

DRINK AND DRUGS IN PREGNANCY: CAN THE LAW PREVENT AVOIDABLE HARM TO THE FUTURE CHILD?

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ABSTRACT

Alcohol and drug misuse in pregnancy can cause long-term harm to the born-alive child. Where pregnant women decide to bring the foetus to term but resist medical treatment that will benefit them both, there are two ways in which the law might force it upon them. English courts have resisted the first option which is to grant the foetus a limited right to life under Article 2 of the Human Rights Act 1998. The second option is to utilise existing criminal, medical and mental health laws to compel pregnant women into treatment for their own good. Some states in the USA utilise such measures. This article considers the potential to do so in English law and the consequences for drug and alcohol dependent pregnant women and their children.

1. INTRODUCTION

It is now well documented that alcohol and drug misuse in pregnancy can cause serious and lasting harm to the born-alive child. The law might seek to compensate children or punish mothers,¹ but can and should it be used to compel pregnant women into treatment? Even minimal intake can damage the foetus,² but in the UK health promotion rather than legal constraint is currently deemed sufficient to protect it. The link between the activity and harm is tenuous and dependent upon multiple factors. It would be unfair to prevent a pregnant woman from drinking a glass of wine when a genetic predisposition, painting the nursery, refuelling the car or passively breathing in her husband's tobacco smoke are potentially as harmful. Further, it would require draconian laws to prioritise foetal health. Maternal choice would inevitably suffer. Given the lack of legal personhood status on the part of the foetus,³ this cannot be countenanced.

Where alcohol or drug misuse in pregnancy reaches the level of dependency, however, a much stronger causal link emerges to harm to any resulting children. Since the National Treatment Agency was established within the NHS in 2001, significant improvements have been made to the availability and effectiveness of voluntary treatment for drug misuse in England.⁴ The objective is a maximum three-week wait for treatment and particular efforts are made to ensure that vulnerable users, such as pregnant women and offenders, are prioritised.⁵ Nevertheless, whilst I do not suggest that pregnant addicts who intend to carry their foetuses to term will deliberately shun treatment, the involvement of the criminal justice system, social stigma, and fear of child-protection policies, not to mention the strong hold drugs and alcohol have over those addicted to them, will inevitably lead to cases where women refuse treatment to the detriment of their future children.

Might an exception to the general rule be made in such cases?

There are two grounds on which it might. In some parts of the USA, the viable foetus has personhood status. ⁶ The first option is to follow this example and accord the foetus a limited right to life under Article 2 of the Human Rights Act 1998, thereby creating a positive duty to protect it from harm. My concern rests with pregnant women who intend to carry their foetuses to term. Short of natural miscarriage, it is the protection of future children that is at issue. Margaret Brazier asserts that a stronger moral duty is owed by women who intend to carry their pregnancies to term than those who choose to terminate their pregnancies,⁷ but warns against translating the moral duty into law:

[O]nce legal means are used to compel a woman to accept the case made for the foetus at whatever cost to her, we have abandoned the language of choice for the crudity of compulsion. We have ceased to recognize the pregnant woman's capacity to make her own moral choices for herself and her child. ⁸

To date the English courts have refused to extend rights to the foetus and, though it would not necessarily contravene the European Convention on Human Rights or the Human Rights Act 1998 to give the viable foetus a limited right to life, it is unlikely that Brazier's wise words of warning will be ignored in the near future.

But the conferral of rights on the foetus is not the only means of protecting it. In *Vo v France*, ⁹ the European Court of Human Rights recognised that it will sometimes be appropriate for the law to safeguard the interests of the foetus without invoking rights language. ¹⁰ The second option involves the utilisation of existing laws to target pregnant women for treatment or incarceration. There is precedent for this option too in the United States." However, though this approach avoids some of the pitfalls inherent in the conferral of rights on the foetus, I argue that it would be discriminatory and of dubious benefit. Pregnant addicts would shun health care to avoid detection. It would constitute a step backwards.

2. ALCOHOL AND DRUGS IN PREGNANCY- THE EFFECTS

Children born to drug and alcohol dependent women can suffer a range of effects. Imbibing heroin and opiates can lead to neonatal abstinence syndrome, ¹² which in turn can affect maternal attachment. ¹³ However, with the pregnant woman's cooperation, this can be managed with few long-term consequences for the born-alive child. The effects of maternal cocaine use in pregnancy however, can be much more enduring. ¹⁴ It is associated with premature birth, withdrawal problems, birth defects and problems with the central nervous system which are not always apparent at birth, but emerge as the child grows. Recently, the rise of pharmaceutical and prescription drug misuse whereby illegal copies of licensed drugs are traded over the Internet is giving increased cause for concern.¹⁵

Alcohol is a known teratogen. ¹⁶ Its effects in pregnancy are rendered more devastating by the prevalence of alcohol addiction and the potential harmful effects of even moderate intake. It has been described as the commonest preventable (non-genetic) cause of mental retardation in neonates in the Western world.¹⁷ Moderate or excessive intake can result in a normal child, a child suffering Foetal Alcohol Effects or, in the worst cases, Foetal Alcohol Syndrome

(FAS).¹⁸ Though this problem is well documented in the USA, the Department of Health has only recently begun to collect data on the incidence of FAS. It is likely that both the prevalence and impact of FAS in the UK is considerably underestimated.¹⁹ Awareness is growing. Foetal Alcohol Syndrome Aware UK,²⁰ and the UK National Organisation on Foetal Alcohol Syndrome²¹ are actively campaigning for greater recognition of the effects of alcohol in pregnancy and better diagnosis and support of children and adults within the Foetal Alcohol Disorder Spectrum.

In 2003 the Advisory Council on the Misuse of Drugs estimated that there were between 250,000 and 350,000 children of problem drug users in the UK.²² The Inquiry highlighted the extent of harm caused by drug misuse that was previously hidden or ignored, emphasising the need for action in policy and practice. Other research indicates that treatment compliance in pregnancy can be directly correlated with superior outcomes for the resulting child.²³ As a result the English National Treatment Agency for Substance Misuse prioritises the treatment of pregnant women and other particularly vulnerable groups.²⁴ It aims to reduce waiting times and ensure better access to treatment including, where appropriate, residential services.²⁵ Ensuring that treatment places are available to those who need them is vital. Pregnancy offers a powerful incentive to seek treatment. However treatment is rarely straightforward due to poly-drug use, the risk of transmission of blood-borne viruses to the foetus, links with mental health problems, poverty, and fear of stigmatisation and child protection policies. Consequently, some pregnant addicts shun medical intervention or present late in pregnancy when treatment options are limited. The impact on the future child of moves to reduce waiting times and improve services in order to support consensual treatment is inevitably limited by these factors. In this paper I explore two options by which the viable foetus could be protected from its mother's potentially harmful addiction.

