MINUTES OF THE MEETING
PUBLIC HEALTH, WELFARE AND SAFETY COMMITTEE
MONTANA STATE SENATE

JANUARY 16, 1985

The meeting of the Public Health, Welfare and Safety Committee was called to order by chairman Judy Jacobson on Wednesday, January 16, 1985 in Room 410 of the State Capitol Builing at 1:00 p.m.

ROLL CALL: All members were present for the meeting, however, Senators Newman and Towe arrived late. Karen Renne, staff researcher, was also present.

There were many, many visitors in attendance. See attachments.

CONSIDERATION OF SENATE BILL 80: Senator Judy Jacobson of Senate District 36, the sponsor of SB 80, gave a brief resume of the bill. This bill is an act to revise the penalty for violation of the child safety restraint law by requiring citation instead of warning for a first offense.

Senator Jacobson stated that this bill amends the child safety restraint bill from last session. The current law requires a warning be issued on the initial violation. The Highway Traffic Safety Department does not have an adequate record system to keep track of the warnings, and therefore, are not punishing repeat offenders. The bill would require that first time offenders be given a citation which would be dismissed if the offender corrects the problem within 30 days.

Al Goke, administrator of the Highway Traffic Safety Department, stood in support of the bill. The child safety retraint law has worked quite well. Activity in the number of loan rental programs and the infant seat unit capacity has increased a great deal over the past two years. Many pamphlets were distributed through law enforcement agencies. He also stated that the state does not have an adequate recording system to keep track of the warnings and repeat offenders are not being punished. Mr. Goke stated that a survey was made in September and at the time there was 71% compliance with the present law. There is nothing in this bill that would keep a law enforcement officer from giving a warning.

With no further proponents, the chair called on the opponents. Hearing none the meeting was opened to a question and answer period from the committee.

Senator Stephens asked how many warnings were issued this last year. At least 500 warnings were issued this past year.

Senator Himsl asked about the compliance with the law. Mr. Goke stated that at the present time there is 71% compliance, however, he would like to have 80% compliance.

Senator Himsl asked about the law being a "heavy hand" with this bill. The citation may be revoked if the offender corrects the problem within 30 days. This bill would just simplify the problem of tracking those individuals who are repeat offenders.

Senator Himsl asked which court would handle this problem. It would either be justice court or district court depending on where the problem occurred.

Senator Norman asked where the fine money goes. He was told that the money is handled differently at different levels, however, it is handled like a traffic fine.

Senator Jacobson closed. She handed out a magazine article entitled "The Use and Efficacy of Child Restraint Devices". See attachments.

CONSIDERATION OF SENATE BILL 19: Senator J. D. Lynch of Senate District 34, the chief sponsor of SB 19, gave a brief resume of the bill. This bill is an act establishing and funding a child abuse prevention program. granting rulemaking authority; requiring mandatory fines for certain offenses against children.

Senator Lunch stated that this bill is a sincere attempt at prevention of child abuse. The Fiscal Note is based on other states the size of Montana. This bill is not an attempt of partisan nature. The funding was discussed by Senator Lynch. This bill has definite merit and he stated that he hoped the entire legislature would give the bill favorable consideration.

Representative Steve Waldron of Missoula County, stood in support of the bill. He stated that he would like to see the bill amended regarding the financial sources. If the money would be put into the general fund from birth certiciates, divorce petitions, marriage certificates, and also check-offs on tax forms then it could flow out through grants. If it were being handled in the general fund there would be no chance of legislative oversight.

Representative Gerry Devlin of Terry stood in support of the concept of the bill. He stated that he has a bill of this nature in the House, however, it has a different funding mechanism. Representative Devlin stated that he would like to see one of the bills passed this session.

Bill Thomas, representing the Children's Trust Fund Steering Committee, stood in support of the bill. He stated that everyone is alarmed at the dramatic increase in reports of child abuse and neglect in recent years. Behind each of these reports is a family and a child in pain. Research indicates that for every one report that is received there are four others that go unreported. The future cost to the well-being for the family, the child and to their community can only be guessed.

Social Service agencies are hard pressed to help these increasing numbers of children and their families. After attending to immediate treatment needs, little time or resources are left for the prevention of child abuse and neglect. Prevention, stopping child abuse and neglect from occurring in the first place makes good sense.

A Children's Trust Fund would provide a powerful incentive for Montana communities to reach out and help families improve themselves and help stop child abuse and neglect. If the state is going to set a Children's Trust Fund, it needs to be done well. It will take a sizeable investment of stable funding. A $250 thousand per year, would not be too much if everyone is really serious about preventing child abuse and neglect and strengthening the families. It will require on-going public involvement in the trust. Mr. Thomas handed in written testimony to the Committee for their consideration. See attachments.

Cindy Gathwait representing the Parents Anonymous of Montana, stood in support of the bill. She stated Parents Anonymous is a self-help program for families who find themselves caught in the cycle of child abuse and neglect and for families who wish to prevent themselves from becoming abusive. She spoke as a professional caregiver---a social worker who has worked in the child abuse and neglect field for 5 intense, frustrating and rewarding years. As a mother of two sons and a former victim she has a large interest in this bill. She was sexually abused by a relative. Her concerns and knowledge are therefore, a result of both personal and professional experiences. Without exception, each parent she has worked with has had a history of abuse as a child. These parents find themselves repeating that same pattern of abuse with their own children. They are desperate to find a way out of this abusive cycle and to prevent the next generation from inheriting these same problems. They have reached out for help many times and found none.

When they are able to find help, in a parenting class or Parents Anonymous, they are able to curb their abuse and replace it with positive parenting methods. They can then become peer counselors to other parents struggling to avoid abuse in their families. It is possible to prevent child abuse and neglect. One must build on that knowledge and apply what is learned to real parents with real children and real needs. We all have the ability to create the kind of climate in which the seeds of prevention can grow. The Children's Trust Fund can help accomplish this by providing funds to local groups who care about children and who have ideas for prevention programs but do not have the money to implement them. The Children's Trust Fund is not the total answer, however, it is a start. Mr. Gathwait handed in written testimony to the Committee. See attachments.

Valerie Murphy of Missoula stood in support of the bill. She stated that she is excited to think that there could be something in our communities as valuable as abuse prevention programs. It is a vitally important step in helping children recognize and perhaps stop abuse or potential abuse in their lives.

Five years ago at age 28, Mrs. Murphy began a process of identification for herself and it has been a long, hard ordeal requiring her to not only face her abusive past but to face her own abusive parenting as well. She came from a home where there was emotional, physical and sexual abuse. After age 11 when she was sexually molested by her father over a period of time, she quit growing emotionally. She had already been stunted emotionally from the first 10 years of living in his rejection. The pain involved with dealing with the past was overhelming much of the time bringing her to the brink of suicide at one point. She felt that she could not live with the pain any longer and did not see an end to it ever. 18 years of keeping a secret about incest thinking she was alone. Eighteen years of denying and stuffing down the rage came rushing out in such a flood that it literally knocked her off her feet. For months she was barely able to make it through each day. She felt incapable of getting up in the morning and unable to face a new day. Nighttime was worse, each night she woke up after a few hours of sleep to lie awake while the memories played over and over in her head. She could not shut them off once they were allowed to surface. She felt that she was going insane. Two years later she had sufficiently recovered from that experience to begin looking at the present and the fact that she was an abusive parent.

She was determined to not repeat the past -- she wanted to give her child a more positive home environment and future. The last three years have been spent working on parenting skills through Parents Anonymous, private counseling and in sharing her experiences with others privately and publicly.

The importance of sharing the details with the Committee stems from the strong belief that this story should not have to be repeated for the children of today. There are alternatives to keeping our children ignorant and, therefore, helpless victims. There are alternatives to burying our heads in the sand hoping the situation will go away if we just don't put ideas in anybody's head. There are alternatives to forcing our easily molded children into lies and supressed anger only to have abuse be passed on from one generation to the next. Those alternatives start with prevention through education. Senate Bill 19 will help establish the Children's Fund. Mrs. Murphy handed in written testimony to the Committee for their review. See attachments.

Gloria Sprague representing the Junior League stood in support of the concept of the bill. She stated that 1 in 4 girls and 1 in 7 boys are abused before they reach the age of 18.

