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FETAL ALCOHOL SYNDROME: THE LEGAL AND SOCIAL RESPONSES TO ITS IMPACT ON NATIVE AMERICANS

CLAIRE E. DINEEN*

I. INTRODUCTION

A Native American mother gave the following poignant testimony before Congress in 1992 about being the mother of a child with fetal alcohol syndrome:

> My name is Jill Plumage. I am a Native American, being an enrolled member of the Assinboine and Gros Ventre tribes of the Fort Belknap Indian Reservation in Montana. . . . I am the mother of a sixteen year old son who is a fetal alcohol syndrome [FAS] victim. My son stand[s] 5 feet tall and weighs 95 pounds. . . . In 1975, when I was pregnant with my son, I never heard the term, "Fetal Alcohol Syndrome." Today, in 1992, this still holds true for many Indian women and young Indian people. . . .
>
> During the years that I was an active alcoholic, I was in over twenty alcoholic treatment programs. It wasn't until I met another Indian woman who was an alcoholic counselor that I felt that there was some hope for me. Previous to that, I was in treatment centers that were primarily non-Indian. Meeting and sharing with this woman changed my life. My child was born at the Indian Health Service hospital at Fort Belknap—DRUNK! He was born drunk and that fact was never addressed to me—his natural mother. Two days after his birth, the doctor who delivered my son advised me, "if I was planning to breast feed my baby, I was to drink at least 2 to 3 cans of beer a day." My son was in alcohol withdrawal at the time. After I was released from the hospital with my child, I continued drinking. I ended up in the detox center at Fort Belknap three times during the first five months of my child's life. Each time, he stayed with me in detox. I don't blame anyone for what happened. I don't

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> blame the doctor who advised that I drink beer for the feeding of my baby. He wasn't trained to identify the problem. I don't blame my tribe for not having the help or information that I needed. I don't blame anyone as the help or the information just wasn't available. My son was eventually adopted by my sister and her husband and has remained in our family. He attended public school and managed to reach the ninth grade without ever being diagnosed again [as a FAS child]. I don't blame the school system. I mention these things only to reinforce the lack of education and training in our society regarding this defect. I blame ignorance for what happened to my son through my alcohol addiction. . . . [T]here are only 5 to 6 . . . treatment programs in the whole country available for pregnant women. We desperately need these treatment programs—jail is not the proper place for an alcoholic addicted pregnant woman. Punishment is not the solution. . . . My hope would be a half-way home . . . so that the woman would continue to have strong support and thereapy following alcoholic treatment. When I was in and out of detox with my child, I used to pray for a safe sober place to live with my baby. Perhaps if this type of facility were available, we would still be a family today. . . . My son gave me this message to bring to you, "If only one baby does not have to be born like me, it will be worth it. Tell them that, Mom. Ask them, what is going to happen to me when I grow up? I want to be able to take care of myself. I know what happened to me isn't my fault."[1]

Ms. Plumage's son was born with fetal alcohol syndrome (FAS), a condition with only one cause: maternal drinking during pregnancy. He has permanent mental and physical handicaps. Her testimony before Congress does not mention her son's specific problems, but she voices very real concerns about his future. He very possibly has a low IQ level, is hyperactive, easily distracted, extremely gullible and trusting, and very impulsive.[2] What may be most frustrating to him, and all parents and caretakers of FAS victims, is their inability to make judgments, their lack of common sense, and their inability to connect present actions with future consequences. These behavioral traits are common among FAS

1. *Indian Fetal Alcohol Syndrome Prevention and Treatment Act: Hearing on H.R. 1322 Before the U.S. House of Representatives Committee on Interior and Insular Affairs*, 102d Cong., 2d Sess. 122 (1992) (statement of Jill Plumage, mother of a child with Fetal Alcohol Syndrome) [hereinafter *Hearing on H.R. 1322*].

2. *See infra* text and footnotes 23-30.

victims, with the result that it may be unlikely that Ms. Plumage's son, or any FAS victim, will be able to live independently.[3]

Ms. Plumage's testimony presents first-hand the devastating impact that alcohol abuse has on pregnant women and their children. This serious public health problem must be brought to the forefront of general public awareness because it is one-hundred percent preventable. It must be removed from purely academic arguments and research disputes and become common knowledge. It is an extremely complex and multi-faceted issue with roots in society, history, public health, culture, and economics. The solution is not in the courts, not in criminal penalties, and not in legal articles that present arguments pitting maternal rights against fetal rights. The answer is to act immediately through public health channels, and it lies in a strong, community-based approach aimed at prevention and treatment. As a public health issue, it can best be addressed by involving everyone in the community, because it is everyone's problem.[4]

Since Biblical times, there have been warnings that alcohol is harmful to the developing fetus.[5] The Navajo also recognized early the danger associated with drinking during pregnancy, as "[s]ome Navajo elders used to say years back that if a woman about to bear a child drinks crazy water, the newborn will be crazy in the body and the mind."[6]

There was a strong suspicion of a link between alcohol and birth defects in the 18th century and scientific evidence of the relationship was gradually produced during the 19th and 20th centuries.[7] It was not until 1973, however, when alcohol's potential as a teratogen[8] was first recognized. The condition was termed "Fetal Alcohol Syndrome" and was described by the modern medical community as an independent medical condition with its own etiology and characteristic physical and mental manifestations.[9] Much has been learned from the research conducted

3. *Id.*

4. Siobhan M. Wescott, *Time to Address a Preventable Tragedy*, 5 WINDS OF CHANGE 30, 33 (1990).

5. Kenneth L. Jones, *Fetal Alcohol Syndrome*, 8 PEDIATRICS IN REVIEW 122, 122 (1986). *See also* James C. Overholser, *Fetal Alcohol Syndrome: A Review of the Disorder*, 20 J. CONTEMP. PSYCHOTHERAPY. 163, 164 (1990) (quoting a warning against drinking by pregnant women present in the Book of Judges, 13:3-6, "you will be with child and bear a son, so take neither wine nor strong drink").

6. Ann P. Streissguth, *A Manual on Adolescents and Adults with Fetal Alcohol Syndrome with Special Reference to American Indians*, (Washington, D.C.: Indian Health Service, 1988) (citing Fetal Alcohol Syndrome Workbook, Behavioral Health Department, The Navajo Tribe, June 1982).

7. Robert J. Sokol, *Significant Determinants of Susceptibility to Alcohol Teratogenicity*, 477 ANNALS N. Y. ACADEMY SCIENCES 87, 87 (1986).

8. "Teratogenic substances are those known to cause adverse effects on offspring as a result of gestational exposure." ANN P. STREISSGUTH & ROBIN A. LADUE, FETAL ALCOHOL: TERATOGENIC CAUSES OF DEVELOPMENTAL DISABILITIES, TOXIC SUBSTANCES & MENTAL RETARDATION 1, 4 (Stephen R. Schroeder ed. 1987), [hereinafter TERATOGENIC CAUSES].

9. Kenneth L. Jones, *Recognition of the Fetal Alcohol Syndrome in Early Infancy*, 2 LANCET 999 (1973).

since then, but more information is necessary in order to properly address and prevent FAS. The need for immediate preventative action is great because if "FAS victims do not learn from experience, they do not get well."[10]

This article will first describe the scope of Fetal Alcohol Syndrome by presenting medical, economic, and epidemiological information about FAS. In addition to focusing on its impact on Native Americans, the article will also examine the etiology of the higher rates of FAS found among Native American populations. It then turns to review the approaches being used to prevent FAS. This article concludes that legal approaches that focus on either the maternal or fetal interests are not the appropriate means of addressing this problem in the general population or in Native American communities. A public health, community-based approach that views the mother and fetus as a unity rather than adversaries is the most effective method to achieve the goal of improving the health and well-being of the mother, the child, and the community.

II. SCOPE OF THE PROBLEM

A. PHYSICAL AND NEUROBEHAVIORAL MANIFESTATIONS

Fetal alcohol syndrome is the name given to a pattern of major and minor physical malformations, growth deficiencies, and central nervous system abnormalities caused by maternal alcohol use during pregnancy.[11] FAS is well defined for the children most severely affected by prenatal alcohol exposure, but there is considerable confusion regarding the more subtle or partial fetal alcohol effects (FAE). The diagnosis of FAS is made when there is a history of heavy maternal drinking during pregnancy along with growth deficiency of prenatal origin (affecting height, weight, and head size), a pattern of specific facial anomalies, and central nervous system manifestations (including delayed development, hyperactivity, attention deficits, learning disabilities, intellectual deficits, or seizures).[12]

Prenatal and postnatal growth retardation in the height, weight, and head circumference is common in those with FAS. The prematurity and low birthweight associated with maternal alcohol abuse are related to other serious complications in young infants, including increased rates of

10. *Fetal Alcohol Syndrome: Hearing Before the Subcommittee on Social Security and Family Policy of the Committee on Finance*, 101st Cong., 2d Sess. (1990) (statement of Michael Dorris, author, THE BROKEN CORD) [hereinafter *FAS Hearing*]. *See generally* MICHAEL DORRIS, THE BROKEN CORD (Harper & Rowe) 1989.

11. Ann P. Streissguth et al., *Studying Alcohol Teratogenesis From the Perspective of the Fetal Alcohol Syndrome: Methodological and Statistical Issues*, 477 ANNALS N. Y. ACADEMY SCIENCES 63, 63 (1986).

12. Ann P. Streissguth, *Fetal Alcohol Syndrome in Adolescents and Adults*, 265 JAMA 1961, 1961 (1991) [hereinafter *Fetal Alcohol Syndrome*].

respiratory illness, sudden infant death syndrome, infections, and developmental delays.[13] Children with FAS tend to be smaller than their peers and their slower growth rates do not allow them to make up for the prenatal deficiencies.[14] Although the growth deficiencies persist well into childhood, the characteristic emaciated appearance disappears in adolescence, especially in females.[15] This change in the appearance of FAS children when they reach their teenage years makes it more difficult to diagnose FAS during adolescence and adulthood.[16]

The FAS facial characteristics are recognizable in children of all races,[17] "but are difficult to objectively describe or quantify."[18] There are, however, several distinct facial features that include short palpebral fissures (eye slits), epicanthal folds (an extra fold of skin at the edge of the eye alongside the nose that overlaps into the eyespace), flat midface, indistinct ridges running between nose and mouth, and a thin upper lip.[19] In the early 18th century, FAS children were described as having a "starved, shriveled, and imperfect look,"[20] which continues to be a relatively accurate, although unscientific, description.[21] Other common physical anomalies include congenital heart disease, limitations of movement (particularly elbow and wrist), genital anomalies, hearing loss, moderate to severe myopia and other eye abnormalities, spinal defects, higher susceptibility to illness, and dental malocculsions.[22]

The central nervous system damage associated with FAS is manifested by varying degrees of mental retardation. At birth, FAS infants are often tremulous, irritable, hypersensitive to sound, and have feeding difficulties all leading to a failure to thrive.[23] In preschool years, FAS children are hyperactive, inattentive, impulsive, and they exhibit impaired fine and

13. Paddy S. Cook et al., *Alcohol, Tobacco, and Other Drugs May Harm the Unborn*, U.S. Dept. of Health and Human Services, Office for Substance Abuse Prevention, at 55 (Tineke B. Haase ed., 1990).

14. Overholser, *supra* note 5, at 167.

15. Ann P. Streissguth et al., *Natural History of the Fetal Alcohol Syndrome: A 10-Year Follow-Up of Eleven Patients*, 2 LANCET 85, 89 (1985) [hereinafter *Natural History*].

16. *Id.*

17. Ann P. Streissguth, *Alcohol and Pregnancy: An Overview and An Update*, 4 SUBSTANCE AND ALCOHOL ACTIONS/MISUSE 149, 151 (1983) [hereinafter *Alcohol and Pregnancy*].

18. Overholser, *supra* note 5, at 167.

19. *Id.*; Streissguth, *Natural History*, *supra* note 15, at 87.

20. *Id.* Overholser, *supra* note 5, at 167 (citing Ann P. Streissguth, *Fetal Alcohol Syndrome: An Epidemiologic Perspective*, 107 AM. J. EPIDEMIOLOGY 467 (1978)).

21. *Id.*

22. *Id.* at 165.

23. Failure to thrive is a recognized health disorder usually due to medical or environmental factors and is common in prenatally substance-exposed infants. The infants exhibit a significant "deceleration in weight gain and may demonstrate poor developmental abilities . . . . [such as] poor sucking, swallowing difficulties, and distractibility that can interfere with adequate weight gain." Judy Howard, *Chronic Drug Users as Parents*, 43 HASTINGS L.J., 645, 654-55 (1992) (citing Abraham M. Rudolph, *Neglect: Failure to Provide Essentials*, in RUDOLPH'S PEDIATRICS § 16.8.2, at 844 (19th ed. 1991)).

gross motor functions. As these children grow older, it becomes apparent that mental handicaps are the most debilitating aspect of FAS.[24]

A recent study involving sixty-one adolescents and adults with FAS/FAE indicated that their "maladaptive behaviors present the greatest challenge to management" of these individuals.[25] This group was fairly representative of the broad range of FAS/FAE characteristics and were found to have an average IQ score of sixty-eight, reflecting overall intellectual functioning in the mentally retarded range.[26] The average academic functioning for this group was at the early grade school level. The most characteristic academic disability was difficulty with arithmetic which is related to the inability of those with FAS/FAE to generalize from one situation to another or to comprehend abstractions like time and space or cause and effect. Without these abilities and skills, it is impossible to live independently. The failure to consider consequences of action, lack of appropriate initiative, unresponsiveness to subtle social cues, and lack of reciprocal friendships are characteristic problems of those with FAS/FAE, even if they technically are not retarded according to their IQ scores. Other frequent maladaptive behaviors include "poor concentration and attention, dependency, stubbornness or sullenness, social withdrawal, . . . crying or laughing too easily, impulsivity, and periods of high anxiety."[27]

These problems observed in adolescents with FAS appear to be different in magnitude and severity when compared to others who are mentally retarded.[28] "[O]nly [fifteen] to [thirty-two percent] of adolescents with Down's syndrome [have] severe behavior problems compared with the [sixty-two percent] of individuals in this study with significant levels of maladaptive behaviors."[29] "'They want so much to fit in with a social group they'll ride their bikes down the freeway on a dare or jump off a bridge on a dare. They wind up being the scapegoats for gang activities. They commit crimes with no sense of remorse or responsibility.'"[30]

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24. Ann P. Streissguth & Robin A. LaDue, *Psychological and Behavioral Effects in Children Prenatally Exposed to Alcohol*, 10 ALCOHOL & RES. WORLD 6, 7 (Fall 1985) [hereinafter *Psychological and Behavioral Effects*].

25. Streissguth, *Fetal Alcohol Syndrome*, *supra* note 12, at 1963. This study has been described as "the most comprehensive and far-reaching study to date" and is frequently referenced and cited. Committee on Substance Abuse and Committee on Children with Disabilities, *Fetal Alcohol Syndrome and Fetal Alcohol Effects*, 91 PEDIATRICS 1004, 1004 (1993).

26. Streissguth, *Fetal Alcohol Syndrome*, *supra* note 12, at 1962. *See also* Ann P. Streissguth, *Neurobehavioral Dose-Response Effects of Prenatal Alcohol Exposure in Humans from Infancy to Adulthood*, 562 ANNALS N. Y. ACADEMY SCIENCES 145, 150 (1989) [hereinafter *Neurobehavioral Dose-Response Effects*].

27. Streissguth, *Fetal Alcohol Syndrome*, *supra* note 12, at 1965.

28. *Id.* at 1966.

29. *Id.*

30. Nancy Plevin, *Fetal Alcohol Syndrome: Educating the Doctors*, L.A. TIMES, Nov. 1, 1992, at B5 (quoting Dr. Jon Aase, a birth defects specialist and researcher of FAS).

B. DIAGNOSIS OF FAS/FAE

The wide range of observable effects in children with FAS led to the "minimal" criteria for the diagnosis of FAS formulated by the Fetal Alcohol Study Group of the Research Society on Alcoholism.[31] To meet the criteria set by the Fetal Alcohol Study Group, a diagnosis requires the specific manifestations of growth retardation, central nervous system abnormalities, and at least two characteristic facial anomalies in addition to a history of maternal drinking. While these criteria are useful in identifying the more severe end of the spectrum of effects associated with prenatal alcohol exposure (FAS), they do not preclude recognition of the entire spectrum of effects, including the more mild fetal alcohol effects (FAE) such as subtle neurological disturbances and low birth weight.[32]

There are estimated to be twice as many children who are "mildly affected" (FAE) as "severely affected" (FAS).[33] Children with FAE may have intellectual function within the normal range, but they can manifest certain behavioral effects including learning disabilities, speech and language problems, hyperactivity, and attention problems.[34] In addition, there is concern that individuals with milder forms of FAS/FAE may fall through the cracks of the system because they may not qualify for some of the special education services or their disabilities may be too subtle to be detected as alcohol-related birth defects.[35]

Early diagnosis of FAS/FAE is important not only to obtain accurate prevalence rates, but also to begin appropriate intervention as soon as possible with the goal of reducing and preventing some secondary behavioral and mental problems.[36] Maternal alcohol abuse has the potential to impact in a cumulative manner on a child's life, beginning with prenatal exposure to alcohol; then there may be problems of postnatal inadequate

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31. Streissguth, *Alcohol and Pregnancy*, *supra* note 17, at 152 (citing Henry L. Rosette, *A Clinical Perspective of the Fetal Alcohol Syndrome*, 4 ALCOHOL: CLINICAL EXPOSURE AND RESEARCH 119 (1980)).

32. *Id.* *See also* Kenneth R. Warren & Richard J. Best, *Alcohol-Related Birth Defects: An Update*, 103 PUB. HEALTH REP. 638, 639 (stating that FAE is diagnosed in children whose mothers consumed significant amounts of alcohol during pregnancy and who have birth defects likely, though not definitively, attributable to alcohol use).

33. Streissguth & LaDue, *Psychological and Behavioral Effects*, *supra* note 24, at 7.

34. Warren & Best, *supra* note 32, at 639 (citing the *National Institute on Alcohol Abuse and Alcoholism (NIAAA): Fifth Special Report to the U.S. Congress on Alcohol and Health from the Secretary of Health and Human Services*. DHHS Publication No. (ADM) 84-1291, U.S. Government Printing Office, Washington, D.C., 1983, at 70). Alcohol-related birth defects (ARBD) is a another term used to address the consequences of prenatal exposure to alcohol that do not meet the minimal FAS criteria. *Id.* ARBD is defined as birth defects that are attributable to alcohol after statistical analysis has corrected for the contribution of other possible factors. *Id.*

35. Western Regional Center for Drug-Free Schools and Communities, A Systematic Approach to Dealing With Fetal Alcohol and Other Drug Affected Children in the Educational Setting, at 20-21 (1991) [hereinafter A SYSTEMATIC APPROACH]. *See also* Streissguth & LaDue, *Psychological and Behavioral Effects*, *supra* note 24, at 7.

36. Streissguth, *Fetal Alcohol Syndrome*, *supra* note 12, at 1966.

care or neglect due to impaired maternal functioning associated with alcohol abuse; and finally, during childhood and adolescence, the child is impacted by a detrimental environment.[37] Recognition of FAS/FAE children early in their lives may provide the opportunity for them to develop to their own best potential, as they are in need of enhanced care and appropriate social and educational interventions. Failure to diagnose FAS/FAE early may exacerbate the impact that adverse environmental factors may have on the maladaptive behaviors that are already present in these vulnerable children.[38] While "[e]arly placement and continued residence in a single foster home [(i.e, a stable home environment) does] not significantly affect intelligence or symptoms of brain damage" of FAS/FAE children, it does "result in fewer psychosocial symptoms" and better social and emotional development.[39] In addition, mothers who give birth to children with FAS/FAE are at high risk themselves for alcohol-related illness and are in need of intensive support from social service and public health agencies.[40] Diagnosis is also important to help the biologic or adoptive families of FAS/FAE children to understand their condition, because if it is left undiagnosed, some parents may believe that they are responsible for their children's behavior problems.[41]

An important concern does exist about early diagnosis of children with FAS/FAE, because it may result in a stigmatizing label that signals "irreversible brain damage" for the rest of their lives.[42] While this controversy of whether or not to label children with FAS/FAE is not the focus of this paper, it is an important issue that needs to be considered in this complex problem. The advantages of a clear and specific diagnosis, rather than a general statement that the child is hyperactive or has an attention deficit, include the development of appropriate interventions and an understanding of the individual's problems.[43] One prominent researcher has responded to this debate in this manner:

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37. Ernestine Vanderveen, *Public Health Policy: Maternal Substance Use and Child Health*, 562 ANNALS N. Y. ACADEMY SCIENCES 255, 256 (1989).

38. Streissguth, *Fetal Alcohol Syndrome*, *supra* note 12, at 1966.

39. *See* Streissguth, *Alcohol and Pregnancy*, *supra* note 17, at 154 (citing M. Aronson et al., *Menial and Somatic Sequelae After Fetal Alcohol Exposure*, BIOLOGICAL PSYCHIATRY, 913-15 (1981)). *See also* Streissguth, *Natural History*, *supra* note 15, at 90. *See also* DORRIS, supra note 10. Dorris, the author and adoptive father of a child with FAS, found that despite his son's stable upbringing from the age of three, he still exhibited serious behavioral problems.

40. Streissguth & LaDue, TERATOGENIC CAUSES, *supra* note 8, at 27.

41. Sharon Kirkey, *Fetal Alcohol Syndrome is the Leading Cause of Mental Retardation in North America*, OTTAWA CITIZEN, Mar. 20, 1992, at F1. According to one parent, before her child was diagnosed "we were told we didn't have good parenting skills. We were referred to counseling twice because we were told the problem was ours." *Id.* *See also* Streissguth, *Fetal Alcohol Syndrome*, *supra* note 12, at 1967 ("[F]amilies often find the diagnosis of FAS helpful in obtaining suitable programs for their children. Patients often express relief at understanding the cause of their lifelong difficulties.").

