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FOETAL ALCOHOL SPECTRUM DISORDER PREVENTION – SHOULD THE STATE INTERVENE?

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Abstract

Foetal alcohol spectrum disorder (FASD) is a prevalent yet preventable issue in New Zealand. The government has FASD action plans however a mother's engagement with these is mostly voluntary. Consequently, these prevention methods are limited. No formalised legal prevention or intervention methods exist in New Zealand's legal landscape to ensure pregnant women who intend to keep their child do not harm their foetus in utero through excessive alcohol or drug consumption. Where illicit substance consumption of a pregnant woman verges on addiction levels, it may be time for state intervention in order to limit the negative effects on the foetus the mother intends to give birth to.

The case of Re an Unborn Child highlighted that New Zealand's wardship legislation (Care of Children Act 2004 and Oranga Tamariki Act 1989) has a wide enough scope to include unborn children. This paper assesses how a court wardship order over an unborn child might be implemented as a mechanism for the state to limit the negative effects of FASD where there is significant concern over it. Further contemplation of compulsory treatment for mothers with addictions is considered through use of the Substance Addiction (Compulsory Assessment and Treatment) Act 2017. The main difficulties with such state intervention are the intrusive nature of these mechanisms impeding upon a mother's autonomy and potentially creating further unintentional fear in a system where distrust already exists.

Key Words: "foetal alcohol spectrum disorder" "autonomy" "court wardship "addiction"

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I Introduction

The pairing of a mother's autonomy against a foetus has been an ever-present issue in many medical, legal and political debates. Abortions, forced caesareans, blood transfusions, and guardianship orders for unborn children are a few examples.[1] In *Re an Unborn Child*, Heath J established that a foetus still in the mother's womb could be the subject of a court wardship order.[2] New Zealand's guardianship statutes and the court's inherent parens patriae jurisdiction allow this.[3] This essay develops Nadia Sussman's contention that there is scope to extend Heath J's guardianship of an unborn child as a tool to prevent foetal alcohol spectrum disorder (FASD).[4] It focuses on mothers who intend to carry their foetus to full term but repeatedly engage in excessive alcohol and/ or drug consumption thus creating a toxic milieu for the foetus.[5]

Currently the government recognises FASD as a problem.[6] Myriad reasons including motherly autonomy have prevented the state from intervening during pregnancy through a heavy-handed approach to inhibit FASD. Consequently, the manner in which a wardship order over a foetus for FASD prevention would be implemented is unknown. Part VI discusses potential terms. Where the mother suffers from an addiction this essay contemplates another form of protection through the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (SACATA). Where risk of FASD is severe enough and a mother is non-compliant with treatment a SACATA order is an intensive but efficient mechanism to remedy the situation. This legislation has some drawbacks as discussed in part VIII.

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[1] Joanna Manning "Court-ordered Caesarean Section – The Priority of Maternal Autonomy" (1999) 18 NZULR 546 at 546 and 550.

[2] *Re an Unborn Child* [2003] 1 NZLR 115 (HC).

[3] *Re an Unborn Child*, above n 2; Nadia Sussman "What to Respect When You're Expecting – Protecting the Foetus from Alcohol Exposure" [2019] NZ L Rev 323 at 327.

[4] Sussman, above n 3, at 330.

[5] At 330.

[6] Ministry of Health *Taking Action on Fetal Alcohol Spectrum Disorder (FASD): A Discussion Document* (online ed, 2015).

Addiction is often a factor with excessive drug and alcohol consumption.[7] Pregnant women have important treatment and medical decisions to make such as whether to have a caesarean. Addiction can affect a mother's capacity to make these important decisions.[8] The Protection of Personal and Property Rights Act 1988 (PPPRA) may become necessary to invoke in such situations.[9] This essay however is concerned with orders for the protection of an unborn child so will not address the PPPRA. The autonomy of mothers and their ability to look after their children without fear of government intervention are important dynamics to recognise. As court wardship or SACATA orders are invasive measures they should not be contemplated lightly. Though this essay does not address Treaty of Waitangi compliance any guardianship or treatment order must be compatible with Te Tiriti o Waitangi. Incorporation of family group conferences (FGCs) during the implementation of a court wardship or SACATA order will be important to encourage whānau involvement.

II Foetal Alcohol Spectrum Disorder

Precise statistics on FASD occurrence in New Zealand are currently unknown but it may affect approximately 10 per cent of births every year.[10] Alcohol is a teratogen, meaning where a mother drinks or consumes alcohol whilst pregnant her baby may be born with FASD and suffer irreversible brain damage.[11] FASD is a preventable disorder which can create many emotional and financial costs on families and the government.[12] The potentially lifelong and varied effects of FASD can impact learning, sociability and

[7] Paige McGuire Linden "Drug Addiction During Pregnancy: A Call for Increased Social Responsibility" (1995) 4(1) Am U J Gender & Law 105 at 115.

[8] Julie Petrow "Addicted Mothers, Drug-Exposed Babies: The Unprecedented Prosecution of Mothers Under Drug-Trafficking Statutes" (1991) 36 N Y L Sch L Rev 573 at 598 – 599.

[9] Protection of Personal and Property Rights Act 198; Joanna Manning "Court-ordered Caesarean section – the Priority of Maternal Autonomy" (1999) 18 NZULR 546 at 578 – 579.

[10] Ministry of Health, above n 6, at 6.

[11] Lisa Elliot and others *Fetal Alcohol Spectrum Disorders (FASD): Systematic Reviews of Prevention, Diagnosis and Management* (Health Services Assessment Collaboration, 2008) at 1.

[12] Ministry of Health, above n 6, at 1 and 13.

emotional control.[13] The exact amount of alcohol or drugs which begin to damage the foetus is unknown.[14] Consequently, it is difficult to produce a coherent and consistent system of when and how to intervene in a pregnancy to prevent FASD.

The approaches taken to prevent FASD have differed internationally. American courts have attempted to criminalise pregnant women who consume alcohol or illicit drugs whilst pregnant.[15] Seeking to imprison these women is an effort to prevent continued consumption to reduce harm to the foetus. A punitive approach however is unlikely to solve a societal problem of addiction. [16] Addiction is an important consideration in these circumstances, as part VIII highlights. In England, an attempt was made to prosecute a mother for giving birth to a child with FASD as a result of consuming excessive amounts of alcohol during her pregnancy.[17] Though this was not found to be a crime, the fact remains that preventable yet irreversible harm took place to such an extent that legal compensation was sought.