Gail Kline representing the Women's Lobbyist Fund stood in support of the bill. She stated that "An ounce of prevention is worth a pound of cure". In child abuse this is especially true for our children and grandchildren.

Researchers from the University of New Hampshire, Rhode Island, and Delaware conducted a study of family violence into the lives of 2,143 families. A conclusion of the study is that "Adults who were frequently abused by their parents as teenagers have a spouse beating rate four times greater than that of other adults". Adults who tend to abuse their spouses tend to be abusive parents and the cycle repeats. This bill, based on other state laws, provides its own funding mechanism that is reliable and on-going and seems to be adequate to meet the needs of the program. Ms. Kline urged support of the Committee for SB 19.

Karen King of Glendive stood in support SB 19. She is a child abuse and battered spouse educator and herself as a victim. She asked the Committee to please stop this terrible repeating cycle.

Norma Harris, representing the Social and Rehabilitation Service, stood in support of the concept of the bill. She stated that prevention is needed.

Bob Johnson of Helena stood in support of the concept of the bill. He stated that Lewis and Clark County Health Department has a very good prevention program in Helena at the present time. He urged the Legislators find some money from somewhere for the program. He encouraged a review at the lower level.

Jennifer Harvey of the Children's Trust stood in support of the bill. She stated that long term effects are needed. SRS lacks the staff needed to help the troubled families.

Chad Smith representing the Montana Hospital Association stated that he supports the concept of the bill as the hospitals see the results of child abuse. However, he was concerned saying the fee charged for birth cetfficates would endanger the accuracy of record keeping. Many county officials with whom certificates are filed have no system for ensuring the proper collection of money.

Dr. Bailey Molineaux a psychologist from Helena stood in support of the concept of the bill.

Phil Campbell representing the Montana Education Association stood in support of the bill.

Tom Drugger representing the National Association of Social Workers and the Montana Residential Child Care Association stood in support of the bill and complimented Senator Lynch for the work he has done on the bill.

Judy Olsen representing the Montana Nurses Association stood in support of the bill and also complimented Senator Lynch for sponsoring such a bill.

With no further proponents, the chairman called on the opponents.

John Wilson, chief of the state Bureau of Records and Statistics, stated that the birth certificate fees would discourage many people from filing a certificate when a child in born outside of the hospital or to an unwed mother. Mr. Wilson is not against the concept of the bill, however, he is very concerned with the portion on birth certificates. Birth certificates are needed for many things such as: social security, pass ports, marriage license, driver's license, entering school and many other times during a person's life. Some registrars may not be bondable. He stated that he has seen nothing in his 36 years of statistical work that poses such a serious threat to accurate registration.

Senator Ethel Harding of Polson stood in opposition to the birth certificate problem, however, she is in support of the concept of the bill. She expressed concern that if this bill is passed as is, some people would not bother to register the birth of their children when they are born at home or out of wedlock.

With no further opponents, the meeting was opened to a question and answer period from the committee.

Senator Towe asked about the problem brought up regarding the fees charged for birth certificates. Senator Lynch stated that this bill is not going to colapse the vital statistics of the State of Montana.

Senator Stephens stated that child abuse is a ghastly subject and a very serious problem but that he is concerned the fee system would really foul up the state's statistics and records.

Senator Hager asked if there could be an indengecy clause if a person was unable to pay for the birth certificate registration.

Senator Stephens asked how SRS is doing this at the present time and also about the funding as called for in the bill. Mrs. Harris stated that SRS would not need any more staff than they presently have to handle the provisions of this bill, much would be handled at the local level.

Senator Himsl asked about the Parents Anonymous Groups. There are chapters in Missoula, Great Falls, Billings, Kalispell, Hamilton, Anaconda, Butte, and Chinook.

Senator Lynch closed. He stated that there is a real compeling need for a Children's Trust Fund. He is willing to work with all those concerned about the funding of the bill to work up amendments to make it a good bill. He urged the Committee to support Senate Bill 19.

ACTION ON SENATE BILL 54: This bill is an act to make it a felony to purposely or knowingly abuse, neglect, or exploit a person 60 years of age or older.

A motion was made by Senator Towe that the bill be amended on page 2, line 19, following: "Any"; Strike: "person"; insert: "individual"; and Page 2,line 21; following, "conviction"; strike: "must"; insert: "may". Motion carried.

A motion was made by Senator Lynch that SB 54 receive a do pass recommendation from the Committee.

Senator Himsl stated that he has some concern regarding how this bill will affect nursing homes.

Senator Lynch called for the question regarding the Committee giving Senate Bill 54 a DO PASS AS AMENDED recommendation. Motion carried with a 5-3 Roll Call Vote taken. See attachments.

DISCUSSION ON SENATE BILL 79: This bill is an act providing for the licensure and regulation of occupational therapists and occupational therapy assistants; creating a Board of Occupational Therapy Practice, and providing an immedate effective date.

Senator Lynch stated that he is not ready to take action on this bill as he doing some more research.

Senator Jacobson announced that the Committee would hold this bill a little longer in consideration of Senator Lynch.

ANNOUNCEMENTS: The next meeting of the Public Health, Welfare and Safety Committee will be held on Friday, January 18, 1984 to take executive action on some of the bills in Committee.

ADJOURN: With no further business the meeting was adjourned.

Judy Jacobson
CAHIRMAN, SENATOR JUDY JACOBSON

eg

ROLL CALL VOTE

SENATE COMMITTEE PUBLIC HEALTH, WELFARE AND SAFETY

Date JANUARY 16, 1985 SENATE Bill No. 54 Time 2:30

NAME	YES	NO
SENATOR JUDY JACOBSON, CHAIRMAN	✓	
SENATOR J. D. LYNCH, VICE CHAIRMAN	✓	
SENATOR TOM HAGER	✓	
SENATOR MATT HIMSL		✓
SENATOR TED NEWMAN		✓
SENATOR BILL NORMAN	✓	
SENATOR STAN STEPHENS		✓
SENATOR TOM TOWE	✓	

Elaine Graveley
Secretary, ELAINE GRAVELEY

Judy Jacobson
Chairman, SENATOR JUDY JACOBSON

Motion: A motion was made by Senator Lynch that SB 54 receive a DO PASS AS AMENDED recommendation from the Committee. Motion carried.

ROLL CALL

PUBLIC HEALTH, WELFARE & SAFETY COMMITTEE

49th LEGISLATIVE SESSION -- 1985 Date 1-16-

SENATE SEAT #	NAME	PRESENT	ABSENT	EXCUSED
6	SENATOR JUDY JACOBSON, CHAIRMAN	✓		
5	SENATOR J. D. LYNCH, V.CHAIRMAN	✓		
42	SENATOR TOM HAGER	✓		
30	SENATOR MATT HIMSL	✓		
17	SENATOR TED NEWMAN	late		
45	SENATOR BILL NORMAN	✓		
14	SENATOR STAN STEPHENS	✓		
26	SENATOR TOM TOWE	late		

Each day attach to minutes.

STANDING COMMITTEE REPORT

JANUARY 16, 19 85

MR. PRESIDENT

We, your committee on PUBLIC HEALTH, WELFARE AND SAFETY

having had under consideration SENATE No. 54

FIRST reading copy (WHITE color)

FELONY TO ABUSE, NEGLECT, OR EXPLOIT A PERSON 60 OR MORE YEARS OLD

Respectfully report as follows: That SENATE No. 54

be amended as follows:

1. Page 2, line 19.
Following: "Any"
Strike: "person"
Insert: "individual"

2. Page 2, line 21.
Following: "conviction"
Strike: "must"
Insert: "may"

AND AS AMENDED
DO PASS

SENATOR JUDY JACOBSON Chairman.