3. A RIGHT TO LIFE FOR THE VIABLE FOETUS?

In England and Wales, the criminal law has gradually limited its protection of the foetus. Section 58 of the Offences Against the Person Act 1861 prohibits pregnant women or third parties from committing any unlawful abortion whatsoever, punishable on conviction by life imprisonment,²⁶ but the definition of 'unlawful' has changed over time. The Infant Life Preservation Act 1929 marked a step away from protection of the foetus as an entity of equal value and gave preference to the health of the pregnant woman when abortion was necessary to save her life.²⁷ At the same time it emphasised the importance of the viable foetus as it neared fulfilment of its potential for human life.²⁸ The Abortion Act 1967, as amended by the Human Fertilisation and Embryology Act 1990, liberalised abortion law further still.²⁹ Today the debate surrounding the appropriate level of foetal protection takes place in the context of the European Convention on Human Rights. The Human Rights Act 1998 came into force in 2000, rendering the Convention articles enforceable against public authorities, but to date its impact on abortion law has been minimal.³⁰

Article 4 of the American Convention of Human Rights provides that the right to life must be protected 'in general, from

the moment of conception'. Conversely, whilst Article 2 of the European Convention on Human Rights protects everyone's right to life, the term 'everyone' is undefined. Article 2 is a fundamental requirement of the Convention, from which no derogation is possible. The right to life imposes upon the state not only negative obligations not to take life, but also positive obligations to protect it. Drug and alcohol dependency in pregnancy clearly endangers foetal life and would arguably, if the foetus were recognised as a 'life', require the government to impose preventative measures.

Whilst the pregnant woman has a 'right to respect for [her] private and family life' under Article 8 of the European Convention on Human Rights, the right is limited by Article 8(2) in order to protect, amongst other things, 'the rights and freedoms of others'³¹, and 'health and morals'. If the foetus is viewed as an 'other' for the purposes of the Convention, then it would arguably be legitimate to compel pregnant addicts into treatment for its protection.

In the English case, *Paton v Trustees of the British Pregnancy Advisory Service*³² a husband, on behalf of the foetus, sought an injunction to prevent his wife from terminating her pregnancy. His case failed: the foetus has no legal standing in English law, nor can it by its next friend restrain its mother from terminating the pregnancy,³³ nor can it be made a ward of court.³⁴

Paton took his case to the European Commission of Human Rights³⁵ where it was established that the right to life contained in Article 2 does not necessarily extend to the foetus. Indeed, it was recognised that an absolute right to life of the foetus would be incompatible with the purpose of the Convention because greater value would be placed on the foetus's life than the pregnant woman's. The position taken in English law did not therefore necessarily contravene the European Convention.

The possibility of a limited right to life, however, was left in *Paton* to each Member State and to the circumstances of the particular case. Due to the foetus's human origins, its potential to become a person and the lack of European consensus on the legal (or scientific) definition of personhood the issue falls within the margin of appreciation. The European Commission of Human Rights was careful not to consider whether a foetal right to life at a later stage, but before birth might be Convention-compliant.³⁶

The issue came to the fore again in *Vo v France*,³⁷ when the European Court of Human Rights considered the relevance of Article 2 in a case involving a third party harming the foetus. Once again, the Court declined to take a stance on when the right to life begins. It was affirmed that the issue comes within the margin of appreciation of each member state.³⁸ The Court did not, however, rule that Article 2 cannot in any circumstances apply to the foetus.³⁹ Instead the Court stated that 'the unborn child is not regarded as a 'person' directly protected by Article 2 of the Convention and that if the unborn do have a 'right' to 'life', it is implicitly limited by the mother's rights and interests'.⁴⁰ Neither did the Court's refusal to recognise a foetal right to life rest on the basis that the foetus is devoid of value. Indeed

the court recognised that safeguards may be extended to the foetus under certain circumstances, in the name of human dignity, without making it a person with human rights.⁴¹

In England, Article 2 of the Human Rights Act 1998 was applied in *Evans v Amicus Healthcare Ltd*.⁴² Arden LJ drew a distinction between an embryo and a viable foetus. The embryo, in her view, does not have even a limited right to life.⁴³ This is not to say that the viable foetus *does* have any such right. Indeed to confer such a right upon it, no matter the limitations, would almost certainly affect the rights of pregnant women in other contexts. Thus, whilst it is established that in English law the foetus does not have an absolute right to life, ⁴⁴ it is at least conceivable that a limited right to life would be compatible with the Convention.⁴⁵ The right might, for example, be applied to the foetus only when it has become viable or reached another gestational juncture.

A limited right to life would, however, be fraught with problems. Definitions such as 'viability' are scientifically imprecise and the right would be difficult to limit. Fears of a slippery slope are well grounded. It would also have harmful practical ramifications for both pregnant woman and foetus. Preventing harm to the foetus only from viability is of limited value. Addiction probably causes more damage to the developing foetus in the first trimester. For the pregnant woman, detection is likely to involve compulsory testing, frightening her from prenatal care, forcing upon doctors an unenviable policing role and compromising confidentiality.

For these reasons, in England at least, the theoretical possibility of a limited right to life is unlikely to be translated into a legal right. The language of rights is an all-or-nothing one. However, we have seen that the European Court of Human Rights in *Vo v France*, whilst reluctant to accord the right to life to the foetus, did recognise it as an organism of worth that deserves protection in the name of human dignity.⁴⁶ In English law too, the non-conferral of rights on the foetus does not mean that the foetus is of no recognised value. As R. Scott eloquently illustrates, English law values the foetus without invoking rights language in a number of ways. In particular, the born-alive child can, in certain situations, act on injuries earlier received.⁴⁸ But in what ways might the foetus be protected *before* it is born? In England, judges have struggled to achieve an appropriate balance. Whilst the foetus does not have a right to life, the pregnant woman *does* have a right to private and family life under Article 8 of the ECHR. This does not rest easily with traditional concepts of autonomy. Autonomy, the ability to self-rule, is traditionally centred on the individual but, in Karpin's words, the pregnant woman is 'not-one-but-not-two'.⁴⁹ The pregnant woman and foetus are inter-connected rather than separate. Behind the English courts alior-nothing language, the assertion of the rights of pregnant women and the lack of foetal rights, judges strive to extend safeguards to the foetus whether out of respect for its human dignity, potential to become human, its human origins or its inter-connectedness with the pregnant woman. Lord Mustill in *Attorney-General's Reference (No. 3 of 1994)*⁵⁰ recognised the foetus as 'a unique organism'. And Lord Justice Judge in *St George's Healthcare N.H.S. Trust v S* stated that

'the interests of the foetus cannot be disregarded on the basis that in refusing treatment which would benefit the foetus, a mother is simply refusing treatment for herself' ;⁵¹ moreover, that ' [w]hatever else it may be, a 36-week foetus is not nothing; if viable it is not lifeless and it is certainly human'.⁵²

Faced with increasing evidence of the ill-effects to the future child caused by addiction in pregnancy, English judges cannot protect the foetus by according it an absolute right to life. Though, in theory, a limited right to life might be Convention-compliant, it would be fraught with difficulties relating to the practical effects on the pregnant woman and foetus and the detrimental effect it would have on the rights of the pregnant woman. Might judges instead utilise existing laws to 'help' pregnant women who intend to carry their pregnancies to term but cannot or will not accept treatment, by compelling them to do so? In the next section I explore means by which the foetuses of drug- or alcohol-addicted women might be protected without violating the women's human rights and warn of the dangers inherent in such a strategy.

