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PROHIBITION DURING PREGNANCY: SUPPORTING MANDATORY OUTPATIENT REHABILITATION FOR WOMEN WHO GIVE BIRTH TO BABIES WITH FETAL ALCOHOL SYNDROME

*Grace Lykins**

“[F]etal alcohol syndrome is preventable—it need not happen ever again. The future of society, in this instance more than in most, is in our hands. We can’t claim ignorance any longer.”¹

INTRODUCTION

“By the time Seth was age two, he was totally out of control.”² Seth’s adoptive mother, a clinical social worker, later reflected that if she were not experiencing life with Seth firsthand that she “would have never believed a two year old could have taken such control of a family’s life.”³ After moving to a new school later in his childhood, Seth’s teacher petitioned

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¹ MICHAEL DORRIS, *THE BROKEN CORD* 281 (Paperback ed. 1990).

² Kathryn Shea, *Raising a Child with Fetal Alcohol Syndrome (FAS)*, NAT’L BIRTH DEFECTS PREVENTION NETWORK 1, http://www.nbdpn.org/archives/2005/2005pdf/Seth_story.pdf (last visited Nov. 28, 2011).

³ *Id.*

to have him removed from her class.⁴ Seth lasted less than one month in his second classroom, when the teacher's aide filed assault charges against him, a felony charge when a student assaults a school employee in Seth's home state of Florida.⁵ By age fifteen, Seth had participated in "more than sixteen different medication trials," and he currently takes five psychotropic medications.⁶ Seth's parents say, "[t]here is probably not a day that goes by that he is not in some kind of pain, either physically or emotionally."⁷ Seth has Fetal Alcohol Syndrome, and his troubled youth is just a preface for the future he faces.

"Fetal alcohol spectrum disorders (FASDs) are a group of conditions that can occur in a person whose mother drank alcohol during pregnancy."⁸ Of the fetal alcohol spectrum disorders, Fetal Alcohol Syndrome ("FAS") is the most severe.⁹ The impacts of FAS on children range from mild birth defects to debilitating mental and emotional disabilities.¹⁰ At its core, FAS is a byproduct of maternal alcohol addiction¹¹ and a lifetime affliction for a child whose mother consumed significant amounts of alcohol during her pregnancy. The U.S. Surgeon General urges all "pregnant women and women who may become pregnant to abstain from alcohol consumption in order

⁴ *Id.*

⁵ *Id.* at 2.

⁶ *Id.* at 1. "Psychotropic drugs are chemicals that affect the central nervous system, altering psychological processes (e.g. mood, thoughts, perception, emotions, behavior)." *Psychotropic Drugs—Definition of Psychotropic Drugs*, ABOUT.COM, <http://bpd.about.com/od/glossary/g/psytropic.htm> (last visited Oct. 10, 2012).

⁷ Shea, *supra* note 2, at 1.

⁸ *Fetal Alcohol Spectrum Disorders (FASDs): Facts About FASDs*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/ncbddd/fasd/facts.html> (last updated Sept. 22, 2011).

⁹ Kenneth Lyons Jones & Ann P. Streissguth, *Fetal Alcohol Syndrome and Fetal Alcohol Spectrum Disorders: A Brief History*, 38 J. PSYCHIATRY & L. 373, 377 (2010).

¹⁰ See *Fetal Alcohol Spectrum Disorders (FASDs): Diagnosis*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/ncbddd/fasd/diagnosis.html> (last updated Oct. 6, 2010) [hereinafter *CDC Diagnosis*].

¹¹ See *infra* notes 85–88 and accompanying text.

to eliminate the chance of giving birth to a baby with any of the harmful effects of the Fetal Alcohol Spectrum Disorders.”¹²

In recent years, states have used child abuse and neglect statutes to criminally prosecute women who consume controlled substances during pregnancy or who give birth to FAS babies.¹³ This Note argues that incarceration and other criminal sanctions are ineffective measures to resolve the root of the problem—the mother’s addiction. Instead, this Note proposes utilizing such statutes to impose sentences of mandatory postbirth outpatient rehabilitation, after medical testing determines that the child was exposed to significant levels of alcohol during the second or third trimester of pregnancy.¹⁴

Part I of this Note provides a medical overview of the causes and effects of Fetal Alcohol Syndrome and discusses why legal intervention is an appropriate means of deterring future FAS-related births. Part II analyzes the current legal treatment of Fetal Alcohol Syndrome at both the state and federal level. Part III compares retributive measures to rehabilitation and argues that criminal sanctions are an ineffective and constitutionally questionable approach to confronting addiction in pregnant women. Part IV examines postbirth rehabilitation models and proposes scientific testing of a newborn’s meconium¹⁵ to determine whether the mother consumed significant amounts of

¹² Press Release, U.S. Dep’t of Health & Human Servs. Office of the Surgeon Gen., U.S. Surgeon General Releases Advisory on Alcohol Use in Pregnancy (Feb. 21, 2005), *available at* <http://www.surgeongeneral.gov/pressreleases/sg02222005.html>.

¹³ *See infra* Part II.A.

¹⁴ This proposal specifically rests upon a mother’s actions during her second or third trimester of pregnancy, after the fetus has reached viability. The author in no way intends to deprive pregnant women of their full rights to timely abortions or for the stated argument to be extended to the abortion realm. This argument discusses the specific issue of FAS and proposes a means for addressing the severe medical and social impact of babies born with the debilitating syndrome. Though this argument, by necessity, enhances fetal rights to a certain extent, it does so only after the point of viability and in no way prohibits or diminishes a woman’s constitutional rights to abortion.

¹⁵ Meconium is the matter excreted during an infant’s first bowel movements and is comprised of substances the baby received from its mother *in utero*. *See infra* Part IV and notes 121–23.

alcohol during the second or third trimesters of pregnancy. Finally, Part V outlines a proposal for a sentence of mandatory postbirth outpatient rehabilitation, analyzing the flexibility provided by such programs against concerns for their potential constraints upon a woman's liberty. Ultimately, this Note concludes that mandatory postbirth outpatient rehabilitation is justified as an effective treatment approach for a mother's alcohol abuse, thus preventing the mother from giving birth to future FAS babies while creating a safer and more supportive home environment for an FAS child with special needs.

I. FETAL ALCOHOL SYNDROME: A MEDICAL OVERVIEW

It is increasingly understood that the formula for predicting an FAS birth is not quite as simple as was once concluded.¹⁶ Early researchers believed that the severity of FAS-related damage was directly correlated to the quantity of alcohol consumed by the mother during pregnancy, the frequency with which she consumed alcohol during pregnancy, and the timing of drinking during key developmental stages of gestation.¹⁷ A more recent study shows that "as the amount of alcohol consumed on one day rises, the risk of fetal alcohol abnormalities also rises: less than one ounce, very little risk; one to two ounces, 10% risk of abnormalities; five ounces, 50% risk of abnormalities; and over five ounces, 75% risk of abnormalities."¹⁸ It is equally clear that frequent consumption of lower quantities of alcohol is also damaging to the fetus.¹⁹

¹⁶ Philip A. May & J. Phillip Gossage, *Maternal Risk Factors for Fetal Alcohol Spectrum Disorders: Not As Simple As It Might Seem*, 34 ALCOHOL RES. & HEALTH 15, 16 (2011).

¹⁷ *Id.*

¹⁸ Claire E. Dineen, *Fetal Alcohol Syndrome: The Legal and Social Responses to Its Impact on Native Americans*, 70 N.D. L. REV. 1, 18-19 (1994) (citing Steven R. Hawks, *Fetal Alcohol Syndrome: Implications for Health Education*, 24 J. HEALTH EDUC. 22, 23 (1993) and Claire B. Ernhart et al., *Alcohol Related Birth Defects: Assessing the Risk*, 562 ANNALS N.Y. ACAD. SCI. 159, 160 (1989)).

¹⁹ See May & Gossage, *supra* note 16, at 17 (citing studies documenting that children who were prenatally exposed to alcohol at a mean daily consumption of more than 0.3 to 0.5 standard drinks per day as averaged

However, although “as little as one dose of alcohol has been demonstrated to reduce brain cell adhesion and cause neurological deficits . . . there is actually little evidence that one drink or even two a day cause harm” to the severe degree of FAS.²⁰ These statistics suggest that the highest risk of abnormalities occurs in infants whose mothers consumed alcohol consistently and heavily during pregnancy, perhaps engaging in binge-drinking patterns.²¹

When a pregnant woman consumes alcohol, the “alcohol passes through the placenta membrane, causing the fetus’s blood alcohol content to equal that of the mother.”²² The mother is able to quickly metabolize the alcohol to eliminate it from her system, but the fetus lacks this ability and the toxins linger inside the placenta.²³ These toxins “disrupt[] the formation of the fetus by impairing fetal oxygen supply and disrupting protein

across seven days were deficient in cognitive and behavioral abilities (including IQ) when compared to children who were not prenatally exposed to alcohol).

²⁰ Kathryn Page, *Fetal Alcohol Spectrum—The Hidden Epidemic in Our Courts*, JUV. & FAM. CT. J., Fall 2001, at 21, 22.