DATE ____________________

COMMITTEE ON ____________________

VISITORS' REGISTER

NAME	REPRESENTING	BILL #	Check One: Support	Check One: Oppose
Charles & Betty McCarthy	self	SB 19		
Karen E. King	self	SB 19		
[illegible] McCarthy	Local Registrar	SB 19		✓
Albert Goke	Highway Traffic Safety	SB 80	✓	
Fran Manes	"	SB 80	✓	
John Wilson	Health & Env. Sciences	SB 19		✓
David Lackman	Mont. Public Health Assn	SB 80	✓	
Jean Thomas	First United Methodist Church	SB 19	✓	
Bill Thomas	CTF Steering Cmte	SB 19	✓	
Valerie Murphy	self	SB 19	✓	
[illegible] Kline	WLF	SB 19	✓	
Gloria Sprague	Butte Junior League	SB 19	✓	
Anne Medsky	WLF	SB 19	✓	
Susan Mathews	Mt Med. Assn Aux.	SB 19		
Chief Smith	Mont. Hosp Assn	SB 19		amend
J. Leenhook	Mt. Rehab. Assn	SB 80	✓	
[illegible] Carlson	Mt. Ch. NASW + Assn of Local Health Dept	SB 19	✓	
[illegible]	self	SB 19		
[illegible]		SB 19	✓	
[illegible]	Children's Trust Fund	SB 19	✓	
Robert R. Johnson	L&C County [illegible]	SB 19	✓	
B. Mowmoux	[illegible]	SB 19	✓	
Norma Harris	SRS	SB 19	X	
Tom Dwyer	NASW [illegible]	SB 19	X	
Nannie Donnelly	MACo	SB 19		—
[illegible]	Montana [illegible]	SB 80 SB 19	X	

(Please leave prepared statement with Secretary)

editorials

Bless the Seats and the Children: The Physician and the Legislative Process

The care of human life and happiness, and not their destruction, is the first and only legitimate object of good government.

THOMAS JEFFERSON

Motor vehicle accidents are the leading cause of death and injury for all children beyond infancy,[1] and more than 90% of children ride unprotected in automobiles.[2] Physicians have recognized that the current epidemic of highway casualties among our very young is essentially preventable and that state-by-state child restraint laws are the most practical approach to "immunizing" most of these children against their leading killer.

Since the nation's first child-restraint legislation, the Tennessee Child Protection Act, was implemented in January 1978, 49 states have enacted similar laws. In each state, pediatricians and other physicians have played a key role in lobbying for this effort. This heartening experience should stimulate physicians of all specialties to consider extending these laws to protect older children and adults from the carnage witnessed daily on our streets and highways.

The remarkable dividends resulting from the Tennessee law, as reported in this issue (p 2571) by Decker et al,[3] document the merit of physician participation in safety legislation. Thus, we will review the Tennessee experience as a guide for future, inevitable legislative struggles.

The idea for legislation requiring the protection of small children while riding in automobiles evolved in 1974 as a recommendation from the Tennessee State Health Planning Council.[4] Ironically, a legislative committee of this council in 1975 failed to approve this proposal, suggesting instead "educational" avenues. This detour in preventing unnecessary morbidity and mortality occurred despite evidence that during the three-year period from 1973-1975, almost 70 children younger than 5 years were killed in Tennessee automotive accidents and some 3,000 suffered serious injuries.[5]

Thus, the thrust for a means of protecting small children was a challenge accepted by the Tennessee Chapter of the American Academy of Pediatrics. Their arguments in favor of a *legislative* approach were that (1) educational efforts to convince adults to use seat belts had been notably unsuccessful; (2) restraint devices were known to reduce the chance of death by 90% and injury by 80%[6]; (3) hospital and rehabilitation costs for accident victims are enormous; (4) young children, safely restrained, are better behaved during travel than unrestrained young riders[7]; (5) unrestrained children are responsible for some accidents by disturbing the driver and, as flying missiles, injure other passengers during collision[8]; and (6) most other industrialized nations mandate seat belt use. (The jurisdictions with seat belt laws, 1971 to 1984, are Australia, Austria, Belgium, Bulgaria, Canada (eight provinces), Czechoslovakia, Denmark, England, Finland, France, Hungary, Ireland, Israel, Japan, Luxembourg, Malaysia, the Netherlands, New Zealand, Norway, Portugal, Puerto Rico, South Africa, Spain, Sweden, Switzerland, USSR, and West Germany.)

The initial legislation required all children younger than 4 years to be restrained in car seats while riding in any vehicle. The bill was killed in committee. The reasons stated for its premature death were reservations concerning individual liberties, difficulties in enforcement, and potential economic burden on low-income families.

However, during the next year, a major "grass roots" movement was started by a small but dedicated band of physicians and safety advocates. The law was rewritten to focus on the family unit, endorsements were obtained from the state's major medical and safety organizations, "fact sheets" were supplied to key pediatricians throughout the state for strategic distribution to legislators and the media, and presentations before legislative committees featured testimony from parents whose children had been severely injured in motor vehicle accidents (with a number of physicians present to "eyeball" committee members). Media coverage of the hearings and floor debates was also felt to exert favorable influence.

But the important factor in convincing elected officials that the legislation had merit was direct contact by constituent pediatricians and other physicians. That busy physicians would appeal to legislators in regard to a political issue that wasn't self-serving, except for the safety of little children, was considered refreshing by many Tennessee lawmakers.

The bill was passed in 1977. Unfortunately, an amendment (introduced by a legislator who recounted that his most joyous experience was seeing his newborn grandchild come home in his mother's arms) was attached allowing adults to hold small children in their laps. Subsequent accident experience demonstrated that these "babes in arms" were at extraordinarily high risk, and the loophole was removed in 1981.

Dividends from the Tennessee law have been gratifying. Use of "kiddie car seats" has notably increased, deaths and injuries have been reduced, and enforcement innovations by state troopers have received commendation from the nation's safety community. Central in this national effort has been the American Academy of Pediatrics, which along with other medical and safety organizations bolstered the thrust for widespread enactment and implementation.

Many physicians and safety advocates believe it is now timely and politically palatable to encourage state legislatures to assert themselves further in the protection of older children and adults. Two recent events support this premise. The state of New York has enacted the nation's first mandatory seat belt law, and the Department of Transportation has issued a requirement for the gradual introduction of air bags or passive restraint devices into new automobiles, unless a significant number of states (accounting for two thirds of the US population) approve mandatory seat belt laws by April 1989.

The Tennessee experience demonstrates that reduction in

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child restraint device virtually eliminates the risk of death in a motor vehicle accident. Based on the deaths of 17 of the 558 child restraint device nonusers, we would have expected 13 of the child restraint device users to have died in 1982 through 1983. Since 1977, however, only two children younger than 4 years have died in Tennessee while properly restrained in a child restraint device. Inasmuch as none of the 433 children younger than 4 years who were in a child restraint device died during the study period, it is not possible to calculate a meaningful odds ratio from the 1982 through 1983 data alone. A previous analysis[10] of child restraint device report form data for the years 1978 through 1980, which included the two deaths, found that two (0.57%) of 350 child restraint device users died compared with 33 (3.4%) of 964 child restraint device nonusers. If these earlier data are aggregated with our own, we find that 0.26% of 783 child restraint device users died, compared with 3.3% of 1,522 child restraint device nonusers (odds ratio, 10.7; $P \ll .001$). In a study of 39,500 children aged 0 to 4 years involved in motor vehicle accidents in Washington State in the years 1970 through 1979,[11] it was found that two (0.032%) of 6,300 child restraint device users died, compared with 146 (0.44%) of 33,346 child restraint device nonusers (odds ratio, 11.1; $P \ll .001$). The fatality rates reported for the Washington analysis are lower than those we report because their study included all accidents, whereas the child restraint device report forms on which our study is based tended not to be filed for minor accidents. Nonetheless, each analysis yielded the same conclusion: children younger than 4 years not protected by child restraint devices are 11 times as likely to die in a motor vehicle accident as children using child restraint devices.

The protection afforded by child restraint devices is not limited to virtually abolishing the risk of death, however. Although perhaps less tragic, injuries as a result of motor vehicle accidents are far more numerous than deaths. For the period 1982 through 1983, seventy-one percent of the children younger than 4 years using child restraint devices were uninjured (Table 3), compared with 45% of the children not using child restraint devices (odds ratio, 2.9; $P \ll .001$). Furthermore, the injuries suffered by children not in child restraint devices were more severe (mean injury score, 1.22) than those suffered by children in child restraint devices (mean injury score, 0.52; $P \ll .001$). Statewide data from the Tennessee Department of Safety for the period 1982 through 1983 show that 1,702 children younger than 4 years were injured in motor vehicle accidents. If we assume that the overall statewide use rate of child restraint devices by children younger than 4 years was 30% in 1982 through 1983, we can calculate that without any child restraint device use, 31 deaths and 1,958 injuries would have occurred. Child restraint device use in this two-year period thus is estimated to have saved 13 lives and prevented 256 injuries, as well as reducing the severity of another 149 injuries. Had all children younger than 4 years been transported in child restraint devices in 1982 through 1983, we would have expected no deaths and 1,104 injuries, all of which would have been of lesser severity than if no child restraint device had been used.