The New Zealand government has created and enacted action plans to tackle the problem of FASD. The plans include: changing New Zealand's drinking culture; clarifying FASD causes message; increases in relevant health care; increase support to families and addicts.[18] The methods are preventative but fall short by not being binding. Their voluntary nature could reduce their effectiveness. These action plans aim to increase engagement within the systems that already exist. Whether a more invasive approach such as guardianship of an unborn child will improve such engagement is debateable.

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[13] At 4 – 5 and 10.

[14] Elliot, above n 11, at xvi.

[15] Grace Lykins "Prohibition during pregnancy: supporting mandatory outpatient rehabilitation for women who give birth to babies with foetal alcohol syndrome" (2012) 21 J L & Pol'y 155 at 166.

[16] Seema Mohapatra "Unshackling Addiction: A public health approach to drug use during pregnancy" (2011) 26(2) Wisconsin Journal of Law, Gender and Society 241 at 253.

[17] "Foetal alcohol syndrome case dismissed by Court of Appeal" *BBC News* (online ed, UK, 4 December 2014).

[18] New Zealand Government "Foetal Alcohol Spectrum Disorder (FASD) Action Plan Activities" (14 September 2018) Ministry of Health <https://www.health.govt.nz >.

A Will Court Wardship Assist with FASD Reduction?

Guardianship of an unborn child was first considered by New Zealand courts in a context outside of FASD. Sussman raised in "What to Respect When You're Expecting" that this guardianship could be extended to the FASD context and used as a FASD prevention method.[19] This would be utilised only where a mother intends to carry her child to full term yet engages in activity harmful to the foetus which may cause FASD.

Under current New Zealand law anyone can refuse medical treatment.[20] No laws prescribe what a mother can or cannot consume during pregnancy. Only recommendations exist. Consequently, a pregnant woman can drink alcohol or consume other illicit substances to excess. As an autonomous being a mother can decide how to act and what to consume during her pregnancy. This autonomy would be restricted if her foetus was made a ward of the court. The mother would have to comply with the terms of the guardianship order. The guardianship order suggested by Sussman is a relatively intrusive measure stemming from *Re an Unborn Child* combined with Major J's dissent in *Winnipeg Child and Family Services. Re an Unborn Child* created precedent binding on the Family Court that enables an unborn child to be the subject of wardship orders.[21] It is hence legally possible to use guardianship as a FASD prevention technique (in limited circumstances).

The terms of the order would impact the effectiveness of guardianship in reducing FASD. If the terms are loose or vague the mother might continue to drink in secret. Where there are more rules, checks and an appropriate agent to ensure order compliance this should encourage a reduction in drinking and thus a reduction in FASD. A necessary implication

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[19] Sussman, above n 3, at 323.

[20] Sussman, above n 3, at 325; Health and Disability Commissioner Act 1994, s 20(1)(a); Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, right 7(7); New Bill of Rights Act 1990, s 11.

[21] Bill Atkin "The Welfare of the Unborn Child: Jurisdiction and Discretion" [2004] International Survey of Family Law 371 at 376.

in using guardianship to prevent FASD is the mother lessening her addiction. Although FASD elimination is the primary objective, ensuring a mother's stability after the guardianship order ends is crucial. It is also imperative such an order and its effects are not something that becomes feared by women.

III Policy Considerations

Pregnancy is a topic which carries a myriad of social judgements and ideologies. There is stigma surrounding an array of activities which women may partake in whilst pregnant. At the top of the list is alcohol/ drug consumption. Given the importance of individual autonomy, a key question surrounding pregnancy is: where should regulation of alcohol/ drug consumption be simply through social stigma and education, and where should the law intervene? Pregnancy and FASD are not just moralistic topics. The safety of children is a legal matter. Numerous pieces of legislation such as the Oranga Tamariki Act 1989 (OTA), and the Care of Children Act 2004 (COCA) attest to this. The United Nations Convention on the Rights of the Child (UNCROC) was also considered in *Re an Unborn Child.* Nonetheless, knowing what daily activities of a pregnant woman need to be regulated is a difficult to decide. Further, it would be near impossible to regulate every potentially harmful item a mother chooses to consume. Every pregnant woman who has a cup of coffee or unpasteurised dairy could not be monitored. The more that becomes regulated the more fearful pregnant women may become of attending doctor appointments or telling the truth to them. This is not a beneficial turn for healthcare to take. Nor are such activities ones that require state intervention, but who draws that line? Perhaps it is only where consumption of harmful substances is at or verging on addiction level that state intervention should occur.

Sussman and Burgess put forward two opposing arguments about state intervention with pregnant women and unborn children.[22] Burgess argues against state intervention, focusing on: the autonomy of the mother; current intervention methods being too draconian; and the

[22] Sussman, above n 3; Taylor Clare Burgess "Reconstructing State Intervention in Pregnancy to Empower New Zealand Women" (2019) 31(1) Yale J L & Feminism 167.

negative and disproportionate impact of state intervention on Māori women and those experiencing poverty.[23] Maternal autonomy as a justifiable right is an important consideration. Rights can be subject to reasonable limitations under the New Zealand Bill of Rights Act.[24] What is reasonable and what is not regarding such limitation may be a spectrum. Situations of serious substance abuse during pregnancy would arguably be an instance of where a limitation on maternal autonomy is reasonable. Thus, allowing intervention to protect the mother from substance abuse and the foetus from FASD. On the other hand, a pregnant woman who occasionally has a glass of wine at dinner should not be a reasonable time to involve the state.

As previously acknowledged, Sussman argues for state intervention in the form of guardianship where mothers consume alcohol during pregnancy.[25] Sussman explains that a paradox exists in the law surrounding abortion. Her contention is that punishment existing for those that pursue termination of a pregnancy is contrary to there being zero legal regulation or enforcement surrounding the care of an unborn child whilst in the womb.[26] This is a valid point as the manner in which the mother conducts herself during pregnancy impacts the child postpartum. Consequently, it is not harmonious in law for the state to be concerned about ensuring a birth occurs yet hold little concern for the foetus' treatment in utero. This argument now holds little weight given abortion has been removed from the Crimes Act.[27] The abortion law changes ensure that abortion is available to mothers (where the relevant criteria are met). A guardianship order over an unborn child could not remove a mother's right in the context of the choice to have an abortion. In fact, in Major J's minimum intervention test, the first requirement is intention of a mother to keep the child.[28] The ability of a pregnant woman to receive an abortion should hence be unaffected by guardianship of her unborn child. This shows a retention of the mother's autonomy even where she consumes harmful substances to the extent that state intervention is required.