²¹ The National Institute on Alcohol Abuse and Alcoholism defines binge drinking in women as a drinking pattern that brings a woman’s blood alcohol content to 0.08 grams per 100 grams blood or above, which corresponds to consuming about four alcoholic drinks or more in a two-hour period. *National Institute on Alcohol Abuse and Alcoholism Council Approves Definition of Binge Drinking*, NIAAA NEWSLETTER (Nat’l Inst. on Alcohol Abuse & Alcoholism, Bethesda, Md.), Winter 2004, at 3, 3. “Binge drinking . . . produces the highest [Blood Alcohol Content (BAC)], and it is the peak BAC that affects the developing fetus most negatively.” May & Gossage, *supra* note 16, at 17 (citations omitted). *See also* Page, *supra* note 20, at 22 (“[B]inge-drinkers are the most frequent mothers of FAS children . . .”). Dr. Kathryn Page further notes that risk factors like poverty can come into play in instances of binge drinking because large (often forty-ounce) malt liquors and other inexpensive intoxicants contain the alcohol level of multiple drinks for a low price, “so one can [of the alcoholic beverage] qualify as a binge and can significantly harm the fetus.” *Id.*

²² Erin N. Linder, Note, *Punishing Prenatal Alcohol Abuse: The Problems Inherent in Utilizing Civil Commitment to Address Addiction*, 2005 U. ILL. L. REV. 873, 883.

²³ *Id.* (citing Dineen, *supra* note 18, at 18–19).

synthesis and hormone production.”²⁴ Additionally, the alcohol is directly toxic to the “rapidly dividing cells of the developing fetus” and interferes with nutrient delivery to the growing fetus.²⁵

Though the dangers of alcohol on fetal development are apparent, physicians and researchers have struggled to develop comprehensive diagnostic guidelines for FAS, in part because of the “lack of clinical expertise among general pediatricians in diagnosing affected children.”²⁶ As a result, the Centers for Disease Control and Prevention (“CDC”) does not have a precise record of how many children are born with FAS.²⁷ CDC studies on the prevalence of FAS births vary, with results ranging from 0.2 to 1.5 cases of FAS for every 1,000 live births to 0.5 to 2.0 cases per 1,000 live births.²⁸ However, the CDC has noted that, “because of the challenges of establishing accurate and timely prevalence information, the magnitude could be even greater than current data indicate.”²⁹ In the U.S. Department of Health and Human Services 2002 Appropriations Bill, Congress expressed an interest in remedying these statistical uncertainties to provide for more accurate accounting.³⁰ Congress mandated that the CDC, along with the

²⁴ *Id.*

²⁵ PADDY S. COOK ET AL., ALCOHOL, TOBACCO, AND OTHER DRUGS MAY HARM THE UNBORN 15–16 (Tineke B. Haase ed., 1990) (cited in Dineen, *supra* note 18, at 18).

²⁶ Jones & Streissguth, *supra* note 9, at 378.

²⁷ *Fetal Alcohol Spectrum Disorders (FASDs): Data & Statistics*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/ncbddd/fasd/data.html> (last updated Aug. 16, 2012) [hereinafter *CDC Data & Statistics*]. According to 2004 CDC estimates, 1,000 to 6,000 infants will be born with FAS each year. NAT’L CTR. ON BIRTH DEFECTS & DEVELOPMENTAL DISABILITIES ET AL., FETAL ALCOHOL SYNDROME: GUIDELINES FOR REFERRAL AND DIAGNOSIS 1 (2004) [hereinafter *FAS GUIDELINES*].

²⁸ *CDC Data & Statistics*, *supra* note 27.

²⁹ *FAS GUIDELINES*, *supra* note 27, at 2 (noting a historical failure among medical care providers to consistently recognize and identify the symptoms of FAS).

³⁰ *See id.* at 3–4 (discussing a Congressional mandate that the CDC develop more structured guidelines and implement those guidelines systematically).

National Center on Birth Defects and Developmental Disabilities, the National Task Force on Fetal Alcohol Syndrome and Fetal Alcohol Effect, and other federally funded and nongovernmental organizations, develop diagnostic guidelines for FAS.³¹ These guidelines are based on empirical and clinical evidence to “allow public health and service professionals to better determine the impact of FAS, and deliver needed services to affected children.”³²

As a result of this congressional mandate, the medical community has developed comprehensive diagnostic guidelines for FAS with the hope that such guidelines will increase the rate and accuracy of FAS diagnoses.³³ The following three criteria must be present for a diagnosis of FAS: (1) facial dysmorphism; (2) growth problems; and (3) central nervous system abnormalities.³⁴

Dysmorphism is a medical term for malformations that occur when the normal growth and development process is interrupted, resulting in the abnormal shape, size, or positioning of particular features.³⁵ Children with FAS exhibit three distinct facial features: (1) “a smooth ridge between the nose and upper lip” (medically termed a “smooth philtrum”); (2) “a thin upper lip”; and (3) a shortened amount of space “between the inner and outer corners of the eyes,” “giving the eyes a wide-spaced

³¹ *Id.*

³² *Id.*

³³ The Foreword to the *Guidelines for Referral and Diagnosis* states in relevant part:

This document represents the deliberations of clinicians, researchers, parents, and representatives of governmental and non-governmental organizations, whose main goals were to increase the identification of individuals with fetal alcohol syndrome (FAS) using uniform criteria, and to improve the delivery of appropriate services to those individuals and their families. These new guidelines will help achieve those goals by educating medical and allied health professionals about FAS.

Id. at v.

³⁴ *Id.* at vii–viii.

³⁵ *Id.* at 9. Alcohol consumption by a pregnant mother can lead to dysmorphism of the fetus by interfering with fetal nerve cell development and function. *Id.*

appearance.”³⁶ To meet the criteria for facial dysmorphism, all three features must be present.³⁷ Next, the child in question must have a documented “prenatal or postnatal height or weight, or both, at or below the 10th percentile, documented at any one point in time (adjusted for age, sex, gestational age, and race or ethnicity).”³⁸ Finally, the child must demonstrate central nervous system abnormalities, which fall into three separate categories—structural, neurological, and functional.³⁹ Structural problems include a smaller head circumference than is proportionally normal for the person’s overall height and weight, typically “at or below the tenth percentile.”⁴⁰ Additionally, brain imaging, such as magnetic resonance imaging (“MRI”) or computer tomography scans (“CT scans”), may evidence changes in the physical structure of the brain.⁴¹ Neurological problems “include poor coordination, poor muscle control, or problems with sucking as a baby,” which cannot be explained by another cause.⁴² Functional disabilities encompass a broad range of cognitive and social defects that essentially demonstrate that “[t]he person’s ability to function is well below what’s expected for his or her age, schooling, or circumstances.”⁴³ Within this category, a child must show either cognitive deficit in multiple areas, with performance below the third percentile, or “significant developmental delay in children who are too young for an IQ assessment.”⁴⁴ Additionally, the child must demonstrate disabilities in at least three of the following areas: (1) cognitive defects or developmental delays;⁴⁵ (2) executive

³⁶ *CDC Diagnosis*, *supra* note 10.

³⁷ FAS GUIDELINES, *supra* note 27, at 9. Other features observed in FAS patients include cardiac abnormalities, ear abnormalities, overlapping fingers, joint disabilities, short or webbed neck, and vertebra and rib abnormalities, among others. *Id.*

³⁸ *Id.* at vii.

³⁹ *Id.* at vii–viii.

⁴⁰ *Id.* at vii; *CDC Diagnosis*, *supra* note 10.

⁴¹ FAS GUIDELINES, *supra* note 27, at vii; *CDC Diagnosis*, *supra* note 10.

⁴² *CDC Diagnosis*, *supra* note 10.

⁴³ *Id.*

⁴⁴ *Id.*; FAS GUIDELINES, *supra* note 27, at viii.

⁴⁵ Cognitive defects or developmental delays may include learning

functioning deficits;⁴⁶ (3) motor functioning delays;⁴⁷ (4) attention problems or hyperactivity;⁴⁸ (5) problems with social skills;⁴⁹ and (6) other problems, including sensitivity to taste or to touch, difficulty reading facial expressions on others, or difficulty understanding disciplinary controls.⁵⁰

A child who is documented to have met all three of the above criteria—facial dysmorphia, growth problems, and central nervous system abnormalities—will receive a positive diagnosis for FAS.⁵¹ A mother's confirmed absence of alcohol ingestion during pregnancy would, of course, rule out a diagnosis of FAS, since exposure to alcohol *in utero* is the only means of developing FAS.⁵² However, CDC guidelines state that it is not necessary to affirmatively confirm the mother's use of alcohol during pregnancy if the child meets the standard diagnostic criteria listed above, as these diagnostic results taken as a whole conclusively establish the child's exposure to alcohol in the womb.⁵³

Beyond the incalculable quality of life costs for children with FAS and their family members, FAS also brings a hefty monetary price tag. In the late 1980s and early 1990s, researcher estimates for the cost for treatment and care resulting from FAS ranged from \$250 million to \$1.6 billion each year

disabilities, poor grades, slowed movements and reactions, or "performance differences between verbal and nonverbal skills." *CDC Diagnosis, supra* note 10.