A study of the costs associated with various important sources of health impairment[12] found that the direct costs associated with motor vehicle accident injuries in 1975 averaged $1,118 per person injured, primarily for medical care. A 1983 study of children between 1 and 4 years of age admitted to a St Louis hospital during a six-month period because of motor vehicle accident injuries found that direct medical care costs averaged $6,226 per child.[13] Given the inflation in medical care costs during the last decade and the evidence that children under 4 years suffered, on average, more severe injuries than adults when involved in motor vehicle accidents, these two estimates appear to be compatible. If we make no attempt to assign a dollar value to the lives saved, but simply assume that each injury prevented by use of a child restraint device saved $6,000 in direct medical care costs, and each injury reduced in severity saved half that amount, then the use of child restraint devices saved $2 million in Tennessee in 1982 and 1983 alone. Had all children traveled in child restraint devices in 1982 and 1983, the total savings in direct costs of medical care for the injured would have been $8.4 million. Many of these costs are borne directly by the taxpayers through Medicaid and other government-supported health care programs; another portion is paid indirectly by the public through higher insurance premiums. It is instructive to calculate that presenting a new $40 child restraint device to each of the 65,000 children born in Tennessee each year would cost only $2.6 million; the benefits would include the saving of lives as well as of dollars.

Child restraint devices are not appropriate for use by children between the ages of 4 and 14 years, of whom 39 died and 3,302 were injured in Tennessee motor vehicle accidents in 1983 alone. Our data (Table 4), however, show that seat belts are as effective for this age group as child restraint devices are for the younger children. Unlike child restraint devices, seat belts are already installed in virtually all automobiles. Extending the protection of the Child Passenger Protection Act to these older children through requiring the use of these belts would, at no cost, have the potential to reap enormous benefits in lives saved, injuries prevented, and expenses avoided.

The Tennessee Department of Safety, particularly the Planning and Research Office of the Highway Patrol, assisted with this study.

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and generous policy has facilitated enforcement of the Child Passenger Protection Act.)

Previous studies of child restraint device use have employed observational techniques, which depended on slower-moving vehicles and predominantly evaluated local traffic. This study, based on accident data primarily supplied by state police, reflects a larger proportion of high-speed interurban traffic. The rates of child restraint device use presented herein are higher than those found in the observational studies, which may be due to a greater propensity to use child restraint devices during interurban trips. The accidents reported through this system tended also to be more severe than the statewide average, which would have the effect of making more apparent the differences in efficacy of the various forms of restraint.

Although the Child Passenger Protection Act has strikingly increased the use of child restraint devices, it has not altered the tendency for them to be used primarily for the very youngest children. A 1974 study found that, while 10% of children below age 2 years were properly restrained, only 4% of those aged 2 years and 1% of those aged 3 years were similarly protected.[8] Our data also showed a decline in use with increasing age (Fig 2) and a corresponding rise in the proportion of children traveling unrestrained. In addition, the proportion of children below age 4 years traveling in seat belts rose with increasing age. The injury data, however, demonstrated that seat belts were less protective than child restraint devices for all ages of children below age 4 years. For children aged 4 years and older, on the other hand, seat belts were associated with a lower injury rate than child restraint devices. The application of the Child Passenger Protection Act to children younger than 4 years thus seems precisely appropriate: these children are best protected with child restraint devices, whereas children older than age 4 years (and adults) are best protected with seat belts.

Children younger than age 4 years traveling with drivers who were not wearing their seat belts were more than four times as likely to be left entirely unrestrained as were children traveling with belted drivers. The unrestrained adults, however, were not exposed to the same risk of injury as the unrestrained children (Table 4). Indeed, the odds of visible injury or death were twice as high for the unrestrained children younger than 4 years as for the unrestrained adults ($P \ll .001$).

Regardless of their form of restraint, children are safer when traveling in the rear seat rather than in the front seat. Although our data indicate that placement of the child to the side rather than in the center affords additional safety, this was not found in an earlier study[9] and merits further research.

A particularly troublesome aspect of the child restraint question is the sentiment that the best place for a baby to travel is in its mother's arms. Proponents of this view have not been easily swayed by studies that have shown that no human can successfully hold on to even a 4.5-kg child under the stress of the decelerative forces involved in a 30-mph crash, and that the adult holding the child usually becomes a huge blunt object that crushes the baby against the dashboard. After passage of the original Child Passenger Protection Act containing the "babes in arms" clause, the proportion of children under age 4 years traveling in this fashion rose in Nashville from 24% to 38%.[6] Subsequent to the removal of this waiver from the Child Passenger Protection Act in 1981, the proportion of children traveling in the arms of a passenger has declined. Of the children younger than 4 years who were in accidents reported through a child restraint device report form, 13% in 1982 and 8% in 1983 were being held in a passenger's arms at the time of the accident. These children suffered injuries and death at a rate approaching that of entirely unrestrained children. The inability of an adult to protect a child in a crash is demonstrated by the fact that there was no significant difference in the rate of ejection from the vehicle between children held in arms and children left entirely unrestrained.

Perhaps the most impressive result of the Child Passenger Protection Act is found in the evidence that use of a

Table 3.—Frequency and Severity of Injuries Associated With Various Methods of Restraint for Children Younger Than 4 Years

Injury Severity Code*	No. (%) of Children			
	No Restraint	Held in Arms	Seat Belt	Child Restraint Device
0 (none)	163 (42)	54 (51)	36 (60)	307 (71)
1 (pain)	39 (10)	7 (7)	3 (5)	43 (10)
2 (bruised)	114 (29)	27 (26)	15 (25)	67 (16)
3 (bleeding)	64 (16)	14 (13)	5 (8)	16 (4)
4 (dead)	13 (3)	3 (3)	1 (2)	0 (0)
Total†	393 (100)	105 (100)	60 (100)	433 (100)

*Complete injury codes: 0, none; 1, complaint of pain, no visible injury; 2, bruises, abrasions, swelling, limping, etc; 3, bleeding wound, distorted member; 4, dead.
†Percentages are rounded off and therefore may not add up to 100.

Table 4.—Frequency of Visible Injury or Death* Associated With Various Methods of Child Restraint

Age, yr	No Restraint		Held in Arms		Seat Belt		Child Restraint Device	
	No.	No. (%) Injured	No.	No. (%) Injured	No.	No. (%) Injured	No.	No. (%) Injured
0-3	393	191 (49)	105	44 (42)	60	21 (35)	433	81 (19)
4-15	299	109 (36)	0	0 (0)	47	7 (15)	17†	4 (24)
≥16	121	383 (32)	0	0 (0)	164	31 (19)	0	0 (0)

*Injury codes 2, 3, or 4.
†Ages of these children ranged from 4 to 7 years.

Table 5.—Frequency of Visible Injury or Death of Children Younger Than 4 Years by Seating Position

	Front Side		Front Center		Rear Side		Rear Center	
	No.	No. (%) Injured	No.	No. (%) Injured	No.	No. (%) Injured	No.	No. (%) Injured
Child restraint device	99	16 (16)	87	23 (27)	184	28 (15)	44	9 (20)
Seat belt	17	9 (53)	12	4 (33)	18	3 (17)	5	1 (20)
Held in arms	78	28 (36)	11	6 (55)	12	7 (58)	1	1 (100)
No restraint	99	50 (51)	129	70 (54)	71	24 (34)	42	17 (40)

Table 1.—Frequency of Use of Various Methods of Restraint for Children Younger Than 4 Years Old Involved in Motor Vehicle Accidents in Tennessee in 1982 and 1983

	No. (%) of Children				
	No Restraint	Held in Arms	Seat Belt	Child Restraint Device	Total*
Resident					
1982	187 (38)	63 (13)	44 (9)	196 (40)	490 (100)
1983	174 (40)	36 (8)	16 (4)	210 (48)	436 (100)
Subtotal	**361 (39)**	**99 (11)**	**60 (7)**	**406 (44)**	**926 (100)**
Nonresident					
1982	19 (63)	3 (10)	0 (0)	8 (27)	30 (100)
1983	13 (37)	3 (9)	0 (0)	19 (54)	35 (100)
Subtotal	**32 (49)**	**6 (9)**	**0 (0)**	**27 (46)**	**65 (100)**
Total*	**393 (40)**	**105 (11)**	**60 (6)**	**433 (44)**	**991 (100)**

*Percentages are rounded off and therefore may not add up to 100.