42. A SYSTEMATIC APPROACH, *supra* note 35, at 23.

43. *Id.*

"I hear this a lot, if you label a kid then they can't ever grow beyond their label. . . . My feeling in terms of FAS/FAE is really the opposite. If you don't label them, if you don't know what's going on, those kids are going to be targeted for problems because they're going to have so many bizarre behaviors that people really don't understand and don't know how to deal with and they will really be out of hand before you figure out what's going on."[44]

The tension created by providing a clear diagnosis and subsequently, a stigmatizing label, is an issue that warrants consideration of individual circumstances.

The prospect of early identification of FAS/FAE in newborns seems unlikely in light of two studies, one documenting a one-hundred percent failure rate in diagnosing FAS at birth.[45] This failure occurred despite the fact that the mothers' obstetric records included a history of alcohol abuse during pregnancy and the characteristics of FAS were recorded in the medical records of infants whose mothers drank excessively during pregnancy.[46] Unlike a diagnosis of Down's syndrome which can be identified from a single laboratory test, a diagnosis of FAS depends on a medical judgment of the individual "along with the presence of a positive history of maternal alcohol abuse during pregnancy."[47] To the untrained health professional, the young infant with FAS may appear to be simply growth deficient, making it difficult to obtain reliable prevalence figures.[48] The problem seems exacerbated by the fact that FAE, which exhibits the less severe impact of maternal alcohol use during pregnancy, is even more difficult to diagnose. In addition, the alcoholic mother may not be identified in the hospital "unless she meets the classic stereotype of the skid row alcoholic."[49] The difficulty in satisfying both factors makes it unlikely that accurate prevalence data will be easy to obtain.[50]

Most medical schools are not educating their students about "'even the most basic information on the dangers of alcohol during preg-

44. *Id.* at 24 (quoting Dr. Ann P. Streissguth, Streissguth et al., *Neurobehavioral Effects of Prenatal Alcohol: Part I*, 11 NEUROTOXICOLOGY AND TERATOLOGY, 461 (1989).

45. Bertis B. Little et al., *Failure to Recognize Fetal Alcohol Syndrome in Newborn Infants*, 144 AM. J. DISEASES CHILDREN 1142, 1145 (1990). *See also* Streissguth, *Fetal Alcohol Syndrome*, *supra* note 12. A study of sixty-one adolescents and adults with FAS or FAE revealed that few were identified as having FAS or FAE in infancy. *Id.* at 1966.

46. *Little*, *supra* note 45, at 1145-46. Three significant facts of this study were: (1) features of FAS were recorded in the medical records of infants whose mothers drank excessively during pregnancy; (2) there was a 100% failure to diagnose FAS; and (3) the mothers' medical records contained documentation of maternal alcohol abuse during pregnancy. *Id.* at 1145.

47. Streissguth & LaDue, *Teratogenic Causes*, *supra* note 8, at 2-3.

48. *Id.*

49. *Id.* at 3.

50. *Id.*

nancy.'"[51] It does not appear that incorporating such a curriculum in medical schools would be difficult as the training does not involve sophisticated laboratory testing or medical procedures. The primary component "'is simply being aware that [FAS/FAE] exists and being willing to question mothers about their drinking.'"[52] "'[P]hysicians have a duty to prevent as well as cure diseases,'"[53] and the duty towards preventing FAS/FAE could be met by providing mandatory training in medical schools and hospitals to recognize the specific physical and neurobehavioral manifestations associated with FAS/FAE.[54] In addition, reliable screening questionnaires to detect alcohol abuse in women prior to conception and during pregnancy, such as the "T-ACE" test, could provide a standardized way to identify early who may be abusing alcohol.[55] Standardized training, screening procedures, and policies can help to ensure reliable diagnoses and accurate prevalence rates.

Each year, thousands of children are born with this disorder that has a known cause and is absolutely preventable. Physicians, however, are not only uneducated about FAS, they are often reluctant to invade patients' privacy because they do not feel confident in counseling women about drinking behavior.[56] It is estimated that "[fifty-five percent] of women of childbearing age have never heard the words fetal alcohol syndrome and more than [sixty-five percent] of pregnant women drink alcohol."[57] In addition to educating health professionals about the signs and symptoms of maternal alcohol abuse and FAS/FAE, it is also necessary to develop effective, visible educational programs for women to alert them to the harms of drinking during pregnancy. Although physicians are often hesitant to confront pregnant women who may be abusing alcohol, they would

51. Plevin, *supra* note 30 (quoting Patti Munter, founder of the National Organization on Fetal Alcohol Sydrome).

52. *Id.* (quoting Dr. Jon Aase).

53. *Id.*

54. *See* Ira J. Chasnoff, *Drugs, Alcohol, Pregnancy, and the Neonate: Pay Now or Later*, 266 JAMA, 1567, 1568 (1991). "Substance abuse education should be integrated into the curricula of all medical schools so that physicians are better able to work with their patients to provide the appropriate interventions and referrals. Physicians need not become detectives in their practices, seeking out pregnant drug users and abusers, but they should become advocates of quality and comprehensive treatment services for their patients, many of whom have no other link to the health care system." *Id.*

55. Enoch Gordis & Duane Alexander, *From National Institute of Health: Progress Towards Preventing and Understanding Alcohol-Induced Fetal Injury*, 268 JAMA 3183 (1992). A four-question test, known as T-ACE, was developed by researchers at the National Institute on Alcohol Abuse and Alcoholism (NIAAA), now part of the National Institutes on Health (NIH), to identify pregnant patients who may have an alcohol problem. *Id.* It takes less than one minute to ask questions that do not prompt untruthful answers. *Id.* "The key question concerns *Tolerance* [and asks]: "How many drinks does it take to make you feel high? [Other questions ask] whether [the person] has been *Annoyed* by criticism of her drinking, has felt she should *Cut* down, has ever had a drink first thing in the morning to steady her or get rid of a hangover (*Eye-opener*). *Id.*

56. Plevin, *supra* note 30.

57. *Id.*

probably be quick to intervene when a pregnant woman has "cocaine rings under her nose or needle marks on her arms."[58]

C. PREVALENCE OF FAS

As a leading cause of mental retardation, the real tragedy is that FAS is a completely preventable condition, unlike Down's syndrome and spina bifida.[59] Worldwide, the prevalence of FAS alone (FAE is not included) has been estimated to be 1.9 FAS children for every 1,000 live births.[60] A more recent study by the same researchers resulted in a significantly lower overall incidence of 0.33 per 1,000 live births or about 1,200 children born with FAS every year in the United States.[61] The reasons given for this revised estimate included that the methodologies utilized in the two studies were different.[62] The authors maintain, however, that this is a very conservative estimate due to variations in diagnostic criteria and definitions used for FAS and the absence of accurate information for certain minority groups, including Native Americans.[63] The National Institute on Alcohol Abuse and Alcoholism (NIAAA), prior to this most current study, agreed that the original estimate of 1.9 FAS children per 1,000 live births was conservative. Further, the NIAAA stated that if children born with only some of the FAS effects were included (i.e., FAE children), the incidence rate of alcohol-related birth defects may be as high as one in 200.[64]

It is apparent that completely accurate statistics on FAS/FAE are not possible. It is significant that despite the lowered estimate, the authors

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58. *Id.* (quoting Patti Munter, founder of the National Organization on Fetal Alcohol Syndrome).

59. *See* Ernest L. Abel & Robert J. Sokol, *Fetal Alcohol Syndrome is Now the Leading Cause of Mental Retardation*, 2 LANCET 1222 (1986). *See also* Kathryn McWhirter, *A Little of What You Fancy? - Medical Opinion Differs on How Safe It is for Pregnant Women to Drink Alcohol*, THE INDEPENDENT, June 9, 1991, at 51 (citing the following statistics: FAS occurs in 1.9 children of every 1000 live births; Down's syndrome occurs in 1.25 children per 1,000 live births; and spina bifida occurs in 1.0 children per 1,000 live births).

60. Ernest L. Abel & Robert J. Sokol, *Incidence of Fetal Alcohol Syndrome and Economic Impact of FAS-Related Anomalies*, 19 DRUG & ALCOHOL DEPENDENCE 51, 56 (1987) [hereinafter *Incidence of FAS*]. In 1984, this rate translated into approximately 7,000 children being born with FAS, as there were 3,697,000 children born that year. *Id.*

61. Ernest L. Abel & Robert J. Sokol, *A Revised Conservative Estimate of the Incidence of FAS and its Economic Impact*, 15 ALCOHOLISM: CLINICAL AND EXPERIMENTAL RESEARCH 514 (1991) [hereinafter *A Revised Conservative Estimate*].

62. *Id.* The authors state that prospective studies in which pregnancies were followed consecutively yielded more accurate, yet lower results than retroactive studies for several reasons. *Id.* One reason is that certain payment systems (e.g., diagnostic-related groups) contain internal financial incentives that encourage "overdiagnostic coding." *Id.* Second, prospective systems underestimate the rates because "women with the greatest risk for having FAS children may not be included because they do not receive prenatal care" and are therefore not included in the studies. *Id.*

63. *Id.* at 514, 522.

64. Henrick J. Harwood & Diane M. Napolitano, *Economic Implications of the Fetal Alcohol Syndrome*, 10 ALCOHOL AND RES. WORLD 41, 38 (Fall 1985). *See also* David Gates & Deborah Beck, *Prevention and Treatment: The Positive Approach to Alcoholism and Drug Dependency*, CLEARINGHOUSE REV. 473, 474 (1990) (stating that there are an estimated 70,000 children under the age of eighteen with FAS and an estimated 160,000 FAS adults).

continued to recognize that "the extent of the problem and the economic consequences are still substantial."[65] This study also recognized that "[w]hile there is a clear-cut consensus that FAS has a higher incidence among minorities in the U.S., the basis of this difference remains to be determined."[66] This study also failed to include data on Native Americans or other racial/ethnic groups in the prevalence calculations because the numbers for these groups had only been gathered from retrospective, rather than prospective, studies. The authors cite the need for prospective studies to provide specific data on the prevalence of FAS/FAE among Native Americans and other racial/ethnic groups and they acknowledge that if such data existed, the incidence of FAS "would have undoubtedly been higher."[67]

In the general population, "[a]s many as one in six women in the peak childbearing years of ages [eighteen to thirty-four] may drink heavily enough, either chronically or episodically, to present a potential hazard to an unborn infant."[68] FAS is thought to occur in thirty to fifty percent of the offspring of alcoholic women (i.e., women with a daily intake of eight or more alcoholic beverages).[69] When infants with FAE are included, an estimated fifty to seventy percent of offspring of mothers who drink alcohol daily during pregnancy are affected.[70] In many Native American tribes, FAS/FAE children are born to a small number of women (six per 1,000 women of childbearing age) who are extremely difficult to reach with intervention efforts due to their isolation from the majority of the tribe.[71] On the average, twenty-two to twenty-five percent of Indian women who have one alcohol-affected child will have another, which indicates that a large part of the problem involves a small number of chronically alcoholic women who elude intervention and prevention efforts.[72]

Native Americans have some of the highest rates of FAS/FAE in the United States,[73] with the incidence of FAS generally thirty-three times

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65. Abel & Sokol, *A Revised Conservative Estimate*, *supra* note 61, at 514.

66. *Id.* at 519.

67. *Id.* at 520.

68. Judith E. Funkhouser & Robert W. Denniston, *Preventing Alcohol-Related Birth Defects*, 10 ALCOHOL HEALTH AND RES. WORLD 54, 55 (Fall 1985) (citing Center for Disease Control, *Behavior Risk Factor Surveillance-Selected States*, MORBIDITY & MORTALITY WKLY REP., Feb. 1983, at 32).

69. Little, *supra* note 45, at 1145.

70. *Id.*

71. Philip A. May, *Alcohol Abuse and Alcoholism Among American Indians: An Overview*, ALCOHOLISM IN MINORITY POPULATIONS, (Watts and Wright eds.) 53, 109 (1989) [hereinafter *An Overview*]. *See generally* Philip A. May & Karen J. Hymbaugh, *A Pilot Project on Fetal Alcohol Syndrome Among American Indians*, 7 ALCOHOL HEALTH AND RES. WORLD 3 (Winter 1983) [hereinafter *Pilot Project on FAS*] (discussing project's purpose of intervention to meet treatment needs).

72. May, *An Overview*, *supra* note 71, at 109.

73. Charon Asetoyer, *Fetal Alcohol Syndrome: An International Concern*, 2 WINDS OF CHANGE 29, 29 (Dec. 1987).

higher among Native Americans than among Caucasians.[74] The incidence, however, varies greatly among the different tribes.[75] On reservations in the southwest United States, prevalence rates range from one in ninety-seven (10.3 FAS children per 1,000 live births for the Plains tribes of the Apache and Ute) to one in 750 live births (1.3 per 1,000 live births for the Navajo tribe).[76] A recent study of four Native American communities in the Northern Plains, conducted by the Aberdeen Area Indian Health Service, found that four of the 1,022 children included in the project had FAS.[77] This rate of 3.9 per 1,000 live births is believed to be an underestimate of the true rate of FAS and a rate of 8.5 per 1,000 live births is postulated as more accurate.[78]

The highest reported prevalence of FAS/FAE is one child in eight (twenty percent or a rate of 190 per 1,000 children), diagnosed in a small Canadian Indian village, where all children and mothers were evaluated in an intensive research program.[79] This prevalence rate was unexpectedly high, but an accurate measurement was obtained as every family and child was screened and special attention was given to maternal alcohol use during pregnancy. Other studies estimated FAS/FAE prevalence rates for Canadian Indians at twenty-six and forty-six per 1,000 Indian children, although they did not involve intensive and individualized methods employed by the smaller study.[80] An undocumented, subjective estimate made by Jeaneen Grey Eagle, a health professional on the Pine Ridge Reservation in South Dakota, is that an astounding twenty-five percent of the children are impaired by prenatal alcohol exposure.[81] Not only is there a higher prevalence of FAS/FAE among Native Americans at the

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74. Gilberto F. Chavez et al., *Leading Major Congenital Malformations Among Minority Groups in the United States, 1981-1986*, 261 JAMA 205, 208 (1989).

75. Philip A. May et al., *Epidemiology of Fetal Alcohol Syndrome Among American Indians of the Southwest*, 30 SOC. BIOLOGY 374 (1983) [hereinafter *Epidemiology of FAS*].

76. *Id.*

77. Cindy Duimstra et al., *A Fetal Alcohol Syndrome Surveillance Pilot Project In American Indian Communities in the Northern Plains*, 108 PUB. HEALTH REP. 225 (1993).

78. *Id.* Reasons cited for the underestimate are that some low birth weight children were not screened, parents or guardians were reluctant to bring children suspected of FAS for evaluation, clinicians were hesitant to diagnose possible alcohol-damaged children for fear of labeling the child, and some children with FAS died before the diagnosis of FAS could be confirmed. *Id.*

79. Geoffrey C. Robinson et al., *Clinical Profile and Prevalence of Fetal Alcohol Syndrome in an Isolated Community in British Columbia*, 137 CANADIAN MED. ASS'N J. 203, 206 (1987). A diagnosis of FAS or FAE was made in twenty-two of the 123 children aged eighteen years or less who lived in the community. *Id.* at 206-207.

80. *Id.* The authors point out that "the elevated death rate among infants with FAS/FAE reduces the number of live affected children," resulting in underestimated prevalence rates. *Id.* at 207.

81. DORRIS, *supra* note 10, at 164 (quoting Jeaneen Grey Eagle). *See also An American Tragedy*, BOSTON GLOBE, July 22, 1989, at 14 (quoting Grey Eagle); Fred Beauvais & Steve LaBoueff, *Drug and Alcohol Abuse Intervention in American Indian Communities*, 20 INT'L J. ADDICTIONS 139, 147-48 (1985). "Health reporting systems on reservations are inefficient and a primary diagnosis of alcoholism or drug abuse is rarely recorded. Most available information is anecdotal and based only on observer impressions." *Id.* at 147-48.

present time, but "'the scary thing [is that] in every tribe we researched, the incidence is on the increase.'"[82]

D. IMPACT OF FAS/FAE ON THE NATIVE AMERICAN POPULATION

The social implications of FAS/FAE are devastating for the future of Native Americans and the existence of their separate and unique cultures.[83] FAS/FAE is a complex and destructive epidemic that threatens the well-being of all tribes. It is one of many problems faced by Native Americans that is directly related to the use and abuse of alcohol. "'[W]e're not *approaching* a crisis but are in the *middle* of one, one that is going to grow geometrically.'"[84]

The increasing prevalence of alcohol abuse over the past twenty to thirty years is cited by some as the basis for the sudden increase of FAS/FAE among the Native American populations.[85] Abusive drinking was once discouraged by society, but because of deteriorating social circumstances such as increasing unemployment and dependence on welfare, it is now more tolerated.[86] Alcohol abuse and its devastating result of FAS/FAE "'[threaten] the very survival of the Indian people.'"[87]

The term "chemical genocide" is used to describe the effect that alcohol and substance abuse is having on the Native American population. Jeaneen Grey Eagle has worked on the Pine Ridge Reservation as the director of a drug and alcohol rehabilitation program for many years. In her public statements and interviews,[88] she describes FAS, its prevalence, and its devastating effects in a way that is very different from the detached information provided by the researchers in the area. Conservative figures for Native American populations have been reported in published studies of only four to five FAS births per 1,000 live births.[89] She believes that even her subjective estimate that twenty-five percent of the children are affected by prenatal drinking may be conservative.[90] Although this rate is undocumented and without absolute proof, Grey Eagle is "in a better position than almost anyone to hazard a guess. She

82. Gina Kolata, *Alcohol Abuse by Pregnant Indians is Crippling a Generation of Children*, N.Y. TIMES, July 19, 1989, at D 24 (quoting Dr. Philip May, prominent FAS/FAE researcher).

83. Asetoyer, *supra* note 73, at 29.

84. Wescott, *supra* note 4, at 31 (1990) (quoting Michael Dorris author of THE BROKEN CORD).

85. Kolata, *supra* note 82 (citing Jeaneen Grey Eagle, who runs Project Recovery, an alcohol treatment program at the Pine Ridge reservation in South Dakota).

86. *Id.*

87. *Id.*

88. DORRIS, *supra* note 10, at 164 (quoting Jeaneen Grey Eagle). *See also FAS Hearing*, *supra* note 10 (statement of Jeaneen Grey Eagle).

89. *Id.*

90. DORRIS, *supra* note 10, at 164; *see also* Kolata, *supra* note 82.

might lack a backup statistical sample, but she had the virtue of being known and trusted in her community . . . ."[91]

The infant mortality rate on the Pine Ridge Reservation and the Aberdeen area is worse than that of many Third World countries, according to a 1986 study by the Children's Defense Fund.[92] The infant mortality rate for the entire population of South Dakota was over thirteen infant deaths per 1,000 live births, as compared to close to twenty-eight Native American infant deaths.[93] The fact that twice as many Native American infants die before they reach their first year is due not only to infants being exposed to high levels of alcohol and drugs before birth, but also to other "adverse environmental factors of poor sanitation, poor living conditions, and delays in obtaining medical care."[94]

If FAS/FAE children survive, the next step is to ensure that they are given an appropriate home environment and education in order to achieve their maximum potential. The large number of affected children, however, is straining the limited resources of many Native American communities.[95] Many women who give birth to FAS/FAE children are so disabled by their alcohol abuse that they are unable to raise and care for their children. The study described earlier involving sixty-one adolescents and adults with FAS/FAE revealed that a majority of them had lived in unstable environments, each with an average of five different homes in their lifetimes.[96] "Only [nine percent] were still with both biologic parents; only three percent were still with their biologic mothers . . . [and sixty-nine percent] of the biologic mothers were known to be dead,"[97] which is alarmingly indicative of the immediate need for screening, prevention, and treatment programs for women at risk. Placing children with FAS/FAE in foster homes or adoptive families is difficult, as they are not easy to raise.[98]

Without early intervention that provides appropriate education, FAS/FAE children are likely to become frustrated with the usual academic expectations, leading them to drop out of school and engage in anti-social behavior.[99] Teenage victims of FAS/FAE are frequently in trouble with law enforcement as a result of their difficulty in understanding cause and

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91. DORRIS, supra note 10, at 164.
92. Statement of Jeaneen Grey Eagle, *supra* note 10, at 22. *See also* Brenda van Breda, *Health Issues Facing Native American Children*, 15 PEDIATRIC NURSING 575, 575 (Nov. - Dec. 1989) (citing the infant mortality rate in South Dakota for the period 1981-1983 as 23.9 per thousand for Native Americans, versus 8.7 per thousand for non-Native Americans).
93. Statement of Jeaneen Grey Eagle, *supra* note 10, at 22.
94. van Breda, *supra* note 92, at 575.
95. Kolata, *supra* note 82.
96. Streissguth, *Fetal Alcohol Syndrome*, *supra* note 12, at 1965.
97. *Id.*
98. Kolata, *supra* note 82.
99. Asetoyer, *supra* note 73, at 29.

effect.[100] In addition to social services, the educational system must do its part in assisting individuals with FAS/FAE to become contributing and productive members of their communities. There is currently an "unwarranted climate of pessimism [that] surrounds the educational prospects of children with FAS/FAE" that must be overcome.[101]

The potential for "chemical genocide" of the Native American population is especially evident when the future generations are considered. When women with FAS/FAE reach adulthood and begin to have children of their own, many will not be able to understand that if they drink, they risk harming their babies. The inability to comprehend cause and effect is a typical characteristic of FAS individuals; they simply cannot understand the consequences of their actions. Without judgment capabilities, they are difficult to counsel, which means that more and more alcohol-impaired children may be born in the community.[102] "It [has been] estimated that within two or three generations nearly every Native American household in the Northern Plains will have at least one spouse who is a descendent of a fetal alcohol birth."[103] People are a tribe's most valuable resource and considering that "[t]he quality of a tribe's or nation's leadership is derived from [its] people, and the vulnerability of a tribe or nation lies in [its] leadership,"[104] it is obvious that it is a resource that deserves great protection.