⁴⁶ Executive functioning deficits may include poor organization, poor planning skills, lack of inhibition, difficulty following instructions with multiple steps, difficulty understanding the concept of cause-and-effect, inability to apply existing knowledge to new situations, or poor judgment. *Id.*

⁴⁷ Motor functioning delays may include delay in walking, difficulty with fine motor skills (such as writing or drawing), clumsiness, problems with balance, or problems with dexterity. *Id.*

⁴⁸ Attention problems or hyperactivity may include difficulty calming down or moving between activities, difficulty paying attention, or easy distraction. *Id.*

⁴⁹ Problems with social skills may include immaturity, inappropriate sexual behavior, trouble understanding the feelings of others, or fears of strangers. *Id.*

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² *See id.*

⁵³ *See id.*

for an FAS incidence of 1.9 per 1,000 live births.⁵⁴ In 2002, the CDC estimated the lifetime cost for one individual with FAS at \$2 million and “the cost to the United States for FAS alone [at] over \$4 billion annually.”⁵⁵ For those afflicted and for society as a whole, the negative effects of FAS are clear.

II. FETAL ALCOHOL SYNDROME IN CURRENT STATE AND FEDERAL LEGISLATION

The two predominant approaches under which prosecutors have attempted to criminalize the actions of drug-abusing pregnant women are by utilizing state child endangerment statutes and by “charging a woman with the ‘delivery’ of a controlled substance to a ‘child’ via the umbilical cord while in the womb or a few moments after birth.”⁵⁶ While these prosecutorial measures have been used primarily to counter maternal drug use during pregnancy, they provide valuable insight into the criminal sanctions facing pregnant women who suffer with any kind of substance abuse. As this Note proposes, incrimination is an ineffective solution for mothers battling drug and alcohol addictions, as well as one that presents additional obstacles for affected children.

A. Criminal Prosecution Under State Child Endangerment Statutes

State child endangerment statutes represent one approach towards the criminal prosecution of drug- or alcohol-abusing mothers. In 1996, the Supreme Court of South Carolina in *Whitner v. State* looked to the state’s child endangerment statute

⁵⁴ Gregory Bloss, *The Economic Cost of FAS*, 18 ALCOHOL RES. & HEALTH 53, 53–54 (1994).

⁵⁵ CDC Data & Statistics, *supra* note 27 (citing C. Lupton et al., *Cost of Fetal Alcohol Spectrum Disorders*, 127C AM. J. MED. GENETICS PART C: SEMINARS IN MED. GENETICS 42 (2004)).

⁵⁶ Tony A. Kordus, Comment, *Did South Carolina Really Protect the Fetus by Imposing Criminal Sanctions on a Woman for Ingesting Cocaine During Her Pregnancy in Whitner v. State*, No. 24468, 1996 WL 393164 (S.C. July 15, 1996)?, 76 NEB. L. REV. 319, 325–26 (1997).

to affirm the criminal conviction of a mother who damaged her fetus by ingesting an illegal drug during her pregnancy.⁵⁷ Moreover, and critical as applied to this Note's lens of alcohol consumption during pregnancy, the court did not distinguish between illegal drugs, like the cocaine ingested by Whitner, and a legal substance like alcohol.⁵⁸ The court "articulated that it did not matter if the action is legal or not, what matters is whether the 'life, health or comfort' of the child is endangered."⁵⁹ Indeed, the child neglect statute in *Whitner* stated that it was a crime for "[a]ny person having the legal custody of any child . . . without lawful excuse, to refuse or neglect to provide . . . proper care and attention for such child."⁶⁰ This was the first time in which a court upheld the conviction of a substance-abusing mother under a child endangerment statute, finding that a viable fetus was considered a "child" as used in the statute.⁶¹

When the United States Supreme Court denied certiorari on the issue presented in *Whitner*, it "open[ed] the door for other states to interpret their statutes similarly."⁶² However, other states have proceeded with mixed results in determining whether to follow South Carolina's lead. In 2009, the Supreme Court of North Dakota held that an unborn child is not defined as a

⁵⁷ See *Whitner v. State*, 492 S.E.2d 777, 780–81 (S.C. 1997); see also Kordus, *supra* note 56, at 320–21.

⁵⁸ See Judith A. Jones, *Fetal Alcohol Syndrome—Contrary Issues of Criminal Liability for the Child and His Mother*, 24 J. JUV. L. 165, 176 (2003–2004) (citing *Whitner*, 492 S.E.2d at 782).

⁵⁹ *Id.* (citing *Whitner*, 492 S.E.2d at 782).

⁶⁰ Kordus, *supra* note 56, at 331 (citing S.C. CODE ANN. § 20-7-50 (1985) (repealed 2008)).

⁶¹ See, e.g., *State v. Gethers*, 585 So. 2d 1140, 1143 (Fla. Dist. Ct. App. 1991) (citing Brian C. Spitzer, *A Response to "Cocaine Babies"—Amendment of Florida's Child Abuse and Neglect Laws to Encompass Infants Born Drug Dependent*, 15 FLA. ST. U. L. REV. 865, 881 (1987) ("Criminal prosecution would needlessly destroy the family by incarcerating the child's mother when alternative measures could both protect the child and stabilize the family.")); *State v. Gray*, 584 N.E.2d 710, 712–13 (Ohio 1992) (holding that the statute in question did not apply to a pregnant woman's ingestion of a controlled substance and that it was the duty of the legislature, not the courts, to impose a statutory duty of care on pregnant women).

⁶² Linder, *supra* note 22, at 878.

“child” under state statutes pertaining to the crime of endangerment of a child.⁶³ But in August 2011, the Alabama Court of Criminal Appeals held that a viable fetus is a “child” as defined in state criminal statutes prohibiting the chemical endangerment of a child.⁶⁴ Because of this interpretation, the Alabama court upheld the defendant’s sentence of one year of supervised probation after she tested positive for cocaine prior to giving birth and her son tested positive for cocaine after his birth.⁶⁵ This recent case shows the willingness of state courts to impose criminal sanctions on women whose drug or alcohol use causes harm to the fetus *in utero*, though such sanctions do not necessarily result in imprisonment.

B. Criminal Prosecution for the Delivery of a Controlled Substance to a Child

Prosecutors have also attempted to convict a woman for substance use during pregnancy by charging her with the delivery of a controlled substance to a child.⁶⁶ In *Johnson v. State*, prosecutors argued that the defendant, Ms. Johnson, “delivered cocaine . . . to her two children *via* blood flowing through the children’s umbilical cords” during the time in which the children were no longer *in utero*, but still attached to the defendant by their umbilical cords.⁶⁷ The defendant had previously delivered a son who tested positive for cocaine after his birth.⁶⁸ While pregnant with her second child, the defendant overdosed on crack cocaine and admitted to using while she was in labor.⁶⁹ Ultimately, the Supreme Court of Florida held that the term “delivery” in the statute at issue did not apply to a mother who had ingested illegal drugs during her pregnancy.⁷⁰

⁶³ *State v. Geiser*, 763 N.W.2d 469, 473–74 (N.D. 2009).

⁶⁴ *Ankrom v. State*, No. CR-09-1148, 2011 WL 3781258, at *8 (Ala. Crim. App. Aug. 26, 2011).

⁶⁵ *Id.* at *1.

⁶⁶ *See Kordus*, *supra* note 56, at 325–27.

⁶⁷ *Johnson v. State*, 602 So. 2d 1288, 1290–91 (Fla. 1992).

⁶⁸ *Id.* at 1291.

⁶⁹ *Id.*

⁷⁰ *Id.* at 1296.

In holding that the statute as written did not apply to Ms. Johnson's case, the court reasoned that if the legislature intended to address the problem of mothers passing illicit substances to a fetus *in utero*, the statute should be redrafted.⁷¹ Furthermore, the court observed that prosecuting women for using drugs and "delivering" them *in utero* to their babies might prompt substance-abusing pregnant women to avoid appropriate prenatal or medical care for fear of prosecution.⁷² Clearly, this outcome would be counterproductive to the public interest goal of encouraging proper medical care for pregnant women and their babies and could increase potential medical risks to both the mother and the baby if the mother withholds critical information from her doctors for fear of criminal punishment.⁷³

III. THE ROLE OF THE LEGAL SYSTEM IN REACHING THE ROOT OF THE PROBLEM

Unfortunately, it seems an impossible feat for any system, legal, medical, or otherwise, to prevent all alcohol consumption during pregnancy.⁷⁴ However, while "the causes of most birth defects [are] unknown,"⁷⁵ a woman's ingestion of alcohol during pregnancy is the clear cause of FAS, thus establishing a causal

⁷¹ *Id.*

⁷² *Id.* at 1295-96.

⁷³ See *id.* at 1296; see also Tiffany Lyttle, Note, *Stop the Injustice: A Protest Against the Unconstitutional Punishment of Pregnant Drug-Addicted Women*, 9 N.Y.U. J. LEGIS. & PUB. POL'Y 781, 790-91 (2006) (arguing that the criminal prosecution of substance-abusing pregnant women could result in a loss of trust between the patient and her doctors, potentially jeopardizing the health of the fetus if the woman hesitates to provide her doctor with accurate information about her pregnancy).

⁷⁴ Page, *supra* note 20, at 22 ("In spite of hard evidence for the widespread damage that prenatal exposure to alcohol causes, drinking during pregnancy persists. Part of this is caused by physicians who will say that a drink or two doesn't hurt; part is caused by conditions of living that beg to be softened by a little daily oblivion; part is caused by cognitive impairment (including not being aware that one is pregnant), and part is caused by addiction.").