Table 2.—Relation Between Seat Belt Use by Driver and Restraint Use by Children Passengers Younger Than 4 Years

	No. (%) of Drivers Reported as Using Seat Belts		
Type of Restraint	Yes	No	*P*
Child restraint device	77 (66)	249 (40)	≪.001
Seat belt	22 (19)	23 (4)	≪.001
Held in arms	6 (5)	86 (14)	<.01
No restraint	11 (9)	263 (42)	≪.001
Total*	116 (100)	621 (100)	. . .

*Percentages are rounded off and therefore may not add up to 100.

injury or death, as compared with 100% of ten seat belt users (P=.001), 73% of 40 held in another's arms (odds ratio, 3.1; P<.001), and 83% of 130 with no restraint (odds ratio, 5.8; P≪.001).

Within each of the four restraint classifications, the risk of visible injury did not significantly differ for children younger than 1, 1, 2, or 3 years. Unrestrained children younger than 1 year, however, were significantly more likely to have died in the motor vehicle accident than unrestrained children between ages 1 and 4 years (odds ratio, 5.2; P<.01). For the 371 unrestrained children of known age, 11% of the 53 children younger than 1 year died, as compared with 4% of the 57 children aged 1 year, 2% of the 121 children aged 2 years, and 2% of the 140 children aged 3 years.

There was no significant difference between injury rates for male and female children of the same age and class of restraint.

When the frequency of visible injury or death was examined for each applicable form of restraint for persons younger than 4 years, persons aged 4 to 15 years, and persons aged 16 years or older (Table 4), it was found that the risk of traveling unrestrained was higher for children younger than 4 years than for children aged 4 to 15 years (odds ratio, 1.6; P<.002) or for persons aged 16 years or older (odds ratio, 2.0; P≪.001). There was no significant difference in the rate of visible injury for children younger than 4 years using a child restraint device, children aged 4 to 7 years using a child restraint device, children aged 4 to 15 years using seat belts, or adults using seat belts.

The likelihood of partial or complete ejection from the vehicle during an accident was strongly correlated with restraint use. Ejection occurred for 7.5% of those held in arms or left entirely unrestrained, and for 2.0% of those using seat belts or child restraint devices (odds ratio, 3.9; P≪.001). In turn, ejection was strongly associated with increased risk of injury or death. Overall, 89% of the 47 children younger than 4 years who were ejected suffered visible injury or death v 31% of the 956 not ejected (odds ratio, 17.0; P≪.001).

Regardless of the form of restraint used, the seating position of the child was found to be significantly associated with the likelihood of suffering injury (Table 5). When analyzed over the four restraint group strata, the risk of visible injury was greater for those in the front seat than in the back (odds ratio, 1.6; P<.01) and greater for those seated in the center than for those against the sides (odds ratio, 1.5; P=.01). Placement of a child in a child restraint device in the front center position exposed the child to a significantly elevated risk of visible injury as compared with the other four seating positions (odds ratio, 1.9; P<.05). Although a greater risk for the rear center as compared with the rear sides was found for child restraint device users in both 1982 and 1983, it did not attain statistical significance.

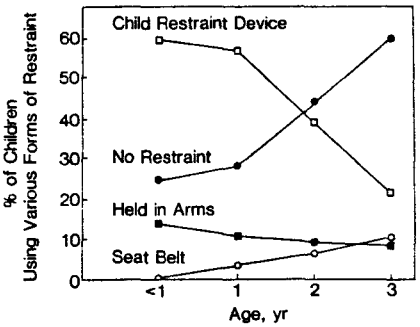

Fig 2.—Proportion of reported children who were using child restraint devices, seat belts, were held in arms, or were entirely unrestrained is shown for each year of age under 4 years.

COMMENT

The Tennessee Child Passenger Protection Act has been a remarkable success. After six years of experience with the law, motor vehicle fatalities among children younger than 4 years have been reduced nearly by half. The remaining fatalities occurred almost exclusively to those children transported without benefit of child restraint devices. The proportion of children transported in child restraint devices has steadily risen from 8% in 1977[6] to 16% in 1978[6] to 29% by mid-1980[7]; our data indicate that child restraint device use continued to increase from 1982 to 1983. These encouraging results, however, should not obscure the fact that the majority of children under age 4 years still traveled without the protection of child restraint devices; education and enforcement efforts must continue. It is noteworthy that the reduction in motor vehicle fatalities among children younger than 4 years was strongly correlated with the number of citations issued for noncompliance with the Child Passenger Protection Act. (Persons cited for violation of the Child Passenger Protection Act are offered the loan of a child restraint device. This child restraint device is reclaimed at the court hearing, and all charges and costs are dropped if the defendant shows proof of having purchased a child restraint device. This farsighted

odds ratios were determined by the Woolf-Haldane method.[45]

RESULTS

In the years 1978 through 1983, the number of children younger than 4 years who died in traffic accidents each year was 17, 22, 15, 10, 7, and 10, respectively. Of these 81 children, only two were using child restraint devices at the time of the accident. Figure 1 shows that the reduction in motor vehicle fatalities among children younger than 4 years during this period is not likely to be explained by changes in the overall pattern of traffic accidents or fatalities, the size of the population at risk, or the number of vehicle miles driven. The incidence of fatalities showed a noteworthy inverse relationship, however, with the increasing number of citations issued in enforcement of the Child Passenger Protection Act.

Restraint Use

As shown in Table 1, of the resident children younger than 4 years for whom child restraint device report forms were filed, 44% were properly restrained in a child restraint device at the time of their accident, 6% were using a seat belt, 11% were held in another passenger's arms, and 40% were entirely unrestrained. Child restraint devices were present in the vehicle but were not used for 14% of the unrestrained children. There was a significant increase in child restraint device use from 1982 to 1983, from 40% to 48% ($P<.02$), accompanied by reductions in traveling in another passenger's arms and in the use of seat belts.

The use of child restraint devices by nonresident children doubled during this period, from 27% in 1982 to 54% in 1983 ($P<.05$). This increase in child restraint device use was accompanied by a concurrent reduction in the number of nonresident children riding unrestrained, from 63% to 37%. Of these unrestrained nonresident children, 28% had an unused child restraint device in the vehicle—twice the proportion found for resident children ($P<.05$).

Use of the various forms of restraint did not significantly vary with the sex of the child, but was strongly correlated with the age of the child (Fig 2). Use of child restraint devices declined from 60% for children younger than 1 year to 22% for those aged 3 years ($P\ll.001$), while the use of no restraint rose from 25% to 60% ($P\ll.001$).

There was a strong relationship between the use of seat belts by the driver of a vehicle and the use of restraints by the children younger than 4 years in that vehicle (Table 2). Of children riding with drivers who were not using seat belts at the time of the accident, 42% were unrestrained, as compared with only 9% of the children riding with drivers who were using seat belts ($P\ll.001$).

