice as issues arise and provide us support when we need to see things changed. ❖

Committee on Women

Alison Heru, MD

The Law, Women, Pregnancy and the Use of Substances

In October 2003, the US Supreme Court upheld the decision to convict Ms. Regina McKnight of homicide after she gave birth to a stillborn child. The prosecution of McKnight was made possible by a 1996 state Supreme Court ruling that a viable fetus is considered a child and mothers can be charged with abuse if they took drugs after their unborn child was able to live outside the womb.



Regina McKnight is a 26-year-old native of South Carolina. She has an IQ of 72 and lived with her mother, who helped her with day-to-day needs. In 1998, however, her mother was killed by a hit and run driver. Left without the support system she became homeless, addicted to both cocaine and marijuana – and pregnant. On May 15, 1999, McKnight was transported, in labor to Conway Hospital, where she delivered a stillborn girl. There had been no prior indication that the fetus was in distress, and it has never been suggested that McKnight intended to harm the fetus. On the contrary, the attending nurse testified at trial to having comforted McKnight, who was grief-stricken by the stillbirth. As is common with distraught parents, she asked to hold the stillborn baby and requested that photographs of the baby be taken. She told hospital staff of the name – "Mercedes" – that she had picked out for the baby. She asked to be given a "memory certificate" with the baby's footprints and the bracelet that the baby had worn. She also asked to see the hospital's chaplain.

Within minutes of the stillbirth, however, hospital staff assumed a second role. Following a carefully developed "protocol," they obtained a urine sample from McKnight, for drug testing. After that screen indicated that cocaine was present, a nurse, following the protocol, obtained McKnight's signature on a form entitled "Informed Consent for Drug Testing," and collected a second sample for "forensic" testing, with positive results reported to the State Department of Social Services ("DSS"). McKnight was arrested on October 7, 1999, and charged under a statute proscribing "homicide by child abuse," which makes it a felony to "cause the death of a child under the age of eleven while committing child abuse or neglect," if the death occurs "under circumstances manifesting an extreme indifference to human life." The law provides for a prison sentence of twenty years to life.

The state had previously prosecuted women for abuse if their delivered babies showed traces of cocaine, but Ms. McKnight's was the first drug-related case to be tried and convicted for murder under a "homicide by abuse" law. The jury deliberated less than 15 minutes before returning a guilty verdict against McKnight who had two other children and was two-months pregnant again.

South Carolina Attorney General Henry McMaster defended the state's position, "This is not a case involving a tragic stillbirth that occurred through no fault of the mother. On the contrary, the evidence established a direct link between McKnight's ingestion of crack cocaine, which she had no legally protected right to do, and her child's in utero death. "The state has a compelling interest in protecting the child's life," and McKnight should have been well aware of the legal risks of drug use that could harm her child. While the fact that other states have failed to take such steps to protect viable fetuses may make South Carolina's decision to do so novel, it does not make it unconstitutional or mandate that this court intervene." Prosecutor Bert von Herrmann told reporters "The state needed to press forward because a child ended up dead." "She smoked cocaine as much and as often as she could…if that's not extreme indifference to life, I don't know what is."

One prior case is relevant; *Whitner vs. the State of South Carolina*. Cornelia Whitner was sentenced to eight years in prison for smoking crack cocaine while she was pregnant. She was charged with unlawful child neglect. In 1997, the South Carolina Supreme Court used the Whitner case rule that pregnant women who risk harm to their viable fetuses may be prosecuted under the state child abuse laws. The South Carolina Supreme Court became the first (and only) state supreme court to issue such a sweeping ruling. The impact of the Whitner decision on the health and well-being of women and children in South Carolina has been devastating. The decision gave law

enforcement a green light to arrest and prosecute pregnant women for child abuse who suffered from drug and alcohol dependence. At least two South Carolina substance abuse treatment programs that give priority to pregnant women reported precipitous drops in their admissions after this decision and South Carolina recorded its most significant increase in infant mortality in a decade in 1997. During a similar period of time, the number of abandoned babies in South Carolina increased twenty percent.

The APA was among many organizations that signed onto the Amicus brief sent to the Supreme Court regarding Regina McKnight. There is another similar case in Hawaii, so it is important that we understand the issues at hand. These are clearly laid out in the following excerpts from the Amicus brief.