⁷⁵ Adolfo Correa et al., *Diabetes Mellitus and Birth Defects*, 199 AM. J. OBSTETRICS & GYNECOLOGY 237.e1, 237.e1 (2008).

link between the mother's actions and the resulting harm to the child.⁷⁶ In fact, "[a]lcohol now is recognized as the leading preventable cause of birth defects and developmental disorders in the United States."⁷⁷ To stop the spread of harm and prevent future FAS births, the legal system must address the pregnant mothers' own issues. Furthermore, the direct cause-and-effect link between a mother's alcohol consumption and the resulting harm to the fetus makes FAS an appropriate disease for legal intervention because of the scientific ability to determine whether the mother's actions caused harm to her unborn child and, if so, to treat the mother accordingly.⁷⁸

By providing the necessary treatment for alcohol-dependent women, or women with alcoholic tendencies, the legal system can prevent the uptick of future FAS births, as well as ensure a healthier and more stable home environment for FAS-afflicted children. The challenge remains in designing a solution that effectively balances the interest in protecting the health and well-being of all parties involved—pregnant women, unborn children, and society at large—and the interest in safeguarding the legal and constitutional rights of pregnant women.

At the heart of the justice system is the concept that criminal behavior may be punished through retribution, rehabilitation, deterrence, or a combination of two or more of these theories.⁷⁹ Behind the theory of retribution is the idea that "[s]ociety is entitled to impose . . . sanctions . . . to express its condemnation of the crime and to seek restoration of the moral imbalance caused by the offense."⁸⁰ Indeed, "incarceration is widely assumed to be the legal punishment of choice."⁸¹ But in

⁷⁶ See, e.g., Dineen, *supra* note 18, at 2 ("[FAS is] a condition with only one cause: maternal drinking during pregnancy.").

⁷⁷ Kenneth R. Warren et al., *Fetal Alcohol Spectrum Disorders: Research Challenges and Opportunities*, 34 J. NAT'L INST. ON ALCOHOL ABUSE & ALCOHOLISM 1, 4 (2001).

⁷⁸ "[T]he real tragedy is that FAS is a completely preventable condition . . ." Dineen, *supra* note 18, at 11.

⁷⁹ See *Kennedy v. Louisiana*, 554 U.S. 407, 420 (2008).

⁸⁰ *Graham v. Florida*, 130 S. Ct. 2011, 2028 (2010).

⁸¹ Richard L. Lippke, *Retribution and Incarceration*, 17 PUB. AFF. Q. 29, 29 (2003).

imposing a proper sentence, courts may also consider the defendant's rehabilitative needs.⁸² This Note advocates for a rehabilitation-focused method over retribution, as it deters future FAS births rather than imposing after-the-fact sanctions.

A. *The Retribution Model*

The imposition of criminal sanctions raises issues of due process notice, specifically, whether women who abuse alcohol during their pregnancies have the appropriate *mens rea* to commit a crime.⁸³ Professor Jean Reith Schroedel, whose publications include the book, *Is the Fetus a Person? A Comparison of Policies Across the Fifty States*, noted that the *mens rea* for cases involving child abuse prosecutions for substance abuse during pregnancy typically “entails either ‘objective’ evidence of recklessness and/or negligence or ‘subjective’ intent with purposeful and knowing action.”⁸⁴ Alcohol is a unique substance for abuse and for statutory regulation because its use is legal by persons over twenty-one years of age, unlike drugs, such as cocaine, which are generally illegal regardless of whether the user is pregnant or not.⁸⁵

⁸² See 24 C.J.S. *Criminal Law* § 1997 (2011) (stating that rehabilitation is considered “one purpose of sentencing” and that rehabilitation must be “balanced and considered along with the other goals of punishment, such as protecting the community”).

⁸³ Jan L. Holmgren, *Legal Accountability and Fetal Alcohol Syndrome: When Fixing the Blame Doesn't Fix the Problem*, 36 S.D. L. REV. 81, 101 (1991) (“Due process requires reasonable notice that the act in question constitutes a crime.”).

⁸⁴ Jean Reith Schroedel & Pamela Fiber, *Punitive Versus Public Health Oriented Responses to Drug Use by Pregnant Women*, 1 YALE J. HEALTH POL'Y L. & ETHICS 217, 218 (2001).

⁸⁵ See *Whitner v. State*, 492 S.E.2d 777, 786 (S.C. 1997) (stating that Whitner's use of crack cocaine during pregnancy does not implicate any fundamental right of Whitner's because “[u]se of crack cocaine is illegal, period” and a user's status as a pregnant woman does not “elevate[] the use of crack cocaine to the lofty status of a fundamental right”); see also Linder, *supra* note 22, at 892 (arguing that statutes “prohibiting prenatal alcohol abuse pose procedural due process problems, as they regulate an otherwise legal activity”).

Accordingly, Linder argues that “[s]tatutes that punish pregnant women for drinking alcohol fail to afford defendants fair notice because ordinary persons will usually not consider the consumption of alcohol an activity giving rise to punitive sanctions,” with the exception of statutes that criminalize acts like “drunk driving or public intoxication.”⁸⁶

On the other hand, the absence of fair notice argument is weakened by widespread media coverage about the births of “crack babies,” which brings to the forefront the harmful effects of drug use on fetuses.⁸⁷ Major institutions like the CDC, the March of Dimes, the Office of the Surgeon General, and the National Institutes of Health outline the risks of alcohol use during pregnancy on their websites and in pamphlet materials, asserting that no amount of alcohol is safe to consume during pregnancy.⁸⁸ Additionally, though it is impossible to determine whether every doctor or clinic in the country does so, physicians presumably inform pregnant women during prenatal visits that it is unsafe to consume alcohol during pregnancy.⁸⁹

The Wisconsin state legislature took an assertive and contentious stance on fetal rights with the enactment of a state statute that permits law enforcement officials to take a pregnant adult mother into police custody when there is a “substantial risk” that the “the child, when born, will be seriously affected or endangered” due to the mother’s inability to control her

⁸⁶ Linder, *supra* note 22, at 892.

⁸⁷ See Lyttle, *supra* note 73, at 792.

⁸⁸ *Fetal Alcohol Spectrum Disorders (FASDs): Alcohol Use in Pregnancy*, CTNS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/ncbddd/fasd/alcohol-use.html> (last updated Oct. 6, 2010) (“CDC urges pregnant women not to drink alcohol any time during pregnancy.”); *Pregnancy: Alcohol and Drugs*, MARCH OF DIMES, http://www.marchofdimes.com/pregnancy/alcohol_indepth.html (last visited Nov. 1, 2012) (“Drinking alcohol during pregnancy can cause permanent harm to your baby. But the good news is that these harmful conditions can be completely avoided. If you stay away from alcohol during pregnancy, your baby can’t have FASDs or any other health conditions caused by alcohol.”); Press Release, U.S. Dep’t of Health and Human Servs. Office of the Surgeon Gen., *supra* note 12 (“We do not know what, if any, amount of alcohol is safe It’s in the child’s best interest for a pregnant woman to simply not drink alcohol.”).

⁸⁹ See *supra* Part II.A.

alcohol consumption during the pregnancy.⁹⁰ The controversial statutory scheme has been criticized as a “draconian approach to protecting fetal rights.”⁹¹ Some scholarly critics argue that “[p]unitive regulations which subject pregnant women to involuntary civil commitment violate the substantive rights of privacy and bodily integrity afforded by the Due Process Clause”⁹² and that “Wisconsin’s regime seems to be an effective solution to prenatal alcohol exposure, [but] the use of coercive legislative tactics is inherently flawed.”⁹³ Focusing on measures designed to decrease the chance, or severity, of harm to the fetus is, of course, a noble goal. But even the most virtuous intentions must be viewed in light of the affected party’s constitutional rights.

Even if a woman knows that consuming alcohol during pregnancy is unsafe, she still may not possess the necessary *mens rea* to commit a criminal act. For instance, she may be unaware of her pregnancy and thus continue to consume alcohol during the critical first months of pregnancy.⁹⁴ Even if the mother is aware of her pregnancy, she may not be acting with intent to harm, but rather an addiction may cause her to lack the voluntary control to curb her alcohol use.⁹⁵ Once viewed under the so-called “sin

⁹⁰ WIS. STAT. § 48.193(1)(d)(2) (2012). An expectant mother may also be taken into police custody under a valid warrant, *id.* § 48.193(1)(a), or by an order of the judge if the expectant mother’s “habitual lack of self-control in the use of alcohol beverages” is satisfactorily shown to the judge and presents a substantial risk of harm to the unborn child, *id.* § 48.193(c).

⁹¹ Linder, *supra* note 22, at 882.

⁹² *Id.* at 889; *see also* Michelle D. Mills, Comment, *Fetal Abuse Prosecutions: The Triumph of Reaction Over Reason*, 47 DEPAUL L. REV. 989, 1020–22 (1998) (arguing that such statutes often invoke constitutional problems of notice and vagueness, as well as the due process right to privacy).

⁹³ Linder, *supra* note 22, at 874.

⁹⁴ *See* Linder, *supra* note 22, at 883 (“Significantly, many women do not even realize they are pregnant during this initial stage when the fetus is most vulnerable to the toxic effects of alcohol exposure.” (citations omitted)).