E. ECONOMIC IMPACT OF FAS/FAE IN THE GENERAL POPULATION

The economic impact of FAS/FAE provides a compelling incentive to take action to prevent this leading cause of mental retardation. The costs involved include treatment and rehabilitation for the physical defects as well as the mental disabilities associated with FAS/FAE. Not only are there costs "in terms of special services for these individuals [but also in terms of] their impaired ability to participate in society's productivity."[105] The significant loss of human potential may be the least quantifiable cost, but it is the most valuable.

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100. *See id. See also* Plevin, *supra* note 30 (citing Dr. Jon Aase, who states that children with FAS/FAE experience a "lack of judgment [which] can lead to dangerous behavior. . . . 'They commit crimes with no sense of remorse or responsibility.'").

101. A SYSTEMATIC APPROACH, *supra* note 35, at 22 (pointing out there was a similar attitude associated with the education of children with Downs syndrome that no longer exists). The manual also emphasizes the importance of educators following certain broad procedures and approaches with FAS/FAE children.

102. DORRIS, *supra* note 10, at 164; *see also* Kolata, *supra* note 82.

103. Asetoyer, *supra* note 73, at 29.

104. *Id.* at 29.

105. Harwood & Napolitano, *supra* note 64, at 38.

Until recently, estimates for the United States placed the total economic cost of FAS at $321 million per year.[106] A more recent study, the same that significantly lowered the estimated incidence of FAS, also lowered the estimated annual cost associated with the disorder to $74.6 million per year.[107] The current estimate is strictly limited to FAS and not specific alcohol-related birth defects or FAE. Approximately three-quarters of this $74.6 million is associated with the care of FAS individuals who are mentally retarded.[108] It also includes the costs associated with pre- and post-natal growth retardation (intensive care and repeat hospitalization) and anatomic abnormalities that require corrective surgery or treatment. Other sources have estimated the cost to be as high as $1.4 billion[109] to $1.6 billion per year,[110] perhaps accounting for costs associated with the broader spectrum of abnormalities associated with prenatal alcohol exposure.

FAS represents merely the extreme of the abnormalities associated with prenatal alcohol exposure. Some experts agree that these cost estimates are conservative, because not only is the incidence of FAS underestimated, but the dollar amounts do not take into account the impairments associated with FAE, which occurs three to five times more frequently than FAS.[111] Regardless of the exact method used to calculate these figures, no amount of money can account for the pain, suffering, lost productivity, and other factors that contribute to the value of human life. In addition, even the lowest, most conservative estimate of $74.6 million "constitutes a high cost by any reasonable standard and represents a benchmark against which costs of potential prevention strategies may be judged."[112]

In response to the recognition that Native Americans in Alaska have one of the highest rates of FAS/FAE in the world,[113] the Alaskan state

106. Abel & Sokol, *Incidence of FAS*, *supra* note 60, at 68. *See also* Dora Beatriz Pinelo & Gina Reischman, *Prevention Resource Guide: Pregnant/Postpartum Women and Their Infants*, at 2 (June 1991) (citing National Institute of Alcohol Abuse and Alcoholism, *Seventh Special Report to the U.S. Congress on Alcohol and Health*, U.S. Department of Health and Human Services; Public Health Service; Alcohol, Drug Abuse, and Mental Health Administration, at 154, (Jan. 1990) (stating that FAS and FAE cost nearly a third of a billion dollars a year)).

107. Abel & Sokol, *A Revised Conservative Estimate*, *supra* note 61, at 514.

108. *Id.*

109. Gates & Beck, *supra* note 64, at 474. There are an "estimated 70,000 children under 18 with [FAS who] cost $670 million annually to treat for an array of problems. In addition, there are an estimated 160,000 [FAS] adults. . . . [whose] health care problems. . . . are estimated to cost more than $760 million annually." *Id.*

110. *Cf.* Indian Health Amendments of 1992, H.R. REP. No. 102-643 Part 1, 102d Cong., 2d Sess., 57 (1992). "It has been estimated that the annual cost of treating the birth defects caused by FAS was $1.6 billion in 1985." *Id.*

111. Abel & Sokol, *Incidence of FAS*, *supra* note 60, at 68.

112. Abel & Sokol, *A Revised Conservative Estimate*, *supra* note 61, at 522.

113. Wescott, *supra* note 4, at 32. A specific rate for prevalence of FAS/FAE in Alaska was not provided in this article.

government has studied the problem. The Alaskan study estimated the lifetime cost for every fetal alcohol syndrome birth to be $1.4 million.[114] The study further estimated that the average sixty-five day stay in intensive care for an FAS infant costs $140,805, or $2,400 per day.[115] On the other hand, it costs $6,000 for one month's treatment in a residential care facility for pregnant women[116] or $54,000 for monitoring, assistance, and support during a nine-month pregnancy.[117] The cost benefits of residential care for pregnant alcoholic women are obvious, and the economics weigh heavily on the side of prevention of FAS/FAE rather than reactive treatment or punishment.[118]

F. FACTORS ASSOCIATED WITH AN INCREASED RISK OF FAS/FAE

"Alcohol is a water-soluble central nervous system . . . depressant that passes easily across the placenta membrane."[119] In alcoholic women, the teratogenic effects of alcohol may be enhanced by the decreased activity of alcohol dehydrogenase, the enzyme that breaks alcohol down to be metabolized.[120] At the present time, only maternal alcohol consumption is known to cause FAS/FAE; the role of paternal alcohol consumption in FAS/FAE requires further study.[121]

The placenta is not a barrier to toxic substances such as alcohol, but rather, it acts as a sieve and allows passage to the fetus. Within "[f]ifteen minutes after alcohol ingestion by the pregnant mother, the blood alcohol content of the fetus is equal to that of the mother,"[122] but the effect is compounded because the metabolism and elimination of alcohol are slower in the fetus.[123] Not only is alcohol directly toxic to the rapidly dividing cells of the developing fetus, it also interferes with the delivery of nutrients to the fetus.[124] Even if the mother is maintaining an adequate

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114. *Id.*
115. *Id.*
116. *Id.*
117. *Id.* at 31 (charting a cost of $6,000 for one female in residential care for 30 days)
118. Westcott, *supra* note 4, at 32. *See also* Streissguth & LaDue, *Teratogenic Causes*, *supra* note 8, at 26 (describing a comprehensive demonstration program to prevent FAS/FAE that was designed to include public education, professional training, adult treatment, and services for those children affected by prenatal alcohol). The project cost about $1 million, which is the cost of maintaining one severely retarded child for his or lifetime. *Id.* It resulted in increased awareness and belief by the local population, the health professionals, and especially the pregnant women that abstinence from alcohol was the best policy. *Id.* Although it was temporary and did not yield concrete results, the cost-effectiveness of the program was evident. *Id.*
119. Steven R. Hawks, *Fetal Alcohol Syndrome: Implications for Health Education*, 24 J. HEALTH EDUC. 22, 23 (1993).
120. Duimstra, *supra* note 77, at 226 (citing M. Frezza et al., *High Blood Alcohol Levels in Women: The Role of Decreased Gastric Alcohol Dehydrogenase Activity and First-Pass Metabolism*, 322 NEW ENG. J. MED. 95-99 (1990)).
121. *Id.* at 226.
122. Hawks, *supra* note 119, at 23.
123. Streissguth, *Alcohol and Pregnancy*, *supra* note 17, at 159.
124. Cook, *supra* note 13, at 15-16.

diet, excessive alcohol consumption can result in nutritional deficiencies in the fetus.[125] Alcohol may also affect the fetus by impairing the fetal oxygen supply, disrupting protein synthesis and metabolism, or stimulating or suppressing hormone production.[126]

Alcohol is known to be the causative agent of FAS/FAE, but individual maternal and fetal susceptibility and other environmental factors also influence the manifestation of the effects of persistent exposure to alcohol.[127] FAS/FAE cannot be treated after the fact, but it is completely preventable. The ability, therefore, to identify those women who are at higher risk "has great importance as a public health issue."[128] The interrelated risk factors associated with FAS/FAE include low socioeconomic status and poverty, low maternal weight and weight gain, binge drinking,[129] the severity or stage of maternal alcoholism,[130] malnutrition, the use of other drugs, and older mothers who have been using alcohol most of their adult lives.[131] It is unknown why some women are able to consume very large amounts of alcohol during pregnancy without apparent fetal damage. The extent to which maternal and fetal susceptibility is influenced by suspected risk "factors such as poor nutrition, use of other drugs, and differences in actual drinking patterns has not been clarified."[132] Research on animals has resulted in some general conclusions about prenatal alcohol exposure:

> there is a dose-response relationship between the magnitude of the dose and the severity of the effect; behavioral effects are observed at levels of exposure too low to produce malformations and growth deficiency; the timing of the exposure is an important factor in the effects produced; and large individual differences exist in vulnerability to damage from a given dose of alcohol.[133]

An accurate assessment of the exact amount of alcohol that will cause damage to the fetus is difficult to obtain, and references to specific

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125. Overholser, *supra* note 5, at 168.

126. Cook, *supra* note 13, at 15-16.

127. *Streissguth & LaDue, Psychological and Behavioral Effects*, *supra* note 24, at 6, 10-11.

128. May, *Epidemiology of FAS*, *supra* note 75, at 385.

129. Funkhouser & Denniston, *supra* note 68, at 55.

130. Overholser, *supra* note 5, at 172 (identifying three stages of maternal alcoholism: prodromal or precursory phase when few and mild FAS symptoms appears in the children; the critical phase; and the chronic or advanced stage, in which there are many moderate to severe cases of FAS). "In the chronic phase, the alcoholic suffers from fears and tremors, is intoxicated for long periods of time, and . . . [has] an enhanced ability to metabolize alcohol, thus leading to higher levels of alcohol in the fetal bloodstream." *Id.*

131. Council on Scientific Affairs, *Fetal Alcohol Effects of Maternal Alcohol Use*, 249 JAMA 2517 (1983).

132. Streissguth, *Alcohol and Pregnancy*, *supra* note 17, at 155.

133. *Streissguth & LaDue, Psychological and Behavioral Effects*, *supra* note 24, at 6.

amounts are only rough estimates.[134] Predicting the effect of alcohol based on the amount ingested is uncertain due to the following factors: individual susceptibility of the mother and fetus; dose and timing of exposure; some effects in children are obvious physical manifestations and others are more subtle neurological effects; and the unreliability of the information derived from "self-reports of women whose individual patterns of consumption vary considerably from woman to woman and from week to week."[135] Thus, although the effects of moderate to heavy prenatal alcohol exposure are dose-related, it is not possible to accurately quantify the precise amounts that cause the wide range of FAS/FAE characteristics.

Children with the full syndrome are born to mothers who drink heavily during pregnancy, but a "safe level" of alcohol use during pregnancy has not been determined.[136] Researchers and health professionals attempt to provide threshold levels in order to assist pregnant women in determining the amount of alcohol at which risk can be identified.[137] Some warn that pregnant women who consistently ingest one ounce of pure alcohol per day are at increased risk for producing FAS/FAE children and thus, increased risk may even extend to women who drink more than one ounce on any given day.[138] In addition, as the amount of alcohol consumed on one day rises, the risk of fetal alcohol abnormalities also rises:[139] 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.[140]

Gestational timing of the prenatal alcohol exposure is an important factor in understanding the effects on the fetus, although alcohol ingestion "during any trimester of pregnancy has a negative impact on fetal development."[141] "'[T]he strongest relationship [between alcohol exposure and birth defects] was the two-to eight-week period [after conception]'", . . . which emphasizes the need "to focus prevention efforts on

134. *See id.* at 12.

135. *Id.*

136. Streissguth, *Alcohol and Pregnancy*, *supra* note 17, at 155-57.

137. Ernhart et al., *Alcohol-Related Birth Defects: Assessing the Risk*, 562 ANNALS N. Y. ACADEMY SCIENCES 159, 160 (1989).

138. Hawks, *supra* note 119, at 23.

139. See Ernhart et al., *supra* note 137, at 170-71; *see also* Overholser, *supra* note 5, at 169 (stating that the "[d]aily consumption of one to two ounces of alcohol was found to produce significant abnormalities in [nineteen percent] of the infants" studied).

140. Hawks, *supra* note 119, at 23 (citing Kinney & Leaton, LOOSENING THE GRIP: A HANDBOOK OF ALCOHOL INFORMATION (4th ed., Mosby Year Book) (1991).

141. *Id.* *See also* Coles et al., *Neonatal Neurobehavioral Characteristics as Correlates of Maternal Alcohol Use During Gestation*, 9 ALCOHOLISM CLINICAL AND EXPERIMENTAL RES. 454 (1985) ("[I]nfants exposed to alcohol at any time during gestation were found to have significant alterations . . . in comparison to unexposed infants").

reaching heavy drinkers before pregnancy."[142] Many women do not realize that they are pregnant during the first eight weeks, when not only the major organ and skeletal systems are forming, but also when the fetus is most vulnerable to the toxic effects of alcohol exposure.[143] The 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.[144] "The central nervous system and brain grow and develop continuously throughout pregnancy," resulting in a constant risk of mental retardation and the conclusion that there is never a safe time to drink during pregnancy.[145] After the first twelve weeks, major "anatomical malformations are unlikely, but disruption of cellular and tissue differentiation can produce reduced growth and functional impairment."[146] Infants whose mothers stop drinking in their second trimester are less affected than those whose mothers continued to drink throughout pregnancy.[147] FAS/FAE is probably not due to a single episode of heavy drinking, but rather, persistent levels of alcohol throughout pregnancy.[148] The earlier in the pregnancy that alcohol consumption is stopped, the greater the potential for an unaffected child, since alcohol can have an adverse impact during each stage of fetal development.[149]

The Surgeon General's recommendation of no alcohol during pregnancy is the safest course of conduct,[150] due to the possibility of some malformations for which no safe drinking level exists. Obstetrical complications can also arise as a result of maternal alcohol abuse.[151] In addition, neurobehavioral effects arise at lower levels of maternal drinking than

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142. Chris A. Raymond, *Birth Defects Linked with Specific Level of Maternal Alcohol Use, But Abstinence Still is the Best Policy*, 258 JAMA 177 (1987) (quoting Dr. Robert J. Sokol).

143. Cook, *supra* note 13, at 55.

144. Council on Scientific Affairs, *supra* note 131, at 2519 (citing Rosett *et al.*, *Strategies for the Prevention of Fetal Alcohol Effects*, 57 OBSTETRICS GYNECOLOGY 1 (1981)).

145. Asetoyer, *supra* note 73, at 30 (see photo caption). *See also* Ann P. Streissguth et al., *IQ at Age 4 in Relation to Maternal Alcohol Use and Smoking During Pregnancy*, 25 DEVELOPMENTAL PSYCHOL. 3 (1989) (stating that the use of alcohol in excess of 1.5 ounces of absolute (or approximately three drinks) per day during pregnancy was related to average IQ reduction of five points).

146. Overholser, *supra* note 5, at 171.

147. Coles, *supra* note 141, at 454.

148. Overholser, *supra* note 5, at 172.

149. Rosette et al., *Treatment Experience With Pregnant Problem Drinkers*, 249 JAMA 2029, 2031-32 (1983).

150. Alpert & Zuckerman, *Alcohol Use During Pregnancy: What is the Risk?*, 12 PEDIATRICS IN REVIEW 375, 375 (1991) (*citing* Surgeon General's Advisory on Alcohol and Pregnancy, FDA DRUG BULLETIN (July 1981)). *See also* James L. Mills, *Is Moderate Drinking During Pregnancy Associated With an Increased Risk for Malformations?*, 80 PEDIATRICS 309, 314 (1987) (stating that no safe drinking level exists).

151. Cook, *supra* note 13, at 16. These complications can include "vaginal bleeding, premature separation of the placenta, and fetal distress" as well as increased risk for spontaneous abortion, miscarriage, and stillbirth. *Id.* A pregnant woman who averages three or more drinks a day is "three times more likely to miscarry than non-drinkers." *Id.* Even one to two drinks a day increases the risk for miscarriage or premature delivery. *Id.*

physical malformations and growth deficiencies and are more incapacitating in the long term.[152]

Some researchers and health professionals are critical of this strict abstinence policy during pregnancy[153] because they find little evidence of risk for a woman who drinks two drinks a day or less, is well-nourished, and engages in no other risky behaviors. One leading researcher advocates a less strict approach, advises "women to 'cut way down, and absolutely . . . never get drunk'" and not worry if they drank before learning they were pregnant because "'[seventy percent] of American women drink and [seventy percent] of us are not retarded.'"[154] This view also argues that focusing on a strict abstinence policy may divert attention from other more serious negative health behaviors, and such a warning may impose unnecessary feelings of anxiety and guilt upon pregnant women.[155]

Favoring a more lenient alcohol policy, however, ignores the simple fact that if a woman does not drink during pregnancy, she will not have a child with FAS or FAE. In addition, many women, including Native Americans, may be more susceptible to the effects of alcohol due to inadequate nutrition and negative environmental factors such as poverty. Further, there is evidence that only one or two alcoholic drinks a day can cause significant problems[156] and that the amount of alcohol is only a part of the problem. Each individual's genetically determined susceptibility makes it impossible to identify a "safe" level of alcohol consumption for all women during pregnancy. While one glass of beer or wine per day may be safe for many women and their babies, it may lead to FAS/FAE for the children of others.[157]

G. ETIOLOGY OF FAS/FAE IN THE NATIVE AMERICAN POPULATION

FAS is the leading major birth defect among Native Americans in the Southwest,[158] and the incidence of FAS/FAE is likely to be as high or higher among other Native American tribes.[159] In addition, the prevalence of FAS/FAE was found to be three to four times higher among

152. *Id.* at 16-17.

153. Alpert & Zuckerman, *supra* note 150 at 378.

154. Raymond, *supra* note 142, at 177 (quoting Dr. Robert J. Sokol).

155. Alpert & Zuckerman, *supra* note 150, at 378.

156. Kenneth L. Jones, *Point-Counterpoint: Fetal Alcohol Syndrome*, 12 PEDIATRICS IN REV. 380, 380 (1991) (citing M.J. O'Connor et al), *Alcohol Use in Primiparous Women Older Than 30 Years of Age: Relation to Infant Development*, 78 PEDIATRICS 444 (1986) and N. L. Day et al, *Prenatal Exposure to Alcohol: Effect on Infant Growth and Morphologic Characteristics*, 84 PEDIATRICS 536 (1989)).

157. Jones, *supra* note 156, at 381.

158. May, *An Overview*, *supra* note 71, at 109.

159. *Id.*

younger age groups, indicating that the incidence of the disorder may be increasing.[160] The basis for concern of an increased risk for FAS/FAE among Native American children begins with the high alcoholism rate in the Native American population, combined with several demographic factors, including a fertility rate twice as high as the national average.[161] Additional significant factors among Native American women include a longer span of childbearing years, a pattern of binge drinking, and a younger age when alcohol abuse begins, all resulting in a greater number of pregnancy-years with exposure to alcohol.[162] These factors, in conjunction with gestational timing of alcohol consumption, amount of alcohol consumed, and the individual fetus's susceptibility, can all be entered into the "maternal black box" containing the mother's metabolism, diet, and physical and social environment[163] to produce a highly complex etiology of FAS/FAE.

The Native American population is comprised of many diverse cultures,[164] which makes it difficult to generalize about the etiology of FAS and alcohol abuse among them as a single group. The susceptibility factors discussed previously are present among the Native American population as they are among the general population, although the significance or weight of the factors varies. Native American alcohol abuse is a highly complex phenomenon with many issues to be considered in gaining a complete understanding. There is tremendous variation in cultural, social, economical, and educational factors from tribe to tribe, reservation to reservation, and community to community.[165] Nevertheless, some general statistics that are related to alcohol abuse among Native Americans include the following:

> "[T]he average income for Indian families in the U.S. was considerably lower ($13,678) than the national average ($19,917) and twice as many Native Americans (25.5%) were below the poverty level."[166]

160. May, *Epidemiology of FAS*, *supra* note 75, at 380. This increased rate seen among children 0 to 4 years may also be due to more effective diagnosis in young children or FAS/FAE children may have unusually high mortality in their early childhood years. *Id.*

161. Jon M. Aase, *The Fetal Alcohol Syndrome in American Indians: A High Risk Group*, 3 NEUROBEHAVIORAL TOXICOLOGY AND TERATOLOGY 153, 154 (1981). For example, the average Navajo mother would have four or five children, compared to a statistical average of 1.8 children for the average American mother. *Id.*

162. *Id.*

163. *Id.* A diagram presents all the factors entering into the individual mother's black box, signifying the complexity and unpredictability of the incidence of FAS/FAE. *Id.*

164. Beauvais & LaBoueff, *supra* note 81, at 141 (discussing "[t]he heterogeneity of Indian culture").

165. May, *An Overview*, *supra* note 71, at 96.

166. *Id.* (citing the U.S. Bureau of Census, 1984a, 1984b).