4. UTILISING EXISTING MEASURES TO VICARIOUSLY PROTECT THE FOETUS

The examination of English cases on the foetal right to life reveals a judicial reluctance to accord personhood status on the foetus. But it also discloses a desire to protect the foetus in certain, unnamed circumstances, on another basis. We have seen that the pregnant woman has a right to respect for her private life under Article 8 of the European Convention. The right is limited by Article 8(2) for 'the prevention of disorder or crime,' and 'the protection of health and morals'. As we shall see, involuntary treatment of an addicted pregnant woman might be defensible under either of these limitations. In this section I will explore three ways in which this might be achieved in the context of drug and alcohol dependency in pregnancy.

4.1 Medical Law

A drug or alcohol addict can rarely desist without extensive support. In the worst cases, support must extend to residential treatment. In pregnancy treatment is especially complex as withdrawal can compromise the health of the foetus. In English law a competent person cannot be treated without consent. In *Re T (Adult: refusal of medical treatment)* Lord Donaldson stated that a person may withhold consent to medical treatment, even if he will die as a result. ⁵³ The morality or rationality of the patient's decision is irrelevant. He went on to state a possible exception to this rule where 'the choice may lead to the death of a viable foetus' ⁵⁴ ; a statement relied upon by Sir Stephen Brown P in *Re S*,⁵⁵ when he authorised a caesarean section operation to save a viable foetus. It has since been established that no such exception exists.⁵⁶ Where a competent pregnant woman withholds consent to treatment that is beneficial or even life-saving to her and / or the foetus, it is a battery to proceed. Any moral duty she may owe to the foetus is not transcribed into law. In the United States there have been cases where pregnant addicts

have been hospitalised to protect the foetus.⁵⁷ Indeed Wisconsin's Children's Code⁵⁸ provides that:

An order of the judge if made upon a showing satisfactory to the judge that due to the adult expectant mother's habitual lack of self-control in the use of alcohol beverages, controlled substances or controlled substance analogs, exhibited to a severe degree, there is a substantial risk that the physical health of the unborn child, and of the child when born, will be seriously affected or endangered unless the adult expectant mother is taken into custody and that the adult expectant mother is refusing or has refused to accept any alcohol or other drug abuse services offered to her or is not making or has not made a good faith effort to participate in any alcohol or other drug abuse services offered to her. The order shall specify that the adult expectant mother be held in custody under s.48.207.

The law in England, however, is clear: the choices and conduct of the pregnant woman which may harm or even kill the foetus and born-alive child, cannot be restrained by law. In *Re F (in utero)*⁵⁹ the Court of Appeal held that a local authority cannot make a foetus a ward of court. ⁶⁰ Having recognised that the case could not proceed on the authorities, Balcombe LJ quoted Lowe on the dangers of allowing such a claim:

It would mean for example, that the mother would be unable to leave the jurisdiction without the court's consent. The court being charged to protect the foetus' welfare would surely have to order the mother to stop smoking, imbibing alcohol and indeed any activity which might be hazardous to the child. Taking it to the extreme were the court to be faced with saving the baby's life or the mother's it would surely have to protect the baby's.⁶¹

The law will protect the pregnant woman's choices, even if harm or death to the foetus results. However, this is not necessarily the case if the pregnant woman lacks the mental capacity to make the particular decision.

The Mental Capacity Act 2005 comes into force in April 2007. To a large extent it codifies the current common law position but for brevity's sake I will restrict my analysis to the new legislation. How might the Act apply to pregnant women refusing treatment for drug or alcohol addiction? There is potential for the Act to be utilised to force some addicts into treatment that would benefit their foetuses, but the circumstances for doing so are restricted.

Five principles underpin the Act.⁶² Section 1(2) contains a presumption of capacity. The pregnant addict will be presumed to have capacity unless it can be demonstrated that she does not. Section 1 (4) provides that 'a person is not to be treated as unable to make a decision merely because he makes an unwise decision'. Clearly the fact that the pregnant woman and the foetus will suffer harm as a result of her refusal to consent will not be indicative of a lack of capacity. A person lacks capacity if '... at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.'⁶³ The test has two stages: The 'impairment or disturbance' stage involves a 'diagnostic threshold' for capacity.⁶⁴ The

existence of the condition of addiction does not necessarily imply that the individual lacks capacity.⁶⁵ The second stage involves the person's inability at the particular time to make a particular decision.

So a pregnant woman will not be viewed as lacking capacity merely by virtue of her addiction. Yet, the terms of the Act are sufficiently wide so that at least some addicts will be viewed as lacking capacity to make a given treatment decision.

The test for capacity is decision-specific. The temporary nature of dependency is irrelevant⁶⁶ provided the impairment exists at the material time. A person is unable to make a decision for himself if he satisfies one of the four conditions listed in section 3(1), one being that he is unable 'to use or weigh that information as part of the process of making a decision'. Butler-Sloss LJ recognised in *Re MB*⁶⁷ that the pregnant woman might suffer temporary incapacity caused by shock, pain or *drugs*. Whilst Butler-Sloss LJ was making reference to drugs administered by medical professionals during labour, it is conceivable that illicit drug dependency may on occasion have a similar effect on capacity under the terms of the new Act. The NHS Direct Online Health Encyclopaedia defines addiction in the following terms: 'Addiction is not having control over doing, taking or using something, to the point that it may be harmful to you. . . . Whatever the addiction may be, the person cannot control how they use it, or become dependant on it to get through daily life.'⁶⁸

The National Pain Foundation defines drug dependency as: 'The situation where a patient may come to feel the absolute need for a drug (psychological dependency) or will experience withdrawal symptoms if the drug is taken away (physical dependency)' .⁶⁹ Though there is not, to my knowledge an English case defining the term 'addiction', the European Court of Human Rights in *Witold Litwa v. Polant*⁷⁰ defined the term alcoholic as a 'psychiatric condition'⁷¹ and later as a 'clinical condition'.⁷²

It is arguable that true dependency renders some individuals incapable of properly 'weigh[ing] that information'. If so, the decision to refuse treatment might be more than 'unwise'. It might constitute a symptom of addiction which treatment would aim to eradicate. Indeed the Draft Code of Practice on the Mental Capacity Act, put out for consultation between January and June 2006 states that: 'The impairment or disturbance may occur in a wide range of situations. Examples include *people who are affected by the symptoms of alcohol or drug misuse*, delirium, or following head injury, as well as the more obvious categories of mental illness ...'.⁷³ It is likely that this example will be retained in the final Code expected early in 2007.⁷⁴ Under section 1(5), once it is shown that an individual lacks the capacity to make a specific decision, any treatment imposed must be in her 'best interests'. The term is defined in section 4. An individual's 'condition' must not lead to the making of 'unjustified assumptions' about her best interests⁷⁵ and the past and present wishes and values and beliefs of the person lacking capacity must be factored into the decision. ⁷⁶For the addict, the fact that treatment is in her *medical* best interests is not by any means determinative.