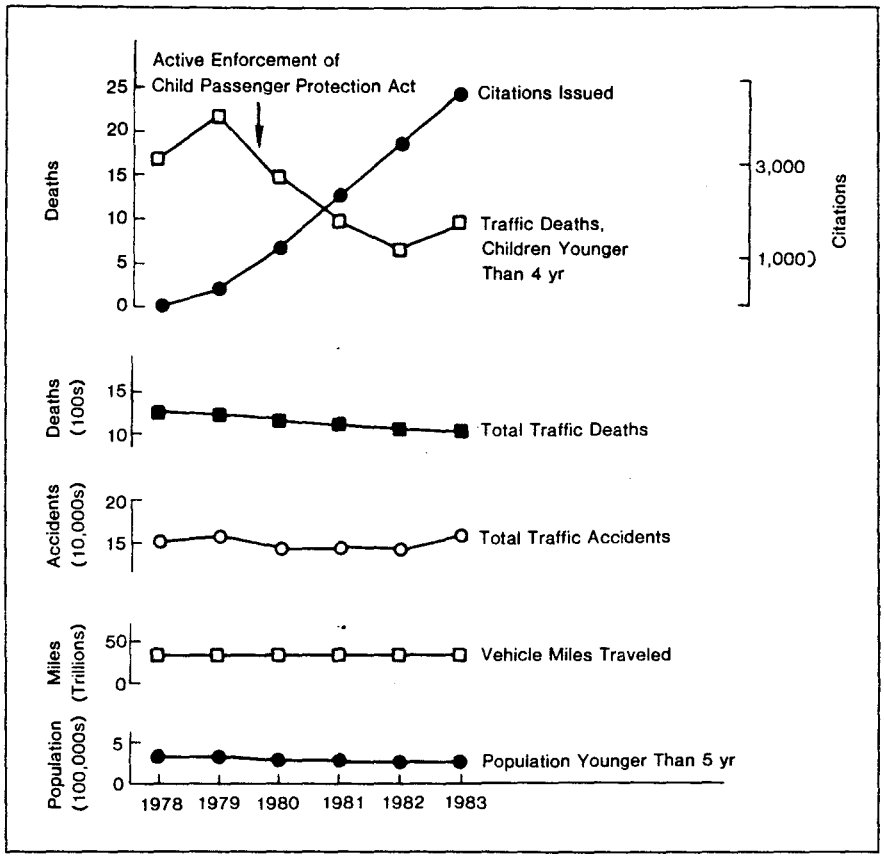

Fig 1.—For period 1978 through 1983, number of traffic fatalities in Tennessee among children younger than 4 years of age are compared with number of citations written for violation of law requiring use of child restraint devices, total number of traffic fatalities, total number of traffic accidents, total number of vehicle miles driven, and number of children younger than 5 years in state. Vertical axes are scaled to permit direct comparison.

Injuries and Fatalities

The risk of death as a result of motor vehicle accidents was highly correlated with use of the various forms of restraint (Table 3). During 1982 and 1983, no child younger than 4 years traveling in a child restraint device died in a motor vehicle accident in Tennessee. In contrast, 17 such children died while not using a child restraint device. The child restraint device report forms indicated that of the children younger than 4 years using seat belts, 1.7% died; of those held in a passenger's arms, 2.9% died (compared with child restraint device users, $P<.001$); and of those left entirely unrestrained, 3.3% died ($P<.01$).

The risk of injury also varied significantly with the form of restraint used. Visible injuries (injury code 2 or 3) occurred in 19% of the children using child restraint devices, as compared with 33% of those using seat belts (odds ratio, 2.1; $P=.01$), 39% of those held in arms (odds ratio, 2.7; $P\ll.001$), and 45% of those left unrestrained (odds ratio, 3.5; $P\ll.001$). The improperly restrained were considerably more likely to suffer serious injuries or death (injury code 3 or 4): such an outcome occurred for 4% of those using child restraint devices, as compared with 10% of the children using seat belts (odds ratio, 3.0; $P<.05$), 16% of the children held in arms (odds ratio, 5.0; $P\ll.001$), and 19% of the children left unrestrained (odds ratio, 6.2; $P\ll.001$).

The protective effect of child restraint device use was particularly apparent in the more serious accidents. When the subset of accidents in which any person in the accident suffered a serious injury or death (injury code 3 or 4) was examined, it was found that 46% of 77 child restraint device users suffered visible

Original Contributions

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The Use and Efficacy of Child Restraint Devices

The Tennessee Experience, 1982 and 1983

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• **The Tennessee Child Passenger Protection Act, mandating the use of child restraint devices for children younger than 4 years, took effect in 1978. In the years 1978 through 1983, eighty-one children younger than 4 years died in Tennessee traffic accidents; only two were in child restraint devices. During this period, as child restraint device use rose from 8% to more than 30%, the number of deaths among children younger than 4 years declined more than 50%. Analysis of supplemental accident reports filed in investigations of motor vehicle accidents involving children younger than 4 years during 1982 and 1983 showed that child restraint devices are highly effective in preventing death and in preventing or reducing injury. Children not in child restraint devices were 11 times more likely to die in an accident than children in child restraint devices. Children traveling in the arms of an adult were exposed to a risk of injury or death comparable to that of children left entirely unrestrained.**

(*JAMA* 1984;252:2571-2575)

MOTOR vehicle accidents are the leading cause of death of Tennessee children. This serious public health problem prompted the Tennessee Legislature to pass the nation's first Child Passenger Protection Act. Effective in January 1978, the law mandated the use of approved child restraint devices for resident children younger than 4 years while being transported by their parent or guardian in a private automobile. The law was further strengthened in 1981 by the elimination of a clause ("babes in arms") that had permitted children to be held by another passenger rather than be restrained.

For editorial comment see p 2613.

We have analyzed traffic accident data collected by the Tennessee Department of Safety for the years 1982 and 1983 and conclude that the Child Passenger Protection Act has resulted in a substantial reduction in traffic fatalities among Tennessee children younger than 4 years.

METHODS

The Tennessee Department of Safety has a special child restraint device report form intended for use in the investigation of motor vehicle accidents involving children younger than 4 years. For each such accident, the investigator records the date, time, and location of the accident; the names and addresses of each driver; and for each occupant of each vehicle, the occupant's seating position, age, sex, restraint use, and ejection and injury status. For occupants younger than 4 years, restraint use is coded as follows: child restraint device used; child restraint device present but not used; child restraint device use unknown; no restraint used; seat belt used; or held in the arms of another passenger. For occupants aged 4 years or older, restraint use is coded as follows: seat belt used; seat belt in vehicle but not used; use unknown; or no seat belt available for use. Ejection is coded as yes, partial, or no. Injury is coded as follows: none (injury code 0); complaint of pain but no visible injury (injury code 1); bruises, abrasions, swelling, limping, etc (injury code 2); bleeding wound or distorted member (injury code 3); or dead (injury code 4). All coding is done at the scene by the accident investigator, except that the Department of Safety recodes the injury status to "dead" for persons who die within 90 days of a motor vehicle accident and for whom the accident was reported as the cause of death.

All child restraint device report forms submitted for accidents occurring within Tennessee in 1982 and 1983 were obtained from the Department of Safety, as well as overall motor vehicle accident statistics for the state, records of the number of citations issued for violation of the Child Passenger Protection Act, and estimates of total passenger miles driven (calculated according to the applicable federal standard). The Tennessee Center for Health Statistics provided general population and mortality data.

As the state does not enforce on its subsidiary jurisdictions the requirement to complete a child restraint device report form, the submitted forms came disproportionately from investigations conducted by state police (in 1982 through 1983, state police investigated 14% of accidents but filed 46% of the child restraint device report forms) and tended not to be filed in minor accidents (74% of all accidents in the period involved no injury, as compared with 40% of the accidents reported on child restraint device report forms).

Accident investigators submitted 432 properly completed child restraint device report forms for 1982 and 419 for 1983; these forms contained usable information on 1,451 persons for 1982 and 1,[illegible] persons for 1983. Of these 2,831 pe[illegible] 991 were younger than 4 years and subject to the provisions of the C[illegible] Passenger Protection Act. Unless otherwise specified, all results refer to these 991 children.

Statistical testing was done using χ^2 and odds ratios (with continuity corrections), the χ^2 test for trend, Fisher's exact test, the normal deviate test for means, and the critical ratio test for proportions.[1,2] For stratified analyses, Mantel-Haenszel significance tests were used[3]; factor-adjusted

From the Division of Field Services, Epidemiology Program Office, Centers for Disease Control, Atlanta (Dr Decker); the Tennessee Department of Health and Environment, Nashville (Drs Decker, Hutcheson, and Schaffner and Ms Dewey); and the Department of Preventive Medicine, Vanderbilt University School of Medicine, Nashville (Dr Schaffner).

Reprint requests to Division of Field Services, Epidemiology Program Office, Centers for Disease Control, Atlanta, GA 30333 (Dr Decker).

unnecessary morbidity and mortality may not respond to educational efforts alone but may require protective legislation. Physicians are the ones who must annually attend to the 2.5 million broken bodies and witness the grief over the 50,000 dead. It would seem that active support for legislation requiring the universal use of seat belts, a simple yet responsible safety practice, would bear remarkable dividends.