⁹⁵ *See* Michael A. Hammer, Comment, *The Constitutional, Judicial and Social Pitfalls Attendant to the Criminalization of Prenatal Maternal Substance Abuse: A Plea for Governmental Uniformity and Mercy*, 22 SETON HALL L. REV. 1456, 1484–85 (1992).

model,”⁹⁶ alcoholism, beginning in the early 1960s, was conceptualized under the “disease model,” which “posited that alcohol abuse was generally outside of the individual’s control and demonstrated neither immorality nor weakness of character.”⁹⁷ Because an alcohol-addicted individual cannot control his or her drinking, this model holds that “an alcoholic simply cannot have the requisite *mens rea* to be criminally liable”⁹⁸

Tied to the absence of *mens rea* is the notion that alcoholic mothers may lack the personal culpability that generally motivates criminal sanctions. In 2011, the Supreme Court declared that “the heart of the retribution rationale is that a criminal sentence must be directly related to the personal culpability of the criminal offender.”⁹⁹ This principle becomes particularly relevant when applied to individuals suffering from drug and alcohol addiction, whose personal culpability in committing a criminal act may be lessened as a result of their addictions. At its root, a retributive system simply ignores the fact that many women who give birth to a baby with FAS are not reckless criminals¹⁰⁰ but women in need of substance abuse treatment.¹⁰¹

⁹⁶ Note, *Alcohol Abuse and the Law*, 94 HARV. L. REV. 1660, 1661 (1981) (describing the “sin model” of alcoholism as the view that “alcohol abuse, however severe, was both willful and culpable, a sign of moral weakness at best, of dissolute immortality at worst”). “The ‘sinful’ alcoholic was thought capable of reforming himself through the mere exertion of will.” *Id.* at 1661–62.

⁹⁷ *Id.* at 1662.

⁹⁸ Hammer, *supra* note 95, at 1491–92 (referencing the court’s findings as to public drunkenness in *Easter v. District of Columbia*, 361 F.2d 50 (D.C. Cir. 1966)).

⁹⁹ *Graham v. Florida*, 130 S. Ct. 2011, 2028 (2010) (quoting *Tison v. Arizona*, 481 U.S. 137, 149 (1986)).

¹⁰⁰ In *State v. McKnight*, the court expanded its definition of criminal recklessness by interpreting reckless disregard for the safety of others as “a conscious failure to exercise due care of ordinary care or a conscious indifference to the rights and safety of others or a reckless disregard thereof” and concluded that McKnight “had demonstrated the requisite criminal intent” by smoking crack cocaine during her pregnancy because she should have known the dangers it presented to her fetus. Shalini Bhargava, Note, *Challenging Punishment and*

B. The Rehabilitation Model

While incarceration largely ignores the role a mother's addiction may play in FAS, rehabilitative responses such as alcohol treatment programs focus on treating the soon-to-be mother, which in turn promotes the health of the fetus. Effective alcohol-abuse treatment also ensures that a mother is capable of parenting a child with FAS.¹⁰² Dr. Kathryn Page, a clinical psychologist who has devoted her career to the study of fetal alcohol spectrum disorders, has perceived significant self-reporting of depression and anxiety among parents raising an FAS child and has noted that drug and alcohol abuse are likely to “begin or increase under the confusion, pressure, and shame” of raising the afflicted child.¹⁰³ Thus, an alcohol-addicted woman parenting a child with FAS may find that she is trapped in a vicious cycle, with her alcohol consumption increasing under the stress of raising an FAS child, thus making parenting even more trying. It is therefore crucial for an alcohol-addicted woman to receive treatment for her substance abuse before taking on such a challenge.¹⁰⁴

Privatization: A Response to the Conviction of Regina McKnight, 39 HARV. C.R.-C.L. L. REV. 513, 520 (2004) (citing *State v. McKnight*, 576 S.E.2d 168, 173 (S.C. 2003)) (internal quotation marks omitted).

¹⁰¹ See *supra* notes 18–21 and accompanying text (referencing statistical data that indicates that the severity of harm to the fetus increases with the amount of alcohol a pregnant woman consumes in a single day, suggesting that alcohol-dependent women give birth to babies with more severe defects than women who consume smaller quantities of alcohol in a given sitting).

¹⁰² “Children with prenatal alcohol exposure are difficult for anyone to raise” Page, *supra* note 20, at 29.

¹⁰³ *Id.*; see also *About Kathryn Page*, FETAL ALCOHOL TEAMWORK, CONSULTATION AND TRAINING, <http://fatcat.vpweb.com/About-Kathryn-Page.html> (last visited Sept. 6, 2012) (discussing Dr. Page's background).

¹⁰⁴ “The law must take the position that, if a woman is incapable of meeting her maternal calling, then it is incumbent upon the state to recognize its own moral duty by providing accessible treatment and educational opportunities that do not focus on criminalizing behavior.” Caroline S. Palmer, *The Risks of State Intervention in Preventing Prenatal Alcohol Abuse and the Viability of an Inclusive Approach: Arguments for Limiting Punitive and Coercive Prenatal Alcohol Abuse Legislation in Minnesota*, 10 HASTINGS WOMEN'S L.J. 287, 307 (1999).

Current rehabilitative approaches tend to focus on prebirth enforcement measures designed to lessen the intensity of harm to the fetus. Determining that a pregnant woman has been drinking alcohol and preventing further alcohol abuse during the pregnancy could lessen the intensity of harm to the fetus, depending in part on how and when the alcohol was consumed.¹⁰⁵ However, there are a number of potential problems with these types of prebirth rehabilitation models. For instance, a pregnant woman “may not report her alcohol consumption accurately because she is embarrassed or afraid to admit to drinking while pregnant,”¹⁰⁶ thus making it difficult for medical practitioners to accurately identify the risk her alcohol consumption poses to her fetus. Even if an alcohol-dependent woman is identified, in actuality many prebirth measures focus less on rehabilitation and more on criminal prosecution¹⁰⁷ or civil commitment.

One problem inherent in prebirth initiatives is that they command legal action before it has been revealed whether the mother’s alcohol consumption has even caused any harm to her fetus. Additionally, these proposals are rife with logistical pitfalls. Though lessening harm to the fetus is the goal of prebirth rehabilitation measures, finding such treatment centers may prove difficult. Studies show that “[t]he insufficient number of treatment programs that will accept pregnant women is a national problem.”¹⁰⁸ Indeed, “the few drug treatment programs

¹⁰⁵ See Dineen, *supra* note 18, at 20–21 (noting both that “infants of women who stop drinking early in their pregnancy exhibit less severe effects, such as less growth retardation, than women who continue to drink excessive amounts” and that “[g]estational timing of the prenatal alcohol exposure is an important factor in understanding the effects on the fetus”).

¹⁰⁶ *Screening for Alcohol Use and Alcohol-Related Problems*, ALCOHOL ALERT (U.S. Dep’t of Health & Human Servs. et al., Rockville, Md.), no. 65, Apr. 2005, at 1, 5. Because many women will alter their answers during pregnancy or may have consumed harmful amounts of alcohol prior to learning of their pregnancies, the National Institutes of Health and the National Institute on Alcohol Abuse and Alcoholism suggest that asking a woman about her drinking patterns before she becomes pregnant would solicit more accurate measures of her first-trimester alcohol consumption. *See id.* at 3.

¹⁰⁷ *See supra* Parts II.A–B.

¹⁰⁸ Victoria J. Swenson & Cheryl Crabbe, *Pregnant Substance Abusers:*

that can handle the diverse mental, physical, and emotional needs of pregnant drug-addicted women usually have long waiting lists, [and] are understaffed.”¹⁰⁹ Thus, prebirth measures are not only logistically faulty, but may toe dangerous constitutional lines as well.

IV. MERITS OF POSTBIRTH REHABILITATION

While proponents of prebirth rehabilitation may criticize postbirth measures as too little too late,¹¹⁰ postbirth treatment actually serves to protect an alcohol-dependent mother’s future children and to provide the mother’s existing FAS child or children with a supportive parenting environment.¹¹¹ A medical study of FAS confirmed that “women who have had one definite FAS child, and who continue to drink, have progressively more severely affected children with subsequent pregnancies.”¹¹² This is because the severity of damage to the fetus depends on both a woman’s age and the number of times she has given birth.¹¹³ Additionally, alcohol treatment at any point increases the likelihood of a stable home environment, which is especially important for parents of special-needs children, who may require more attention and assistance.¹¹⁴ Thus, there is a strong incentive to mandate alcohol rehabilitation for mothers even after their

A Problem That Won’t Go Away, 25 ST. MARY’S L.J. 623, 637 (1994).

¹⁰⁹ Lyttle, *supra* note 73, at 810 (citing Philip H. Jos et al., *Substance Abuse During Pregnancy: Clinical and Public Health Approaches*, 31 J.L. MED. & ETHICS 340, 343 (2003)).

¹¹⁰ See *supra* Part I for a medical overview of the effects of Fetal Alcohol Syndrome.

¹¹¹ See *supra* notes 102–04.

¹¹² INST. OF MED., DIV. OF BIOBEHAVIORAL SCI. & MENTAL DISORDERS, COMM. TO STUDY FETAL ALCOHOL SYNDROME, FETAL ALCOHOL SYNDROME: DIAGNOSIS, EPIDEMIOLOGY, PREVENTION, AND TREATMENT 136 (Kathleen Stratton, Cynthia Howe & Frederick Battaglia eds., 1996) (internal citations omitted).

¹¹³ *Id.* The effect of the mother’s age on the pregnancy “might, in part, be related to length of time of alcohol abuse and the consequent liver damage.” *Id.* at 137.