What of the best interests of the foetus? As we have seen, the foetus is not a separate entity in English law. Its best interests are irrelevant under the Act except insofar as they impinge on the interests of the pregnant woman.

Yet, the best interests of the pregnant woman might incorporate those of the foetus where it is felt that the beliefs and values and the past feelings and wishes of the pregnant woman would support such a decision.⁷⁷ In making this determination the views of relevant others, including carers and family should be taken into account.⁷⁸ The Mental Capacity Act imposes additional conditions where restraint is required. Under section 6, the practitioner must reasonably believe that it is necessary to restrain the patient in order to prevent harm to her and the act must be a proportionate response to the likelihood of her suffering harm and to the seriousness of the harm. Where the practitioner can demonstrate the likelihood of harm to the born alive child resulting in substantial harm to the future mother it is possible that section 6 would be satisfied.

Section 6(5) goes on to stipulate that the restraint should not offend Article 5(1) of the European Convention on Human Rights which protects the right to liberty subject to six limitations, the most pertinent being Article 5(1)(e): 'the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, *alcoholics or drug addicts*, or vagrants.'⁷⁹ In *Witold Litwa v Poland*⁸⁰ the European Court of Human Rights gave alcoholism a wide meaning which incorporated intoxication. The purpose of Article 5(1)(e), the court held, is to protect anyone whose conduct under the influence of alcohol threatens public order or their own health or personal interests.⁸¹

Under section 1(6) '... regard must be had to whether the purpose for which [the act] is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action' and under s.4(3)(a) the person making the determination must consider 'whether it is likely that the person will at some time have capacity in relation to the matter in question'. Treatment during pregnancy will benefit the foetus. But by waiting until a later date, the woman may be persuaded to undergo consensual treatment. Arguably her best interests would be served by delaying treatment. However this will not prove the case where it can be demonstrated that the pregnant woman would want to undergo treatment to protect her own health and that of the foetus, but for the influence of the drugs. Recall that the temporary nature of capacity is irrelevant if the person lacks capacity at the 'material time'.⁸² Delaying treatment in the hope that the pregnant woman regains capacity may result in additional damage to the foetus. This, in turn, may prove harmful to the pregnant woman.

Might one go further and suggest that a medical practitioner who is aware that his pregnant patient is dependent on drugs and alcohol but unconditionally accepts her refusal of treatment or her decision to withdraw from treatment might be liable for his omission? The Act is framed to protect people from being labelled as lacking capacity when in fact they have the competence to make the relevant decision. It is not designed to protect those who would benefit from being labelled

as lacking capacity from failures to do so. Thus section 5 states that a person making a care or treatment decision without the consent of the person ('P') will not be liable under the Act provided he properly assessed capacity and acted in 'P's best interests. The converse is not true: a doctor failing to label someone as lacking capacity faces no liability under the Act. However, nothing in Section 5 excludes a person's civil liability: an action in negligence on these grounds is not inconceivable though the causational difficulties inherent in such a claim would be onerous.

Given the complexities involved in assessing the capacity and best interests of a pregnant addict, it is likely that someone making a treatment decision will seek permission to apply to the new Court of Protection, established by section 45 of the Act. Alternatively, if the pregnant woman wishes to object to treatment under compulsion under the Act, she has a right to apply to the court under section 50(1)(a); permission is not required. The court can make declarations regarding the person's capacity and the lawfulness of an act done, or yet to be done. Alternatively it can make decisions on the person's behalf or appoint deputies to do so.

We must await a decision of the new Court of Protection for further guidance on this issue, but it seems reasonable to suggest that a court seeking to protect the foetus from harm caused by its drug or alcohol-dependent mother without giving it human rights, would have a means of doing so via the Mental Capacity Act 2005. Indeed, it may be that a lower threshold will suffice: that drug or alcohol *misuse* rather than dependency or addiction will enable a lack of capacity to be established in relation to a relevant treatment decision. The Draft Code of Practice on the Mental Capacity Act refers to 'misuse', and we have seen that the European Court of Human Rights has held that Article 5(1)(e) incorporates both addiction and intoxication. Proving lack of capacity is not insurmountable. Proving best interests is more problematic and is dependent on the aligning of the interests of mother and foetus.

4.2 Mental Health Law

If the pregnant woman can be shown to be suffering from a mental disorder under the Mental Health Act 1983, then her capacity to decide is irrelevant. Compulsory emergency treatment for the mental disorder can be ordered under section 63. The relationship between drug misuse and mental disorder is complex but frequently interlinked. Dual diagnosis is becoming increasingly common. In *Tameside and Glossop Acute Services Trust v CH*⁸⁴ a 41-year-old pregnant woman suffering from paranoid schizophrenia was detained under the Mental Health Act 1983, section 3. The court granted a declaration that a caesarean section operation could be performed without her consent on the ground that it was treatment ancillary to her mental health. Her mental health would suffer if the baby was still-born and the operation would prevent her mental health deteriorating. The decision was much criticised and seems to extend the scope of the Act far beyond the intention of the framers,⁸⁵ but it has not been overruled. Conceivably, the fact that a patient is pregnant and will harm her future child through drug or alcohol abuse might, in the face of evidence that it will lead to a worsening of her mental

disorder, be enough to convince a judge that she should be compelled to undergo treatment.

This is all very well when the pregnant woman suffers an ancillary mental disorder, but can drug or alcohol dependency alone lead to treatment under compulsion under the Mental Health Act 1983?

At present an exclusion clause prevents the labelling of a person as suffering from a 'mental disorder' purely 'by reason of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs'.⁸⁶ The government, in their ill-fated draft Mental Health Bill 2002 sought to remove this exclusion clause in order to allow detention and treatment on grounds of dependency alone.

As we have seen, the deprivation of liberty under Article 5 of the European Convention on Human Rights provides an exception for alcoholics or drug addicts, so the draft was arguably Convention compliant. Several states in America have successfully implemented involuntary treatment programmes⁸⁷ supported by the National Institute for Health which states that treatment does not need to be voluntary to be effective and that motivations, sanctions and enticements increase both treatment entry and success.⁸⁸

In England uproar from the mental health profession⁸⁹ prevented the proliferation of a similar policy here. The government at last agreed to reinsert the exclusion clause in 2005,⁹⁰ and then abandoned the Bill altogether in March 2006. The aim is now to modify the 1983 Act. The government's message that dependency can and should on occasion be equated to mental disorder is at odds with its work to secure additional treatment places for those who want them. Trust is essential if dependent persons are going to come forward for voluntary treatment.

