Silent Violence: Is Prevention a Moral Obligation?

ABBREVIATION. CPS, Child Protective Services.

You are a fool if you wait until you are thirsty to start digging a well.

—Chinese proverb

The study by Lustbader and colleagues1 in this month's Pediatrics electronic pages confirms what many have known for a long time: the epidemic of substance abuse that has been the constant companion of this country for the last two decades continues to broaden its impact on the lives of children. Although we have recognized the effects of substance abuse on children prenatally exposed to illicit drugs and alcohol1,2 and the problem of adolescent substance abuse,3 the impact of a family's drug and alcohol use on infants and young children has eluded discussion. The "new morbidity" described by Haggerty, Roghmann, and Pless4 in 1975 has taken a new twist as drugs have incipiently invaded children's lives. We face a not unique problem, however, for again our need for public health policy has outstripped the scientific information available to guide that policy.

THE IMPACT OF SUBSTANCE ABUSE ON A YOUNG CHILD'S LIFE

The most recent data from the National Institute on Drug Abuse suggest that >1 million children per year are exposed to alcohol and/or illicit substances during gestation.4 Across a wide array of studies, most researchers now agree that neonates prenatally exposed to alcohol or illicit drugs exhibit high rates of intrauterine growth impairment, prematurity, and impaired neurobehavioral functioning.5,6,7,10 Recent

Received for publication Apr 1, 1986; accepted Apr 2, 1986.

Reprint requests to [LLC], National Association for Families and Addiction Research and Education, 122 S Michigan Ave, Suite 1038, Chicago, IL 60603.

PEDIATRICS (ISSN 0021-4958) Copyright © 1986 by the American Academy of Pediatrics.

COMMENTS 145
long-term studies have revealed that prenatal drug exposure has a direct impact on the child's behavior at 4 to 6 years of age, with prenatally-exposed chil-
dren showing significantly high rates of depression and anxiety, aggressive behavior, thought problems, impulsivity, and distractibility. In addition, the
mother's continuing drug use during the early child-
hood years is a major factor that predicts the child's level of cognitive functioning at school age. Beyond the scope of the individual child, sub-
stance abuse in families has overwhelmed the child
welfare system. With 2-500,000 children now in fos-
ter care in the United States, it is the fastest-growing
entitlement in government, far outpacing Medicaid and
Medicare. Infants removed from their homes
because of substance abuse problems in the family
are a huge proportion of this growth. In fact, nearly
half the states report that substance abuse is the
dominate characteristic in Child Protective Services
(CPS) caseloads. In 1991, it was estimated that 55% of
the very young children placed in substitute care had
been prenatally exposed to cocaine or cocaine deriv-
atives, and another 11% had been exposed to alcohol
and other drugs. In 1992, it was reported that up to
80% of the children in substitute care were placed
there because of substance abuse-related reasons.
In studies of the association between substance
abuse and child abuse, researchers have found that
children born to substance-abusing women have a
rate of physical abuse two to five times higher than
matched children from similar backgrounds but with
no history of prenatal drug exposure. The National
Committee for Prevention of Child Abuse has
estimated that 675,000 children are seriously mis-
treated annually by an alcoholic or drug-abusing
caretaker. Using data from the National Institute
for Mental Health's Epidemiologic Catchment Area
survey, researchers recently found that about half of
abusive or neglectful parents have "a lifetime prev-
alence substance abuse disorder." When other fac-
tors were taken into account, substance-abusing par-
ents were approximately three times more likely to
abuse or neglect their children than nonsubstance
abusers.
In addition, studies of marijuana, cocaine, and
amphetamine smoke is probably the most common
method of a child's passive intoxication, but there
are also reports of children being exposed to illicit
drugs through breastfeeding, accidental in-
gestion, and forced feeding. We have no information
on the long-term implications of chronic inhalation
or ingestion of illicit drugs, but based on our current
understanding of the pathophysiology of these sub-
stances, we can recognize the imminent danger to a
young child's development.