I. INTERESTS OF THE AMICI CURIAE

Amici include national and South Carolinian physicians, nurses, counselors, social workers, public health practitioners, and their professional associations. These individuals and organizations are experts in the fields of maternal and neonatal health, *and* have a collective interest in providing care to women who suffer from the tragedy of miscarriage. Together, they embrace an enduring commitment to minimizing the effects of drugs and other substances on users, their families and society. Through this brief, *amici* seek to expose the substantial health risks that will likely result when courts depart from science and medical knowledge by prosecuting, convicting and imprisoning women who suffer stillbirths for the crime of homicide. Because of the intolerable risks to the well-being of both women and children created by the South Carolina Supreme Court's decision in *State v. Regina D. McKnight*, 576 S.E. 2d 168 (2002), as well as what threatens to become a trend in prosecuting women who experience stillbirths, *amici* urge this Court to grant certiorari in order to undo the grievous harms unleashed by the decision below.

II. INTRODUCTION

A fractured South Carolina Supreme Court took a dangerous and unprecedented departure from science and established medical practice when upholding the homicide conviction of Regina McKnight. The prosecution, conviction, and sentencing of Regina McKnight for experiencing a stillbirth after having used drugs contradicts the clear weight of available medical evidence, violates fundamental notions of public health, and undermines the physician-patient relationship.

Amici's longstanding commitment to the care of pregnant women and their unborn fetuses give rise to this brief. *Amici* do not advocate or condone the non-medical use of drugs – including alcohol or tobacco – by either parent during pregnancy. Nor do *amici* contend that there are no health risks associated with illicit drug use during pregnancy. Although the medical literature unequivocally belies South Carolina's assertion that prenatal cocaine exposure caused the stillbirth experienced by Ms. McKnight, it does not indicate that such exposure is entirely benign. Nonetheless, *amici* contend that the factual record and current state of medical science wholly fail to support any claim that Ms. McKnight's stillbirth was caused by the ingestion of cocaine. The scientific literature reveals two clinical conditions linked to pre-natal cocaine ingestion that may result in miscarriage or stillbirth: placental abruption and ruptured membranes. Neither condition was present in Ms. McKnight's case. Moreover, there are several other factors that further demonstrate the implausibility of South Carolina's theory of causation, including the absence of a medically identifiable cause of death.

Tens of thousands of women suffer from stillbirths each year. For a substantial number of stillbirths, medical professionals are unable to provide the parents with any explanation (beyond mere conjecture) of how or why the stillbirth happened. As in the case of Regina McKnight, parents typically experience stillbirths as personal tragedies, not criminal acts. Yet, by conferring boundless discretion on South Carolina's prosecutors to investigate and punish women who suffer a pregnancy loss, the *McKnight* decision transmogrifies a medical and public health matter into an issue of serious criminal liability. The likely consequences are difficult to overstate. The *McKnight* decision makes a potential prosecutorial target of all women in South Carolina who are unfortunate enough to suffer stillbirths, and dubiously transforms prenatal service providers from health care and social service professionals into agents of law enforcement. As a result mothers (particularly those most at risk for losing their pregnancies for whatever reason) will be deterred from accessing medical care, prenatal treatment and related services for fear of eventual prosecution if they are unable to deliver a living and full-term child.

III. REASONS FOR GRANTING THE PETITION

A. Review should be granted because the *McKnight* decision potentially endangers all child-bearing women in South Carolina.

A multi-layered approach is needed to properly assess the cause of fetal demise, including an examination of the fetus, the placenta, and the mother. Even after carefully evaluating the fetus and the mother's clinical history, at least ten percent of all fetal deaths remain *entirely* unexplained. For numerous other incidents, several possible reasons may emerge, but no clear answers are forthcoming. As noted by the *Guidelines for the College of American Pathologists*, "although many conditions can be ruled out, it may be impossible to determine the actual cause of death in a fairly large number of cases."

Pregnant women can engage in a wide range of conduct, including the ingestion of various licit and illicit substances during pregnancy, that can create a risk of stillbirth that exceeds the conduct prosecuted in *McKnight*. And, to paraphrase the South Carolina Supreme Court, these dangers are "within the realm of public knowledge." For example, a recent study indicates that women who smoke tobacco during

pregnancy double their risk of delivering a stillborn child. Becoming pregnant after the age of 35 carries with it a heightened risk of pregnancy loss, even when controlling for diabetes, hypertension, and other complications associated with increased maternal age such as abruption. It is also "within the realm of public knowledge" that many prescription drugs can cause fetal death or serious fetal harm. For example, use of the popular acne medication Accutane, gives rise to a 35% chance of delivering a child with multiple major deformities while also greatly increasing the risk of miscarriage or stillbirth. Although these risks are listed prominently on Accutane's label, and have been reported in the news media, nearly three out of 1,000 women between the ages of 14 and 44 use Accutane to improve their complexions. Under the *McKnight* decision, each of these scenarios could give rise to criminal culpability.