4.3 Criminal law

Drug and alcohol use are high on the political agenda, but there is debate as to whether dependency is a criminal or a clinical problem. In England it is frequently treated as an amalgamation of the two, with potentially damaging consequences.⁹¹ Where a pregnant addict commits a criminal offence, the criminal law might be utilised to protect the foetus. Incarceration should in theory limit access to illicit drugs⁹² or alternatively, a treatment order may be made in certain circumstances.

Drug users frequently come into contact with the criminal justice system when the aim of their criminal offence is to fund drug purchase, when an offence is committed whilst under the influence of an illicit drug, or when they are found to be in possession of an illegal drug. The latter scenario is the most controversial. Liberalists argue that personal use should be decriminalised and recognised as a clinical rather than a criminal justice problem.⁹³ It is the traffickers and suppliers, they claim, who should be the subject of criminal investigation. The voluntary organisation Turning Point, for example, counsels against the imprisonment of drug users, except where they pose a risk to public protection.⁹⁴

Historically users coming into contact with the criminal justice system were frequently propelled back into dependency after completion of their sentence.⁹⁵ Recent legislation is designed to

counteract this trend.⁹⁶ From 1 October 2000, inspired by the success of designated 'drugs courts' in the USA, English courts were able to issue Drug Testing and Treatment Orders (DTTOs)⁹⁷ where offenders tested positive for a Class A drug on arrest. DTTOs required the consenting offender to undergo an intensive programme of treatment and testing. In April 2005 they were replaced by the new generic community sentence⁹⁸ to enable bespoke sentencing to suit the offender's needs and crime. With the offender's consent, mental health treatment, drug treatment and testing or alcohol treatment⁹⁹ amongst other tailor-made requirements, can make up part of his community sentence. Failure to adhere to the treatment plan results in a return to court for breach of the order. In April 2005, the Drugs Act 2005 entered into force giving law enforcement agencies powers to test persons for cocaine and heroin on arrest and, the test proving positive, to require a drug counselling session.

Difficulties surround the merging of health and criminal justice initiatives.¹⁰⁰ Where one views the drug user as an offender, the other treats him as a patient. Confidentiality is severely compromised and the therapeutic aims of treatment do not rest easily with the mandatory testing elements of the Order, though there is evidence that treatment provided by the criminal justice system is as effective as voluntary treatment.¹⁰¹ Consent of the offender is only partial in that an initial or subsequent refusal of consent or withdrawal of cooperation will lead to resentencing. Nevertheless, this remains one potential means of getting users (including pregnant users) into treatment.

The law might go further in the case of drug- or alcohol-dependent pregnant women and criminalise intentional behaviour that creates a substantial risk of serious injury without justification. Illicit drug use or alcohol consumption over a prescribed limit might be outlawed in this way. Just as it is illegal to drive with a certain level of alcohol in the blood, so too excessive alcohol consumption in pregnancy could be proscribed. But, even if human rights objections could be overcome, how would such a law be policed? More importantly, what effect would the policing of the law have on the numbers of pregnant addicts opting for treatment?

Whilst the existing criminal law might be utilised to incarcerate pregnant users, the likelihood of new laws being introduced to render their actions criminal is remote. Even in the USA where numerous bills have proposed the criminalisation of drug or alcohol use in pregnancy,¹⁰² only one has actually been enacted¹⁰³ due to the potential conflicts such legislation would have with the human rights of pregnant women and the overwhelming evidence from medical organisations that foetal health would not be protected by criminalisation measures.¹⁰⁴

5. CONCLUSION

Judge LJ stated in *St George's*, that '[i]n our judgment while pregnancy increases the personal responsibilities of a woman it does not diminish her entitlement to decide whether or not to undergo medical treatment'.¹⁰⁵

If we accept that there is an element of choice in drug and alcohol dependency, then that choice, however morally reprehensible,

must be upheld. To do otherwise is to dictate to the pregnant woman standards of rationality and normality; to curb her ability to selfgovern; and to recognise the foetus as a rights holder. If, however, we accept that there are cases where drug- or alcohol-dependent individuals are not free to choose treatment because of their clinical or psychological drug dependency, then the law might protect the foetus without recognising it as a rights-holder. It may do so by aligning the interests of mother and future child and compelling treatment in the woman's best interests by finding that, in relation to the particular decision, she lacks capacity. Alternatively, in cases of dual diagnosis, treatment might be compelled where the pregnant woman suffers a mental disorder under the Mental Health Act 1983. Finally, where the addict has committed a crime, a prison sentence may be used as a threat, in order to achieve compliance with a drug testing or treatment order.

Ultimately the moral duty of the pregnant woman to accept treatment beneficial to the foetus is strengthened if that duty is made less onerous. Funding for specialist treatment placements, communication, education and the reduction of stigma will increase the number of women successfully treated in pregnancy. Coercion and compulsion will generate fear and distrust. Yet I have advanced four reasons why the current political climate gives cause for concern. First, as Scott eloquently demonstrates,¹⁰⁶ though both the European Court of Human Rights and the English courts are reluctant to give the foetus legal rights, this does not imply that the foetus is not valued at all. In *Vo v France* it was recognised that: 'The potentiality of that being and its capacity to become a person . . . require protection in the name of human dignity, without making it a 'person' with the 'right to life' for the purposes of Article 2'.¹⁰⁷ In England, Lord Justice Judge in *St George's Healthcare N.H.S. Trust v S* stated that ' [w]hatever else it may be, a 36-week foetus is not nothing; if viable it is not lifeless and it is certainly human'.¹⁰⁸

There is much to recommend this approach. Whilst opinion is divided as to the best way to adjudicate potential conflicts of interest between the foetus, the pregnant woman and the state, most would agree that the foetus should not be discounted altogether. The paramount importance of the pregnant woman's rights does not render the foetus meaningless. Difficulties only arise if the judges' wise words are applied so as to give effect to the moral duty to protect the foetus in a manner that harms the interests of pregnant women. 'Interests' are not as assiduously protected as rights. They are also harder to define. Care must to be taken to ensure that where the pregnant woman loses her right to give and withhold consent, by virtue of committing a crime, lacking mental capacity or suffering a mental disorder, her interests are still paramount.

Second, there is the recent criminal justice initiative to employ treatment as a sentencing alternative. Where a drug or alcohol misuser commits an offence, the English criminal justice system has at last reacted to evidence that punishment without treatment lacks efficacy. Following the model of the US 'drug courts', which have existed since 1989, testing, treatment, sanctions and incentives replace punishment. We have only followed the USA part of the way. At present in the

UK the consent of the offender is required before a treatment order can be made. The US drug courts have considerably reduced the level of reoffence¹⁰⁹ and are clearly effective,¹¹⁰ and this has led many states to extend the principle to non-offenders. Involuntary commitment programmes, some of which are state-funded, often prioritise pregnant women.

Third there is the government's reluctance to incorporate an exclusion clause in the doomed draft Mental Health Bill to prevent the labelling of drug- or alcohol- dependent individuals as suffering from a mental disorder. In view of this, the likelihood of our eventually following the worrying precedent created by the extension of the American 'drug courts' to involuntary civil commitment seems more plausible.