¹¹⁴ See *supra* notes 103–05 and accompanying text.

babies are born to prevent future FAS births and to counsel mothers on raising FAS children.

To justify the imposition of mandatory rehabilitation, the court must first find a suitable method of confirming that the newborn was exposed to alcohol *in utero*. While the telltale facial features of a child with FAS are often immediately clear at birth, growth problems and central nervous system abnormalities may not become apparent until the child's development is underway.¹¹⁵ Therefore, a more immediate test is needed to determine whether newborn infants have been exposed to dangerous levels of alcohol *in utero*.

Meconium testing provides scientific accuracy in verifying *in utero* exposure to alcohol within the constitutional limits of a woman's rights. In *Ferguson v. City of Charleston, S.C.*, the Fourth Circuit held that it is constitutional to test a newborn infant's bodily fluids.¹¹⁶ Ellen Knight, one of the appellants in *Ferguson*, was arrested after her newborn baby's urine tested positive for cocaine.¹¹⁷ The court noted that diagnostic searches of a *mother's* urine are unconstitutional under the Fourth Amendment, unless the search is authorized by a valid warrant.¹¹⁸ However, the Fourth Circuit wrote that it was "aware of no decision holding, or even suggesting, that a mother has a reasonable expectation of privacy in her newborn child's bodily fluids. Indeed, such a holding would conflict with the general rule that an expectation of privacy does not arise from one's relationship to the person searched."¹¹⁹ Because only searches performed on the mothers' urine were considered by the Supreme Court on appeal, this holding remains intact. Thus, it is constitutional to test a newborn's bodily fluids for evidence of alcohol exposure *in utero*.

From a scientific standpoint, meconium provides doctors with an unrivaled means of determining whether a mother

¹¹⁵ See *supra* notes 36–51 and accompanying text.

¹¹⁶ *Ferguson v. City of Charleston, S.C.*, 308 F.3d 380, 395 (4th Cir. 2002).

¹¹⁷ *Id.* at 390. The charges against Knight were dismissed after she successfully completed a drug treatment program. *Id.*

¹¹⁸ *Ferguson v. City of Charleston*, 532 U.S. 67, 68 (2001).

¹¹⁹ *Ferguson*, 308 F.3d at 395–96.

consumed harmful amounts of alcohol during pregnancy.¹²⁰ Meconium is the matter excreted during a baby's first bowel movements.¹²¹ It "concentrates all substances received from the mother during gestation."¹²² Scientific studies have tested meconium to measure concentrations of fatty acid ethyl esters ("FAEEs"), which develop when the mother's body metabolizes the ethanol contained in alcohol.¹²³ "Meconium testing for FAEEs serves as an objective biomarker of prenatal alcohol exposure and confirms the answers with a biological marker."¹²⁴

"Traditionally, samples of neonatal or maternal urine and blood have been used to determine prenatal alcohol use."¹²⁵ However, these samples are mainly capable of reflecting alcohol exposure "only in the [two] to [three] days before delivery."¹²⁶ Additionally, "neonatal urine is difficult to collect, and blood collection for a neonate is an invasive procedure."¹²⁷ Meconium, on the other hand, can be collected "directly from the infant's diaper" and indicates *when* the fetus was exposed to alcohol.¹²⁸ "Meconium begins to form as early as the thirteenth week of pregnancy and continues to accumulate thereafter."¹²⁹ Low levels of FAEEs are found in meconium samples of the general

¹²⁰ As of September 2012, not a single case was found in which a mother brought suit for the testing of her child's meconium.

¹²¹ *Haught v. Maceluch*, 681 F.2d 291, 294 (5th Cir. 1982).

¹²² Raquel Magri et al., *Advances in the Determination of Alcohol and Other Drug Consumption During Pregnancy: A Study of 900 Births in Montevideo, Uruguay*, 34 CONTEMP. DRUG PROBS. 445, 460 (2007); *see also Haught*, 681 F.2d at 294 n.1 (noting that meconium is composed of the contents "accumulated during the fetus's gestation").

¹²³ *See* Magri et al., *supra* note 122, at 458. *See also* Cynthia F. Bearer et al., *Biomarkers of Alcohol Use in Pregnancy*, 28 ALCOHOL RES. & HEALTH 38, 39, 41 (2004), *available at* <http://pubs.niaaa.nih.gov/publications/arh28-1/38-43.pdf> (internal citations omitted) ("Fatty acid ethyl esters are metabolic products that result from the interaction between alcohol and fatty acids.").

¹²⁴ Magri et al., *supra* note 122, at 458.

¹²⁵ Bearer et al., *supra* note 123, at 39.

¹²⁶ *Id.*

¹²⁷ *Id.*

¹²⁸ *See id.*

¹²⁹ *See id.*

population; therefore, “[a] positive test for FAEEs in meconium means that the mother consumed alcohol in the second and/or third trimester.”¹³⁰

The time period made available for analysis using meconium testing respects a woman’s constitutional rights as established in *Roe v. Wade* and affirmed in *Planned Parenthood of Southeastern Pennsylvania v. Casey*. In *Roe v. Wade*,¹³¹ the Supreme Court determined that before the fetus has reached viability, “the State’s interests are not strong enough to support a prohibition of abortion or the imposition of a substantial obstacle to the woman’s effective right to elect the procedure.”¹³² Thus, a state may not interfere with a woman’s constitutional right to make decisions regarding her fetus before the fetus has reached viability.¹³³ However, States have the right to legally constrain such decisions after the point of viability, and individual states can determine whether or not their state statutory definitions of “personhood” include viable fetuses.¹³⁴ Therefore, governmental measures directed towards the development of a fetus *in utero* must be mindful of the point at which the fetus reaches viability. Because meconium does not begin to accumulate until approximately the thirteenth week of pregnancy, it does not contain evidence of prenatal alcohol consumption from the first trimester of a woman’s pregnancy. Importantly, since the mother’s first trimester actions are not available for analysis, meconium testing respects the central holdings of *Roe* and *Casey* that a state’s interests in a fetus that has not yet reached viability are not strong enough to justify government action.

In sum, a positive test for FAEEs in meconium provides affirmative evidence that the mother consumed three or more alcoholic drinks per month during the second or third trimesters of her pregnancy, after the fetus had reached viability, and that she likely consumed the alcohol in larger quantities on a single

¹³⁰ Magri et al., *supra* note 122, at 459.

¹³¹ *Roe v. Wade*, 410 U.S. 113 (1973).

¹³² *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 846 (1992).

¹³³ *Id.*

¹³⁴ Linder, *supra* note 22, at 876.

occasion as opposed to in smaller quantities throughout each month.¹³⁵ A 2003 scientific study showed that “FAEE concentration in meconium was more strongly related to the mother’s self-reported alcohol consumption *per occasion* than to the overall average she consumed per week.”¹³⁶ This makes meconium testing an especially helpful indicator of fetal harm because it correlates to the scientific research referenced *supra* in Part I, that binge drinking is “the most damaging form of alcohol consumption on fetal development.”¹³⁷ Indeed, it appears that fewer than three drinks per month will not result in a positive FAEE meconium test.¹³⁸ Additionally, meconium testing resolves the issue of notice during the early weeks of a woman’s pregnancy,¹³⁹ when a woman may consume alcohol before realizing that she is pregnant. Presumably, most women would recognize their pregnancies by the thirteen-week point, so the issue of notice is largely moot within the scope of this Note.

V. PROPOSAL: MANDATORY POSTBIRTH REHABILITATION

Forty-eight of the fifty states specifically require physicians, nurses, and various other health and medical practitioners to report instances of child abuse and neglect, while the remaining two states require all individuals to report instances of suspected or observed child abuse.¹⁴⁰ Statutory standards typically state that

¹³⁵ It should be noted that the “correlation between FAEEs in meconium and prenatal alcohol use is not perfect.” Bearer et al., *supra* note 123, at 42. Possible reasons for this include the fact that “genetically determined variations in alcohol metabolism may influence the synthesis of FAEEs” and that “illness or the use of some medications and food additives may affect FAEE concentrations.” *Id.*

¹³⁶ *Id.* at 41 (citing Cynthia F. Bearer et al., *Validation of a New Biomarker of Fetal Exposure to Alcohol*, 143 J. PEDIATRICS 463 (2003)).

¹³⁷ May & Gossage, *supra* note 16, at 17 (citing E.L. Abel, *Fetal Alcohol Syndrome in Families*, 10 NEUROTOXICOLOGY & TERATOLOGY 1, 1–2 (1998)).

¹³⁸ See Magri et al., *supra* note 122, at 459.

¹³⁹ See *supra* Part III.A (discussing the issue of whether pregnant woman who abuse alcohol have the appropriate *mens rea* to commit a crime).

¹⁴⁰ See CHILD WELFARE INFO. GATEWAY, MANDATORY REPORTERS OF CHILD ABUSE AND NEGLECT: SUMMARY OF STATE LAWS, *available at*

a report must be made when the reporter has reasonable cause to suspect that the child has suffered harm as a result of abuse or neglect.¹⁴¹ This Note proposes that health practitioners who suspect that a mother may have consumed alcohol throughout her pregnancy test the FAEE concentration in the newborn baby's meconium to determine whether the baby was exposed to alcohol *in utero* during the second or third trimesters of the mother's pregnancy. If the infant's meconium tests positive for such alcohol exposure, its mother will be issued a citation to appear before a state court judge and sentenced to mandatory outpatient rehabilitation.