B. Review should be granted because the pathologists findings fail to support the conclusion that Ms. McKnight's cocaine use resulted in still birth.

In the case of Regina McKnight, the overwhelming weight of the scientific evidence not only does not support the conclusion that cocaine caused Ms. McKnight's stillbirth, but affirmatively points to other non-cocaine-related explanations. A recent meta-analysis of cocaine use during pregnancy found that two complications are uniquely associated with prenatal cocaine exposure and stillbirths: placental abruption and premature rupture of the membrane. Neither condition, however, was present in Ms. McKnight's case. The fetal autopsy report fails to mention placental abruption, and both of the State's pathologists testified at trial that Ms. McKnight did not experience this condition. Similarly, the State's pathologists, Ms. McKnight's medical records, and the autopsy report all omit any reference to premature rupture of membranes. Furthermore, other conditions that some researchers have found to be associated with in utero cocaine exposure, e.g., reduced birth weight and congenital defects (conditions that cocaine research has been unable to isolate from factors such as maternal exposure to alcohol, tobacco, or poverty) were also absent in this case. In fact, the State's pathologists testified that the organs of McKnight's fetus were normal and that it appeared to have developed without incident prior to the stillbirth. In short, the full weight of medical evidence in this case points to a cause or causes for fetal demise other than cocaine exposure.

In light of the absence of any recognized indicia for cocaine-associated fetal demise, the State's claim that cocaine use *caused* Ms. McKnight's stillbirth must derive from a "presumptive diagnosis," or the elimination of alternative causes. The factual record in this case, however, thwarts such reasoning. Instead of excluding alternative causes, the medical evidence underscores the fact that several possible factors other than cocaine ingestion were far more likely to have caused Ms. McKnight's stillbirth. In particular, the autopsy report identifies chorioamnionitis and funisitis as two additional causes of fetal death. Ms. McKnight also had syphilis, was indigent, suffered from hyperthyroidism, and smoked tobacco. Each of these factors alone increases the risk of pregnancy loss. In combination, the risk is only intensified. Yet the State does not appear to have considered, let alone excluded these additional, pertinent, and proven causes of fetal demise that plainly appear in the factual record.

The State's pathologists' repeated failures to properly establish the cause of Ms. McKnight's stillbirth are further exposed by two studies at the Medical University of South Carolina. These studies highlight not only the difficulty in determining the cause of stillbirths, but also the near impossibility of concluding that cocaine can be its sole cause. The first study, a ten-year retrospective of pediatric toxicological deaths, showed that only 1.1% of the neonatal and fetal deaths examined were *associated* with prenatal cocaine abuse. Despite this association, cocaine was not listed as the sole cause of death in *any* of the fetal deaths. The second study focused on the 42 fetal deaths referred for autopsy to the Forensic Section of MUSC between 1990 and 1999. Twenty seven of these autopsies included toxicologic analysis, in which seven tested positive for cocaine. As with the previous study, all of the cocaine associated deaths were designated as "natural" or "undetermined," *not* as homicides.

C. Because Scientific research is inconclusive about whether prenatal cocaine exposure inflicts "harms" on the fetus, the South Carolina Supreme Court erroneously found that such harms are "common knowledge" and so erroneously determined that petitioner has sufficientl *mens rea* to commit homicide by child abuse.

Contemporary research on the developmental impact of cocaine use during pregnancy has debunked the myth that mere exposure to cocaine causes certain fetal harms. The Journal of the American Medical Association recently published a comprehensive and authoritative analysis of all medical research assessing the relationship between maternal cocaine use during pregnancy and adverse developmental consequences for the fetus and child. Using carefully developed selection criteria, JAMA researchers identified all seventy-five English-language studies of the effects of *in utero* cocaine exposure. They then undertook a detailed review of all the studies that complied with accepted scientific practices. The researchers concluded that there is no convincing evidence that prenatal cocaine exposure is associated with any developmental toxicity difference in severity, scope, or kind from the sequelae of many other risk factors. Many findings once thought to be specific findings of *in utero* cocaine exposure can be explained in whole or in part by other factors, including prenatal exposure to tobacco, marijuana, or alcohol and the quality of the child's environment. In light of these findings, the JAMA researchers condemn as "irrational" policies that selectively "demonize" *in utero* cocaine

exposure or target pregnant cocaine users for special criminal sanction.

None of this is to say that prenatal cocaine exposure is benign. While current studies are unable to causally connect cocaine to adverse fetal developments, neither do they exclude cocaine as a potential fetotoxin. Without doubt, more research is needed. But it is precisely this fact that exposes the injustice and irrationality of the *McKnight* decision. Where science has yet to speak with assurance, the Court below found sufficient *mens rea* to convict a young, border-line retarded, substance-dependent woman of homicide for conduct that is not causally connected to the death of her fetus.