Finally the Draft Code of Practice on the Mental Capacity Act accepts that the symptoms of alcohol or drug misuse might constitute 'impairment' for the purposes of the Act. Where this is the case, provided the treatment is in her 'best interests' then the individual may be treated without consent. If it can be demonstrated that but for the addiction, the pregnant woman would have consented to treatment of benefit to the foetus, and that a failure to treat at the relevant time could be detrimental to the pregnant woman, then treatment may be declared lawful. And this is as it should be, provided that the decision is motivated by the best interests of the pregnant woman rather than those of the 'unique organism' which is 'certainly human'. The NHS National Treatment Agency for Substance Misuse¹¹¹ is working to make the route into treatment less onerous. Let us support that and resist the American way.

NOTES

* LL.B., M.Jur., Ph.D. Acknowledgements: thanks to Margaret Brazier for comments on an earlier draft. Any remaining weaknesses are mine.

1 E. Cave, *The Mother of All Crimes* (Ashgate: Aldershot, 2004); S. Fovargue and J. Miola, 'Policing Pregnancy: Implications of the Attorney-General's Reference (No. 3 of 1994)' (1998) 6(3) *Medical Law Review* 265.

2 *Infra*, fn 16.

3 See *Re MB (medical treatment)* [1997] 2FLR 426.

4 NHS National Treatment Agency for Substance Misuse, *Treatment Journeys: Annual Report for 2004-05* (National Audit office, 2005), 7.

5 See NHS National Treatment Agency for Substance Misuse, *Business Plan 2005/06* (London: NTA, 2006), 15.

6 In South Carolina, a viable foetus is a person, covered by state child protection laws. See *Whitner v State* (1997) 328 S.C. 1, 492 S.E.2d 777, cert. denied (1998) 523 U.S. 1145. The baby was born with crack cocaine in its system. Whitner was prosecuted for criminal child neglect under South Carolina Code § 20-7-50 which made it a felony to cause the death of a child under eleven through child abuse or neglect 'under circumstances manifesting an extreme indifference to human life'. Whitner was sentenced to eight years in prison. The sweeping rule was extended in 2001 when Regina McKnight was sentenced to 12 years in prison for homicide by child abuse after four doctors testified that her cocaine habit had caused the still-birth of her baby. *South Carolina v McKnight* (2003) slip. Op. No. 25585; cert. denied (2003) 540 U.S. 819. Justice Moore dissented stating: '... Our abortion statute, S.C. Code Ann. § 44-41-80(b) (2002), carries a maximum punishment of two years or a \$1,000 fine for the intentional killing of a viable fetus by its mother. In penalizing this conduct, the legislature recognized the unique situation of a feticide by the mother. I do not believe the legislature intended to allow the prosecution of a pregnant woman for homicide by child abuse under S.C. Code Ann. § 16-3-85(A)(l) (Supp. 2001) which provides a disproportionately greater punishment

of twenty years to life. . . .'

7 M. Brazier, 'Liberty, Responsibility, Maternity' (1999) 52 *Current Legal Problems* 359, 364-65.

8 Brazier *ibid.*, 375. A consideration of the moral duties owed by pregnant women to the foetuses they carry is beyond the scope of this paper.

9 [2004] 2 FCR 577, ECtHR.

10 *Ibid.*, 'At best, it may be regarded as common ground between States that the embryo/foetus belongs to the human race. The potentiality of that being and its capacity to become a person . . . require protection in the name of human dignity, without making it a 'person' with the 'right to life' for the purposes of Article 2'. Para 84 per L. Wildhaber. See also para 80.

11 From 1 July 2005 four states; North Dakota, South Dakota, Oklahoma and Wisconsin have involuntary statutory authorisation for civil commitment of women abusing alcohol in pregnancy. See Alcohol Policy Information System <http://www.alcoholpolicy.niaaa.nih.gov> (accessed 11/12/06).

12 Neonatal abstinence syndrome refers to the signs and symptoms exhibited by infants with drug dependencies. See <http://www.emedicine.com/ped/topic2760.htm> (accessed 11/12/06).

13 The Report of an Inquiry by the Advisory Council on the Misuse of Drugs *Hidden Harm - Responding to the Needs of Problem Drug Users* (Home Office June 2003), 2.12.

14 *Ibid.*, 2.13.

15 International Narcotics Control Board, *Report of the INCB for 2005 (EI INCB/2005/1)*, (2005) para. 570. <http://www.incb.org/> (accessed 11/12/06), para. 313.

16 Research suggests that even small amounts of alcohol intake can prove harmful to the foetus. P.G. Hepper, J.C. Doman, J.F. Little, 'Maternal Alcohol Consumption During Pregnancy May Delay the Development of Spontaneous Fetal Startle Behaviour' (2005) 83(5) *Physiology and Behavior* 711. Hepper et. al. captured on video camera abnormal hyperactive behaviour in foetuses of women who drank as little as one unit a week. Australia, Austria, Canada, Denmark, Ireland, Sweden and the United States recommend alcohol abstinence in pregnancy (International Center for Alcohol Policies, *Government Policies on Alcohol and Pregnancy* (ICAP Reports, 6 January 1999)) but the UK and New Zealand have traditionally promulgated 'occasional drinking policies'. (The Royal College of Obstetricians and Gynaecologists *Alcohol Consumption in Pregnancy* (RCOG Guideline No. 9) (RCOG, 1996)). Recently, however, the English Strategy Unit, *Alcohol Harm Reduction Strategy for England* (Strategy Unit: London, 2004) <http://www.cabinetoffice.gov.uk/strategy/downloads/su/alcohol!pdf/CabOffice%20AlcoholHar.pdf> (accessed 2/11/06) stated that: 'some groups, such as pregnant women . . . should drink less or nothing at all'.

17 R.A. Minns, 'Pre and Perinatal Conditions Contributing to Mental Retardation' (1997) 10(5) *Current Opinion in Psychiatry*, 354.

18 Advisory Council on the Misuse of Drugs, *op. cit.*, 2.16 '... Fetal exposure to prolonged heavy maternal alcohol use can lead to a range of serious developmental problems including delayed neurological development, growth impairment and a variety of physical abnormalities.' Alcohol is a teratogen associated with mental retardation and behavioural problems in the child born alive.

19 As demonstrated in a small study by W. Cousins, K. Wells 'One More For My Baby: Foetal Alcohol Syndrome and its Implications For Social Workers', (2005) 11(3) *Child Care in Practice* 375.

20 <http://www.fasaware.co.uk> (accessed 11/12/06).

21 <http://www.nofas-uk.org/index.asp> (accessed 11/12/06).

22 Advisory Council on the Misuse of Drugs, *op. cit.*

23 H.E. Jones, D.S. Svikis, G. Tran, 'Patient Compliance and Maternal / Infant Outcomes in Pregnant Drug-Using Women' (2002) 37 *Substance Use and Misuse* 1411.