A. Mandatory Meconium Testing

Some state statutes explicitly recognize the need to address prenatal exposure to alcohol. Kentucky is considering proposed legislation that expressly authorizes "[a]ny physician or person legally permitted to engage in attendance upon a pregnant woman" to conduct a toxicology test "to determine whether there is evidence of prenatal exposure to alcohol . . . if the attending person has reason to believe, based on a medical

http://www.childwelfare.gov/systemwide/laws_policies/statutes/manda.pdf (listing the mandatory reporters under the state child abuse and neglect statutes of each of the fifty states). While most states specifically identify physicians and licensed nurses as mandatory reporters, other states define this category more broadly as health practitioners generally. *See, e.g.*, IOWA CODE § 232.69 (2011) (mandating reporting by "every health practitioner who in the scope of professional practice, examines, attends, or treats a child"); MD. CODE ANN., FAM. LAW § 5-704 (West 2006) (mandating reporting by "each health practitioner . . . acting in a professional capacity in [the] State"). The New Jersey statute states that "[a]ny person having reasonable cause to believe that a child has been subjected to child abuse or acts of child abuse shall report the same immediately," N.J. STAT. ANN. § 9:6-8.10 (West 2012), and the Wyoming statute states that "[a]ny person who knows or has reasonable cause to believe or suspect that a child has been abused or neglected or who observes any child being subjected to conditions or circumstances that would reasonably result in abuse or neglect, shall immediately report it . . . or cause a report to be made." WYO. STAT. ANN. § 14-3-205(a) (West 2005).

¹⁴¹ *See, e.g.*, ALASKA STAT. § 47.17.020 (2012); ARIZ. REV. STAT. ANN. § 13-3620 (2010); COLO. REV. STAT. § 19-3-304 (2012).

assessment of the mother or the infant, that the mother used any such substance . . . during the pregnancy.”¹⁴² Likewise, a Minnesota statute requires:

A physician shall administer to each newborn infant born under the physician’s care a toxicology test to determine whether there is evidence of prenatal exposure to a controlled substance, if the physician has reason to believe based on a medical assessment of the mother or the infant that the mother used a controlled substance for a nonmedical purpose during the pregnancy.¹⁴³

This Note proposes that if the newborn’s meconium sample tests positive for FAEE concentration, thus indicating that the newborn was exposed to high doses of alcohol after reaching viability, the health care practitioner should report an instance of child abuse or neglect under the applicable state statute.

It is at the discretion of individual states to determine whether their state statutory definition of a “child” includes a viable fetus.¹⁴⁴ Some states expressly include alcohol-exposed newborns in this category. For example, a Missouri state statute authorizes “any physician or health care provider” to report instances where a child has been exposed to alcohol, “as evidenced by . . . [m]edical documentation of signs and symptoms consistent with . . . alcohol exposure in the child at birth” or “[r]esults of a confirmed toxicology test . . . performed at birth on the mother or the child,” along with “[a] written assessment . . . which documents the child as being at risk of abuse or neglect.”¹⁴⁵ Furthermore, a Utah state statute mandates that any person who attends the birth of a child or cares for a child and “determines that the child, at the time of birth, has fetal alcohol syndrome . . . shall report that determination . . . as soon as possible.”¹⁴⁶ Additionally, Indiana has passed legislation to include a child who

¹⁴² H.B. 131, 2011 Gen. Assemb., Reg. Sess. (Ky. 2011).

¹⁴³ MINN. STAT. § 626.5562 (2011).

¹⁴⁴ See *supra* Part II.A.

¹⁴⁵ MO. REV. STAT. § 191.737 (2011).

¹⁴⁶ UTAH CODE ANN. § 62A-4a-404 (LexisNexis 2012).

is born with FAS within the category of “a child in need of services.”¹⁴⁷

B. Mandatory Outpatient Rehabilitation

Unlike the criminal prosecutions described *supra* in Part II, the reporting under this proposal would not be used as prosecutorial evidence for criminal sanctions. Rather than arresting the mother, this Note proposes that mothers whose newborn children are born with FAS are issued a citation to appear before a state court judge and sentenced to mandatory outpatient rehabilitation to confront their addiction problems.

Though the ultimate object of this proposition is to provide alcohol-dependent mothers with treatment to prevent future FAS births, such a proposal must also consider the best interests of the FAS child and the mother’s other children, if any. Intensive inpatient treatment is clinically necessary in certain instances,¹⁴⁸ but should be avoided if possible, as it separates the mother from her newborn child and creates issues of its own. “Attachment is the social and emotional relationship children develop with the significant people in their lives. An infant’s first attachment is usually formed with its mother”¹⁴⁹ The

¹⁴⁷ IND. CODE § 31-34-1-10 (2012). This puts children born with FAS in the same category as children who are victims of more traditional forms of abuse, including sex abuse, and children whose “physical or mental health is seriously endangered due to injury by the act or omission of the child’s parent, guardian, or custodian.” *See id.* § 31-34-1-2; *see also In re Crawford*, No. 1998CA00194, 1999 WL 100377 (Ohio Ct. App. Feb. 1, 1999) (holding that a newborn baby is “neglected” under the state’s neglected child statutes who tests positive for drug exposure *in utero* and whose mother admits to alcohol use during her pregnancy).

¹⁴⁸ “[I]npatient care remains more appropriate for patients with serious concurring medical or psychiatric conditions or in social environments that are not supportive of recovery.” Nat’l Inst. on Alcohol Abuse & Alcoholism, *Research Refines Alcoholism Treatment Options*, 24 ALCOHOL RES. & HEALTH 53, 53 (2000).

¹⁴⁹ *Effects of Attachment and Separation*, CHILD SERVICES PRAC. NOTES (N.C. Div. of Soc. Servs. & the Family & Child. Res. Program, Chapel Hill, N.C.), July 1997, at 1, available at http://www.practicenotes.org/vol2_no4/cspnv2_4.pdf.

attachment process begins at birth and helps the child to “develop intellectually, organize perceptions, think logically, develop a conscience, become self-reliant, develop coping mechanisms, . . . and form healthy and intimate relationships” through continuous interaction with his or her primary caregiver.¹⁵⁰ Separation is the removal of a child from the caregiver to whom he or she is attached and can interfere with the child’s ability to develop psychologically healthy attachments.¹⁵¹

Because children with FAS are already prone to impaired executive functioning and cognitive and social defects,¹⁵² the added consequences of poor attachment may be especially detrimental.¹⁵³ Therefore, for the sake of the child, as well as any other children the mother may already have at home, outpatient rehabilitation should be the preferred treatment method whenever possible.¹⁵⁴ Furthermore, outpatient rehabilitation allows the mother to maintain independence and daily freedom, thus differentiating it from traditional forms of retributive punishment and incarceration.¹⁵⁵ To mandate inpatient treatment for all women would support the same principles as incarceration, simply disguised in a different form.

1. The Effect of Mandatory Rehabilitation on a Woman’s Constitutional Liberty Rights

Proposing *mandatory* outpatient rehabilitation necessarily raises liberty concerns. In *Dow v. Circuit Court (Huddy)*, the

¹⁵⁰ *Id.* (citations omitted).

¹⁵¹ *Id.* at 2–3.

¹⁵² See *supra* notes 43–50 and accompanying text. See generally *supra* Part I (discussing the causes and effects of FAS).

¹⁵³ “[P]oor infant-mother attachment can result in childhood mood disorders and learning difficulties” and can put children at “higher risk for substance abuse and delinquent behavior in their teenage years.” *Effects of Attachment and Separation*, *supra* note 149, at 4.

¹⁵⁴ Additionally, “escalating health care costs have propelled a shift from inpatient to outpatient treatment at all stages of recovery.” Nat’l Inst. on Alcohol Abuse & Alcoholism, *supra* note 148, at 53.

¹⁵⁵ See *supra* Part III.B.

Ninth Circuit examined whether fourteen hours of attendance at an alcohol rehabilitation program amounted to “custody” under 28 U.S.C. § 2254(a), which permits a person held in custody to invoke federal habeas corpus review.¹⁵⁶ The appellant, Dow, was convicted of driving under the influence of alcohol and sentenced to fourteen hours of attendance at an alcohol rehabilitation program, which could be scheduled by the appellant to take place over either a three- or five-day period.¹⁵⁷ The Ninth Circuit noted that “requiring appellant’s physical presence at a particular place . . . significantly restrains appellant’s liberty to do those things which free persons in the United States are entitled to do and therefore must be characterized, for jurisdictional purposes, as custody.”¹⁵⁸ Therefore, the Ninth Circuit determined that mandatory class attendance, such as alcohol rehabilitation, permits a person to invoke federal habeas corpus jurisdiction because he or she is deemed to be “in custody” under 28 U.S.C. § 2254(a).¹⁵⁹

Court-ordered alcohol rehabilitation is not uncommon. Many state statutes involving driving while under the influence of alcohol require offenders to attend alcohol rehabilitation programs and other rehabilitation as the court deems necessary.¹⁶⁰ Numerous

¹⁵⁶ Dow v. Circuit Court (*Huddy*), 995 F.2d 922, 922–23 (9th Cir. 1993). “Habeas corpus” is defined as “a writ requiring a person under arrest to be brought before a judge or into court, especially to secure the person’s release unless lawful grounds are shown for their detention.” *Habeas Corpus*, OXFORD DICTIONARIES (Apr. 2010), <http://oxforddictionaries.com/definition/english/habeas%2Bcorpus?q=habeas+corpus>.