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[23] Burgess, above n 22, at 169 – 170.

[24] Sussman, above n 3, at 338; New Zealand Bill of Rights Act 1990, s 5.

[25] Sussman, above n 3, at 347.

[26] At 334.

[27] Abortion Legislation Act 2020; Crimes Act 1961, s 182(2).

[28] *Winnipeg Child and Family Services (Northwest Area) v DFG* [1997] 3 SCR 925 (SCC) at [96].

State intervention before birth already occurs in New Zealand. The Oranga Tamariki Ministry can investigate reports of concern over unborn children.[29] New Zealand communities do not always welcome state intervention in this context. This is an issue that disproportionately affects Māori children. Albeit the positive aspirations of New Zealand's child welfare legislation to incorporate Māori culture and accordingly assist Māori childcare, there has remained a disproportionate number of Māori children in state care.[30] Allowing guardianship of unborn children may exacerbate the problem. Where a guardianship order is sought cultural considerations are paramount. Incorporation of FGCs is a good start, but more could be done to create culturally sensitive and appropriate orders.

Fear of child upheaval at birth by the Ministry is present in New Zealand.[31] Ensuring more fear is not instilled in the community through the implementation of guardianship orders over unborn children must be a paramount consideration in their construction. A guardianship order could: provide mothers with addictions the opportunity to receive treatment for their addition; learn coping techniques; or generally allow them to reach a more stable condition for their child's birth. Despite these benefits a guardianship order might disconcert some women. Some United States legislatures and courts have ruled drug addicted women unfit to parent.[32] New Zealand should not go down such a drastic path, but if guardianship orders over unborn children become common this fear may escalate. Such fear may prevent women from attending doctors' appointments in trepidation of being deemed unfit to parent. This current concern in communities emphasises that there is a difficult balance to strike in protection versus autonomy and not being overly paternalistic.

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[29] Burgess, above n 22, at 169; *L v Chief Executive Oranga Tamariki – Ministry for Vulnerable Children* [2018] NZHC 1420 at [26].

[30] Amohia Boulton "E tipu E rea: the care and protection of indigenous (Māori) children" [2018] NZLJ 3 at 3 – 4.

[31] Vita Molyneux "Survey Reveals Fear Over Oranga Tamariki Keeping Māori Awake at Night" (25 November 2019) Newshub <www.newshub.co.nz>.

[32] Nora Christie Sanstad "Pregnant Women and the Fourteenth Amendment: A Feminist Examination of the Trent to Eliminate Women's Rights During Pregnancy" (2008) 26(1) Law and Inequality: Journal of Theory and Practice 171 at 176.

The above points highlight key considerations with a guardianship order over an unborn child: autonomy and even-handed regulation which reduces FASD rates rather than spiking fear in the community. Whatever form an order over an unborn child takes there will always be tension between the rights of the mother and the rights (if any exist) of the foetus. Given such tensions exist it is understandable judges have said such an area of law should be left to Parliament.[33] As part V discusses, New Zealand courts have the power and legislative mechanisms to make guardianship orders over unborn children. These need to be used carefully with strict criteria. Sussman's proposal of combining Major and Heath JJ's judgments would provide a good base but only in necessary situations. This is to keep negative consequences to a minimum. Anxieties over needing to limit the floodgates of stripping maternal autonomy, fear of seeking medical advice, and cultural biases must to be continuously monitored.

IV Key Court Decisions on Unborn Children

A In Re F (in utero)

In this 1988 case, Hollings J stated that there had been no prior attempt to place an unborn child under court wardship.[34] The mother in *Re F (in utero)* was 28 weeks pregnant and struggled with drug use.[35] Her already born son was in long-term foster care and her access to him had been terminated.[36] The UK Court of Appeal did not think a matter as sensitive as pairing the mother's rights against the foetus's rights in this context was for the Court to decide.[37] *In the matter of Baby P* and *Re an Unborn Child* held that *In Re F* did not apply to New Zealand's context.[38]

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[33] *In Re F (in utero)* [1988] 3 WLR 1288 (CA) at 1306.
[34] At 1293.
[35] At 1290.
[36] At 1290.
[37] At 1307
[38] *In the matter of Baby P (an unborn child)* [1995] NZFLR 577 (FC) at 476; *Re an Unborn Child,* above n 2, at [61].

B In the Matter of Baby P

Following *R v Henderson,* where a man was convicted for killing an unborn child, the Family Court in *Baby P* held that "child" in the Children, Young Persons, and their Families Act 1989 (CYPF) (now the OTA) can include already born children.[39] Judge Inglis held that entitlement to protection is a separate question to whether a foetus is a legal person.[40] Thus, protection of the foetus could be assessed. *Baby P* will be further discussed in part VII in relation to a wardship order where the mother is a minor. The mother being a minor creates an interesting element of herself and the foetus being able to be subject to the same protective legislation.

C Re an Unborn Child

Re an Unborn Child is the main decision this essay rests upon. In *Re an Unborn Child,* the mother, Nikki, wanted the birth of her child to be filmed as part of a pornographic film.[41] As a result, Heath J put Nikki's unborn child into the guardianship of the court. Heath J concluded that "child" under s 2(1) of the Guardianship Act 1968 included "unborn child".[42] This conclusion was reached through considering international obligations such as the UNCROC and previous case law that indicated an unborn child is independent of the mother.[43] The inclusion of "unborn child" in the legislative definition of "child" meant there was scope under the Guardianship Act for an unborn child to be subject to a wardship of the court order. The court's inherent jurisdiction and parens patriae powers also allowed for this.[44] Heath J gave narrow reasoning about the circumstances in which such a guardianship order should be made. He required there to be likely harm to the child which

[39] *In the matter of Baby P,* above n 38, at 478; *R v Henderson* [1990] 3 NZLR 174; Crimes Act 1961, s 182.
[40] *In the matter of Baby P,* above n 38, at 476.
[41] *Re an Unborn Child,* above n 2, at [3].
[42] At [63].
[43] At [63].
[44] At [35].

requires intervention to protect the unborn child's welfare.[45] Further, the intervention must be at a minimum and cannot require the mother to do anything positive against her will.[46]