> The unemployment rate is twice the national average and "on some reservations unemployment is over 60%."[167]
>
> "[T]he educational attainment of Indians is below national averages especially when measured by college experience."[168]

Although almost one-half of the Native American population now lives in urban areas off the reservation,[169] common factors in reservation life are significant in relation to the social problems of drug and alcohol use.[170] In many reservation areas, poverty, poor nutrition, poor health, and inadequate housing and transportation are constant facts of daily life.[171] "[T]hese conditions lead to chronic stress and put many Indian people in a vulnerable position when they are confronted with the opportunity to use alcohol and drugs. The short-term relief provided by chemicals may well outweigh any perceived long-term damage that alcohol or drugs might do."[172]

Another sociocultural explanation for Native American drinking is the theory of anomie, which "maintains that Native Americans are mourning the loss of a historical tradition and reacting to the stresses of acculturation, including the demand to integrate and identify with mainstream society."[173] This situation was created by such historical events as "the forced relocation of tribes, the break up of families, constant harassment from soldiers and settlers, and the failure of the reservation system to provide a well-defined set of social roles."[174]

According to Dr. Philip May, a sociologist and leading researcher in the area of Native American alcohol abuse, the overall rates of alcohol abuse are affected by a tribe's traditional cultural and social integration patterns, as well as by social change factors exerted on the tribe by modernization.[175] Tribes who are characterized by loose social integration with a high tolerance of individuality, such as Plains Tribes, have higher rates of alcohol abuse.[176] Conversely, tribes who are tightly integrated and expect a high degree of conformity, such as the Pueblo, are character-

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167. *Id.* (citing the U.S. Bureau of Census, 1984a, 1984b).
168. *Id.* (citing the U.S. Bureau of Census, 1984a, 1984b).
169. May, *An Overview*, *supra* note 71, at 95. In the United States, there are over 300 different tribes recognized by the federal government. *Id.* The Indian and Alaskan Native population numbered 1.4 million in the 1980 census. *Id.* Of this population, more Indians live off reservations and away from traditional Native communities (63%) than live on one of the 278 reservations and 209 Alaska Native villages. *Id.*
170. Beauvais & LaBoueff, *supra* note 81, at 145.
171. *Id.* at 145-46.
172. *Id.* at 146.
173. Thomas J. Young, *Native American Drinking: A Neglected Subject of Study and Research*, 21 J. DRUG EDUC. 65, 69 (1991).
174. *Id.*
175. Philip A. May, *Substance Abuse and American Indians: Prevalence and Susceptibility*, 17 INTERNAL J. ADDICTIONS 1185, 1200, 1205 (1982).
176. *Id.* at 1202.

ized by lower rates of alcohol abuse.[177] Further, tribes who are experiencing high rates of cultural change and acculturation stress will have higher rates of alcohol abuse than similar tribes who are not experiencing similar stress.[178]

Individual susceptibility of each Native American, subject to both modern and traditional systems of social control, is also related to the variables of integration and conformity. The better integrated one is to both Native American and modern systems, the less the susceptibility to substance abuse.[179] Natives Americans who have meaningful roles in both traditional and modern cultures have the lowest susceptibility to alcohol and drug misuse.[180] Native Americans who are well integrated into only their traditional culture or only a modern society role have a lower susceptibility, although not as low as those who are well integrated in both worlds. "Those with the highest risk for misuse are marginal to both traditional Indian and modern cultures."[181]

The susceptibility scheme corresponds with the ability of an individual to cope and the social resources available. Coping in both worlds is what most Native Americans are asked to do, particularly the young and middle-aged. "Lack of adequate social support and personal skills increase the likelihood for alcohol and substance use and misuse. . . ."[182] If Native American communities have not created social sanctions against alcohol and drug use, then acceptance becomes widely established.[183] In addition, the cohesiveness and strength of the Native American family will impact on whether family members abuse alcohol or drugs.[184]

A higher prevalence of alcohol-related problems must not be interpreted to mean that Native Americans are more prone to alcoholism, as many Native Americans drink very little or not at all.[185] There is little evidence that supports the "Firewater Myth" subscribed to by some researchers or the "drunken Indian" image held by the general public.[186] The "Firewater Myth" is the belief that Native Americans are physiologi-

177. *Id.*

178. *Id.* at 1205.

179. May, *An Overview*, *supra* note 71, at 110.

180. *Id.*

181. *Id.*

182. *Id.*

183. Beauvais & LaBoueff, *supra* note 81, at 152-153.

184. *Id.* at 153.

185. *National Clearinghouse for Alcohol and Drug Information*, Sept. 1989, at 3 (citing Jones-Saumty et. al, NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM, 1978).

186. Aase, *supra* note 161, at 154. The binge pattern of drinking, combined with the high visibility of intoxicated Native Americans in off-reservation towns, has led to this "unwarranted image of the drunken Indian." *Id.* *See also* May, *An Overview*, *supra* note 71, at 113 (citing a major factor for binge drinking and the myth of the "drunken Indian" as being due to the fact that over sixty percent of reservations are under a system of prohibition, which results in long drives to obtain alcohol, binges, and interaction with non-Native Americans during the binges).

cally more susceptible to alcohol, that they metabolize alcohol differently, that it causes them to become more drunk and disorderly than non-Native Americans, and that Native Americans crave continually greater amounts of alcohol.[187] In reality, the tribes and individual members vary greatly with regard to alcohol use. The physiology of alcohol abuse is an individual matter and not one that is characteristic of any ethnic group, particularly Native Americans.[188]

The evidence of a greater prevalence of alcohol abuse among Native Americans is gathered from arrest records, suicide rates, and medical records.[189] In general, however, a higher percentage of Native American adults never drink, compared to non-Native Americans.[190] In addition, the Native American drinking population declines sharply after the age of forty.[191] Among the group that drinks, many are heavy drinkers with high rates of alcohol abuse and alcohol-related problems. There has also been an increase in the number of Native American women who use alcohol, although males continue to outnumber the females drinkers,[192] as it is more socially acceptable for Native American males to drink than for females.[193]

National surveys indicate that while sixty percent of all women in the United States drink some alcohol, the rates among Native Indian women vary from tribe to tribe. A very high alcohol consumption rate is estimated for the Pine Ridge Reservation in South Dakota, where approximately fifty percent of the pregnant women on the reservation drink alcohol on a weekly basis.[194] This estimate is supported by a report that "[forty percent] of Native American women meet the criteria for alcohol dependencies."[195] Additionally, while only thirteen to twenty-three per-

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187. Lamarine, *Alcohol Abuse Among Native Americans*, 13 J. OF COMMUNITY HEALTH 143, 147-48 (Fall 1988); May, *An Overview*, *supra* note 71, at 101.

188. May, *An Overview*, *supra* note 71, at 101.

189. Lamarine, *supra* note 187, at 144. "Of all Indian deaths, 3.2% are diagnosed as alcoholism. This rate is four times the national average. . . . An estimated 75% of all accidental deaths . . . are alcohol related. . . [C]irrhosis [of the liver] accounts for six percent of all deaths [among Native Americans]," compared to 1.7% in the general population. *Id.* The suicide rate of 2.9% is more than double the national average. It is estimated that 80% of these deaths are alcohol related. "Approximately 90% of [the] homicides [among Native Americans] occur while either the victim or perpetrator are intoxicated." *Id.*

190. *Id.* at 144. "[A] [sixty percent] abstention rate [was found] among Navajos compared to [twenty-five percent] for the general population." *Id.*

191. *Id.* (citing Indian Health Service Task Force on Alcoholism, *Alcoholism: A High Priority Health Problem*, Washington, D.C.: Department of Health and Human Services, 1977). The author does not expand on reasons for this decrease, but it is noted that "drinking among Native Americans reaches its highest prevalence among Native Americans in the 25-44 year-old age group." *Id.*

192. *Id.* at 144.

193. May, *An Overview*, *supra* note 71, at 104.

194. DORRIS, *supra* note 10, at 165 (quoting Jeaneen Grey Eagle, director of the drug and alcohol rehabilitation center on the Pine Ridge Reservation in South Dakota).

195. *Hearing on H.R. 1322*, *supra* note 1, at 78 (quoting Robin LaDue, Ph.D., researcher with the Fetal Alcohol and Drug Unit, University of Washington, Seattle, WA).

cent of Navajo and Pueblo women drink, the rate increases to fifty-five percent among the Plains women.[196] Explanations for why Native American women become alcohol or drug abusers are similar to those for Native Americans as a whole: cultural disruption, loss of social controls, prejudice, poverty, peer group dynamics, and decreased self-worth and alienation.[197] Jeaneen Grey Eagle's first-hand experience on the Pine Ridge Reservation led her to cite social circumstances as the most significant reason, such as unemployment rates as high as eighty to ninety percent, no business or industry, and almost one-hundred percent welfare, causing Native Americans to drink as a means of escape from the despair.[198]

Within the Southwest tribes, certain distinct factors influence the severity of alcohol abuse in women and the resulting incidence of FAS/FAE.[199] The Plains rate of FAS/FAE is five to seven times higher than the rates of the Navajo or Pueblo which may be due to the Plains tribes allowing the individual to behave in an alcohol-abusive manner.[200] The lower incidence rates of the Pueblo and Navajo exemplify stricter control on alcohol abuse.[201] Bearing an FAS/FAE baby is not condoned in any of these tribes, "but it is more common with the loose social integration of the Plains groups."[202]

The combination of long-term alcohol abuse and prolonged childbearing years among Native American women increases the risk for FAS/FAE.[203] Among women who gave birth to more than one FAS/FAE child, the later children were always diagnosed as having equal or more severe damage.[204] Thus, as long as a mother continues to drink, the degree of severity of FAS/FAE appears to increase with each child.[205] The Native American mothers of FAS/FAE children studied exhibited

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196. May, *Epidemiology of FAS*, *supra* note 75, at 383.

197. *Hearing on H.R. 1322*, *supra* note 1, at 137 (statement of Cecelia Firethunder, Health Planner, Oglala Sioux Tribe, Pine Ridge, SD).

198. Kolata, *supra* note 82.

199. May, *Epidemiology of FAS*, *supra* note 75, at 383.

200. *Id.*

201. *Id.*

202. *Id.* at 383. "Ostracism from a tribal culture may also affect the severity of alcohol abuse" and the related incidence of FAS/FAE. *Id.* at 384. Among the Navajo and especially the Pueblo, women who continue to drink heavily on a regular basis are removed from family and tribal participation. *Id.* Once this occurs, they are stigmatized in their alcoholic lifestyle, which often promotes increased abuse and may contribute to the severity and duration of abusive drinking. *Id.* This might explain the birth of more than one alcohol-affected children to a single mother and also the higher rate of FAS/FAE among the Pueblo than among the Navajo. *Id.* This finding is supported in the ratio of FAS to FAE among all three tribes. *Id.* In the Plains groups, there is a one to one ratio of FAS to FAE, while among the Navajo and Pueblo, the ratio was two to one and four to one, respectively. *Id.* This variation is consistent with the predicted effects of ostracism and drinking behavior, as "the Pueblo exercise the strongest ostracism and the Plains the weakest." *Id.*

203. *Id.*

204. *Id.* Among the women who had more than one FAS/FAE child, the later children were always diagnosed as having equal (forty-seven percent) or more severe damage (fifty-three percent). *Id.*

205. May, *Epidemiology of FAS*, *supra* note 75, at 383.

many of these characteristics, including social maladjustment, having a high-risk lifestyle, and having a high mean maternal age at birth of the damaged children.[206]

The relationship between the pattern of alcohol consumption and FAS/FAE is not fully understood.[207] However, binge drinking (drinking a large amount at one time) is believed to have more serious effects on the unborn child than chronic drinking (drinking one or two drinks per day).[208] Binge drinking tends to be a common pattern among Native Americans, as they tend to drink large amounts of alcohol at social occasions or during visits to off-reservation towns, resulting in days of continuous drinking to the point of severe intoxication.[209] Self-reported binge drinking, defined as ever having used five drinks or more on one occasion, is indicated to be one of the strongest predictors of later neurobehavioral problems in the children exposed to prenatal alcohol.[210]

H. CONCLUSION TO THE SCOPE OF THE PROBLEM

The indications are that as a group, women of childbearing age continue to have an increased risk of heavy and abusive drinking.[211] FAS/FAE is a grave and disabling condition with life-long consequences to the mother, the child, and the community. Societal costs directly and indirectly associated with maternal drug abuse cannot be accurately calculated, yet the cost is not all financial. There is an individual cost to those who might have been born healthy, without the disabilities associated with prenatal alcohol exposure. There is a personal cost to the families who must live with pain and sorrow for their children who have lifelong physical and mental barriers imposed on them by FAS/FAE. Finally, there is a cost to the community which has lost the opportunity to benefit from the potential contributions these impaired individuals may have

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206. *Id.* at 380. Of this group of FAS/FAE children in the study, seventy-three percent were adopted or in foster placement and in twenty-three percent of the cases the mothers were dead, almost always from accidents, cirrhosis of the liver, or other alcohol-related trauma or illness. *Id.*

207. Little, *supra* note 45, at 1145.

208. Cook, *supra* note 13, at 19. Binge drinking of more than five drinks on any occasion and drinking during the first two months of pregnancy are two of the strongest maternal predictors of later neurobehavioral deficits among offspring. *Id. See also* C. Duimstra et al., *supra* note 77, at 226 (stating that binge drinking probably causes more retardation of brain development than drinking the same amount during a longer period of time) (citing D.J. Bonthius et al., *Blood Alcohol Concentration and Severity of Microencephaly in Neonatal Rats Depend on the Pattern of Alcohol Administration*, 5 ALCOHOL 209 (1988)).

209. Aase, *supra* note 161, at 154. The pattern of drinking differs among Indians because liquor is illegal on many reservations. *Id.* "Many Indians engage in binge drinking, in which a visit to an off-reservation city or town will result in two or three days of almost continuous drinking, to the point of very severe intoxication." *Id. See also* May, *An Overview*, *supra* note 71, at 111. The drinking is done in groups, forced by social pressure, consumed in large amounts and quickly, and may continue for extended periods of time. *Id.* It is sporadic in occurrence with long periods of abstinence in between. *Id.*

210. Streissguth, *Neurobehavioral Dose-Response Effects*, *supra* note 26, at 156-57.

211. Vanderveen, *supra* note 37, at 256.

made if not limited by FAS/FAE.[212] This problem is most serious among the Native American population, in which the incidence of FAS/FAE is estimated to be thirty-three times higher than in the general population.[213] It is time to stop reacting to this problem, and to begin comprehensive prevention and intervention efforts in order to confront the problem directly.

III. APPROACHES TO PREVENTING FAS/FAE

A. INTRODUCTION

FAS is not only a leading cause of mental retardation and developmental disability,[214] it is also the only cause that is absolutely preventable if women abstain from alcohol use during pregnancy.[215] Prevention is the primary goal in the approaches taken to combat FAS/FAE, but it is the means taken to achieve the goal that differentiate the legal and public health positions. An analysis of two legal approaches, one focusing on fetal rights and the other on maternal rights, and a public health approach, are presented in the following discussion. The legal approaches view either the maternal or fetal interest as being greater, while the public health approach advocates the good of the mother, the child, and the community.

The means to prevent prenatal alcohol abuse, according to the legal approaches, reside in the resolution of the maternal rights versus fetal rights controversy. The question of whether a pregnant mother has a legal, as well as moral, obligation to her unborn fetus is presented as a central issue in this debate. The fetal rights advocates believe that a legal obligation does exist and that the unborn child has a protected interest in remaining free from injury that may occur as a result of maternal behavior, such as substance abuse.[216] Since the fetus is unable to protect itself, this approach advocates that the federal, state, or tribal government should intercede using whatever means are necessary including involuntary civil commitment or criminal penalties to prevent further harm.[217] Maternal rights supporters see the obligation as being a moral, not legal

212. Jan L. Holmgren, Comment, *Legal Accountability and Fetal Alcohol Syndrome: When Fixing the Blame Doesn't Fix the Problem*, 36 S.D. L. REV. 81, 94-95 (1991).

213. Chavez, *supra* note 74, at 208.

214. *See* Abel & Sokol, *supra* note 59. *See* McWhirter, *supra* note 59.

215. *See* McWhirter, *supra* 59.

216. *See generally* Sam S. Balisy, Note, *Maternal Substance Abuse: The Need to Provide Legal Protection for the Fetus*, 60 S. CAL. L. REV. 1209 (1987).

217. *See* Margery W. Shaw, *Conditional Prospective Rights of the Fetus*, 5 J. LEGAL MED. 63, 89 (1984) (stating that "[i]t is conceivable that an alcoholic or an addict could be institutionalized for the specific purpose of protecting her fetus"). The author later states that "[i]n addition to criminal sanctions, punitive damages for these intentional torts should be vigorously pursued by the child's next friend." *Id.* at 104.

issue, and argue that a state cannot dictate an individual's lifestyle.[218] They believe that governmental control of a pregnant woman's behavior by involuntary civil commitment or criminal penalties should not be permitted because not only does it deny pregnant women the basic rights of equality, due process, and privacy, it is also unclear where the state's control will end.

A situation that occurred recently in Wyoming illustrates how each perspective would approach a case of prenatal alcohol exposure. Diane P., four months pregnant, sought police protection after she had been beaten by her husband. She was taken to the hospital for treatment for her injuries, where she was determined to be legally intoxicated. She was subsequently charged with felony child abuse, but her husband was not indicted for any crime. Diane had previously given birth to a child affected by prenatal alcohol exposure and she had been ordered by a judge two months earlier to stop drinking during this pregnancy. The charges against her were eventually dismissed because Wyoming's child abuse laws do not apply to fetuses.[219]

From the fetal rights' perspective, Diane's case is ironic, as she is able to receive police protection from her abusive husband, but she could not be prosecuted for harming her unborn infant with her excessive drinking. She can be arrested for drunk driving without injuring anyone, yet she can legally do permanent harm to her unborn baby. The effects of prenatal alcohol exposure have a severe and permanent impact on the infant and therefore, the infant's rights may outweigh the woman's right to drink as much as she chooses.[220] Under the fetal rights approach, a child with FAS/FAE is too great a price to pay to allow a woman to drink as much as she chooses.[221]

Advocates of maternal rights would see Diane as the victim. She is an alcoholic woman with an abusive husband. Although the judge ordered her to stop drinking, there was no mention of providing treatment or support to assist her. Diane's maternal behavior was "subjected to government scrutiny and punishment, but [her husband was] spared exposure to criminal sanctions for behavior which [was] equally or more

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218. *See* Helene M. Cole, American Medical Association Board of Trustees, *Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women*, 264 JAMA 2663, 2663 (1990).

219. Joan Beck, *Womb Not a Haven for the Babies of Women Who Drink*, CHICAGO TRIBUNE, Feb. 8, 1990, at 23.

220. John A. Robertson & Joseph D. Schulman, *Pregnancy and Prenatal Harm to Offspring: The Case of Mothers With PKU*, HASTINGS CENTER REP. 23, 1987. "Ethical analysis must balance the mother's interest in freedom and bodily integrity against the offspring's interest in being born healthy." *Id.*

221. Beck, *supra* note 219, at 23.

harmful to the fetus."[222] State intervention resulted when her private medical history was turned over to the police and used as evidence against her. She went to the police and the hospital for help, but they only made her situation worse. Under the maternal rights approach, she may have been receptive to treatment during this crisis, but with the focus on punishment, this opportunity was lost.

A public health, community-based approach would have tried to intervene before this unfortunate event occurred. As a member of her community, she would have been targeted for community assistance and support to change her lifestyle and her home environment. She would not simply be ordered to stop drinking and then left to do it alone without support. If this event happened despite the community's involvement, she would be ordered into treatment. In an extreme case where a mother refused to be treated, the option of involuntary commitment to a residential treatment facility in or near her community would exist. Ideally, the treatment would include care for her children so that they would not have to be separated and it would offer training in daily living skills, parenting, and job skills.

The fetal rights and maternal rights approaches may each contain parts of the solution, but the position taken in this paper is that FAS/FAE is a public health concern and that the individual communities should play the major role. The fetal and maternal rights rationales have a common weakness that ultimately results in their failure to address the problem. This overriding weakness is that the central parties of this problem, mother and fetus, are viewed as being on opposing sides of this issue. Pitting the mother against her unborn baby is not a positive approach nor a resolvable issue, because the rights of one cannot be subordinated to the other. To present pregnancy as a conflict of rights between a woman and her fetus is entirely inappropriate. A fetus is as much a part of a woman as any part of her body, and to view them as being in conflict serves only to ignore this organic unity.[223] A public health, community-based approach recognizes this unity which is instrumental in truly addressing the underlying issues.

A public health, community-based program is appropriate for Native American communities, since it will permit the integration of unique cultural aspects as designed by the community. In addition, the legal analysis used by the fetal and maternal rights advocates may not work, due to a United States Supreme Court decision which held that the Constitution

222. *Id. See also* Jacqueline Berrien, *Pregnancy and Drug Use: The Dangerous and Unequal Use of Punitive Measures*, 2 YALE J. L. & FEMINISM 239, 246 (1990).

223. Julius Landwirth, *Fetal Abuse and Neglect: An Emerging Controversy*, 79 PEDIATRICS 508, 512 (1987).

does not necessarily apply within the sovereign boundaries of federally recognized reservations.[224] For example, the maternal rights arguments may fail in Native American communities when they rely upon Constitutional rights of privacy, due process, and liberty to prevent incarceration or involuntary civil commitment of pregnant alcoholic women. This is because the Constitution may not be recognized and tribal law may not provide the same protections.

The arguments in favor of the legal approaches are presented below without judgment or qualification. The purpose of this discussion is to provide a fair portrayal of these positions clearly and concisely.