24 National Treatment Agency, *Business Plan 2005/6: Towards Treatment Effectiveness*, (NTA, June 2005). <http://www.nta.nhs.uk/publications/Businessplan05.pdf> (accessed 11/12/06). See also C. Hogg, T. Chadwick, A. Dale-Perera, *Drug Using Parents: Policy Guidelines for Inter-Agency Working (England and Wales)* (LGA Publications, 1997); Scottish Executive, *Getting our Priorities Right: Policy and Practice Guidelines for Working with Children and Families Affected by Problem Drug Use* (Scottish Executive, 2003).

25 National Treatment Agency, *Models of Care for Treatment of Adult Drug Misusers* (NTA, 2002) http://www.nta.nhs.uk/publications/Models_of_care.pdf

(accessed 1/12/06).

26 Offences Against the Person Act 1861, section 58: 'Every woman, being with child, who, with intent to procure her own miscarriage, shall unlawfully administer to herself any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, and whosoever, with intent to procure the miscarriage of any woman, whether she be or not with child, shall unlawfully administer to her or cause to be taken by her any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, shall be guilty of felony, and being convicted thereof shall be liable to be kept in penal servitude for life.'

27 Infant Life Preservation Act 1929, section 1(1): 'Subject as hereinafter in this subsection provided, any person who, with intent to destroy the life of a child capable of being born alive, by any wilful act causes a child to die before it has an existence independent of its mother, shall be guilty of felony, to wit, of child destruction, and shall be liable on conviction thereof on indictment to penal servitude for life. Provided that no person shall be found guilty of an offence under this section unless it is proved that the act which caused the death of the child was not done in good faith for the purposes only of preserving the life of the mother.'

28 Infant Life Preservation Act 1929, section 1(2): 'For the purposes of this Act, evidence that a woman had at any material time been pregnant for a period of twenty-eight weeks or more shall be prima facie proof that she was at that time pregnant of a child capable of being born alive.' Under the Abortion Act 1967, s.5(1) as amended, 'No offence under the Infant Life (Preservation) Act 1929 shall be committed by a registered practitioner who terminates a pregnancy in accordance with the provisions of this Act.'

29 Abortion Act 1967, s.1(1) (as amended by the Human Fertilisation and Embryology Act 1990, s.37) 'Subject to the provisions of this section, a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if two registered medical practitioners are of the opinion, formed in good faith (a) that the pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family; or (b) that the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman; or (c) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated; or (d) that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.'

30 See Committee on Medical Ethics, BMA, *The Impact of the Human Rights Act 1998 on Medical Decision Making*, October 2000.

31 See *Evans v United Kingdom* [2006] ECHR 6339/05.

32 [1979] QB 276.

33 *C v S* [1988] QB 135.

34 *Re F (in utero)* [1988] Fam 122.

35 *Paton v United Kingdom* (1980) 3 EHRR 408, E ComHR.

36 *H v Norway* (unreported) but cited by Butler-Sloss LJ in *Re MB (An Adult: Medical Treatment)* [1997] 2 FLR 426, 443.

37 *Op. cit.* n. 9.

38 *Vo v France* *ibid.*, para 82 and 85 per L. Wildhaber, affirmed in *Evans v The United Kingdom* *op. cit.*

39 See K. O'Donovan, 'Taking a Neutral Stance on the Legal Protection of the Fetus' (2006) 14 *Medical Law Review*, 115.

40 *Op. cit.*, para. 80.

41 *Ibid.* paras 80 and 84 per L. Wildhaber.

42 [2003] EWHC 2161 (Fam). See also *Evans v. United Kingdom* *op. cit.* ..

43 Per Arden LJ, 106-107.

44 In English civil law the foetus has no legal standing in relation to harm done *in utero* and no claim can be made on its behalf: *Paton v British Pregnancy Advisory Service Trustees* [1979] QB 276.

45 *Vo v France* *op. cit.*, para. 80: 'It follows ... that in the circumstances examined to date by the Convention institutions ... the unborn child is not regarded as a 'person' directly protected by Article 2 of the Convention and that if the unborn do have a 'right' to 'life', it is implicitly limited by the mother's rights and interests. The Convention institutions have not, however, ruled out the possibility that in certain circumstances safeguards may be extended to the

unborn child.'

46 *Op. cit.* para 84.

47 See R. Scott 'The English Fetus and the Right to Life' (2004) 11 *European Journal of Health Law* 347, 347. (See also R. Scott, *Rights, Duties and the Body: Law and Ethics of the Maternal-Fetal Conflict* (Oxford: Hart Publishing, 2002).)

48 *Ibid.* 348.

49 I. Karpin, 'Legislating the Female Body: Reproductive Technology and the Reconstructed Woman' (1992) 3 *Columbia Journal of Gender and Law* 325.

50 [1997] 3 All ER 936, 943.

51 *Op. cit.*, 689.

52 *Ibid.*, 687. See Scott *op. cit.* ..

53 [1992] 4 All ER. 645, 652-3.

54 *Ibid.*, 653.

55 [1992] 4 All ER 671.

56 *Re MB (medical treatment)* [1997] 2FLR 426; *St. Georges op. cit.* ..

57 *State ex rel Angela MW v Kruzicki* (1995) 541 NW 2d 482 (Wis. App.), revoked by the Wisconsin Supreme Court: *State v Kruzicki* (1997) 561 NW 2d 729 holding that a child is a person born alive and not a foetus. See C.L. Glaze, 'Combating Prenatal Substance Abuse: The State's Current Approach and the Novel Approach of Court-Ordered Protective Custody of the Fetus' (1997) 80 *Marquette Law Review* 793.

58 2003-04 Wisconsin Statutes & Annotations § 48.193(1)(c). See also § 48.133; § 48.135 and § 48.981(3). Two other states allow civil detention of pregnant women using drugs: see S.D. Codified Laws Ann. § 34-20A-63 and Minn. Stat. Ann. § 626.5561(2).

59 *Re F (in utero)* [1988] 2 AllER 193, reaffirmed in *Rance v Mid Downs Health Authority* [1991] 1 All ER 801.

60 Though *obiter dicta* May LJ showed some sympathy for the local authority's case, stating, 'On these facts ... I have no doubt myself that if the court had the power I would give leave to issue the necessary originating summons and make the unborn child a ward of court'. *Ibid.*, 194.

61 Lowe, 'Wardship and Abortion Prevention - Further Observations' (1980) 96 *Law Quarterly Review* 29 at 30. As referred to by Balcombe LJ *ibid* at 200.

In a civil law Canadian case, *Winnipeg Child and Family Services (Northwest Area) v G* (1997) 3 SCR 925 (Sup Ct (Canada)) a woman addicted to sniffing glue had given birth to three children, two of which were adversely affected by her addiction. During her fourth pregnancy, the Queen's Bench made the unborn child a ward of court and ordered her detention until the birth of the child. The order was overturned by the Court of Appeal and the appeal was rejected in the Supreme Court. Applying *Re F (in utero) ibid.*, it was held that the unborn child cannot be made a ward of court.