Interestingly, Heath J did not consider *Winnipeg* in his judgment. The 1997 Canadian Supreme Court decision concerned a pregnant mother with a glue sniffing addiction. The mother had already given birth to two permanently disabled children whose conditions were a result of being exposed to the substance in the womb.[47] The Manitoba Court of Queen's Bench decision ordered the unborn child a ward of the court and detained the mother in a treatment centre until she gave birth.[48] The Court of Appeal reversed the order, ruling the parens patriae jurisdiction could only be exercised once the child was born.[49] The Supreme Court upheld the Court of Appeal's decision concluding no power existed through the common law or parens patriae jurisdiction to detain a mother for reason of protecting her unborn child.[50] Major J in the Supreme Court disagreed, contending the state could intervene as the trial judge ruled. Major J understood the parens patriae jurisdiction to be undefinable but existing to ensure protection of those who could not protect themselves. This included unborn children in situations like the present.[51] Sussman suggests incorporating Major J's 'minimum threshold' into New Zealand law when dealing with guardianship of an unborn child.[52] This is appropriate for the court to consider. The test is as follows: [53]

> (1) The woman must have decided to carry the child to term.
> (2) Proof must be presented to a civil standard that the abusive activity will cause serious and irreparable harm to the foetus.
> (3) The remedy must be the least intrusive option.

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[45] At [88].
[46] At [94].
[47] *Winnipeg*, above n 28, at [5].
[48] At [1].
[49] At [7].
[50] At [59].
[51] At [91].
[52] Sussman, above n 3, at 342 – 343.
[53] *Winnipeg,* above n 28, at [96].

(4) The process must be procedurally fair.

In *Re an Unborn Child* Heath J envisioned limited intervention in pregnancy.[54] Similarly, Major J in *Winnipeg* indicated it was only where a mother was using a serious substance that conduct should be restrained.[55] Both Heath and Major JJ attempted to confine the limits of guardianship of the unborn but have left enough scope for excessive alcohol/ illicit substance abuse to be included. Alcohol and illicit substances can cause irreparable harm.[56] The seriousness of damage is evinced by the children in *Winnipeg.* These FASD effects are possibly of greater significance than the harm in *Re an Unborn Child* which was difficult to assess. Damage of some degree is inevitable with FASD. Heath J's reluctance in extending this guardianship jurisdiction too far is somewhat puzzling given publication of the pornographic film could have been prevented once the child was born.[57] This means there was no pressing need to extend the jurisdiction as he did. Regardless, the precedent has been created.[58]

V Implementation of a Guardianship of the Court Order?

Guardianship of the court is a last resort executed in limited circumstances.[59] Heath and Major JJ made this clear. Situations where guardianship of unborn children can be implemented include where a serious matter of physical or mental health is at stake.[60] FASD affects both the physical and mental health of children and hence is a significant concern. The key pieces of wardship legislation in New Zealand are the COCA and the OTA. The tests to implement guardianship orders under these Acts are procedurally different. The COCA is the only Act under which court wardship can occur. Orders under the OTA could co-exist with a court wardship order but they cannot contradict one

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[54] *Re an unborn,* above n 2, at [88].
[55] *Winnipeg,* above n 28, at [122].
[56] Sussman, above n 3, at 343; Ministry of Health, above n 6, at 1 – 13.
[57] M Henaghan *Family Law Service NZ* (online ed, LexisNexis) at [6.301].
[58] Atkin, above n 21, at 376.
[59] M Henaghan, above n 57, at [6.301].
[60] At [6.301].

another.[61] Section 30 of the COCA provides that both the Family Court and High Court have jurisdiction to make any order under s 31.[62] The parens patriae powers of the High Court can be utilised where there are gaps in precedent or legislation. The High Court is the most suitable court to deal with wardship over an unborn child. Using the High Court gives security for the possibility of parens patriae powers being required. Where orders are made under one Act (COCA or OTA) all orders of that subject must continue through that Act.

A continued difficulty for courts in any scenario concerning an unborn child is at what point in the foetus's development an order can be made. As a teratogen, alcohol can harm the foetus at any development point.[63] Where a mother intends to carry the child to full term, the age of the foetus should not be the court's concern. The relevant concern is whether the mother wants to carry the foetus to term and is directly contradicting medical advice by excessively consuming substances harmful to the foetus (alcohol and drugs). Henceforth, this essay will not address any of the still contentious arguments about a foetus's age.

A Inherent Jurisdiction of the Court and Parens Patriae

Heath J found that ss 9 and 10A – 10E of the Guardianship Act did not replace the inherent jurisdiction of the court but created a procedural framework.[64] Meanwhile, parens patriae powers are derived from the common law and lay mostly in ss 16 and17 of the Judicature Act 1908 (now the Senior Courts Act 2016).[65] The inherent jurisdiction of the court allows the court to exercise its powers which include parens patriae.[66] The parens patriae

[61] Care of Children Act 2004, s 30.
[62] Section 30.
[63] Ministry of Health, above n 6, at 3.
[64] *Re an Unborn Child,* above n 2, at [35]; Stewart Bartlett "Wardship – the First Resort or the Last Resort" (2003) 4 BFLJ 133, at 133.
[65] *Re an Unborn Child,* above n 2, at [38]; Senior Courts Act 2016, ss 14 and 16.
[66] Rosara Joseph "Inherent Jurisdiction and Inherent Powers in New Zealand" (2005) 11 Canta L Rev 220 at 225.

jurisdiction exists to protect those who cannot protect themselves, hence is applicable to situations where a foetus cannot protect itself against substance abuse.[67] It is unclear how far these inherent powers extend, but Heath J did not believe they would need to invoking beyond wardship provisions as they were largely codified in that context.[68] Nonetheless, these powers can be a safety net for any gaps missed by case law or legislation.

B Care of Children Act

"Unborn child" falls within the definition of "child" in the COCA and OTA.[69] Heath J clarified this when implementing a guardianship order under s 10B of the Guardianship Act 1968 (now COCA) in *Re an Unborn Child*. When making any order under the COCA an essential consideration is the "welfare and best interests" of the child.[70] Considerations usually relevant with an already born child such as their opinion or sense of stability will not hold much weight. Principles with more bearing in s 5 would include the child's safety and development.[71] Medical evidence has shown a foetus's safety and development are compromised when consistently exposed to illicit substances in utero.[72] This should be relevant to the court's decision on whether to make the unborn child a ward of the court. For an unborn child to become a ward of the court an application can be brought by an "eligible person" under s 31. A s 31 application can also appoint an agent of the court for the child.[73] The definition of "eligible person" is broad ranging from the parents themselves, to the Chief Executive of Oranga Tamariki, to anyone granted leave by the court.[74]

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[67] At 226.