D. The petition should be granted to prevent the erosion of the patient-physician relationship between women and their caregivers.

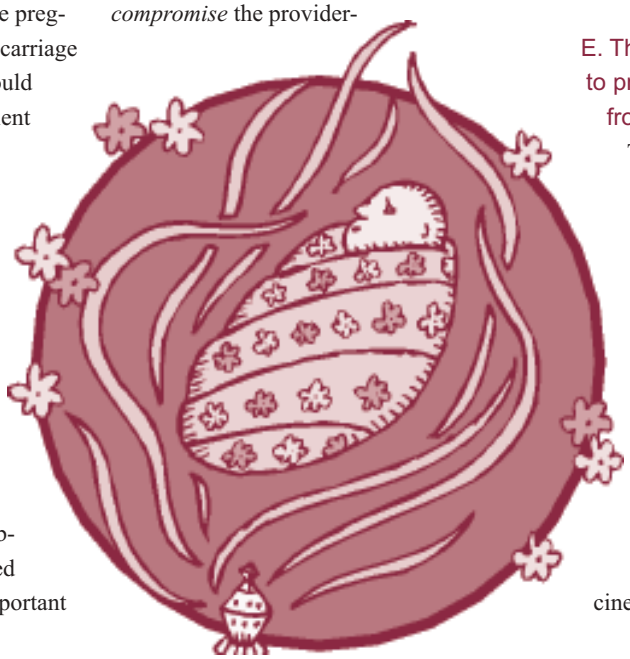
Amici also oppose the prosecution and conviction of Ms. McKnight on broader public health grounds. Medical and public health professionals uniformly object to the prosecution of women for their behavior during pregnancy because it erodes their willingness to seek health care or to confide openly with their health care providers. This inevitably endangers the health of both women and their fetuses.

Amici are firmly convinced that the prosecution of Ms. McKnight undermines the quality and accessibility of health care for substance abusing women who are pregnant or recovering from delivery, miscarriage or stillbirth. Trust and confidence should define the relationship between a patient and her caregiver. It is thus critical to ensure that all patients, especially those suffering from substance abuse, can speak with their care providers in an open and candid manner. *Amici* believe that the prosecution and conviction of women like Ms. McKnight corrodes the sanctity of this relationship. Additionally, as *amici* can attest, and clinical experience confirms, the prosecution of pregnant substance abusers deters similarly situated women from seeking or obtaining important obstetrical care. As a result, maternal and fetal health suffers.

There are several reasons why a pregnant, recently delivered or miscarried patient's reluctance to confide openly to care providers can endanger her health. First, drug use is one of the most commonly missed diagnoses in obstetric and pediatric medicine. In most cases, a patient's drug use is not readily apparent if the patient does not disclose such information. Additionally, health care workers and pregnant patients must be able to discuss many sensitive matters to protect both maternal and fetal health. Among these are whether she and the fetus are at risk of HIV, Hepatitis C, or herpes infection due to unprotected sex or intravenous drug use. Important medical benefits accrue when treatment providers permit patients to feel sufficiently comfortable in divulging highly personal, often stigmatizing, and sometimes incriminating information. And since complete and accurate patient information is essential for the delivery of proper medical care, health care professionals across all disciplines are expected to uphold the duty of medical confidentiality. In addition to medical and public health professionals, the courts have long recognized the obligation of confidentiality as not solely a matter of principle, but a necessary precondition of a beneficial relationship between a patient and caregiver.

Prosecutions like that of Ms. McKnight *compromise* the provider-patient relationship by placing medical providers in the role of law enforcement while at the same time allowing, if not encouraging, criminal justice officials to abuse confidential medical tests that are administered by health care professionals for therapeutic and evaluative purposes. Although medical professionals failed to conduct many of the standard tests necessary to deduce the actual cause of Ms. McKnight's stillbirth (to the extent the cause could ever be identified), Ms. McKnight believed the tests that were performed were done to assist in the discovery of medical information that could benefit her and help her reconcile the tragedy she just suffered – not aid the State in her prosecution.

In sum, patients like Ms. McKnight seek medical care and counseling, answer questions from health providers about their personal and medical backgrounds, and consent to the administration of intrusive, sometimes painful medical tests because they believe that the information that they provide the medical professionals will be handled in the utmost confidence and will be used strictly to advance the patient's treatment interests. The *McKnight* decision, however, changes these once true assumptions and replaces a medical protocol for the treatment of women who suffer stillbirths with a criminal law protocol for the investigation, prosecution and punishment of women grieving the loss of their pregnancy.