¹⁵⁷ *Dow*, 995 F.2d at 922–23.

¹⁵⁸ *Id.* at 923 (internal quotations omitted).

¹⁵⁹ *Id.*

¹⁶⁰ N.M. STAT. ANN. § 66-8-102 (2012). *See also* ALA. CODE § 32-5A-191 (2010) (ordering the Department of Public Safety not to reissue a driver’s license to a person convicted of driving while under the influence of alcohol without receiving proof that such person successfully completed a mandatory DUI or substance abuse court referral program); N.Y. VEH. & TRAF. LAW § 1196 (McKinney 2011) (permitting persons convicted of alcohol or drug-related traffic offenses to participate in “at least fifteen hours” of an alcohol and drug rehabilitation program within the Department of Motor Vehicles, the satisfactory completion of which “shall result in the termination of any sentence of imprisonment that may have been imposed . . .”).

outpatient alcohol treatment programs exist throughout the country, from local community groups to nationwide treatment providers. Alcoholics Anonymous (“AA”) is arguably the most well-known outpatient alcohol treatment program, with an estimated 113,000 meeting groups throughout the world as of 2007,¹⁶¹ including groups in all fifty states and throughout Canada.¹⁶² According to a 2007 survey of more than 8,000 American and Canadian AA members, eleven percent were introduced to AA by court order,¹⁶³ evidencing the prevalence of court-mandated alcohol rehabilitation. The incidence of AA court mandates suggests the efficacy of the AA model in achieving such directives.

Outpatient alcohol addiction groups such as AA require a relatively minimal time commitment when measured against the commitment that was upheld as constitutionally appropriate in *Dow*. The state court in *Dow* ordered appellant Dow to attend fourteen hours of rehabilitation over a three- or five-day period, which amounted to a minimum daily commitment of 2.8 hours per day. In contrast, the average AA meeting lasts only about one hour.¹⁶⁴ The court in *Dow* noted that “to satisfy the custody requirement, petitioner must demonstrate that [he or she] is subject to a significant restraint upon [his or her] liberty not

¹⁶¹ *Alcoholics Anonymous 2007 Membership Survey*, ALCOHOLICS ANONYMOUS (2008), http://www.aa.org/pdf/products/p-48_07survey.pdf.

¹⁶² *Local Resources that Provide A.A. Meeting Information*, ALCOHOLICS ANONYMOUS, http://www.aa.org/lang/en/central_offices.cfm?origpage=373 (last visited Sept. 29, 2012).

¹⁶³ *Alcoholics Anonymous 2007 Membership Survey*, *supra* note 161. An informative PDF released by Alcoholics Anonymous titled *Alcoholics Anonymous as a Resource For Drug & Alcohol Court Professionals* states, “A.A. groups have welcomed many new members from court programs and treatment facilities. Some have come to A.A. on their own; others arrived under a degree of pressure. While the voluntary nature of meeting attendance is part of A.A.’s strength, many A.A.s first attended meetings because attendance was mandated” *Alcoholics Anonymous as a Resource For Drug & Alcohol Court Professionals*, ALCOHOLICS ANONYMOUS (Nov. 2009), http://www.aa.org/lang/en/en_pdfs/smf-177_en.pdf.

¹⁶⁴ *What are A.A. Meetings Like?*, ANONYMOUS PRESS, <http://anonpress.org/faq/files/read.asp?fID=166> (last visited Sept. 29, 2012).

shared by the public generally.”¹⁶⁵ It is unclear whether a one-hour time commitment would be deemed a “significant” restraint on liberty, though it is clearly less of a restraint than the time commitments held to constitute “custody” in *Dow*. However, the principle ultimately stands that court-mandated rehabilitation requires a person’s “physical presence at a particular place” and thus restrains the person’s “liberty to do those things which in this country free [people] are entitled to do.”¹⁶⁶

The Ninth Circuit’s finding that mandatory alcohol rehabilitation constitutes “custody” is not binding on other jurisdictions and does not end the discussion supporting mandatory rehabilitation. It simply allows a woman placed in court-ordered rehabilitation to invoke federal habeas corpus jurisdiction within the meaning of 28 U.S.C. § 2254.¹⁶⁷ Under this statute, “[a]n application for a writ of habeas corpus . . . [will] not be granted unless . . . [1] the applicant has exhausted the remedies available in the courts of the State . . . [2] there is an absence of available State corrective process[,] or [3] circumstances exist that render such process ineffective to protect the rights of the applicant.”¹⁶⁸ Because an application may also be denied on the merits,¹⁶⁹ a writ of habeas corpus will not necessarily be granted simply because the petitioner is within her rights to apply. As discussed above, a woman who has been ordered to mandatory outpatient alcohol rehabilitation for giving birth to a baby with FAS has the right under *Dow* to apply for a writ of habeas corpus. The proposal for mandatory outpatient rehabilitation outlined in this Note does not deprive a woman of any of the constitutional rights provided to American citizens, and she is free within the boundaries of the law to appeal her sentencing.¹⁷⁰

¹⁶⁵ *Dow v. Circuit Court (Huddy)*, 995 F.2d 922, 923 (9th Cir. 1993) (internal quotation marks omitted).

¹⁶⁶ *Id.*

¹⁶⁷ *Id.*

¹⁶⁸ 28 U.S.C. § 2254(b)(1) (2011).

¹⁶⁹ *Id.* § 2254(b)(2).

¹⁷⁰ Hypothetical scenarios that could cause a court to grant a woman’s application for a writ of habeas corpus are beyond the scope of this Note.

2. *The Flexibility of Modern Outpatient Rehabilitation Programs*

The wide variety of outpatient rehabilitation groups affords a level of flexibility that makes this form of mandatory treatment significantly less burdensome than inpatient treatment. AA alone offers features compatible to many different lifestyles, thus softening restraints upon a woman's liberty when enrolled in one of these programs. One concern for mothers participating in alcohol treatment programs may be childcare while she attends meetings. It is possible that women mandated to treatment may not have family or friends available nearby to watch their children while they attend meetings or may not have the funds to pay for a babysitter. One AA website includes testimony from a parent who wrote: "I found meetings where my son could play in the hall while I sat/stood in the doorway. Many other groups, like my current homegroup, have use of a nursery."¹⁷¹ Testimony like this indicates the accessibility and flexibility of such programs for mothers of young children.

Another likely concern is payment for treatment. Numerous nationwide outpatient alcohol programs provide services to members completely free of charge and finance their operations through voluntary donations, profits from literature sales, and corporate contributions.¹⁷² Because of the variety of outpatient groups available throughout the United States, women can receive

¹⁷¹ *Are Kids Allowed in Meetings?*, ANONYMOUS PRESS, <http://anonpress.org/faq/files/read.asp?fid=120> (last visited Sept. 29, 2012).

¹⁷² See, e.g., ALCOHOLICS ANONYMOUS, A BRIEF GUIDE TO ALCOHOLICS ANONYMOUS (1972), available at http://www.aa.org/pdf/products/p-42_abriefguidetoaa.pdf ("Newcomers do not pay any fees for membership. And members do not pay dues."); *FAQs: How Is LifeRing Financed?*, LIFERING, <http://lifering.org/faqs/> (last visited Oct. 23, 2012) ("LifeRing is a nonprofit with 501(c)(3) charitable status. LifeRing is supported by passing the basket at meetings, sales of LifeRing Press literature, and individual donations."); *Frequently Asked Questions About SMART Recovery: Where Does SMART Recovery Get Its Money, and How Does It Spend It?*, SMART RECOVERY, <http://www.smartrecovery.org/resources/faq.htm> (last visited Oct. 23, 2012) ("Primary funding is obtained from individual contributions, sale of publications, group donations to the Central Office, grants, and corporate sponsor-level contributions.").

necessary treatment with limited inconvenience to their daily lives.

CONCLUSION

FAS has a negative impact on all parties involved—parents, schools, courts, and, first and foremost, the affected child, whose life potential is threatened by the effects of the disease. Though it is clear that a solution is desperately needed, current incarceration and civil commitment models contravene a pregnant woman's constitutional rights and fail to address addiction as the root of the problem. FAS statistics will not improve until alcohol-dependent women are forced to confront and overcome their addictions, a process that the criminal justice system is ill equipped to handle. Rather than imposing criminal sanctions, sentencing a woman to outpatient rehabilitation provides her with the addiction treatment that is necessary to prevent future FAS births and to handle the challenges of parenting an FAS child, within a flexible model that significantly decreases restrictions on a woman's liberty. Though this method will not preclude all FAS births, it will help prevent subsequent FAS births to mothers with multiple children and will ensure a healthier home environment for affected children while respecting the constitutional rights of addicted pregnant women. It is fair to assume that most women do not choose to be alcohol dependent and do not want their addictions to cause harm to their babies *in utero*. The goal of the proposal outlined in this Note is to help women, not to punish them. The legal system may not be able to completely eradicate FAS from society, but it holds the power to improve today's troubling statistics and recognize that certain situations demand treatment that cannot be solved by traditional forms of criminal punishment.