B. THE FETAL RIGHTS APPROACH

The fetal rights approach believes that a pregnant mother's obligations to her unborn fetus are not only moral, but also legal. Meeting these obligations may place limits on the mother's behavior that would not exist if she were not pregnant. The mother's interest in autonomy and bodily integrity must, at a minimum, be balanced against her baby's welfare,[225] although "a woman's right to abuse her own body and threaten her own health should not extend to the body of her fetus."[226] Like the obligation not to harm children after birth, a woman must not harm her child by her prenatal behavior. Under the fetal rights approach, failure to fulfill her duty to her unborn child should subject a woman to pre- and post-natal criminal sanctions, involuntary civil commitment, or liability for the damage to the child.[227]

The Supreme Court held in *Roe v. Wade* that a fetus is not a "person" within the meaning of the Fourteenth Amendment.[228] The fetus, therefore, is not entitled to the constitutional rights of life and liberty,[229] although it may have other legal sources of protection such as tort, child abuse, and neglect laws.[230] In addition, the fetus possesses the rights to

224. *See* Santa Clara Pueblo v. Martinez, 436 U.S. 49, 59 (1978). *See also* DORRIS, *supra* note 39, at 176.

225. John Robertson, *Fetal Abuse: Should We Recognize It as a Crime?*, 75 A.B.A. J., Aug. 1989, at 38. *See also* Balisy, *supra* note 216.

226. Shaw, *supra* note 217, at 104.

227. Landwirth, *supra* note 223.

228. Roe v. Wade, 410 U.S. 113, 158 (1973). *See* John E.B. Myers, *Abuse and Neglect of the Unborn: Can the State Intervene?*, 23 DUQ. L. REV. 1, 60 (1984).

229. Kristen Rachelle Lichtenberg, Comment, *Gestational Substance Abuse: A Call for a Thoughtful Legislative Response*, 65 WASH. L. REV. 377, 383 (1990).

230. *See* Holmgren, *supra* note 212, at 87. Michigan has permitted a child to recover in tort against its mother for negligently inflicting prenatal injuries. Grodin v. Grodin, 301 N.W.2d 869 (Mich. Ct. App. 1980). The mother was held liable for the discoloration of her child's teeth because she took the antibiotic tetracycline late in the pregnancy. *Id.* The court determined the standard of care to be that of a reasonable pregnant woman. *Id.* at 871. The case has not been overruled, but Michigan has not followed it in imposing a duty of care upon a pregnant woman toward her fetus. *But see* Mayberry v. Prior, 352 N.W.2d 322 (Mich. Ct. App. 1984); Thelen v. Thelen, 435 N.W.2d 495

be born without injury and free from abuse or neglect inflicted by maternal conduct.[231] The fetus, however, is incapable of protecting itself, so the state must do so using its *parens patriae* power and transfer the custody of the child to the state.[232] Recognition of these rights is consistent with the state's interest in viable fetal life and with societal interests in the prevention of needless harm and the protection of health. The combination of the interests of the state, society, and fetus create a strong argument in favor of state intervention.[233]

In *Roe v. Wade*,[234] the Supreme Court also recognized that the state has an "important and legitimate"[235] and even "compelling"[236] interest in the life of the fetus during the third trimester.[237] In *Webster v. Reproductive Health Services*,[238] the Supreme Court held that a state has a compelling interest in protecting life at viability instead of the third trimester, as held in *Roe*. This decision resulted in strengthening the state's interest in regulating abortions.[239] Although *Roe* and *Webster* do not directly address the status of fetal rights, the analyses can be useful in justifying the state's interest in protecting a fetus from harm by prohibiting certain maternal conduct such as drinking alcohol. Unlike the right to have an abortion before viability of the fetus, the use of alcohol is a privilege rather than a fundamental right. This presents a strong argument in favor of the state having the power to restrict such behavior when it poses a threat to the fetus.[240] Upon viability of the fetus, the state's interest in protecting the potential life of a fetus may also include protection from being unnecessarily injured by maternal behavior.[241] The holding in *Webster*, that the state's interest does not become compelling until the fetus is viable,[242] does not preclude a finding that states have a compelling interest in ensuring that a fetus will be born without injury and in protecting the child's quality of life from reckless or negligent harm. In fact, "[s]tates may have a greater interest in preventing future suffering of

(Mich. Ct. App. 1989); Ashley v. Bronson, 473 N.W.2d 757 (Mich Ct. App. 1991) (cases disagreeing or disapproving of the *Grodin* decision).

231. Roe v. Wade, 410 U.S. 113, 158 (1973). *See* Myers, *supra* note 228, at 60.

232. Lichtenberg, *supra* note 229, at 384 (using the BLACK'S LAW DICTIONARY definition of *parens patriae* as the power to "protect those quasi-sovereign interests such as health, comfort and welfare of the people").

233. Myers, *supra* note 228, at 60.

234. 410 U.S. 113 (1973).

235. Roe v. Wade, 410 U.S. 113, 163 (1973).

236. *Id.* at 163-64.

237. *Id.* at 160.

238. 492 U.S. 490 (1989). *See* Holmgren, *supra* note 212, at 86.

239. Webster v. Reproductive Health Serv., 492 U.S. 490, 519-20 (1989); *see also* Holmgren, *supra* note 212, at 86.

240. Balisy, *supra* note 216, at 1221.

241. *Id.*

242. *Webster*, 492 U.S. at 519-20.

those who will be born than in ensuring that any particular fetus will be born."[243]

The state's interest in this dilemma can readily be determined to be compelling when the direct and indirect costs of FAS/FAE born by society are considered. These costs include not only those associated with the physical and mental impairments discussed previously, but also the costs of providing treatment and rehabilitation programs for mothers. The state's interest is not only compelling because of potential monetary savings, but also because the life of a child abused by prenatal alcohol exposure is beyond economic valuation. The state's primary goal, therefore, must be to protect their lives, even if that means prohibiting certain maternal conduct.[244]

In contexts other than maternal substance abuse, it is not unusual for the state to intervene in pregnancy when the state's interest in protecting the fetus overcomes a woman's right to autonomy. For example, courts have ordered women to undergo caesaerean sections even when the surgical procedure has violated their religious beliefs. In *Jefferson v. Griffin Spalding County Hospital Authority*,[245] the Georgia Supreme Court authorized the hospital to perform a caesaerean section against the mother's wishes if she was unable to deliver naturally due to a condition called placenta previa.[246] The state should recognize an interest in potential life in fetal substance abuse cases as it does in situations where forced medical treatment is deemed necessary to protect the life of the fetus.[247]

Legal and medical communities have recognized that actions or omissions during pregnancy can be as harmful to a child as those that occur after the child is born. As of 1991, there were no criminal statutes that directly applied to maternal conduct that causes prenatal injuries to the fetus.[248] In order to initiate criminal actions, prosecutors have had to turn to the authority of a variety of criminal statutes relating to criminal child neglect, child endangerment, child abuse, delivery of drugs or controlled substances to minors, and assault.[249] An example is the case of Jennifer Johnson, a cocaine-addicted mother who was convicted of deliv-

243. Note, *Maternal Rights and Fetal Wrongs: The Case Against Criminalization of "Fetal Abuse,"* 101 HARV. L. REV. 994, 997 (1988) [hereinafter Note, *Maternal Rightsand Fetal Wrongs*].

244. Balisy, *supra* note 216, at 1221.

245. 274 S.E.2d 457 (1981).

246. *Jefferson v. Griffin Spalding County Hosp. Auth.*, 274 S.E.2d 457, 458 (Ga. 1981). Mrs. Jefferson went into hiding, and after the placenta shifted, she delivered a healthy baby vaginally. *See* Holmgren, *supra* note 212, at 88 n.70.

247. Jefferson, 274 S.E.2d at 457.

248. Shona B. Glink, *The Prosecution of Maternal Fetal Abuse: Is This the Answer?*, U. ILL. L. REV. 533, 546 (1991).

249. Abigail English, *Prenatal Drug Exposure and Pediatric AIDS: New Issues for Children's Attorneys*, 24 CLEARINGHOUSE REV. 452, 454 (1990) (citing ACLU REPRODUCTIVE FREEDOM PROJECT & ACLU WOMEN'S RIGHT PROJECT, STATE BY STATE CASE SUMMARY OF CRIMINAL PROSECUTIONS AGAINST PREGNANT WOMEN (Apr. 1990)).

ering drugs to minors through the umbilical cords of her children during birth.[250] She was placed on probation, ordered to submit to drug testing, and directed to participate in a supervised prenatal program if she became pregnant again.[251] In this case, the use of criminal law was an effective tool to demonstrate society's strong interest in protecting children and to deter harmful prenatal conduct.[252]

The distinction made in child abuse law of whether the injury occurs before or after birth is counterproductive. Child abuse statutes do not necessarily include the fetus within their protection. In order to convict a woman for harmful prenatal conduct, the definition of child must be extended to include a fetus.[253] Unless the definition is expanded, only children injured by maternal conduct after birth will be protected by child abuse laws. In *In re Baby X*,[254] a case involving a newborn infant exhibiting symptoms of drug withdrawal, the court held that it had no jurisdiction over a fetus because it was not a child, but that the prenatal exposure to drugs could be considered probative of a neglected child within the court's jurisdiction.[255] This distinction is not a rational one because the time of the injury is irrelevant, since the child is injured in both the womb and the outside world.[256] Society should have the ability to prohibit fetal abuse as it does child abuse with the use of criminal sanctions, compulsory reporting of fetal abuse by all hospitals, confinement and rehabilitation, and recognition of prenatal tort.[257]

The fear that physicians will become pregnancy police is no more valid than "fears that pediatricians will become 'child-rearing police' under statutes requiring the reporting of post-natal child abuse."[258] There are concerns that policies to compel certain behavior would be inequitable, as women who were poor, indigent, or members of racial minorities would receive the greatest pressure to conform, while those who are educated and have sufficient resources could more easily obtain legal counsel and resist the orders. This, however, is not a sufficient argument against policies to protect infants from permanent injury.[259] The inequity and unfairness must be corrected, but they are not strong enough reasons to reject important preventive measures.

250. *See* Glink, *supra* note 248, at 537.
251. Holmgren, *supra* note 212, at 90-91.
252. *See* Robertson, *supra* note 225, at 38.
253. Glink, *supra* note 248, at 537.
254. *In re* Baby X, 293 N.W.2d 736 (Mich. 1980).
255. *Id.* at 738.
256. *See* Balisy, *supra* note 216, at 1228.
257. Robertson, *supra* note 225.
258. *Id.*
259. Fost, *Maternal-Fetal Conflicts: Ethical and Legal Considerations*, 562 ANNALS NEW YORK ACADEMY OF SCIENCES 248, 253 (1989).

Another legal intervention method is the use of existing civil commitment procedures to hospitalize substance-abusing pregnant women in a mental hospital, a residential treatment facility, or an outpatient treatment setting.[260] The purpose of involuntary civil commitment is to rehabilitate rather than to punish. Civil commitment involves assessing whether the risk of the fetus being exposed to drugs or alcohol is so great as to necessitate institutionalizing a woman to prevent this harm from occurring.[261] The basic legal standard for commitment is whether a person is a danger to him/herself or others.[262] In order to satisfy this legal standard, the state must present clear and convincing evidence that the substance-abusing pregnant woman is presenting a danger to herself or her fetus. Since alcohol's effects on the developing fetus are well known, this legal standard will be satisfied in many cases, allowing civil commitment statutes to be used as a viable preventive intervention for FAS/FAE.[263]

If a pregnant, addicted woman is unwilling to enter treatment, involuntary placement may be an appropriate alternative. The civil commitment systems utilized by the states vary, but due to common elements, they can be categorized into three models.[264] The first type of civil commitment system uses a state's general commitment statute for persons with mental disorders, which recognizes that a person with an alcohol and/or drug dependency has a mental disorder.[265] The second type of civil commitment system utilizes an alcohol or drug-specific commitment statute, either as a part of or independent from the general commitment statute. There are many types of substance abuse that may form the basis for state action that is targeted at persons with drug and/or alcohol addictions.[266] The third kind of civil commitment system is the most recent

260. David F. Chavkin, *"For Their Own Good": Civil Commitment of Alcohol and Drug-Dependent Pregnant Women*, 37 S.D. L. REV. 224, 262 (1992). Although the United States Supreme Court has not ruled that treatment in the least restrictive setting appropriate to the patient's needs is constitutionally required, such a requirement may be imposed by § 504 of the Rehabilitation Act of 1973. 29 U.S.C.A. § 794 (West Supp. 1991). This provision prohibits discrimination on the basis of handicap by recipients of federal financial assistance against otherwise qualified handicapped persons. *Id.* A similar requirement is imposed under the Americans with Disabilities Act of 1990 even in the absence of federal financial assistance. Pub. L. No. 101-336, 104 Stat. 327 (1990) (codified at 42 U.S.C.A. §§ 12, 101-12, 213 (West Supp. 1991).

261. *Substance Exposed Babies*, 33 VA. CHILD PROTECTION NEWSLETTER 1, 8 (Bureau of Child Protective Services, Va. Dept. of Social Services) (Spring 1991).

262. *Id.*

263. *Id.* (stating that this conclusion on the use of civil commitment as a preventive intervention was based on drug abuse).

264. *See* Chavkin, *supra* note 260, at 250-53.

265. *Id.* (citing AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 166 (3d ed. rev. 1987)). It is more commonly known as the DSM-IIIR.

266. *Id.* at 251-52.

and consists of state and tribal statutes specifically targeted at pregnant women with an alcohol or drug dependency.[267]

An example of a tribal civil commitment statute aimed specifically at pregnant women is the Cheyenne River Sioux Tribe of South Dakota's Liquor Ordinance No. 48, which governs "the possession, consumption and importation of alcohol into the Cheyenne River Sioux Reservation."[268] In finding "that alcohol abuse is an epidemic," Ordinance No. 48 states that "Fetal Alcohol Syndrome and Fetal Alcohol Effect occur at alarming rates among children born within the territory of the Tribe and children born with prenatal alcohol damage have difficulty caring for themselves all of their lives. The Tribe has a compelling interest in protecting children from Fetal Alcohol Syndrome and Fetal Alcohol Effect,[269] and therefore, it is a policy of the Tribe "[t]o protect unborn children, who are people in their own right, from prenatal damage."[270] In the prohibitions listed in the ordinance, two pertain specifically to pregnant women. The first prohibits anyone from knowingly providing alcoholic beverages directly to any person who is pregnant. Violaters are subject to a civil fine of up to $500 for each violation.[271] The second prohibits a pregnant woman from purchasing or obtaining alcoholic beverages while pregnant, also subjecting violaters to a $500 civil fine.[272] If, however, "there is serious danger of prenatal alcohol damage to the unborn child, the violator may be civilly committed to an alcohol abuse treatment facility for a period of time not to exceed the duration of the pregnancy by order of the Superior Court," who will follow the tribal procedural rules for involuntary civil commitments in making such determinations.[273]

The use of criminal sanctions or civil commitment to prevent and deter harmful maternal behavior during pregnancy will not result in a slippery slope to arbitrary and loosely-justified regulations on prenatal conduct.[274] It is not disputed that state intervention, whether civil or criminal, must be limited to ensure that there is minimal intrusion on

267. *Id.* at 252-53 (citing Minnesota and Tennessee state statutes). *See* MINN. STAT. ANN. § 253B.02(2) (West Supp. 1991) ("'Chemically dependent person' also means a pregnant woman who has engaged during the pregnancy in habitual or excessive use, for a nonmedical purpose, of any of the following controlled substances. . . ."); TENN CODE ANN. §§ 33-8-103(a), (e) (Supp. 1991) (authorizing pilot programs for low-income, pregnant substance abusers), and 33-8-104 (1984) (allowing involuntary commitment).

268. Cheyenne River Sioux Tribe of South Dakota's Liquor Ordinance No. 48, 57 Fed. Reg. 21,554 (amended Feb. 7, 1991) (effective as of May 20, 1992).

269. *Id.* at § 1-1-1(C).

270. *Id.* at § 1-1-2(D).

271. *Id.* at § 4-1-6.

272. *Id.* at § 4-1-7.

273. *See* Cheyenne River Sioux Tribe of South Dakota's Liquor Ordinance, *supra* note 268, at § 4-1-7.

274. *See* Robertson, *supra* note 225, at 38.

maternal autonomy. This can be achieved, however, by carefully evaluating several relevant factors.[275] The first factor is the magnitude of harm to the child by the mother's behavior and to the mother by the state's intervention. In the case of FAS/FAE, state intervention could be justified based on the severity and permanence of the injury to the child. The second factor examines the interests involved and determines whether the fetus's safety interest outweighs the mother's interest in her bodily integrity and in drinking alcohol.[276] The third and fourth factors assess the risk of whether the maternal behavior will result in harm to the infant and whether state intervention will decrease that risk.

Although many factors are involved in the equation leading to FAS/FAE, a high probability exists that the fetus will be injured by alcohol abuse.[277] If the civil or criminal intervention results in the mother abstaining from drinking alcohol, both the severity and likelihood of injury are decreased depending on when the intervention occurs during the pregnancy. A final consideration is that the least intrusive means possible must be utilized to produce the healthy child. That is, the state intervention must not create more harm than it will prevent.[278] It is important that the state proceed cautiously in order to find the most appropriate environment for the mother. In sum, all five factors weigh heavily in favor of state intervention where there is the potential for FAS/FAE.[279]

C. THE MATERNAL RIGHTS APPROACH

The maternal rights approach provides that state interference in a woman's pregnancy in order to protect the fetus by prohibiting certain maternal behavior is a frightening situation, as pregnancy is an intensely personal and private experience.[280] A pregnant woman has a moral responsibility to make reasonable efforts toward preserving fetal health; however, this responsibility does not necessarily imply a legal duty.[281] Women are much more than just "containers" for their infants, yet recognition of fetal rights by the law deprives women of their autonomy on the basis of pregnancy.[282] The constitutionally protected rights of privacy,

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275. Deborah Mathieu, *Respecting Liberty and Preventing Harm: Limits of State Intervention in Prenatal Choice*, 8 HARV. J.L. & PUB. POL'Y 19, 50 (1985).

276. *See* Holmgren, *supra* note 212, at 89. The granting of court-ordered caesaerean sections in seventeen out of twenty reported requests, a physically intrusive intervention, indicates that the fetal interest in being free from harm outweighs a pregnant woman's interest in her bodily integrity. *Id.*

277. *See supra* notes 119-157 and accompanying text.

278. Balisy, *supra* note 216, at 1234 (citing Deborah Mathieu, *Respecting Liberty and Preventing Harm: Limits of State Intervention in Prenatal Choice*, 8 HARV. J. L. & PUB. POL'Y, 19, 53-54 (1985).

279. *See id.* at 55 (articulating factors that should be accounted).

280. Myers, *supra* note 228, at 55.

281. Cole, American Medical Association Board of Trustees, *supra* note 218, at 2663.

282. Dawn Johnsen, *A New Threat to Women's Autonomy*, HASTINGS CENTER REP. at 35 (August 1987) [hereinafter *A New Threat*]; Katha Pollitt, *Fetal Rights: A New Assault on Feminism* -

liberty, and equality should prohibit legal recognition of fetal rights that would diminish these rights.[283] Under the maternal rights approach, a woman is not defined and valued solely by her status of being pregnant, as she is first an individual, with her own needs, beliefs, and identity. A pregnant woman who abuses alcohol is not just potentially harming her baby, she is also injuring herself; her life is equally as valuable.[284]

Maternal behavior is only a small part of the total picture of the problem of prenatal substance abuse, yet, it is the primary focus of fetal rights proponents. Efforts to criminalize maternal conduct during pregnancy reflect the belief that the economic and social costs of allowing drug- and alcohol-addicted women to bear children are too great and that it is, therefore, permissible to violate a woman's rights.[285] Although judges may order a pregnant woman to jail because her behavior may place her unborn infant at risk, judges do not order treatment centers to accept women and their children or Medicaid to cover the costs of treatment. Landlords are not ordered to keep them as tenants; obstetricians are not ordered to care for them; treatment centers are not designed with the needs of pregnant, addicted women and their children in mind; nor is the federal government ordered to fully fund maternal and infant health care and food programs.[286] "[P]olicy makers are nonetheless frighteningly willing to punish women who use drugs during pregnancy, rather than recognizing drug [and alcohol] addiction as . . . medical problem[s], rather than 'furnish[ing] treatment for their addictions during pregnancy and

Laws Protecting the Fetus from the Mother, 250 THE NATION 409 (Mar. 26, 1990). *See In re* A.C., 533 A.2d 611 (D.C. 1987), *vacated and remanded for reh'g en banc*, 539 A.2d 203 (D.C. 1988), *rev'd*, 573 A.2d 1235 (D.C. 1990). Although in *In re A.C.* the issue was not about state regulation of maternal behavior, it is an example of how far the courts may go in protecting the fetus's rights over the rights of the mother. The legal department of a hospital in Washington, D.C., successfully obtained a court order permitting the hospital to perform a caesaerean section on Angela Carder, a cancer patient who was twenty-six weeks pregnant, without her consent. *In re* A.C., 533 A.2d at 616. The order was issued despite medical testimony that the surgery would shorten Ms. Carder's life and over the objections of her husband, her family, and her physician. Although the court noted that the state interest in preserving life usually will not override an adult's right to refuse medical treatment, the court denied the stay based on the medical judgment that the mother would not survive for a significant time after the surgery and that the fetus had a better, though small, chance if delivered before her death. *Id.* at 613, 616. The infant died within hours after birth and Ms. Carder died two days later. The surgery was listed as a contributing cause of her death. After her death, the D.C. Court of Appeals acknowledged that the order may have shortened Mrs. Carder's life but concluded that the fetus's slight chance of survival outweighed the value of her remaining life. *Id.* at 617. *See also* Deborah J. Krauss, Note, *Regulating Women's Bodies: The Adverse Effect of Fetal Rights Theory on Childbirth Decisions and Women of Color*, 26 HARV. C.R.-C.L. L. REV. 523, 544 (1991) (discussing the effect on low income women of color); *see also* Holmgren, *supra* note 212, at 89 n.82 (noting that "[j]udicial intervention into medical treatment has been extended to include hospital detention of pregnant women in order to protect their fetuses"); and Note, *Rethinking (M)otherhood: Feminist Theory and State Regulation of Pregnancy*, 103 HARV. L. REV. 1325, 1328 (1990) [hereinafter Note, *Rethinking (M)otherhood*].