E. The petition should be granted to prevent the deterence of women from medical care.

The Board of Trustees of the American Medical Association determined that when the criminal justice system is used to deal with drug-abusing mothers, "pregnant women will be likely to avoid seeking prenatal or other medical care for fear that their physicians' knowledge of substance abuse or other potentially harmful behavior could result in a jail sentence rather than proper medical treatment. In addition, the American Society of Addiction Medicine declared that "criminal prosecution of

chemically dependent women will have the overall result…of increasing, rather than preventing, harm to children and to society as a whole." Even a study by the United States General Accounting Office concluded that "the threat of prosecution poses… [a] barrier to treatment for pregnant women." These organizations are not alone. Every prominent public health and medical organization that has seriously considered this subject agrees that a punitive approach to drug use during pregnancy will worsen rather than resolve the problem. The American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the March of Dimes, the National Association of Public Child Welfare Administrators, the National Council on Alcoholism and Drug Dependence, and the American Nurses Association are a few of the many organizations that share this view.

Because the prosecution of women like Ms. McKnight sends a perilous message to pregnant addicts *not* to seek prenatal care or drug treatment, *not* to confide their addiction to health care professionals, and *not* to give birth in hospitals – or not to carry the fetus to term – such prosecutions fail to serve any legitimate purpose, and in fact undermine South Carolina's objectives of promoting maternal and fetal health. Instead of saving lives, Ms. McKnight's prosecution is likely to endanger them.

CONCLUSION

The conviction of Regina McKnight for homicide by child abuse is not supported as a matter of science, inappropriate as a matter of public health, and unfounded as a matter of law. ❖

Opportunities

HELP WANTED

Part-time position for psychiatrist to join established, multidisciplinary practice in Foxboro, MA. Currently, we are 7 psychologists, 1 psychiatrist, and 1 LISCW. Medication evaluation and management and therapy cases available in abundance. Very collegial work environment and excellent fee for service rates.

To discuss, call Dr. Kerzner at
508-543-2133 x1 or send resume to
Kerzner Associates, PC
17 Cocasset Street, Foxboro, MA 02035

Mental Health Center News

NRI COMMUNITY SERVICES, INC.

News and Notes

• The Robert J. Wilson House, a NRI residential substance abuse treatment facility in Pawtucket, was named the Substance Abuse Treatment Provider of the Year by the Rhode Island Department of Mental Health, Retardation and Hospitals for its innovative work with ex-offenders, methadone maintenance clients, homeless veterans, and dually diagnosed clientele.

• NRI Community Services is the recipient of a multi-year federal grant awarded by CSAT in collaboration with the Robert Wood Johnson Foundation. The grant will establish information, referral, and case management service to enhance access and retention for clients with substance abuse problems.

• NRI Community Services' most recent HUD project is about to open in Providence. The ten low income apartments are specifically developed for adults with disabilities, other than severe and persistent mental illness. NRI hopes to lease units to its clients with other mental health and substance abuse problems.

• NRI Community Services has recently received a three-year CARF accreditation of its housing, substance abuse, mental health, crisis intervention, case management and residential treatment services. In light of the absence of DCYF or MHRH licensing of children's mental health services, NRICS also obtained CARF accreditation for its home and community-based children's services. ❖

THE PROVIDENCE CENTER

Medical Practitioner Appointments

ADRIENNE K. HALL, MD

Dr. Hall has been named psychiatrist for child and family outpatient services. A graduate of Occidental College in Los Angeles, CA and the University of Southern California School of Medicine, Hall brings extensive experience in management of psychiatric patients in a variety of settings to the child and family unit at The Center.

RICARDO RESTREPO, MD

Dr. Restrepo has been named psychiatrist for adult behavioral outpatient services at The Providence Center. Restrepo is a graduate of Instituto de Ciencias de La Salud medical school in Medellin, Colombia. He recently completed a residency in general psychiatry, along with a fellowship program in substance abuse treatment at Boston University Medical Center. Restrepo is currently a fellow at Boston University Medical Center for refugees and human rights as well as a member of its Physicians for Human Rights organization. Restrepo resides in Boston, MA.

The Providence Center is a community-based, outpatient behavioral health organization, annually serving over 8,000 adults, children, and adolescents who struggle with mental illness, addiction and emotional problems. Since its establishment in 1969, The Providence Center has been part of Rhode Island's exemplary behavioral health care system, offering a comprehensive array of treatment and rehabilitation services. ❖

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