[68] At 227 and 234.

[69] Care of Children Act 2004, s 3(2)(g); *Re an Unborn Child,* above n 2, at [50], [63] and [88].

[70] Care of Children Act, s 4.

[71] Section 5.

[72] Lane Strathearn and others "Pathways Relating the Neurobiology of Attachment to Drug Addiction" (2019) 10(737) Frontiers in Psychiatry 1 at 1 – 2.

[73] Care of Children Act, s 31(1).

[74] Section 31(2).

C Oranga Tamariki Act

The OTA does not provide for court wardship, but it can be used to appoint the Chief Executive or other suitable persons as effective foster parents.[75] The principles under the OTA differ slightly from the COCA.[76] It was under the OTA (as the CYPF) that *Re Baby P* established an unborn child could be the subject of a declaration of a child in need of care.[77] Section 110 of the OTA provides that the court can appoint a guardian to a child who is "in need of care or protection". An unborn child whose mother is consuming excessive amounts of drugs or alcohol whilst the child is in utero will likely satisfy s14(1)(a)(i) and/or s14(1)(a)(ii). If the mother suffers from an addiction which leaves her 'unable' to care for the child whilst in utero s14(1)(b) could apply. Under s14AA(1)(a) ill-treatment of the foetus might be argued due to being forcibly exposed to a teratogen which can cause serious harm. Moreover, s 14AA(1)(b) concerns the impairment or neglect of a child's development, physical, mental or emotional well-being when such impairment or neglect is avoidable. This is a strong argument since FASD is avoidable and medical evidence has seen it cause problems with development, mental and emotional wellbeing.[78]

Whilst the OTA and COCA overlap it is the COCA that deals with court wardship. The OTA's broader processes beyond guardianship could be used in conjunction with a COCA order to create flexibility in the order. [79] The OTA would likely provide for more outside input and a deeper assessment of options with FGCs or huis. FGCs are an important option to make this process more culturally inclusive. Cultural appropriateness should also encourage engagement from mothers and thus effectiveness with orders. Where court wardship is deemed excessive in the circumstances, a care and protection order under the OTA may be an alternative.

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[75] Oranga Tamariki Act, s 110.

[76] Oranga Tamariki Act, ss 4A – 5 and 14.

[77] Atkin, above n 21, at 376.

[78] Elliot, above n 11, at 5.

[79] S Burnhill *Family Law Service NZ* (online ed, LexisNexis) at [6.583O]; *Tipene v Henry* [2001] NZFLR 967, at [7].

VI Terms of the guardianship Order

A wardship order can be for a specific purpose or all-inclusive.[80] In *Re an Unborn Child,* Heath J stipulated the order was for the purpose of ensuring the unborn child was not sexually exploited. Hence, the birth was not to be filmed for use in the porn film.[81] An order over an unborn child to prevent FASD must state only what is essential for FASD prevention, it should not be all-encompassing. A blanket statement of necessary terms for an order is difficult to create as individual mothers may have differing needs. Where Major J's test is used it will be necessary to ensure the mother intends to carry the foetus to full term. Even after a wardship order over a foetus has been made an abortion must remain available to a mother who wishes to terminate her pregnancy (where legislative criteria met). This wardship order is about protecting future children from FASD. It should not affect a mother's ability to choose to carry her foetus or not. Given the rights of a mother are pinned against the foetus in a guardianship order over an unborn child, the mother should maintain autonomy over whether or not she has a child. Where the mother chooses to carry the child to full term however, the child should not be disadvantaged before birth as a result of the mother's pregnancy choices.

A Positive Actions

Little guidance exists on how a guardianship order of an unborn child would or should play out. *Re an Unborn Child* made clear that no mother should be made to do any positive action against her will.[82] Whilst it is important for a mother to maintain her autonomy this limitation ignores the reality and purpose of these orders. Heath J found it acceptable to prevent Nikki from partaking in the filming of her birth for the porn film.[83] By this logic, forbidding a mother from partaking in alcohol or drug consumption during her pregnancy

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[80] Law Commission *Adoption and its Alternatives a Different Approach and a New Framework* (NZLC R65) at 33.

[81] *Re an Unborn Child*, above n 2, at [102] and [106].

[82] At [94].

[83] At [109].

would not be a positive action. It is however a naïve conclusion to think no positive action would be necessary.

Sussman raised the fact that where a mother has an addiction an order that forbids her from partaking in drug and alcohol consumption is not just an omission on her behalf.[84] She will likely have to seek help to be able to stop which entails a positive action.[85] If the mother is not battling a diagnosed addiction her consumption of harmful substances would need to be at an excessive level to warrant court intervention with a guardianship order. Where the mother is battling an addiction the more invasive route of detainment in a treatment facility used in the first instance of *Winnipeg* may be required. This would force the mother into a positive action against her will. Canadian law has explicitly stated that the court's parens patriae jurisdiction does not allow for forced treatment of a pregnant woman.[86] The *Winnipeg* decision has however been criticised. The interpretation of the foetus as static ignored the inevitability of birth and the consequences the child and the family will face due to the foetus's harmful substance exposure in the womb.[87] Part VIII further discusses compulsory treatment under the SACATA where the mother has an addiction.

Another form of positive action that would be necessary in a wardship order is some form of 'check'. A check would be required to ensure the mother is compliant with the order. If a simple good faith interview check is all that ensures compliance, an intrusive court wardship process would feel futile. Therefore, making the mother partake in some form of positive action to regularly check her compliance with the order would be necessary to assist the achievement of protection from FASD. Weekly drug and alcohol tests by doctors or a social worker could be implemented for this compliance purpose. This positive action could be justified on the basis that this is a relatively simple yet effective way to monitor compliance with the court order. It is less intrusive than compulsory treatment. There will of course be difficulty incentivising the mothers to comply. Engagement is hard to achieve.

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[84] Sussman, above n 3, at 329.

[85] At 329.

[86] *Winnipeg,* above n 28; *Halsbury's Law of Canada* (47th ed, reissue, 2017, online ed) Medicine and Health at 269.

[87] Christian Witting "Forced Caesareans Reconsidered" (1999) 7 TLJ 96 at 100.

Monetary incentives have been used with pregnant women to stop them smoking.[88] A similar incentive could be considered here.