283. Johnsen, *supra* note 282, at 35. *See also* Pollitt, *supra* note 282.

284. Pollitt, *supra* note 282.

285. Berrien, *supra* note 222, at 240-41.

286. *Id.*

making safe termination of pregnancy [more] accessible.' "[287] The focus on maternal behavior allows the government to appear concerned about babies without having to spend money or address the actual underlying issues.[288]

It is unlikely that a statutory recognition of fetal abuse could be drafted "narrowly enough to protect a woman's right to privacy or due process."[289] To argue that state intervention will be limited only to truly egregious cases where the medical evidence is compelling begins the slippery slope into "criminalizing pregnancy . . . because no woman can provide the perfect womb."[290] A "save the babies" mentality has the potential of reaching further than prenatal substance abuse, such as regulating a pregnant woman's smoking habits, eating habits, or certain job-related or recreational activities.[291] Virtually every action of a pregnant woman has some effect on the fetus. If the current trend in recognizing fetal rights continues, "pregnant women would live in constant fear that any accident [or decision] could be deemed 'unacceptable' and become the basis for a criminal prosecution."[292]

A pregnant woman has constitutional rights that protect her from state intervention.[293] The first is her fundamental right to privacy in decision-making about her pregnancy. In *Eisenstadt v. Baird*,[294] the Supreme Court wrote that "[i]f the right of privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision to bear or beget a child."[295] In *Whalen v. Roe*,[296] the Supreme Court distinguished between two kinds of privacy interests: one in avoiding disclosure of personal matters, and the other in independence in making certain kinds of important decisions.[297] The privacy interests entitled to protection from governmental control are those "'matters relating to marriage, procreation, contraception, family relationships, and childrear-

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287. Berrien, *supra* note 222, at 241.

288. Pollitt, *supra* note 282.

289. Lynn Paltrow, *Fetal Abuse: Should We Recognize it as a Crime?*, 75 A.B.A. J., Aug. 1989, at 39.

290. *Id.*

291. Pollitt, *supra* note 282; Lawrence J. Nelson & Nancy Milliken, *Compelled Medical Treatment of Pregnant Women: Life, Liberty, and Law in Conflict*, 259 JAMA, 1060 (1988).

292. Dawn E. Johnsen, Note, *The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy, and Equal Protection*, 95 YALE L. J. 599, 607 (1986).

293. Myers, *supra* note 228, at 57-58.

294. 405 U.S. 438 (1972).

295. Eisenstadt v. Baird, 405 U.S. 438, 453 (1972) (clarifying the right to privacy by striking down a Massachusetts statute prohibiting the sale or distribution of contraceptives to single people).

296. 429 U.S. 589 (1977).

297. Whalen v. Roe, 429 U.S. 589, 598-600 (1977).

ing and education. In these areas, it has been held that there are limitations on the States' power to substantively regulate conduct.'"[298]

"The fourteenth amendment protects the fundamental rights to liberty and freedom from unwarranted bodily restraint."[299] State action that limits a pregnant woman's freedom by incarcerating her or by involuntarily committing her in order to protect her fetus violates these rights. There are constitutional limitations on government interference with a woman's pregnancy, because the probability and degree of harm to the fetus are uncertain since not all alcoholic women who drink during pregnancy have children with FAS/FAE. Efforts to prevent her from drinking would be a great invasion of her right to privacy, since such monitoring would involve constant surveillance. If she refused to stop drinking, the next step would be to incarcerate her, which would deprive her of her liberty for up to nine months. Where, as here, the likelihood of injury is speculative and the amount of governmental intrusion is high, the argument in favor of intervention is weak. Although the mother's behavior is unfortunate, government intervention is not warranted.[300]

Under the maternal rights approach, although a pregnant woman has a moral obligation to her future child, it does not follow that the state should be permitted to see if it has been violated.[301] It would be very difficult for a judge, a person far-removed from the daily life of a pregnant woman, to determine the decision-making process that went into her behavior, as no decision is made in isolation. A pregnant woman cannot base every decision she makes solely on how it will affect her child. Many factors influence a pregnant woman's behavior, including her economic status, her employment situation, her access to prenatal care, her physical and mental condition prior to and during pregnancy, the demands of her children and husband, whether her husband is supportive or abusive, and whether she was addicted to alcohol, drugs, or cigarettes prior to her

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298. *Id.* at 600 n.26 (quoting Paul v. Davis, 424 U.S. 693, 713 (1976).

299. Myers, *supra* note 228, at 58.

300. *Id. Cf.* American Public Health Association, *Public Health Policy-Making in the Presence of Incomplete Evidence*, 80 AM. J. PUB. HEALTH 746, 748 (June 1990) (discussing the use of the rational basis and strict scrutiny tests by the courts to determine the validity of state police power).

> Normally, governmental action under the state police power need only meet the rational basis test—i.e., serve a rational purpose and be undertaken by reasonable means. However, if the governmental action conflicts with fundamental individual right, then the state must show a compelling state interest to sustain the action and override the individual right (the close or strict scrutiny standard). The rational basis test allows broad scope for the exercise of the state police power, whereas adoption of the compelling interest standard requires close scrutiny and the least possible intrusion on the right in question.

Id.

301. Johnsen, *A New Threat*, *supra* note 282 at 36.

pregnancy.[302] It is an illusion to believe that just by protecting a fetus from its mother's behavior, a healthy future is guaranteed.[303]

In several recent cases, prosecutors have attempted to apply child protection laws to fetuses in order to criminalize maternal behavior during pregnancy. In *State v. Johnson*,[304] the court convicted a twenty-three year old African American woman of delivering drugs to a minor immediately after delivering her child and before the umbilical cord was cut. The significant fact in this case was that Johnson, a cocaine addict, had sought assistance and was turned away from a treatment center.[305] She was prosecuted for her failure to obtain the help she sought and that no one would provide.[306]

In *People v. Pamela Rae Stewart*,[307] a woman was prosecuted on the basis of her alleged failure to furnish necessary care to her unborn child. The prosecution was triggered by detection of drugs in the urine of her newborn son who died soon after delivery and also because her behavior was not in accord with her doctor's orders to "stay off her feet" and to avoid sex and drugs. Little consideration was given by either the judge or the prosecutor to the fact that she lived in poverty, that she was the primary caretaker of two small children, and that her husband also ignored the doctor's orders by having sex with her, beating her, and taking drugs with her.[308] In another case, a Washington, D.C. woman was convicted of check forgery to support her drug habit.[309] The judge decided to incarcerate her rather than give her the customary probation sentence for first time offenders when he learned she was pregnant.[310] The imposition of

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302. *Id.*

303. Pollitt, *supra* note 282.

304. *See* Berrien, *supra* note 222, at 243 (citing State v. Johnson, No. 89-1765 (Cir. Ct., 18th Jud. Dist., Seminole Co., Fla. July 13, 1989). *See also* Johnson v. State, 578 So.2d 419 (Fla. Dist. Ct. App. 1991), *decision quashed*, 602 So.2d 1288 (Fla. 1992) (quashing a conviction for intentional delivery of a controlled substance to a minor via the umbilical cord because the statute did not intend to cover such actions).

305. Tamar Lewin, Drug Use in Pregnancy: New Issue for the Courts, N.Y. TIMES, Feb. 5, 1990, A14.

306. *Id.* *See also One Drug-Using Mother's Story*, 11 J. NAT'L CENTER FOR YOUTH L. 1, 19 (Special Issue 1990). A woman in California found that there were no treatment programs near her, so she entered a methadone program, the program of choice for pregnant heroin addicts, that was seventy miles from her home. She drove every day until her car broke down, and at eight months pregnant she had to stop going because of a lack of transportation and funds. She had to resume the use of illegal drugs because sudden withdrawal could have been fatal to her fetus. After she delivered, she informed the hospital of her drug addiction and her attempts to get treatment. Although the charges brought against her were dropped, her child was taken from her by the county child protective services. *Id.*

307. *See* Berrien, *supra* note 222, at 244 (citing People v. Pamela Rae Stewart, No. M508197 (San Diego, Cal., Mun. Ct., Feb. 23, 1987)).

308. *Id.* at 245. *Stewart* was one of the first criminal prosecutions based upon maternal conduct during pregnancy. *Id.* at 244; *see also* Pollitt, *supra* note 282, at 415.

309. Wendy Chavkin, *Drug Addiction and Pregnancy: Policy Crossroads*, 80 AM. J. PUB. HEALTH 483, 484 (April 1990) [hereinafter *Policy Crossroads*]. A reference to this case is not provided because it is an unreported case.

310. *Id.*

criminal punishment on these pregnant, substance-addicted women presupposes their capacity to voluntarily conform their conduct to the requirements of the law. When viewed as medical conditions, it is apparent that alcohol and drug dependency cannot be deterred by legal penalties.[311]

Government intervention and prosecution is premised on several erroneous assumptions that have a serious impact on pregnant substance abusers. The first is that these women are indifferent to the health of their fetuses or that they are intentionally seeking to cause them harm.[312] The complex and multi-faceted problem of prenatal substance abuse is simplified into merely being a matter of women who just do not care about their babies; who choose an abusive lifestyle; who are selfish, confused, potentially violent; and who are incapable of making responsible choices.[313] "If you portray [babies] as innocent victims, it almost implies that women are assailants."[314] It must be recognized however, that not only are these women uncontrollably addicted to alcohol or drugs, they also lack the resources to secure the necessary treatment during their pregnancies.

The second erroneous assumption is that drug treatment is available for pregnant women.[315] The misplaced focus on imposing penalties and prosecuting pregnant women has actually been at the expense of providing effective, affordable, and accessible prenatal care and alcohol and drug treatment for women at risk.[316] More than one-third of all low-income women of child-bearing age have no health insurance,[317] and one out of five women receives no prenatal care at all.[318] The increasing incidence of maternal substance abuse and of infants affected by prenatal drug and alcohol exposure is not matched by an increase in treatment

311. *Id.* at 485.

312. Kary Moss, *Substance Abuse During Pregnancy*, 13 HARV. WOMEN'S L.J. 278, 287 (1990).

313. Pollitt, *supra* note 282, at 411.

314. Krauss, *supra* note 282, at 543 n.127 (quoting Dr. Paul Wise, specialist in infant mortality and health policy at the Harvard School of Public Health).

315. Moss, *supra* note 312, at 287.

316. *See* Pollitt, *supra* note 282; *see also* Note, *Rethinking (M)Otherhood*, *supra* note 282, at 1325.

317. Molly McNulty, *Pregnancy Police: Implications of Criminalizing Fetal Abuse*, 11 J. NAT'L CENTER FOR YOUTH L. 33, 34 (Special Issue 1990). The author reports that "[t]he average bill for having a baby is nearly $4,500 and the number of women without private insurance has increased significantly in recent years. Even for those who are insured, policies often exclude maternity coverage or do not pay the full cost. Many of these women are employed, but they tend to be concentrated in industries that do not offer employer-purchased health insurance." *Id.* "The ability of [public health] programs [e.g., Medicaid, the Title V Maternal and Child Health Block Grant, Community Migrant Health Centers, Women, Infants & Children Supplemental Food Program, and Family Planning Programs], to fill the gap has greatly diminished during the last 10 years because of funding cuts. . . . The Public programs that remain experience a much greater demand for services than they are able to meet." *Id.* at 34-35. In addition, many private physicians do not accept Medicaid patients. *Id.* at 35.

318. Pollitt, *supra* note 282.

facilities for pregnant women.[319] Most treatment programs will not take pregnant women who need help with substance abuse problems for liability reasons. In addition, a majority of the facilities "operate on an adult-male centered model."[320] They are not designed to meet the specific psychological or physiological needs of these women,[321] and there is concern that withdrawal of treatment will harm the fetus or cause miscarriage.[322]

A survey conducted in New York City in 1989 revealed that over half of the drug treatment facilities in the city refused to treat pregnant women under any circumstances, in part due to concerns over liability. Further, nearly two-thirds refused to treat pregnant Medicaid recipients.[323] Additionally, of the few that accepted pregnant women, even fewer had child care facilities.[324] The lack of child care is known to preclude participation of women in substance abuse treatment.[325] Another discouraging factor for women seeking treatment is that the wait for admission can be as long as six months or more, which does little to help a woman with her current pregnancy.[326] If the goal is to truly help women and children, legal penalties and law enforcement measures are not the remedy. Rather, the answer is to provide women with a full range of health care services, including prenatal care and substance abuse treatment.

The final erroneous assumption of fetal rights advocates, according to the maternal rights approach, is the belief that prosecution will deter women from abusing alcohol and drugs.[327] Laws requiring doctors to report women who use alcohol or illegal drugs to state officials have the opposite effect, however, because punitive measures will likely drive women away from health care if they know their doctors are informing the police about their substance abuse.[328] Policing pregnancy conflicts with society's strong interests in the freedom of a person to make individual decisions.[329] By allowing a physician to determine what is correct

319. Berrien, *supra* note 222, at 249.

320. Cole, American Medical Association Board of Trustees, *supra* note 218, at 2269. *See also* McNulty, *supra* note 317, at 35.

321. *Id.*

322. *See also* McNulty, *supra* note 317, at 35.

323. Wendy Chavkin, *Help, Don't Jail, Addicted Mothers*, N.Y. TIMES, July 18, 1989 [hereinafter *Help*] (reporting that of 78 drug treatment programs in New York City, 54% refused service to all pregnant addicts); Senator Tom Daschle reported that only 11% of the more than 280,000 pregnant alcohol- and drug-dependent women who seek treatment will receive it in the publicly funded treatment system in the United States. *Hearing on FAS/FAE in Native Americans Before the House Committee on Interior and Insular Affairs* (statement of Senator Tom Daschle, March 5, 1992).

324. Chavkin, *Help*, *supra* note 323. *See also* Berrien, *supra* note 222, at 249.

325. *Id.*

326. Berrien, *supra* note 222, at 249-50.

327. Moss, *supra* note 312, at 288.

328. *Id.*

329. Paltrow, *supra* note 289, at 39.

maternal behavior, rather than the mother, the woman is stripped of her power to control her pregnancy.[330] In addition, reporting requirements violate a woman's right to confidential medical information. The privacy interest of a patient should prevent hospitals from revealing medical histories to prosecutors. Further, researchers in Florida have found that doctors and hospitals apply such a mandatory reporting requirement to low-income minority women much more frequently.[331] Finally, mandatory reporting also interferes with a physician's ethical and legal obligations to protect patient confidences.[332]

Professional health organizations view the government's efforts to control women's conduct during pregnancy with much concern.[333] The Ethics Committee of the American College of Obstetricians and Gynecologists states that the use of "judicial authority to implement treatment regimens in order to protect the fetus violates the pregnant woman's autonomy. Furthermore, inappropriate reliance on judicial authority may lead to undesirable societal consequences, such as the criminalization of noncompliance with medical recommendations."[334] The American Academy of Pediatrics (AAP) also opposes the use of criminal law to prosecute pregnant women who are substance abusers. The position of AAP is that

> [p]unitive measures taken toward pregnant women, such as criminal prosecution and incarceration, have no proven benefits for infant health. . . . The American Academy of Pediatrics is concerned that such involuntary measures may discourage

330. Note, *Rethinking (M)otherhood*, *supra* note 282, at 1339-40.

331. Chasnoff *et al.*, *The Prevalence of Illicit-Drug and Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida*, 322 N. ENG. J. MED. 1202 (1990). Despite the fact that a higher percentage of white women than African American women tested positive for alcohol and illegal drug use during pregnancy, the African American women were reported to state officials at approximately ten times the rate for white women. *Id.* at 1204. A factor in this disparity is that these reporting requirements do not account for affluent women who can utilize private care and remain shielded from the testing and reporting that is required only in government funded health care. *Id.* at 1205. This racial bias may also be the result of vague statutory guidelines that give doctors broad discretion in deciding when to test for substance abuse, and this decision may be based on stereotyped assumptions of substance abusers. The preconception that substance abuse, especially during pregnancy, is a problem that affects minority groups, urban populations, and lower socioeconomic groups could bias physicians in newborn infants. This would result in more frequent suspicion of fetal drug exposure and, thus, a higher rate of testing and reporting of infants born to black or poor women. *Id.* at 1205-06.

332. Glink, *supra* note 248, at 545-46. Four negative results of imposing a mandatory reporting scheme on physicians include forcing the physician to play the role of enforcement officer; discouraging women from seeking prenatal care out of fear they will be reported; undermining the traditional patient/doctor relationship; and forcing a woman who receives care to conceal important facts.

333. Berrien, *supra* note 222, at 248.

334. *Patient Choice: Maternal-Fetal Conflict*, American College of Obstetricians and Gynecologists, Committee on Ethics Opinion, October 1987.

> mothers and their infants from receiving the very medical care and social support systems that are crucial to their treatment.[335]

The National Association for Perinatal Addiction Research takes the position that in addition to discouraging women from seeking prenatal care, criminalization also places health care practitioners in the difficult position of being forced to choose between maintaining their patients' confidence or reporting them to the police. "'It is unreasonable to punish a woman who needs society's help when society has done little to assist her.'"[336] Lastly, the American Public Health Association stated in its amicus brief in the case of *Johnson v. State*[337] that "'criminalizing the use of drugs by women in pregnancy is a dangerous policy . . . . [that] destroys a patient's trust in the confidentiality of the physician-patient relationship and threatens to drive pregnant women at high risk of complications during pregnancy away from the health care system.'"[338]

Since drug and alcohol addictions are physical dependencies and not failures of the individual to resist temptation, incarcerating a pregnant alcoholic woman may place her life and her unborn child's life at risk.[339] "Pregnant women who consume over eight ounces of alcohol daily should be assumed to have developed a tolerance. Sudden cessation of drinking will result in withdrawal symptoms that can be life-threatening to the mother and the fetus."[340] Therefore, it is desirable to conduct detoxification under medical supervision. Punitive measures are also harmful to fetal health. Most prisons provide little or no prenatal care and have inadequate procedures, staff, and training to respond to the needs of pregnant women. Prison conditions such as overcrowding, poor nutrition, and exposure to contagious diseases are hazardous to fetal health. In addition, prison does not prevent substance abuse, as illegal drugs are readily available in prison.[341]

The position of maternal rights advocates is similar to that of the public health approach in many ways. The significant differences are its reliance upon legal solutions and rationales to address the problem, along with its stance that maternal interests ultimately outweigh that of the fetus at the expense of the fetus's well-being.[342]

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335. American Academy of Pediatrics, Committee on Substance Abuse, DRUG-EXPOSED INFANTS, PEDIATRICS 639, 641 (Oct. 1990).

336. *Substance Exposed Babies*, *supra* note 261, at 8 (quoting the National Association for Perinatal Addiction Research's position paper).

337. *See* Berrien, *supra* note 222, at 249.

338. *Id.* (quoting Brief of American Public Health Association and Other Concerned Organizations as Amici Curiae in Support of Appellant Johnson v. State, No. 89-1765 (Ct. App., 5th Dist., Fla. 1989)) (alterations in original).

339. Krauss, *supra* note 282, at 537.

340. *Id.* at 197.

341. Krauss, *supra* note 282, at 537.

342. Paltrow, *supra* note 289, at 38, 39.

The maternal rights philosophy can be summarized by a quote from John Stuart Mill: "Mankind are greater gainers by suffering each other to live as seems good to themselves, than by compelling each to live as seems good to the rest."[343] In other words, society will gain far more by allowing a pregnant woman to conduct her life in a manner that seems correct to her, rather than by compelling her to live in a manner deemed appropriate by society.[344] "The only constitutional and common-sense solution" is to provide women with a complete range of health care services, including prenatal care, substance abuse treatment, and abortion services. Then, the "decision-making [should be left] where it belongs—with the woman herself."[345]

D. THE PUBLIC HEALTH, COMMUNITY-BASED APPROACH

Maternal substance abuse resulting in prenatal harm is a public health issue[346] that demands a community approach. The goal of public health policy is to promote the health and safety of the community.[347] A public health, community-based approach is especially appropriate in the communities of Native Americans in order to address the tragedy of FAS/FAE. The two legally-based approaches that advocate either fetal or maternal interests as the focus of the problem do not effectively address the problem as discussed below. The traditional medical model of alcohol prevention and treatment programs has not taken into account the culture, values, and belief systems of Native Americans. Only a public health approach will allow for the development of such programs by Native Americans for Native Americans. A first step in such an approach could be taken by the community in a way suggested by Sitting Bull: "Let us put our minds together and see what kind of life we can make for our children."[348]

1. *The Legal Approaches are Inappropriate Means of Addressing FAS/FAE*

Judicial intervention will not help the problems of FAS and FAE.[349] Legal solutions focusing on maternal or fetal rights are inappropriate

343. Nelson, *supra* note 291, at 1065 (citing J.S. MILL, *On Liberty*, UTILITARIANISM AND OTHER WRITINGS, 126, (M. Warnock ed., World Publishers).