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β-Blockers and Migraine

Experience with propranolol hydrochloride as an effective agent in the prophylaxis of migraine dates from the mid-1960s.[1-3] A series of uncontrolled observations was published then, leading to subsequent controlled data that confirmed these observations in the next decade.[4-6]

Subsequently, as the number of β-blockers proliferated, like mushrooms in a bog, questions have arisen regarding their relative efficacy in migraine prophylaxis. To wit, which drug to use? Is one drug better than the other? Physicians who treat migraine, already confronted by patients holding their heads, and beset by shadows dancing on the wall, have been unable to answer these queries.

That may still be the case, but enough information pertaining to β-blockers and migraine has now been accumulated from various sources to be summarized in tabular form (Table).

In a study published in this issue (p 2576), Stellar et al[7] have reconfirmed that migraine can be prevented by timolol used prophylactically, daily, in adequate doses, although the severity and duration of headaches that did occur "were unchanged."

What to do then in the usual clinical situation? Functional headaches including migraine are best treated using as little medication as possible. However, if migraine consistently disturbs patterns of work and behavior, as often as once weekly, prophylaxis can be undertaken. In this situation, β-blockers are the medication of choice. The practitioner may wish to select one or two of these drugs that are demonstrably effective and learn to use them well; that is probably enough. There would be little reason to run through a laundry list of

Effectiveness of Various β-Blockers in Migraine

β-Blocker	Effective in Migraine Prophylaxis	Not Effective in Migraine Prophylaxis	Perhaps Effective, Perhaps Not
Propranolol hydrochloride[5]	+	...	...
Oxprenolol[8]	...	+	...
Alprenolol[9]	...	+	...
Acebutolol hydrochloride[10]	...	+	...
Pindolol[11-13]	...	...	+
Nadolol[14]	+	...	...
Timolol maleate[15,16]	+	...	...
Atenolol[17,18]	+	...	...
Metoprolol[19,20]	+	...	...

β-blockers in a single patient with migraine if the initial experience with those one or two drugs proved disappointing.

Why some β-blockers are useful in the prophylaxis of migraine while others are not is unexplained. I believe that nonselective β-blockers are more effective in migraine prophylaxis than are the more cardiac-selective drugs. The nonselective drugs generally decrease the sympathetic activity in the autonomic nervous system. Migraine can be viewed as a disorder of heightened sympathetic stimulation. Some β-blockers have themselves possessed sympathomimetic activity; it would be prudent to avoid these for migraine prophylaxis.

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(This sheet to be used by those testifying on a bill.)

NAME: Bill Thomas DATE: 1-16-85

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PHONE: 728 9107, 243 2942

REPRESENTING WHOM? Children's Trust Fund Steering Committee

APPEARING ON WHICH PROPOSAL: SB 19

DO YOU: SUPPORT? ✓ AMEND? _____ OPPOSE? _____

COMMENT:

(see attached)

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

Testimony before the Senate Public Health Committee
regarding SB 19 Jan. 16, 1985

Madame Chairwomen and members of the committee:

We are all alarmed at the dramatic increase in reports of child abuse and neglect in recent years. Behind each of these reports is a family and a child in pain. And, research indicates that for every one report we receive there are four others that go unreported. The future cost to the well-being of the family, the child and, hence, to their community can only be guessed.

Social Service agencies are hard pressed to help these increasing numbers of children and their families. After attending to immediate treatment needs, little time or resources are left for the prevention of child abuse and neglect. Prevention, stopping abuse and neglect from occuring in the first place, makes good sense. Why should we wait until the worst happens before we offer our assistance?

Prevention saves future costs in both dollars and suffering. But there is also another benefit to prevention. In addition to forestalling abuse and neglect, it also helps to promote strong and stable family life.

It seems to me that families are usually getting either better or worse, there's no standing still. If we can reach out to families before the worst trouble starts and help that family interact more appropriately, they feel better and things can turn around. Where previously you had a family on the edge, you now have a family feeling pretty good about themselves and doing pretty well. The value of well functioning families is obvious.

A Children's Trust Fund would provide a powerful incentive for Montana communities to reach out to help families improve themselves and help stop child abuse and neglect. But if we're going to set up a Children's Trust Fund, we need to do it well. It will take a sizable investment of stable funding. A committment of one dollar for each child in the state, or roughly $250 thousand per year, would not be too much if we're really serious about preventing child abuse and neglect and strengthening our families.

It will also require on-going public involvement in the Trust. I would therefore, also respectfully recommend that consideration be given to requiring some form of citizen input in the Trust, perhaps a small advisory board. ammend

In conclusion, Montana's future rests on the well-being of our children and the strength of our families. We should invest in that future. SB 19 represents a very positive step in that direction. I request on behalf of the Steering Committee that it be given favorable consideration by this committee. Thank you.

Bill Thomas, Missoula (representing the CTF Steering Committee)

Testimony
Senate Public
Health Committee
1/16/85

My name is Cindy Garthwait, and I am executive director of Parents Anonymous of Montana. Parents Anonymous is a self-help program for families who find themselves caught in the cycle of CAN and for families who wish to prevent themselves from becoming abusive. In the three years of our operation in Montana, we have learned a great deal about CAN in Montana and about the needs of troubled families. We are encouraged by the interest in CAN during recent years and are delighted that the Montana legislature is considering the enactment of Children's Trust Fund legislation during this session.

I would like to speak in favor of ~~the bill~~ the CTF concept ~~bill senate bill 14, and I have some very sound reasons for offering my support~~.

I ~~represent~~ am speaking today from more than one perspective. I am speaking as a member of the CTF steering committee. I am speaking as a professional caregiver — a social worker who has worked in the CAN field for 5 intense, frustrating, and rewarding years. I also speak as a parent of 2 young sons. I also speak as a former victim — or as a survivor as I like to call myself, of child sexual abuse outside my immediate family. My knowledge and my concerns are therefore a result of both personal and professional experiences. They have come from my personal pain as well as that of those with whom I work.

As P.A. state director, I represent the P.A. local chapters in Missoula, G.F., Billings, Kalispell, Hamilton, Anaconda, Butte and Chinook. ~~Those local programs involve parents courageous enough to seek help for their problems, their children, teenage parents, and children~~ adolescent ~~victims of abuse. These programs also involve volunteer professional counselors, child care workers and~~ others who donate time ~~& energy~~.

*Let me tell you what they have told me.

Without exception, each parent I have worked with has had a history of abuse as a child. These parents find themselves repeating that same pattern of abuse with their children. They have told me that they are desperate to find a

way out of this abusive cycle — to prevent the next generation from inheriting these same problems. They tell me that they have many times reached out for help and have found none. They told me that when they do find help (in P.A. or a parenting class or in a parent aide program or a crisis nursery) that they are able to end their abuse and replace it with positive parenting methods. They have shown me that they can then become peer counselors to other parents struggling to avoid abuse in their families. Their success at redirecting their lives has proven to me that we are beginning to find some answers. We know that it is possible to prevent CAN. We must build on that knowledge and apply what we learn to real parents with real children. We have the ability to create the kind of climate in which the seeds of prevention can grow.

There is no one prevention program that will be the total answer. Each community needs to design its own programs, which could include hotlines, P.A. support groups, parenting classes, crisis nurseries, parent aide programs, children's groups, school curriculums, community CA Councils, and many more.

Research shows that communities with low CAN rates are communities where families feel comfortable asking for help from agencies or peers. We can make our communities approachable to troubled families. We can create the kind of climate in which the seeds of prevention can begin to grow.

The CTF can help accomplish this by providing funds to local groups who care about children and who have ideas for prevention programs but have no money to implement them. This money spent on prevention can represent great cost savings to society, as CAN leads to further abuse, alcoholism & drug abuse, J.D.'s, psychiatric problems and many

The CTF can help us make the switch from continually responding to existing problems to tackling them before they appear. The CAN problem is already overwhelming and can't be adequately addressed. It appears that our only choice is to become involved in prevention.

Possible modifications in the proposed legislation could include a concern I've noticed & might recommend
1) administration by an advisory board rather than by SRS
2) a built-in provision for building an endowment fund to maintain the C.Trust.
3) whatever funding mechanisms we agree to must yield $300,000.