In summary, despite Heath J's distaste in mothers having to partake in positive actions, a FASD prevention guardianship order would have little worth without positive actions. The compulsory treatment discussed in *Winnipeg* should only be considered in serious addiction cases. This would involve the SACATA as part VIII contemplates. Situations of serious alcohol/ drug consumption below addiction which necessitate a guardianship order will still require a positive action to ensure order compliance. This should take the form of regular alcohol/ drug tests.

B Foetus's Agent

By placing the unborn child under court wardship the court essentially becomes the guardian of the foetus in place of the parents.[89] However, the court will not directly watch out for the mother or unborn child. An agent of the court must be appointed. Heath J did not believe it was appropriate to make the chief executive of the department agent of the court.[90] Nikki was therefore the agent to her foetus in *Re an Unborn Child.* In situations of preventing FASD the mother would not be an appropriate agent as it is her own actions that are the risk. The selection of an appropriate agent will have to be decided on a case by case basis. Many factors for who is a suitable agent will warrant consideration but crucially the mother's family support would be relevant. COCA principles and cultural considerations must be taken into account. Court agents in New Zealand have included: the child's counsel; a relative of the child; the Chief Executive; and a testamentary guardian.[91] Other appropriate agents may be appointed as the court sees fit.

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[88] Notley C "Incentives for Smoking Cessation (Review)" (2019) 7 Cochrane Database of Systematic Reviews at 2.

[89] S Burnhill, above n 79, at [6.302].

[90] *Re an Unborn Child,* above n 2, at [103].

[91] S Burnhill, above n 79, at [6.302].

A FGC or hui would be useful to establish the network of people available to the mother. This would give the court and Ministry a good indication of who in the mother's circle is best suited to be an agent to her unborn child. A family member or partner could be a suitable agent. They would be regularly involved in the mother's life and this order would be pervasive across the mother's life. A social worker should work alongside the agent if the social worker is not an agent themselves. Currently, FGCs are only available under the OTA. As OTA and COCA orders can be made at the same time, having an order to set up a FGC under the OTA would be useful. Otherwise, Parliament should consider incorporating FGCs into the COCA as part of the process to bring an application for court wardship.

C Length of the Order

The length of the order could be approached in two main ways. Firstly, the order could end upon the birth of the child leaving the parents of the child as sole guardians.[92] Alternatively, the order could continue after birth until the court conducts an assessment of when to end the order. The latter was seen in *Re an Unborn Child* but would be inappropriate here.[93] The length of the order should be from the guardianship order's execution until the birth of the child. Key reasons for this time frame are: the mother's autonomy; to encourage a bond between the child and mother; and risk of an overstepping court.

Implementing a guardianship order over an unborn child is already an infringement on a mother's autonomy as it affects her choices and actions. Where the purpose of the guardianship order is to prevent FASD effects on a foetus that implies the purpose of the order is for the duration of the pregnancy. There is risk of a mother's breast milk passing on alcohol or other harmful drugs to the child once born.[94] A mother's actions after birth however should not be a concern of a guardianship order implemented to prevent FASD

[92] Care of Children Act 2004, s 17.

[93] *Re an Unborn Child,* above n 2, at [109].

[94] Lauren M Jansson "Maternal Alcohol Use During Lactation and Child Development" (2018) 142(2) Official Journal of the American Academy of Paediatrics at 1.

on a foetus. Furthermore, a successful order would mean increased stability and decreased intake of drugs and alcohol for the mother. This should mean the mother's natural neuro-endocrine reflexes would be elicited, allowing her to bond with her child, since she is no longer under the influence.[95] This is an important step postpartum for the mother and baby.[96] The court should not interfere with this by extending the guardianship order after birth. Such extension could create anxiety for the mother over potential uplift and negatively affect bonding.

One does not want the court to overstep and become a child protection agency itself.[97] Going to court to have the guardianship order assessed directly after birth inhibits the mother's ability to engage in motherhood. Further, this would involve the court where a problem does not necessarily exist. Though prevention of harm is a goal for the Oranga Tamariki Ministry there is fear over the number of child upheavals.[98] A guardianship order over an unborn child needs to be constructed in a manner that will not instil further fear of this for mothers.

D Summary

There can be no cookie-cutter mould for a wardship order. Individual circumstances of the mother including her support network and level of alcohol/ drug consumption will vary what is necessary to protect the foetus from FASD. A wardship order over an unborn child to protect them from FASD will forbid the mother from consuming any alcohol/ drugs for the duration of her pregnancy. Viewing this simply as an omission overlooks the reality of what would be required. To make an order worthwhile some form of positive action will be necessary. This positive action would be by way of a drug or alcohol test conducted weekly (or as court ordered) to ensure compliance. The appropriate court agent should be assessed through a FGC and could range from a partner, relative, friend, or social worker.

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[95] Strathearn, above n 72, at 3.

[96] At 7.

[97] S Burnhill, above n 79, at [6.583Q].

[98] Vita Molyneux, above n 31.

The order should last the length of the pregnancy and end upon birth of the child so as not to overstep on the mother's autonomy and time with her child more than necessary. Instances of pre-term delivery have not been considered in this essay though excessive alcohol consumption can lead to this.[99]

VII Guardianship Order where Mother is a Minor

Minors can be subject to the OTA and COCA. Consequently, if a pregnant minor consumes alcohol/ illicit substances to an excessive degree, more aspects of the COCA or OTA can be utilised to prevent FASD than with an adult. There are legal restrictions on those under 18-years-of-age accessing and consuming alcohol.[100] This highlights that other considerations exist with a pregnant minor in this context. This essay however will not delve into aspects external to the COCA or OTA. People are generally regarded as having reached a higher mental capacity than that of a minor from 16-years-old. This can be seen in the legal age of consent to sexual intercourse and medical procedure consent or refusal.[101] This means the age of the minor (above or below 16-years) may influence the court's approach to a guardianship order.

Re Baby P illustrates how a guardianship order might work where the mother is a minor. At the time the case was heard the 15-year-old mother was due to give birth in the coming weeks. She was in a violent relationship with the baby's father.[102] The mother was already under both a care and protection order and under the custody of the Director-General.[103] Judge Inglis decided any care and protection order over Baby P was really an extension of the mother's order.[104] Judge Inglis saw no reason to wait until Baby P's birth to make an

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[99] Healthwise Staff "Alcohol Effects on a Fetus" (12 December 2018) HealthLink BC <www.healthlinkbc.ca>.

[100] Sale and Supply of Alcohol Act 2012.

[101] The Crimes Act 1961, s 134; Care of Children Act 2004, s 36.