62 Sections 1(2)-1(6).

63 Section 2(1).

64 See Department for Constitutional Affairs, *Mental Capacity Act 2005: Draft Code of Practice* (DCA, 9 March 2006), 3.10

65 Section 2(3) provides that: 'A lack of capacity cannot be established merely by reference to - . . . (b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity'.

66 Section 2(2).

67 [1997] 2 FCR 541.

68 <http://www.nhsdirect.nhs.uk/articles/article.aspx?articleId=650>

(accessed 1/12/06).

69 http://www.nationalpainfoundation.org/MyTreatment/articles/CRPS_PainDefinitions.asp (accessed 11/12/06).

70 [2000] ECHR 141.

71 At para. 54, per Judge Fischbach.

72 Per Judge Bonello, concurring.

73 Department for Constitutional Affairs, *Mental Capacity Act 2005 - Draft Code of Practice* (DCA, 9 March 2006), para. 3.11. *Italics added.*

74 The consultation closed in June 2006. The Department for Constitutional Affairs *Response Paper to the Consultation Paper: Mental Capacity Act Code of Practice*, September 2006, CP/R 05/06 makes no reference to proposed changes to this part of the Code.

75 Section 4(1)(b).

76 Section 4(6).

77 Section 4(6).

78 Section 4(7).
79 Italics added.
80 *Op. cit.* ..
81 *Ibid.*, para 61 per M. Fischbach.
82 Section 2(1).
83 Section 15.
84 [1996] 1 FLR 762.
85 For example see A. Downie, 'Case Commentary: Extra Statutory Confinement' (1998) *Child and Family Law Quarterly* 10, 101; L. Jewell, 'Treatment without Consent' (1998) *Family Law Journal* 28, 774.
86 Mental Health Act 1983 s.1(3).
87 Georgia Unannotated Code § 37-7-81.1; § 37-7-1.3. See http://www.athensclarkecounty.com/probatecourt/invol_std.html (accessed 1/12/06); General Statutes of North Carolina *Mental Health, Developmental Disabilities and the Substance Abuse Act 1985* Chapter 122C; The Revised Code of Washington (RCW) § 70.96A.140 'authorises a designated county chemical dependency specialist to investigate and evaluate specific facts alleging that a person is incapacitated as a result of chemical dependency. If it is determined that the facts are reliable and credible, the specialist may file a petition for commitment of such a person with the superior or district court.' The treatment is funded and pregnant women are prioritised: <http://www.co.elark.wa.us/alcohol-drug/terms.html> (accessed 11/12/06).
88 National Institute on Drug Abuse, *Principles of Drug Addiction Treatment: A Research Guide* (National Institute of Health: NIH Publication No 99-4180, October 1999). <http://www.drugabuse.gov/PDF/NNCollections/NNTreatment.pdf>, at 69 (accessed 11/12/06).
89 Joint Parliamentary Committee on the Draft Mental Health Bill, (*H.L. Paper 79-I H.C. 95-I, Session 2004-5*). Evidence was received from various professional groups including Alcohol Concern (para. 102) and the Sainsbury Centre for Mental Health (para. 103) leading the Joint Committee to conclude at 104 that, '... We recommend that a specific exclusion on the grounds of substance misuse alone (including dependence on alcohol or drugs) be inserted into the Bill'.
90 Department of Health, *Government Response to the Report of the Joint Committee on the Draft Mental Health Bill 2004* Cm 6624 (2005).
91 This is criticised by the UK Harm Reduction Alliance (<http://www.ukhra.org> (accessed 1/12/06)) which aims to replace criminal justice strategies for dealing with drug-use with public health and human rights centred initiatives.
92 But see D. Kennedy, 'Payout for Prison Drug Addicts' *The Times*, 13 November 2006.
93 See for example Home Affairs Committee, *Third Report: The Government Drugs Policy: Is it Working?* May 2002, paras. 67-72. In particular, see the evidence of 'Liberty'.
94 Turning Point, *Routes into Treatment: Drugs and Crime*, (2004), 3.1. Turning Point is the countries largest voluntary-based provider of drugs services. <http://www.turning-point.co.uk/NR/rdonlyres/A903EA89-5FC5-4607-8F13-05C9B8C03EF8/0/Routesintotreatrntreport.pdf> (accessed 11/12/06).
95 Howard League for Penal Reform, *A Chance to Break the Cycle: Women and the Drug Treatment and Testing Order*, 2000.
96 Drugs Strategy Directorate, *Updated Drug's Strategy* 2002, 50 promised to bring the total direct annual spend on drugs treatment to £573m by 2005.
97 A sentencing option introduced by ss.61-64 of the Crime and Disorder Act 1998. See also: Home Office, *Drug Treatment and Testing Order Consultation Paper: Summary of Responses*, (London: Home Office, 1997) Dep. 5893 (3S); Home Office *Drug Treatment and Testing Order: Background and Issues for Consultation* (London: Home Office, 1997); Home Office, *Tackling Drugs to Build a Better Britain: the Government's Ten-Year Strategy for Tackling Drugs Misuse* (London: Home Office, 1998).
98 The generic community sentence was introduced in the Criminal Justice Act 2003, s.177. In relation to less serious crimes, the Act also introduces the conditional caution (ss.22-27) whereby the offender admits that he committed the offence and consents to given conditions attached to the caution, which he must meet or risk re-sentencing.
99 Criminal Justice Act 2003. Mental health treatment requirement defined s.207; drug rehabilitation requirement defined s.209; alcohol treatment requirement defined s.212.
100 C. Walsh, 'Sentenced to Treatment' 5 (1999) *Web Journal of Current Legal*

Issues.

101 M. Hough, *Drug Misuse and the Criminal Justice System: A Review of Literature* (Home Office Drugs Prevention Initiative, Paper 15, 1996).

102 J.R. Schroedel, *Is the Fetus a person? A Comparison of Policies Across the Fifty States* (Cornell University Press: New York, 2000).

103 Mass. Gen. Laws Ann. Ch. 119 No 51A, 1990.

104 V. Toscano, 'Misguided Retribution: Criminalization of Pregnant Women who Take Drugs' (2005) 14(3) *Social and Legal Studies* 359, 360.

105 [1998] 3 All ER 673, 692.

106 R. Scott, 'The English Fetus and the Right to Life' *op. cit.*

107 *Op. cit.*, at Para 84 per L. Wildhaber.

108 *Op. cit.*, 687.

109 National Drug Court Institute, 'DWI Courts and DWI!Drug Courts: Reducing Recidivism, Saving Lives' http://www.ndci.org/dwi_drug_court.htm (accessed 1/12/06).

110 D.B. Marlowe, D.S. DeMatteo, D.S. Festinger, 'A Sober Assessment of Drug Courts' (2003) 16(1) *Federal Sentencing Reporter* 113.

111 National Treatment Agency for Substance Misuse, *Models of Care for Treatment of Adult Drug Misusers: Framework for Developing Local Systems of Effective Drug Misuse Treatment in England* (Department of Health, 2002). www.nta.nhs.uk (accessed 1/12/06).