344. Nelson, *supra* note 291, at 1066.

345. Paltrow, *supra* note 289, at 39.

346. Vanderveen, *supra* note 37, at 258.

347. Dan E. Beauchamp, *Community: The Neglected Tradition of Public Health*, 15 HASTINGS CENTER REP. 28, 33 (1985).

348. Streissguth, *Manual*, *supra* note 6, at i.

349. Renee I. Solomon, *Future Fear: Prenatal Duties Imposed by Private Parties*, 17 AM. J. L. & MED. 411, 431 (1991). *See also supra* note 269 and accompanying text (providing a statutory provision which describes the Tribe's compelling interest to protect unborn children).

means of addressing FAS/FAE, especially when used alone without first exhausting community-based solutions and public health intervention. The legal arguments that favor utilizing criminal liability, incarceration, or involuntary civil commitment as the only means of attacking the problem fail for the reasons presented below, as well as because these penalties simply do not address the underlying issues that lead to maternal substance abuse and children with FAS/FAE. It is perhaps easier to blame the victim—a pregnant woman who yields to the real-life pressures including the poverty and unemployment that are so prominent in Native American communities—than to find solutions to these complex problems.[350] In extreme cases, it is necessary that the option of involuntary civil commitment exists provided that treatment is guaranteed in a facility designed to treat pregnant women. Only when community support systems are able to meet the demand of those who seek treatment voluntarily by providing them with sufficient treatment resources and facilities does involuntary civil commitment become a viable option. Incarceration and criminal penalties are an unacceptable means to either address the underlying issues of FAS/FAE or to prevent it.

a. Constitutionally-Based Arguments are not Effective

The legal approaches that focus on the distinction between maternal and fetal interests rely on constitutionally protected rights that are not necessarily applicable to Native Americans, because the United States Constitution and its recognition of due process and the right to privacy does not apply to federally recognized Native American tribes.[351] In *Santa Clara Pueblo v. Martinez*,[352] the Supreme Court held that the Indian Civil Rights Act (ICRA)[353] did not create a claim within the jurisdiction of federal courts for tribal governmental decisions that may violate civil rights.[354] The Native American nations generally have the right to create their own codes of conduct that apply to the tribe's resident members. These tribal laws take precedence over the principles of American justice even when they appear to violate the United States Constitution or

350. Solomon, *supra* note 349, at 417.

351. Santa Clara Pueblo v. Martinez, 436 U.S. 49 (1978) (holding that the Indian Civil Rights Act does not expressly or impliedly authorize bringing civil actions to a federal court for declaratory or injunctive relief to enforce its substantive provisions). The issue in *Martinez* was whether a federal court could decide on the validity of an Indian tribe's ordinance denying membership to the children of certain female tribal members. *Id.* at 51.

352. 436 U.S. 49 (1978).

353. Indian Civil Rights Act of 1968, Pub. L. No. 90-284, 82 Stat. 77 (codified as amended at 25 U.S.C. §§ 1301-1303). The Indian Civil Rights Act of 1968 was the first major federal legislation regarding the operation of tribal government since 1934 and applied many, but not all, provisions of the Bill of Rights to Native American tribes. *See* ROBERT N. CLINTON *et al.*, AMERICAN INDIAN LAW 384 (3d ed. 1991).

354. Santa Clara Pueblo v. Martinez, 436 U.S. 49, (1978); *see also* CLINTON, supra note 353, at 395 (discussing the impact of *Santa Clara Pueblo).*

are discriminatory.[355] The application of American constitutional analysis to the actions of tribal councils and courts in situations of prenatal alcohol abuse is thus unclear.[356]

One commentator believes that the legal arguments relying on constitutional law to protect women from intrusion will fail to be effective in the general population as well for three reasons.[357] First, the rights protected by the Constitution are not applied by the courts predictably or consistently, and often fail to consider a woman's autonomy.[358] Second, it is not wise to rely on the right to privacy, especially as established in *Roe v. Wade*,[359] which recognizes that a woman's right to abortion outweighs the state's interest in the fetus up to the time of viability.[360] Not only do the constitutional law principles seem to be in constant flux, but the date of viability also seems to vary.[361] In other words, there is a concern that the legalization of abortion is in danger of being washed away due to changing public attitudes and the changing members of the Supreme Court. The third reason is that constitutional law cannot protect a woman if the courts continue to view women and fetuses as adversaries.[362] "[T]he legal analysis must shift from an assumption of conflict to an acknowledgment of the interdependence of the maternal-fetal relationship . . . . [B]y characterizing the fetus as 'other,' this model of conflicting rights has undermined the development of effective policy alternatives."[363]

The constitutionally-based analysis utilized in *Roe* and *Webster* does not logically apply to the general situation of prenatal alcohol abuse. Prior to viability of the fetus, the state does not have a compelling interest in protecting the life of the fetus, because the mother can still choose to abort the fetus. Yet, it is at this stage of pregnancy where there is great potential for serious injury to the fetus as a result of prenatal alcohol exposure. Later, when the fetus is termed legally viable and the state's interest in potential life becomes compelling, much of the harm has already occurred to the fetus. When the state attempts to intervene and impose criminal sanctions on the mother, it may often be too late to prevent the harm and therefore, the state's actions will be purely punitive with little protection for the fetus.

355. DORRIS, *supra* note 10, at 176.

356. Alvin J. Ziontz, *After Martinez: Civil Rights Under Tribal Government*, 12 U.C. DAVIS L. REV. 1, 10-33 (1979) (discussing the difficulty tribal judges may have had in applying American constitutional analysis to the actions of tribal councils).

357. Solomon, *supra* note 349, at 424.

358. *Id.*

359. 410 U.S. 113 (1973).

360. Roe v. Wade, 410 U.S. 113 (1973); *see also* Solomon, *supra* note 349, at 424. *Id.* at 425.

361. *See* Webster v. Reproductive Health Services, 492 U.S. 490 (1989).

362. Solomon, *supra* note 349, at 426.

363. *Id. See also* Note, *Rethinking (M)otherhood*, *supra* note 282, at 1326.

Further, the analysis presented in *Roe* and *Webster* does not apply to many Native American tribes who believe that life begins at conception. This belief results in a compelling tribal interest in the fetus that ignores the issue of viability. In the Cheyenne River Sioux Tribe's Liquor Ordinance No. 48, the Tribal Council expressly states that a policy of the Tribe is "[t]o protect unborn children, who are people in their own right, from prenatal alcohol damage."[364] A conversation with Judge Michael Swallow from the Standing Rock Sioux Tribal Court also revealed that the same belief is held by his tribe.[365] Both tribes authorize involuntary civil commitment of mothers who refuse to stop drinking after the interventions of the community have failed. Judge Swallow cited a strong and proactive community attitude towards addressing this problem, with "the hammer" of civil commitment used only as a last resort.[366]

The above discussion of the inapplicability and ineffectiveness of constitutional law to defend Native American women against intrusion by their tribal court system or the state emphasizes the need for a public health, community-based approach to maternal alcohol abuse and FAS/FAE in Native American communities. An argument premised on constitutional rights would not support such an approach because, as one researcher explained, the Constitution was created when protection of individual rights was necessary because the norm was to focus on the rights and interests of the group and the community over those of the individual.[367] Today, this situation is reversed, and emphasis is needed on group rights, which is the position taken in a community-based approach.[368] In sum, an analysis grounded in constitutional law will not avert the threat of criminal liability, will not address the needs of maternal substance abusers or individuals with FAS/FAE, and will not support the community-based approach that places significant value on the interests of the group.

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364. Cheyenne River Sioux Tribe of South Dakota's Liquor Ordinance, No. 48, 57 Fed. Reg. 21,554 § 1-1-2(D) (amended Feb. 7, 1991) (effective as of May 20, 1992).

365. Interview with Chief Judge Michael Swallow, Standing Rock Sioux Tribal Court, Standing Rock Sioux Indian Reservation, Fort Yates, North Dakota (Nov. 16, 1993).

366. *Id.* In a letter sent by the Tribal Court to all expectant mothers in the tribal community, the protection of the unborn children is emphasized. The letter warns the mothers that if they refuse to stop drinking and if commitment to alcoholic treatment centers "doesn't work, mothers can be held in Contempt of Court and face imprisonment until the baby is born." Letter from Chief Judge Michael Swallow, Standing Rock Sioux Tribal Court, to Expectant Mother (July 1993).

367. Interview with Vernellia R. Randall, R.N., M.S.N., J.D., Assistant Professor of Law, University of Dayton School of Law (Mar. 3, 1993).

368. *Id.*

b. Legal Approaches Create an Unresolvable Conflict Between Maternal and Fetal Interests

Utilizing either legal approach creates a problematic distinction between maternal and fetal interests because it characterizes them as simultaneously inseparable and adversarial.[369] "Fetal rights discourse places the duty to promote infant well-being, a responsibility which belongs to the community as well as to individuals, upon individual pregnant women alone."[370] The woman is blamed and held accountable if she violates this duty. The focus on maternal rights also distorts the maternal-fetal relationship by forcing women to see their fetuses as adversaries who curtail their own rights. This perspective leaves the ultimate decision of whether or not to drink alcohol or take drugs with the individual woman and ignores the well-being of the fetus and the community in order to protect the maternal rights. Such a decision cannot be made by the woman alone because it not only places her infant at risk, but it also will affect the human, health care, and financial resources of her community.

By characterizing the issue of fetal endangerment as a choice between a woman's autonomy and fetal health, the legal rights framework leads to policies that effectively protect neither by focusing on competing needs rather than the common needs of both.[371] A purely legal approach conceals the fact that FAS/FAE is a social and public health issue in which the focus must be on helping the woman and the fetus in order to benefit the health of the entire community. Instead of viewing the mother and child as being in conflict, a community-based approach will treat them as a single entity with the understanding that by helping the pregnant woman, the future child's interests are also being protected.[372]

c. Criminal Liability Fails to Address Maternal Addiction or Prevent FAS/FAE

Imposing criminal liability on pregnant alcoholics is ineffective because it does not resolve the underlying causes of FAS/FAE or protect the fetus from harm. Strong arguments against criminal liability for mothers,[373] such as the misplaced focus on maternal behavior, ignore the many causes of the mother's conduct, including social factors such as poverty and unemployment. It is a complex problem, and a simple solution

369. *See* Note, *Rethinking (M)otherhood*, *supra* note 282, at 1341 (recognizing the "[c]onnection, [c]onflict, and [c]ommon [n]eeds" of both mother and fetus).

370. Krauss, *supra* note 282, at 544.

371. Note, *Rethinking (M)otherhood*, *supra* note 282, at 1336-37.

372. Johnsen, *supra* note 282.

373. See *supra* notes 280-345 and accompanying text.

of criminalizing prenatal substance abuse will not cure the maternal addiction or ensure a healthy fetus or a healthy childhood.

Legal penalties against a small number of pregnant women may save a few children from the life sentence of mental and physical disabilities, but the bigger problem of the causes of alcohol abuse cannot be ignored. "[T]he dominant emerging view from a variety of professional specialists in health care, child welfare, and the law is to approach adverse consequences of prenatal and postnatal drug [and alcohol] use as social-medical problems, not readily amenable to punitive legal sanctions."[374] Women who harm their fetuses through drinking alcohol, intentionally or unintentionally as the result of an addiction, are in need of treatment, education, and prenatal care. Punishment will not help the women, the children, or the community—it will only hurt.

Before Native American communities pass fetal abuse statutes that would impose criminal liability on women, they should consider the negative social effects of such statutes and the fact that a public health approach is an effective solution. Criminal liability discourages maternal-fetal bonding and forces women to see their fetuses as objects that curtail their legal rights. In addition, criminalizing a woman's behavior during pregnancy deprives her of control over her own body and pregnancy. This only serves to reinforce the views "of women as persons deserving less than full autonomy" and views of pregnancy that portray women simply as "fetal containers."[375] Criminal liability would also impose on physicians a duty to report maternal conduct, which would undermine any attempts to develop a trust relationship between the physician and the patient, potentially destroying the patient-physician privilege of confidentiality. This would impose a system where physicians become part of the criminal justice system resulting in ethical dilemmas for the physician, and reluctance and fear on the part of the woman to disclose addiction.[376] In addition, the criminalization of maternal substance abuse would also have a detrimental impact on the woman and her family. A "woman is no longer available to care and provide for her family" if she is incarcerated, and if fines are imposed, the already limited financial resources of the family would be further diminished.[377]

Even if tribes recognize these serious detrimental effects, it may not be enough to dissuade them from attaching criminal liability to maternal conduct. Perhaps, however, the situation must be recognized not as a

374. Cook, *supra* note 13, at 54.

375. Note, *Maternal Rights and Fetal Wrongs*, *supra* note 243, at 1010.

376. *Id.* at 1011.

377. Elizabeth L. Thompson, *The Criminalization of Maternal Conduct During Pregnancy: A Decisionmaking Model for Lawmakers*, 64 IND. L.J. 357, 371 (1989).

woman's duty to her fetus, but as the prevention of damaged babies[378] and the well-being of their mothers. The infant mortality rate in the United States in 1985 ranked nineteenth in the world,[379] and as discussed earlier, the Native American infant mortality rate is much higher.[380] These shocking statistics are not due to "bad" behavior by Native American women, but to a lack of adequate and early prenatal care.[381] The barriers to care faced by women include the lack of financial resources, cash, or insurance, transportation difficulties, and an unawareness of the pregnancy.[382]

"Traditional justifications for punishments—restraint, . . . deterrence, retribution, and rehabilitation—do not support imposition of criminal liability. Although criminal liability [will restrain] a pregnant woman from further gestational substance abuse"[383] if she is incarcerated during her pregnancy, it must be recognized that addiction is a disease and not a "moral weakness" cured by incarceration.[384] The threat of punitive measures will not deter a woman from drinking alcohol during her pregnancy. It will only deter her from seeking prenatal care due to fear of being reported by her physician.[385] Utilizing the criminal justice system to provide rehabilitation for an addicted person via incarceration is not practical because jails may not be drug or alcohol-free.[386] In addition, there is no guarantee that inmates will receive similar civilian treatment for their addiction.[387] Ironically, incarceration will do only harm to both the mother and the fetus due to inadequate medical care and substance abuse treatment, as well as an overall unhealthy environment.

Incarceration does not further the goal of punishing pregnant substance abusers because they lack the mental culpability.[388] Criminalizing maternal conduct raises concerns about an appropriate mens rea standard because none fit this "crime." Imposing strict liability on all women who abuse substances during pregnancy regardless of their state of mind is problematic because it subjects women to punishment based on an addiction over which they have little control. Such a standard would also pun-

378. Solomon, *supra* note 349, at 433.
379. *Id.*
380. *See* van Breda, *supra* note 92, at 575 (discussing Native American infant mortality statistics). *See also* Statement of Jeaneen Grey Eagle, *supra* note 10, at 22.
381. Solomon, *supra* note 349, at 433-34.
382. *Id.*; *see also* Note, *Maternal Rights*, *supra* note 243, at 1010.
383. Lichtenberg, *supra* note 229, at 391-92.
384. *Id.* at 392.
385. Moss, *supra* note 312, at 288. "Yet criminal prosecutions have shown so far that punitive measures will have the effect of deterring women from using the very health-related services that will most benefit themselves and their children. Punitive actions will drive these women away from the health care community as soon as they believe that their doctors also function as police." Id.
386. Lichtenberg, *supra* note 229, at 392.
387. *Id.*
388. *Id.*

ish women who abused substances before they were aware of their pregnancies. A standard that would permit prosecution of only those who knowingly abused substances while pregnant also fails because both elements, substance abuse and knowledge of the pregnancy, would be difficult to prove.[389] A third standard, recklessness, requires knowledge and disregard of a substantial risk that a wrongful act may occur. This is a broad standard, and its application may lead to the prosecution of women who are not pregnant but who ignored the risk of becoming pregnant while drinking.[390]

Criminalization of prenatal substance abuse needlessly and unjustifiably elevates fetal rights at the expense of both the woman and ultimately the community. As noted by one commentator, "[t]he harm to the fetus does not make the woman's addiction more criminal. Rather, it highlights the severity of her disease."[391] The power used by the state or tribe to protect the fetus should not be used to punish the mother. By failing to address the underlying causes of the maternal addiction in order to cure it, criminalization of maternal conduct also fails to ensure a healthy fetus and a productive member of the community.

d. Involuntary Civil Commitment is a Viable Option

Involuntary civil commitment is a viable option for preventing the occurrence of FAS/FAE, contingent upon the existence of two factors: It should be utilized only in extreme cases when all other community and public health efforts have failed, and when treatment is guaranteed in facilities that are already meeting the needs of those seeking assistance voluntarily.[392] Civil commitment may succeed when criminal liability fails by addressing the maternal addiction and thereby protecting the woman, the child, and the community.[393] It is more humane and effective than sending pregnant alcoholics to local jails. Civil commitment in a treatment facility designed to meet the needs of a pregnant addict will ideally respond to the individual woman's needs and treat her as more than simply a "fetal container." In a treatment facility, the woman's health and well-being will be recognized as affecting her, her baby, and her community.

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389. *Id.* at 393.

390. *Id.* "Because a woman knows when she uses drugs or alcohol, the recklessness standard would apply to the element of pregnancy. The state could then prosecute non-pregnant women who disregarded the risk of pregnancy when using drugs or alcohol." *Id.* In other words, it would be "difficult [for the state] to define substance abuse without penalizing casual users." *Id.*

391. Note, *Rethinking (M)otherhood*, *supra* note 282, at 1342.

392. *See* Chavkin, *supra* note 260, at 246 (discussing involuntary civil commitment).

393. Lichtenberg, *supra* note 229, at 391-92.

Modifying existing civil commitment laws to specifically address the needs of pregnant, addicted women who refuse assistance from the community has been suggested.[394] A narrow definition of alcoholism (and drug addiction) may decrease the risk of arbitrary or erroneous commitment.[395] The requirement of addiction would make civil commitment a tailored solution that addresses maternal substance abuse and avoids the "slippery slope" of being committed for less egregious maternal behavior.[396] Minnesota has expressly addressed this issue and requires that "'[b]efore any commitment there must be referral for chemical dependency assessment, relevant out-patient treatment and prenatal care. Only after the woman has refused to enter, or failed in treatment, may involuntary commitment processes be implemented.'"[397] In addition, before a woman is committed involuntarily, she must be shown to be a danger to herself or to her fetus and only after other interventions have failed.[398] These requirements do not involve mens rea requirements, thus avoiding this problematic issue raised by the criminal liability context.[399]

Only when the treatment needs of pregnant women who are voluntarily seeking care and services are adequately met does involuntary civil commitment become a viable option.[400] While the absence of appropriate treatment services for pregnant women voluntarily seeking care does not prevent imposing mandatory treatment, it raises the question of whether limited governmental resources should be so allocated when women are regularly being excluded from treatment.[401] Involuntary civil commitment will not prevent FAS/FAE if communities do not change their attitudes and responses to alcohol abuse and show their concern by providing treatment and support for those who are in need.[402] Involuntarily sending a pregnant woman through alcohol abuse treatment and then

394. *Substance Exposed Babies*, *supra* note 261, at 8.

395. Lichtenberg, *supra* note 229, at 394.

396. *Id.*

397. *Substance Exposed Babies*, *supra* note 261, at 8 (quoting Howard Davidson, director of the American Bar Association Center on Children and the Law, describing how Minnesota has tailored its civil commitment law for substance-abusing women).

398. Lichtenberg, *supra* note 229, at 395.

399. *Id.*

400. Chavkin, *supra* note 260, at 242-43.

401. *Id.* at 242 (citing SENATE COMM. ON FINANCE, U.S. GEN. ACCT. OFF., No. GAO/HRD-90-138, REPORT ON DRUG-EXPOSED INFANTS: A GENERATION AT RISK 8 (June 1990)). "'[T]reatment experts believe that unless women who have decided to seek treatment are admitted to a treatment facility the same day, they may not return. However, women are rarely admitted the day they seek treatment.'" *Id.* (quoting GAO report). This report "described one treatment center in Boston that received 450 calls for detoxification services during a one month period. The callers were told that it usually took one to two weeks to be admitted and were instructed to call back every day to determine if a slot had become available. Of the 450 callers . . ., about one-half never called back and about 150 were eventually admitted to treatment." *Id.*

402. Wescott, *supra* note 4, at 32-33.

returning her to a community in which almost everyone around her drinks practically guarantees failure.

The purpose of involuntary civil commitment is to present a least restrictive option to those women who refuse to or cannot stop drinking; it is a hammer to be used as a last resort. The purpose of such action is to rehabilitate the woman and prevent harm to the fetus. This purpose can be achieved if comprehensive treatment is provided in an appropriate and supportive environment.

2. *Rationale for a Public Health, Community-Based Approach*

Community regulation of prenatal alcohol use can be justified by asserting the moral primacy of the health of its women and children as a social good and the well-being of the members of the community as a legitimate concern of public policy.[403] Individual private behavior can have a significant impact on a community,[404] and therefore, the community will benefit in providing support and guidance. Guidance by trained community experts will enable pregnant women to make informed decisions as opposed to attempting to obey paternalistic rules and empty slogans that are without a sufficient basis in the community's values and traditions.[405]

"Without the guidance of concerned and knowledgeable professionals, [a woman] may give up those habits and exposures that are easiest for her to change, and maintain behaviors which in fact pose a greater risk."[406] Lack of motivation or ability to change may be caused by barriers related to peer pressure, socioeconomic status, psychological stress, and other environmental factors. Even when motivated, a person may lack knowledge of the specifics of what to do or may not have access to resources that enable change.[407] A community approach to this public health issue can be instrumental in not only continuing to educate about the danger of prenatal alcohol consumption, but to assist in making community awareness lead to individual behavioral change.

A public health approach is conducive to decision-making by the community for the good of the group, which is necessary to address the

403. Jonathan D. Moreno & Ronald Bayer, *The Limits of the Ledger in Public Health Promotion*, 15 HASTINGS CENTER REP. 37, 41 (1985).