[102] *In the matter of Baby P,* above n 38, at 472.

[103] At 479.

[104] At 479.

order.[105] Baby P thus had a care and protection order as well as an interim custody order to the Director-General whilst in the womb. The order would become fully effective once Baby P was born.[106] The order in *Baby P* superficially appears to be applicable to any situation with a pregnant mother whose foetus needs protecting. There is however a distinction between *Baby P* and FASD prevention cases. Specifically, a lack of eagerness from mothers who have to change their behaviour to prevent FASD. The mother in *Baby P* wanted this order unlike the likely occurrence in a FASD situation. As previously mentioned, there are engagement difficulties within the current FASD action plan framework. *Baby P* is nevertheless an important case in demonstrating the ability of an unborn child of a minor also being subject to a wardship of the court order in conjunction with the mother.

If the mother is herself under a COCA or OTA order the existing order could be amended to suit the needs of the unborn child. This makes protecting the foetus of a minor from FASD effects appear easier than with adults, since the mother can be a ward of the court herself not just the foetus. Where the mother is harming herself with alcohol/ drug consumption she may fall under s14(1)(d)(i) as a child in need of care or protection.[107] The mother would be harming herself with substance abuse and the foetus with FASD, meeting the legislative criteria. [108] The mother can hence have an order made over her which ultimately ensures her safety with the secondary outcome of preventing FASD. Placing the mother under an OTA or COCA order side-steps the difficulties with Heath J's distaste in forcing a mother to partake in a positive action because of an order over her unborn child. This is because the order can be framed as for the mother's health. Two orders would however likely made where the mother is a minor, one over the mother and one over the foetus. Implementing orders for both parties is reasonable given the previously made critiques on Heath J's statement.

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[105] At 480.

[106] At 480.

[107] Oranga Tamariki Act 1989, s 14(1)(d)(i).

[108] Section 14(1)(d)(i).

VIII Compulsory Treatment for Substance Addiction

The SACATA may become a key aspect of FASD prevention where a pregnant woman suffers from an addiction. Consuming excessive amounts of illicit substances is not always a display of free will by the mother. Excessive consumption may be a result of an addiction the mother has no control over.[109] Where a mother suffers from an addiction the best course of action may be to receive treatment for the addiction. There has been argument that treatment would have benefited the mother in *Winnipeg*.[110]

In New Zealand, substance addictions do not fall under the Mental Health (Compulsory Assessment and Treatment) Act 1992.[111] The SACATA is separate legislation which aims to protect individuals from harm whilst balancing their ability to make decisions about their own health.[112] The SACATA could provide an alternate route of preventing FASD albeit more intrusive. Where the mother has a severe substance addiction and meets the criteria in s 7 of the SACATA the Act could be used to place the mother in a treatment facility which would reduce her substance abuse and likely the deleterious effects on the foetus. This tactic would be a direct contradiction of Heath J's desire to not force the mother to do anything against her will. As previously discussed though, Heath J's positive action disproval is not conducive to effective outcomes nor is it representative of reality.

Similar to wardship, the SACATA is an option of last resort.[113] Compulsory treatment is only to be used where voluntary treatment would not work.[114] This is a severe method and

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[109] Yasmin Senturias and Michael Baldonado "Fetal Spectrum Disorders: An Overview of Ethical and Legal Issues for Healthcare Providers" (2014) 44 Current Problems in Paediatric Adolescent Health Care 102 at 102.

[110] At 126.

[111] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 4; Ministry of Health "Guideline of Assessing Capacity to Make Decisions about Treatment for Severe Substance Addiction" (2017) <https://www.health.govt.nz/> at 2.

[112] Substance Addiction (Compulsory Assessment and Treatment) Act 2017, s 3; Ministry of Health, above n 111, at 2.

[113] Ministry of Health, above n 111, at 3.

[114] Substance Addiction (Compulsory Assessment and Treatment) Act 2017, s 10.

hence should only be considered in extreme situations. The criteria for compulsory treatment under the SACATA are as follows:[115]

a) The person has a severe substance addiction; and
b) The person's capacity to make informed decisions about treatment for that addiction is severely impaired; and
c) Compulsory treatment of the person is necessary; and
d) Appropriate treatment for the person is available.

A person has a severe substance addiction where the addiction is an ongoing or intermittent condition in which the person uses the substance compulsively.[116] The person must have at least two of the following features: neuro-adaptation to the substance; craving for the substance; unsuccessful attempts to control use of the substance; or using the substance despite harmful consequences.[117] The addiction must also be of such severity that it poses a real danger to the health or safety of the person and reduces their ability to care for themselves.[118] There is a further test in s 9 to determine if under s 7(b) the person has the capacity to make informed decisions about treatment.[119] The capacity of the person to make decisions can be determined through a clinical interview.[120]

The requirement of "serious danger" in s 8 does not include danger to others. Consequently, the court will have to ensure the capacity assessors' explanations are focused on the mother herself and her actions, disregarding the pregnancy. [121] The removal of "others" is a change from the Alcoholism and Drug Addiction Act 1966 (which the SACATA repealed).[122] The old definitions of "alcoholic" and "drug addict" included "harm,

[115] Section 7.
[116] Section 8 (1).
[117] Section 8 (2).
[118] Section 8 (1)(b).
[119] Section 9.
[120] Ministry of Health, above n 111, at 4.
[121] At 8.
[122] Substance Addiction (Compulsory Assessment and Treatment) Act 2017, schedule 2.

suffering, or serious annoyance to others".[123] Despite several calls for "harm to others" to be included in the SACATA criterion during parliamentary debate, the Law Commission did not think it was appropriate.[124] The Law Commission wanted to ensure the test considered the patient and their needs without outside influence. The Law Commission claimed it could not foresee instances where someone harmed others but not themselves.[125] Such reasoning looks at the harm as purely physical.[126] This is not reflective of reality. It ignores the emotional and financial harm caused to families and friends.[127] The purposeful removal of "harm to others" is particularly troublesome when trying to prevent FASD. Irreversible harm can occur to the foetus the mother is choosing to carry as a result of the mother's addiction. That foetal harm should be a factor in the mother's assessment for compulsory treatment.