PROTECTING CHILDREN: WHEN SYSTEMS
COLLIDE
The question of exactly what parental behaviors
during or after gestation require protective interven-
tion and the question of risk associated with the
child's use of legal drugs such as tobacco
or alcohol during pregnancy or in the growing
child's household. This dilemma of defining high-

risk behavior is bolstered by physicians' general lack of
knowledge about addiction and about referral
options, a lack of confidence in treatment programs,
and an assumption that substance use is not preva-
ent among their own patients. These issues con-
verge to result in a very low rate of intervention be-
tween families and physicians regarding substance
abuse problems, leaving us only with legal alterna-
tives. But we turn to a purely legal approach to
resolve the conundrum of substance abuse and child
abuse, we will find that when public law replaces
the health, the law becomes a very blunt instru-
ment. To complicate matters further, when interventions
for a substance-abusing family are initiated, multiple
systems—health care, child welfare, legal, substance
abuse treatment—become involved in the care of
that family, and friction frequently arises (Table 1).
Each profession speaks a language that supports its
own goals: law is about enforcement of rights and
responsibilities; health is about healing; child welfare
is about protection; substance abuse treatment is
about sobriety. The ultimate goal—protection of the
child—is lost in a morass of bureaucracy and, often,
incriminations.

PREVENTION AS A MORAL OBIGATION
The author Jonathon Kozol speaks of silent vio-
lence as a violence of inaction. This tendency to
inaction, especially in situations in which substance
abuse is present in a family, has become a character-
istic of the health care system. The Lustbader article
serves notice, however, that significant numbers of
children are being exposed to toxic substances dur-
ing early childhood. The physiologic impact of that
exposure is not fully understood, but the relational
impact is clear: the child who is exposed to drugs
is at high risk for abuse, neglect, and behav-
ioral problems that may interfere with long-term
academic, emotional, and social development. Is this
a compelling reason for the state to enter family life
at the infant's birth if the mother used drugs during
pregnancy, or in the child's early years if he is found
to be exposed to a toxic environment, and then to
prescribe how the child shall be raised? What is a
moral decision when there is a moral right on both
sides of the issue, one side being the need for early
intervention on behalf of the child, the other being
the sanctity of the family and the right to raise chil-
dren according to one's own beliefs? This is
the quandary.

Given the complexity but immediacy of this issue,
I propose that if a young child presents with a pos-
itive urine toxicology or a young child's family is
found to be using illicit drugs or abusing alcohol, the
family should be referred to treatment. If the family
refuses treatment or fails to comply with treatment,
CPS should be notified. For a first report to CPS, the
family should be evaluated and referred to a struc-
tured educational and/or treatment program. If the
family does not participate fully in treatment or con-
tinues to use drugs or alcohol, although family mem-
bers have been offered treatment, parental rights
<table>
<thead>
<tr>
<th>Child/Health/Welfare</th>
<th>Substance Abuse Treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target population</td>
<td>Substance-abusing adult</td>
</tr>
<tr>
<td>Mandate</td>
<td>Substance/dependence</td>
</tr>
<tr>
<td>Perception</td>
<td>Addiction is a weakness.</td>
</tr>
<tr>
<td>Criteria</td>
<td>Relapse is failure.</td>
</tr>
<tr>
<td>Major goal for family</td>
<td>Protect the child from harm.</td>
</tr>
<tr>
<td>Long-term perspective</td>
<td>Substance abuse is a marker of risk for child abuse and for health and behavioral problems for the child.</td>
</tr>
</tbody>
</table>

Parents are thus under obligation to make significant progress toward treatment goals within 1 year if they wish to keep their children. No one knows how this approach will work, but it cannot work unless there is a twist and thorough initial needs assessment of families reported to the child welfare system and credible treatment opportunities for the families.

The decisions that health care and social service professionals must make on a daily basis are becoming progressively more complex and more intricate. We find ourselves knowing in our hearts what we believe, knowing through our advocacy what we support, but lacking many of the basic facts that must inform our actions. By improving access to treatment but tightening the consequences for parents who fail to take advantage of opportunities for treatment, we build on what knowledge we have, even though there is, and always will be, more to be discovered. Above all, we do know that there is an indubitable connection between child abuse and substance abuse. Silence may be violence.

ISA J. CHAMOFF, MD
National Association for Families and Addiction Research and Education
Chicago, IL 60603

ACKNOWLEDGMENTS
Supported by Grant Nos. S18 U70005 from the US Department of Education, Safe and Drug Free Schools and Communities Program.

The author thanks Judith Lassen, JD, for her thorough review of this manuscript.

REFERENCES

COMMENTS: 147