404. *Id.* at 39. "'[O]ne person's independent decision not to wear a seatbelt has adverse consequences for other people's pocketbooks'" (quoting Kenneth Warner, *Bags, Buckles, and Belts: The Debate Over Mandatory Personal Restraints in Automobiles*, J. HEALTH POL'Y POL. L. 67 (1983)).

405. Vanderveen, *supra* note 37, at 258.

406. Lyn Weiner et al., *FAS/FAE: Focusing Prevention on Women at Risk*, 24 INT'L J. ADDICTIONS 385, 389 (1989) [hereinafter *Women at Risk*].

407. Funkhouser & Denniston, *supra* note 68, at 54-56.

devastating social impact of FAS/FAE on Native Americans.[408] The high incidence of FAS/FAE in Native American communities forces the recognition of rights of the group over those of the individual in order to prevent the very real potential of the chemical genocide of Native Americans.[409]

The idea of political individualism is a dominant tradition in American politics, but there also exists a tradition of community that limits the scope and application of individualism.[410] Public health is a reminder that we are not only individuals, but also a community with shared commitments to one another. A community practice of preventing alcohol abuse is concerned with the well-being of the community as a whole and not just the well-being of one particular person. Community practices are shared activities that shape and affirm the common life and are unlike individual behavior in that they have a stability and endurance that is passed on to future generations.[411] Yet, it is through these community practices that societal change can occur, including how FAS/FAE is addressed and viewed. Public health policy can help to remove the blame placed on the pregnant alcoholic mother. Instead, emphasis should be placed on addressing the underlying problems and assisting the woman during and after her pregnancy in order to protect the collective good. The motto of such a public health approach might be: "'The lives we save together might include your own.'"[412]

Programs developed and implemented by the community are supported by the finding that the greater ethnic affiliation an individual has to his or her group, the less likely the person will be impaired by substance abuse.[413] Greater involvement with an individual's own people, religion, social activities, and other traditions may act as a buffer against the harsh realities of life on some reservations.[414] This research has practical implications for the development of Native American alcohol abuse prevention programs. Resources that affirm or support Native American ethnic affiliation may alleviate alcohol abuse in some Native American communities. These resources include Native American community centers, self-help groups, associations, and cultural activities.[415] They not

408. *See supra* notes 83-104 and accompanying text.

409. Wescott, *supra* note 4, at 31 (citing Michael Dorris, author of THE BROKEN CORD); *see generally* DORRIS, *supra* note 10.

410. Beauchamp, *supra* note 347, at 33.

411. *Id.* at 34.

412. *Id.* at 35 (quoting commentator's motto).

413. Joseph Westermeyer & John Neider, *Cultural Affiliation among American Indian Alcoholics: Correlations and Change over a Ten-Year Period*, 472 ANNALS N. Y. ACADEMY SCIENCES 179, 185-86 (1986).

414. *Id.*

415. *See generally* U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, BREAKING NEW GROUND FOR AMERICAN INDIAN AND ALASKA NATIVE YOUTH AT RISK: PROGRAM SUMMARIES, Pub.

only provide cultural enrichment, but will likely have positive effects on enhancing health and reducing social and behavioral problems. In addition, culturally sensitive treatment resources may attract those most in need and those least likely to enter a mainstream, non-Native American program. These treatment resources should include detoxification facilities, halfway homes, and residential treatment facilities that integrate traditional ways and values.[416]

Conventional therapy programs are ineffective for Native American substance abusers.[417] These programs are often imposed on a Native American community with its success depending on the chance that it will fit with the actual needs of the community. "Disparity in values and world views" between non-Native American counselors and therapists and the Native American client is one reason why so few Native Americans are successful in mainstream alcohol treatment programs.[418] Programs developed and staffed by Native Americans for Native Americans provide the "teaching of traditional ways and culture. . . . [and] aim to restore self-esteem, pride, and self-respect through the teaching of traditional values. . . . [which] are contrary to drug and alcohol abuse."[419]

3. *What is a Public Health, Community-Based Approach?*

"[C]ommunity controlled and community empowered strategies to prevent and intervene in substance abuse" are being implemented by Native Americans on and off reservation communities.[420] For example, ten years ago "Pow-wows, rodeos, and Indian gatherings [did not demand] a "No Drugs or Alcohol Allowed" message and today [they] do."[421] In addition, the need is now recognized "to understand the social, cultural, and tribal diversity, and geopolitical realities of Indian life in order to facilitate appropriate effective solutions to social problems including alcohol and drug use."[422] The individual tribes must create programs which are based on their perspective and which contain regulations that fit with the tribe's direction and goals. Native American ownership and participation must be maximized.

No. (ADM) 90-1705 (1990) (describing and summarizing preventive intervention programs as of 1988 that focus on alcohol and other drug abuses for Native Americans) [hereinafter BREAKING NEW GROUND].

416. Westermeyer & Neider, *supra* note 413, at 187.

417. van Breda, *supra* note 92, at 577.

418. *Id.* at 577 (citing P.J. Flores, *Alcoholism Treatment and the Relationship of Native American Cultural Values to Recovery*, 20 INT'L J. ADDICTIONS 1707 (1985)).

419. *Id.*

420. Theda New Breast, *Stop Contributing to Our People's Genocide: The Role of Community Prevention*, 5 WINDS OF CHANGE 41, 41 (Summer 1990).

421. *Id.* *See generally* BREAKING NEW GROUND, *supra* note 415 (citing specific program information).

422. New Breast, *supra* note 420, at 41.

If a community permits or ignores a person's behavior, such as alcohol abuse, the behavior will continue. If the role models offered by the community are not sober, if the standards convey the message that binge drinking means fun, and if pregnant alcoholic women are ignored, then "no clear value message [is] coming from the community."[423] An intervention must be "aimed at the community's values . . . to create an observable ethic which encompasses the community's stance on drug and alcohol use."[424] Clear, visible and acceptable options must be communicated to everyone, but most importantly, the "community [must decide] what is acceptable and what is not."[425]

"Community action usually begins with a small group of interested and committed people" around which the rest of the community can unite.[426] "Who these people are and how they initially come together will vary from place to place. Personal initiative is a key factor in the early stages of community action."[427] The first function [of this group or task force] is to create an awareness that a problem does exist and to define its dimensions."[428] This allows the development of a formalized, effective prevention plan that inventories the existing internal resources and determines the need for external resources. If this is done carefully, the group will be in a good "position to request funding for treatment and prevention approaches which are culturally and socially appropriate for the particular tribe or inter-tribal community."[429] The types of interventions will vary from one community to the next, but "[i]t is important that the [plan] be developed locally. Imposition of predetermined solutions leads to inappropriate programming, stifles creativity, and causes resistance among community members. The more investment people have in the initiation of [their community's] activities, the more likely they are to provide continuing support."[430]

Community-based substance abuse prevention efforts "must be directed toward potential and active users . . . ; toward the sources, sup-

423. *Id.* at 42.

424. *Id.*

425. *Id.*

426. *Id.* at 43. The author describes a method of program and community development first presented by Beauvais and LaBoueff. The Office of Substance Abuse and Prevention was also instrumental in the process. The author notes that "[i]t is particularly relevant to Indian communities since it takes into account many of the unique socio-cultural factors of contemporary Indian affairs." *Id.* at 42.

427. New Breast, *supra* note 420, at 43.

428. *Id.*

429. *Id.*

430. *Id.* Some examples of interventions include focusing on "traditional Indian therapies with strong cooperation from traditional healers. For example, sweat lodge treatments, return to the Native American Church, vision quests, or clan-based dances. In other places modified psychological approaches" may be most effective, such as family therapy. *Id.* "Educational efforts are necessary and perhaps could be integrated with the traditional story-telling role of tribal elders." *Id.*

plies, and availability of the drugs . . . ; and toward the social environment that encourages, supports, reinforces, or sustains the problematic use of alcohol and other drugs. . . ."[431] The program must reach everyone in the community and "be ethnically and culturally appropriate."[432] Other characteristics of an effective substance abuse prevention program are that it is viewed by the community as morally and ethically necessary, it respects and treats all groups equally, a willingness exists in the community to change for the social good, the community is seen as the expert, and credit for success is shared.[433] The responsibility and power lies with the community.

"[T]he role of [government] agencies and organizations shifts [from being deliverers of services] to one of working to facilitate the communities acquisition and effective use of the knowledge, skills, and resources necessary to respond to the needs and the problems as expressed and defined by the community."[434] While federal and state legislation and programs are important, the "community-based prevention and treatment [programs] can more closely be in touch with the needs of individuals."[435] Therefore, the two must work together to create effective programs: the federal and state governments and agencies, as external sources, provide funding, training, and professional assistance for the programs and treatment facilities, while the communities retain the power and responsibility to develop appropriate program content and structure.

An example of a community that successfully addressed its severe alcoholism problem is an Aleut village.[436] During a fifteen year period, the community built a concept of wellness which promoted and supported individual growth and abstinence as the village residents overcame alcoholism and other lifestyle-related problems. The village enabled itself to change by accepting the responsibility for change and by encouraging key community members to receive proper training and assistance in order to achieve its goal. The change "involved village awareness that alcoholism was not acceptable and that the consequences of alcoholism would not be tolerated."[437] The process did not begin all at once, but was the result of many smaller ideas moving in the same direction at the same time. First, the Community Health Nurse decided to teach an alcoholism

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431. *Id.* at 44. This framework is based upon the Public Health Prevention Model that is utilized by the Office of Substance Abuse Prevention in its Community Prevention System Framework. *Id.*

432. New Breast, *supra* note 420, at 44.

433. *Id.*

434. *Id.* at 46-47.

435. Wescott, *supra* note 4, at 34.

436. Ann P. Streissguth, *Today I Visited an Aleut Village: Observations on Preventing Fetal Alcohol Syndrome*, 15 INDIAN HEALTH SERVICE PRIMARY CARE PROVIDER 125 (Sept. 1990). The author provides no specifics on the village, such as its location and demographics.

437. *Id.* at 125.

curriculum against the objection of the school teachers who felt that academics were more important.[438] Next, the local law enforcement stopped tolerating drinking and disorderly conduct. Spouses also started to expect more responsible behavior from each other. One community member explained, "'The village was so low it couldn't sink further. We were full of disgust with ourselves. Out of that disgust came our awareness of alcoholism as the root of our problems. Change grew out of disgust.'"[439] A key role was played by an external support system that assisted in "training and guiding the village team," but the power and responsibility to change belonged to the community.[440]

An ideal program for the prevention of FAS/FAE would provide a community-wide, holistic approach that would assist women in escaping from "fragmented, socially and economically deprived circumstances to an environment that minimizes drug using behavior, reduces fetal and neonatal risk, and supports growth of self-esteem along with coping and maternal functioning skills."[441] This could only be achieved by the recognition that social, economical, psychological, and biological factors all contribute to this serious public health problem. This recognition calls for a multidisciplinary approach utilizing a team of professionals from health and medicine, public policy, science, economics, business, and "experts" from the community.

Several prominent FAS researchers provided the following specific recommendations for Native American communities to address FAS/FAE.[442] It is an example of outside experts providing general professional guidance and advice for a program that each community must design and implement to fit their needs.

1. Each tribe and urban Indian community should systematically evaluate the prevalence of FAS/FAE among all its members in order to properly plan for the community's needs.
2. The existing community policies should be reviewed in order to ensure proper education and training.
3. "Each community should establish an FAS Program to coordinate education, prevention and intervention efforts across all community agencies."[443]

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438. *Id.*

439. *Id.* (quoting a community informant)

440. *Id.* The author provided no information on the external support system which provided the guidance and training to the village.

441. Vanderveen, *supra* note 37, at 258.

442. Ann P. Streissguth et al., *Indian Adolescents and Adults with Fetal Alcohol Syndrome: Findings and Recommendations*, 12 INDIAN HEALTH SERVICE PRIMARY CARE PROVIDER 89, 90 (Nov. 1987) [hereinafter *Findings and Recommendations*].

443. *Id.*

4. "Community-wide screening programs should be developed to identify newborn infants with possible FAS/FAE. Identification of pregnant women with alcohol problems and families at risk for producing children with FAS will facilitate both prevention and intervention efforts in the community."[444] Comprehensive, multidisciplinary, residential treatment facilities for the mother and their existing children are also necessary.
5. "A FAS registry should be maintained by each tribe and used to monitor the needs and services provided to [those affected by FAS/FAE]."[445]
6. "A court or tribally-appointed advocate should be actively involved with each patient diagnosed with FAS/FAE [in order to address]. . . . the special needs of [these] families."[446]
7. "Full psychosocial and medical examinations of each patient with FAS/FAE and multi-disciplinary staff conferences" should occur at key transitional ages to "facilitate planning for the next stage" in the person's life.[447]
8. Community policies and programs can be developed to assist in identifying "when to terminate maternal rights permanently or temporarily, when to encourage adoption, and when to develop special programs" including temporary care homes, work programs, and programs to develop job and personal management skills.[448]
9. Programs and policies should also "meet the needs of caretakers of FAS/FAE patients." These would include respite care for vacations, support groups, and information sessions on receiving adequate subsidies for care as well as learning how to approach their FAS/FAE children on issues of sex education, driving, and dating.[449]

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444. *Id.*
445. *Id.*
446. *Id.*
447. Streissguth, *Findings and Recommendations*, *supra* note 442, at 90.
448. *See also* Marty Jessup & James R. Green, *Treatment of the Pregnant Alcohol-Dependant Woman*, 19 J. PSYCHOACTIVE DRUGS 193 (1987). "Prenatal noncompliance in the pregnant alcoholic woman may result in legal action with regard to custody issues." *Id.* at 200. "At birth, evaluations of parenting capacity should be conducted. Infants of parents considered to be high risk for abuse or neglect will be placed in temporary or permanent foster . . . homes pending further evaluation of the parents and the home situation." *Id.* Criteria in this evaluation include whether the mother sought and attained prenatal care and alcohol dependence treatment, the home environment, willingness to return for pediatric care, the "medical and psychiatric status of the parents," and "the strengths of the parents." *Id.* at 201. "In the case of the mother who received little or no prenatal care or alcohol dependence treatment yet is judged competent to take the infant home, a protective services referral should be made by the hospital for follow-up. Continued custody of the child should be contingent . . . [on such factors as] (1) participation in an alcohol treatment program; (2) visits by a public health nurse . . . ; (3) medical services for the infant . . .; (4) individual or family therapy . . .; and (5) regular meetings with protective services." *Id.* at 200.
449. Streissguth, *Findings and Recommendations*, *supra* note 442, at 90.

10. Tribes should take advantage of the "unique opportunities that exist on reservations for providing many types of traditional environments that may facilitate the adaptive functioning and good mental health of [those] with FAS/FAE."[450]
11. A strong "commitment to the eradication of alcoholism and to abstinence from alcohol during pregnancy."[451]

Drug treatment, obstetric and pediatric care should be coordinated together with services such as day care, job preparation, and parenting and other life skills training in order to provide the best chance that the woman will make a long-term recovery.[452] "While these measures may be costly, they will be far less costly than hospital-based treatment of . . . complications of perinatal drug use, and hospital or foster-based custodial care of the children." The costs of constructing barriers between the woman and fetus and between the woman and her physician are too great and cannot be afforded.[453] "[B]y initiating prevention and intervention programs, we can reduce the cost of caring for drug- and alcohol-exposed infants and we can quickly recover our initial expenditures through the savings that will be incurred."[454] The health care system will have to change, because it is currently designed to react to this problem rather than prevent it.[455] The few programs that do exist contain "barriers that push high-risk women away" because of such problems as "lack of transportation and child care, cultural insensitivity, and poorly coordinated services," as well as lack of funding necessary to provide these services.[456]

A pregnant woman who exposes her unborn infant to alcohol is a highly stigmatized individual, even though alcohol dependency is a recognized disease.[457] "Compulsion, loss of control, and continued use of alcohol despite adverse consequences is one description of alcohol dependence" that identifies the compulsive drinking by a pregnant alcoholic as a disorder.[458] Viewed as a disease rather than a moral issue, it is obvious that slogans of "just say no" or an order to stop because of harm to the baby will not only be ineffective, but also destructive, because guilt will create a "cycle of self-recrimination and continued alcohol abuse."[459] Pregnancy, however, is "a time of change and motivation [which initiates] a desire for recovery."[460] Pregnancy can be viewed as a window of oppor-

450. *Id.*
451. *Id.*
452. Chavkin, *Policy Crossroads*, *supra* note 309, at 486.
453. *Id.*
454. Chasnoff, *supra* note 54, at 1568.
455. *Id.*
456. *Id.*
457. Weiner et al., *Women at Risk*, *supra* note 406, at 390.
458. Jessup & Green, *supra* note 448, at 193.
459. Weiner, *Women at Risk*, *supra* note 406, at 390.
460. Jessup & Green, *supra* note 448, at 193.

tunity when a woman can be encouraged to seek treatment and recovery for herself and her baby. It is "the one time in a woman's life when drinking decreases spontaneously and substantially" due to concern for the health of her unborn child, "physiological aversion, or nausea caused by the pregnancy."[461] Supportive, nonjudgmental counseling will be more "conducive to behavioral change" than messages that convey guilt and criticism.[462]

Recent legislation at the federal government level is aimed at efforts such as residential treatment programs for pregnant women rather than criminal penalties. A recent example is the authorization legislation contained in the Indian Health Amendments of 1992.[463] Section 1665(b) of the United States Code, Indian Women Treatment Programs, authorizes "grants to Indian tribes and tribal organizations to develop and implement a comprehensive . . . program of prevention, intervention, treatment, and relapse prevention services that specifically addresses the cultural, historical, social, and child care needs of Indian women, regardless of age."[464] Section 707, Fetal Alcohol Syndrome and Fetal Alcohol Effect Grants, authorizes the Secretary to "make grants to Indian tribes and tribal organizations to establish Fetal Alcohol Syndrome and Fetal Alcohol Effect programs . . . ."[465] This legislation authorizing these program is an important step in the right direction, but whether funding will be appropriated remains to be seen.

The federal and state governments must recognize that the economics of this issue are on the side of prevention so that the necessary funding is provided. Lack of prenatal care among substance-abusing women is a major factor in neonatal costs, yet many such women receive inadequate prenatal care, if any.[466] Providing prenatal care and assisting women who use drugs or alcohol to abstain during pregnancy reduces the incidence of prematurity, low birth weight, and other perinatal complications.[467]

The Institute of Medicine of the National Academy of Sciences concluded that providing prenatal services to women in the high-risk category would actually save money.[468] If the expanded availability of prenatal

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461. Sandra C. Anderson & James Fraser Grant, *Pregnant Women and Alcohol: Implication for Social Work*, SOC. CASEWORK: J. CONTEMP. SOC. WORK 3, 7 (1984).

462. Lyn Weiner et al., *Training Professionals to Identify and Treat Pregnant Women Who Drink Heavily*, 10 ALCOHOL HEALTH RES. WORLD 33, 35 (1985) [hereinafter *Training Professionals*].

463. Indian Health Amendments of 1992, Pub. L. No. 102-573, §§ 703(a), 708(a)(1). *See also* 25 U.S.C. 1665b(a), 1665 g(a)(1) (Supp. 1992).

464. Indian Health Amendments of 1992, Pub. L. No. 102-573, § 703(a). *See also* 25 U.S.C. 1665b,(a) 1665 (Supp. 1992).

465. Indian Health Amendments of 1992, Pub. L. No. 102-573, § 708(a)(1). *See also* 25 U.S.C. 1665 g (a)(1) (Supp. 1992).

466. Chasnoff, *supra* note 54, at 1568.

467. *Id.*

468. *Id.*

care reduced low-birthweight infants from the present eleven and half percent rate to nine percent, which was the goal set by the Surgeon General for 1990, the report calculated that every additional dollar spent for prenatal care within the target group would save $3.38 in the total cost of caring for low birthweight infants requiring expensive medical care.[469] In addition, according to the Alaskan study previously mentioned, alcoholism treatment for a pregnant woman would cost an estimated $6,000 per month, compared to $2,400 per day for intensive care costs of an FAS infant.[470] The cost-effective course of action seems obvious: develop intervention programs that can reach pregnant Native American women who are at highest risk for drug and alcohol use and provide the medical and social services that can address their needs prior to delivery. Not only is this the socially correct course of action, it is also economically prudent. "[E]conomics has everything to do with health care and . . . failure of our health care system to deal with the social and educational issues that plague perinatal medicine has everything to do with economics."[471]

IV. CONCLUSION

In Michael Dorris's testimony before the Senate in 1990, he drew the following analogy: A blind woman has a child by the hand, and in her attempt to cross a busy street, misjudges the traffic. The child is hit by a car and killed. We, the community, watch this tragedy and then move on, minding our own business. The next year, the woman does the same thing, and again, the child is hit and dies. Again, we look on, watch this happen for a second time, and continue to remain detached from the situation. We avoid getting involved to help her and her child by not even telling her when the light is green. How many women and children will be injured or die before help is offered? It does not solve the situation to blame the woman because she too is a victim—do we punish her for being blind? The answer is obviously no. Instead, assistance, support, and treatment are vitally needed to save her and her child.[472]

469. *Id.* at 1568 (citing a National Institute of Medicine study discussed in BROWN, PRENATAL CARE: REACHING MOTHERS, REACHING INFANTS (1988)).

470. Wescott, *supra* note 4, at 32.

471. Chasnoff, *supra* note 54, at 1568.

472. *Fetal Alcohol Syndrome: Hearing Before the Subcommittee on Social Security and Family Policy of the Committee on Finance*, 101st Cong., 2d Sess. 19 (1990) (statement of Michael Dorris, author, THE BROKEN CORD). *See generally* DORRIS, *supra* note 10.

being blind? The answer is obviously no. Instead, assistance, support, and treatment are vitally needed to save her and her child.[472]

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