Substance abuse during pregnancy carries such social stigma that it is plausible a clinician may superimpose their own views on the situation when assessing the capacity of the mother. Hence, the foetus and possible FASD would be a factor in the mother's treatment despite attempts to focus on the individual by removing "harm to others". Section 9(c) of the SACATA states that a person's capacity to make informed decisions about treatment for a severe substance addiction is impaired where they are unable to "use or weigh that information as part of the process of making the decisions".[128] The assessor has principles to keep in mind. They must ensure they assess capacity to make a decision rather than evaluating the decision itself (and whether the assessor considers it a 'good' decision).[129] However, as the above indicates, this could be manipulated.

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[123] Alcoholism and Drug Addiction Act 1966, ss 2 – 3.

[124] Pita Roycroft "A Critical Analysis of the Substance Addiction (Compulsory Assessment and Treatment) Act" (2017) 9 NZFLJ 15 at 17; (8 February 2017) 720 NZPD 16047.

[125] Roycroft, above n 124, at 17; Law Commission *Compulsory Treatment for Substance Dependence: A Review of the Alcoholism and Drug Addiction Act 1966* (NZLC R118, 2010) at 64.

[126] Roycroft, above n 124, at 17.

[127] At 18.

[128] Substance Addiction (Compulsory Assessment and Treatment) Act 2017, s 9.

[129] Ministry of Health, above n 111, at 2 and 4.

The assessment for treatment under SACATA is a lengthy process. It requires a comprehensive assessment even before a capacity assessment and consultation with whānau is also necessary.[130] This is important from a cultural perspective, similar to FGCs. Nonetheless, the adequacy of the SACATA is mitigated by placing too much emphasis on individualism. The application for assessment itself has multiple requirements including a medical certificate which will limit applications.[131] The requirements are important given the seriousness of a compulsory order. Despite the desire to prevent FASD it must be ensured that a compulsory treatment order is only made where limiting the mother's autonomy in that way is justified. The lengthy assessment helps ensure it is only the serious cases of addiction where this occurs.

Where the court is concerned a pregnant woman has a "severe substance addiction", and reasonably believes a wardship order would not be complied with, the court may consider a compulsory treatment order under the SACATA. It should be left to the court's judgment whether a wardship order should be attempted before an order under the SACATA. Given FASD effects can differ with the same level of alcohol/ drug intake amongst people a judgment call about the level of risk at stake versus the mother's autonomy is difficult. Implementation of FGCs or huis in this context would be useful to understand the level of the mother's substance use and what would be a more culturally appropriate way to approach the order. The difficulty with the SACATA, as discussed above, is the exclusion of "harm to others". Any SACATA order has to be made for the benefit of the mother, not the foetus. This is a shortfall of the legislation. If FGCs are incorporated into the process of seeking compulsory treatment the FGC could consider the pregnancy whilst the "severe substance addiction" legislative criteria analysis could focus on the mother. A FGC could consider the clinicians' conclusion of the mother's addiction level alongside the pregnancy to recommend an outcome of compulsory treatment or not. The SACATA may be used on its own or in conjunction with a COCA or OTA wardship of the court order. Both wardship

[130] Ministry of Health, above n 111, at 9.

[131] Substance Addiction (Compulsory Assessment and Treatment) Act 2017, ss 14 – 15.

of the court and compulsory treatment are last resort options.[132] A combination of the two therefore should not be considered unless absolutely necessary.

If there are concerns a minor is suffering from a severe substance addiction and needs to be assessed under SACATA the Ministry should be involved.[133] Court wardship under COCA would be a simpler solution. Sometimes, where a minor is 16 or younger and is charged by the police for buying alcohol, the Youth Justice part of the OTA becomes applicable.[134] A FGC will then be necessary.[135] Under s 259A, alcohol and drug rehabilitation programmes as well as parenting and mentoring programmes should be considered as options for the minor to attend.[136] This reiterates how the OTA or COCA are better platforms to deal with minors. Including FGCs within the SACATA framework would be beneficial with adults as well. As previously discussed, FGCs can assist in establishing both the mother's support network, and also create more solutions than just those the legislation contemplates. A FGC may also help achieve engagement from the mother with the assistance available to her since it involves whānau and can provide a more culturally sensitive setting. Application of how compulsory treatment or wardship orders would work with mothers who have diagnosed or undiagnosed mental disorders such as schizophrenia is beyond the scope of this essay.

IX Conclusion

Re an Unborn Child created a precedent for New Zealand courts to place an unborn child under wardship of the court where the circumstances deem it necessary to protect the foetus from harm.[137] FASD is a serious, prevalent and preventable issue in New Zealand which appears to require more stringent efforts than currently exist to see legitimate change. Sussman raised the legal possibility for court wardship of an unborn child, as seen in *Re*

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[132] Section 10; C McGeorge *Laws of New Zealand* Wardship (online ed), at [22].

[133] Substance Addiction (Compulsory Assessment and Treatment) Act 2017, s 24.

[134] Oranga Tamariki Act 1989, s 251; Youth Law Aotearoa "Your Rights" (2020) < http://youthlaw.co.nz/>.

[135] Oranga Tamariki Act 1989, s 251; Youth Law Aotearoa, above n 134.

[136] Oranga Tamariki Act 1989, s 259A.

[137] Bill Atkin, above n 21, at 376.

an Unborn Child, to have its scope extended to preventing FASD.[138] Implementing such an order is heavy-handed state intervention which must be carefully assessed and only utilised where risk of FASD is so apparent that limiting a mother's autonomy is justifiable. Heath and Major JJ's judgments create a good base but any further formalisation of this form of guardianship in New Zealand must be done in within a tight structure. One would not want this to create any further distrust in the system.

A wardship order can be made under the COCA. The OTA should also be utilised to instigate FGCs to learn about the mother and encourage a culturally respectful environment. Key considerations in making any order are the mother's support network and addiction level. Any order over an adult or minor must entail only what is necessary to reduce FASD albeit this will involve positive actions to ensure compliance. Compulsory treatment of an addiction should only be considered within the SACATA framework where a mother meets the definition of a "severe substance addiction".[139] Finding an appropriate balance between autonomy, not disproportionately affecting sectors of society and reducing FASD for foetus's that mothers intend to give birth to is difficult. Many policy, social and trust factors such as these must be considered with these last resort, intrusive guardianship mechanisms.

This essay has been limited in its scope. There is still much to contemplate in the context of FASD prevention such as: compliance with the Treaty of Waitangi; complexities of mental disorders beyond addiction; pre-term births; engagement or disengagement with the system; and different cultural reactions to these orders.

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[138] Sussman, above n 3.

[139] Substance Addiction (Compulsory Assessment and Treatment) Act 2017, ss 7 – 8.

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