Now that the data is in, and we know that prevention can work, it is our responsibility to respond now. This chance to enact CTF legislation is not only an opportunity; it is a necessity. We certainly must not let this time slip by w/o acting to establish a Montana CTF. We must not let it be said ~~that~~ of us in this room that we had the chance to improve the quality of life for Mt's children and did not do it.

We also must not delude ourselves by thinking that the CTF is the total answer, but it is a start. If the legislature passes the CTF, ~~they~~ ~~would~~ will have done a great thing. ~~We~~ will have done what truly needs to be done. The danger is becoming too pleased with ourselves and what we have done is that we blind ourselves to future problems and unmet needs. We must recognize that ~~this~~ adopting the CTF would not be the end of our responsibility. Rather it is just the beginning. We would be giving ourselves some tools with which to attack the problem.

I have not spoken with anyone who does not favor the concept of a CTF. We all seem to agree that it is a very needed program in Montana. There may be disagreements about its administration or about the mechanisms used to fund it, or about whether there should be an endowment or about whether the funds should be earmarked for the prevention of CAN. As ~~you deal~~ those issues, I ask that you ~~[illegible]~~ do not let them stop you from enacting the CTF. Make your decisions based on your concern for children as well as on the practical considerations of setting up a program, but I ask you to decide ~~to~~ act in favor of the CTF. I have come to realize that ~~[illegible]~~ not all of our failures lie in the bad that ~~we~~ do or the wrong decisions we make. Sometimes our failures are ~~in~~ not making decisions. We may fail by not being sensitive to the human hurts around us or by not using our hands and our hearts to respond to those hurts. We are now given this opportunity to leave a legacy of hope for abused children, an opportunity to break the cycle of CAN which persists so stubbornly from generation to generation within families. ~~[illegible]~~ I urge you to not let this opportunity pass. Thank you, Sen. Lynch, for your ability to look to the future. I hope your colleagues will join you.

(This sheet to be used by those testifying on a bill.)

NAME: Cindy Garthwait DATE: 1/16/95

ADDRESS: 4106 Fox Farm Rd., Missoula MT 59802

PHONE: 721-7323 W, 721-4792 H

REPRESENTING WHOM? Parents Anonymous of Montana

APPEARING ON WHICH PROPOSAL: Senate Bill 19

DO YOU: SUPPORT? ✓ AMEND? _____ OPPOSE? _____

COMMENT:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

(This sheet to be used by those testifying on a bill.)

NAME: VALERIE MURPHY DATE: 1/16/85

ADDRESS: 906 PARKVIEW Way MISSOULA

PHONE: 543-0266

REPRESENTING WHOM? self

APPEARING ON WHICH PROPOSAL: SB 19

DO YOU: SUPPORT? ✓ AMEND? _____ OPPOSE? _____

COMMENT:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

I AM EXCITED TO think there could be something as valuable as abuse prevention programs established in our ~~schools~~ communities. I believe it is a vitally important step in helping children recognize and perhaps stop abuse or potential abuse in their lives.

FIVE YEARS AGO at age 28, I began a process of identification for myslef and it has been a long, hard ordeal requiring me not only to face my abusive past but to face my own abusive parenting as well. I came from a home where there was emotional, physical and sexual abuse. After age 11 when I was sexually molested by my father over a period of time I quit growing emotially. I had already been stunted ~~emotially~~ emotionally from the first 10 years of living with his rejection.

THE PAIN INVOLVED with dealing with the past was overwhelming much of the time bringing me to the brink of suicide at one point. I felt I could not live with the pain any longer and did not see an end to it ever. 18 years of keeping a secret about incest thinking I was alone, [illegible] 18 years of denying and stuffing down the rage came rushing out in such a flood that it literally knocked me off my feet. For months I barely made it through each day--I felt incapable of getting up in the morning--unable to face a new day. Nighttime was worse. Each night I woke up after just a few houss of sleep to lie awake while the memories played over and over and over. I could not shut them off once they were allowed to surface. I was sure I was going insane.

TWO YEARS LATER I had sufficiently recovered from that experience to being looking at my present and the fact that I was an abusive parent.

I was determined to not repeat the past--I wanted to give my child a more positive home enviconment and future. The last three years have been spent working on my parenting skills through Parents Anonymous, private counselling and XXXXXXXXXXXX in sharing my experiences with others privately and publicly.

THE IMPORTANCE OF sharing these details with you stems from the strong belief that this story should not have to be repeated for the children of today. There are alternatives to keeping our children ignorant and therefore helpless victims. There are alternatives to burying our heads in the sand hoping the situation will go away if we just don't put ideas into anybody's head. There are alternatives to forcing our easily-molded children into lies and supressed anger only to have abuse be passed on from one generation to the next. Those alternatives start with prevention through education.

I support Senate Bill 19 establishing the Children's Trust Fund.

WOMEN'S LOBBYIST FUND

Box 1099
Helena, MT 59624
449 7917

January 16, 1985

TESTIMONY IN SUPPORT OF SB 19

Madam ~~Mr.~~ Chairman and other members of this Committee:

The Women's Lobbyist Fund (WLF) supports Senate Bill No. 19 and I, Gail Kline, will be speaking in favor of this bill.

We often use the saying, "An ounce of prevention is worth a pound of cure." In child abuse this is especially true for our children and grandchildren.

Researchers from the University of New Hampshire, Rhode Island and Delaware conducted a study of family violence into the lives of 2,143 families. A conclusion of the study is that "Adults who were frequently abused by their parents as teenagers have a spouse-beating rate four times greater than that of other adults." Adults who tend to abuse their spouses tend to be abusive parents and the cycle repeats.

We have learned much recently about the cycle of violence. The extent of this learned behavior appears in a journal called "Child Abuse and Neglect", published in 1983, which states that 38% of women reported at least one sexually assaulted experience before the age of 18. These women usually do not become abusers of others, but of themselves through drugs, alcohol or prostitution.

This priority issue, the child abuse prevention program, can help children control and understand themselves so that when they become adults their chance of being abusers or being abused will be lessened. This program, through education and counseling, among other support systems, will reduce fear and depression that so often keep people where they are.

This bill, based on other state laws, provides its own funding mechanism that is reliable and on-going and seems to be adequate to meet the needs of the program.

Our children and grandchildren deserve our support. Give them a place to go for help. The WLF urges you to pass Senate Bill No. 19.

1-11-85

Honorable Tom Towe D- Billings
Montana Legislature
Helena, Montana 59601

January 7,1985

Dear Mr. Towe:

As read in the Montana Elder, Jan./Feb. 1985 issure (Se Enclosed)

1 am writing you regarding your bill to make it a felony to exploit fathers and mothers over aged (60)

1 commend you for your bill.
1 am seventy and will be seventy one on March 9,1985 - My wife Mary is sixty seven.

One year ago about this time, and for six months period, We were going through hell here in our home. our oldest son, Now living in Washington state, age fifty Jan. 31/st.1985, came home to live with us. his fourth wife had just left him.

At first, he began calling us collect at all odd hours, mostly in the wee hours. Threatening suicide. Following such calls, we would attempt calling him to see how he was. but his phone was going unanswered, his phone off the cradle, we could hear him moaning in a back room as if dieing. we spent money calling police, rescue squads hospitals etc. He had us very frightened and we have aged from it all.

Finally, he called from the Great Falls Airport, (Last Winter) we went and picked him up. The second night he was here, he slept on a living room couch, where 1 also slept nearby. He awoke me at 3:A.M. and said he wanted to ask me a question. 1 said ask on. His question was, how much money did we have on hand? To shorten this story up, He got, all our savings. when he came back a second time for more, is when both me, and my wife were abused. he held me against a wall choking me. he threatned beating me several times. on one occassion, he attacked his mother, my wife, Between you and 1, Mr. Towe, 1 got in our car and left the house. Why? 1 was simply afraid maybe, 1 might

soon, being worried, 1 returned to my home. My wife and son, was in the back yard. She was telling him he needed to be in a mental institution. He had slapped her around and until she ran and hid in the bushes. 1 had a revolver, and told him to leave. which he did.

We will never recover from the financial loss, and definately never from the mental anxiety. Our son is a scotch drinker and chews a cud. His wives all leave him because of his assaults. He has just now, a year later, began to call, and be friendly again.

1 am a very small man. at the time my weight was only 86 pounds. just now 1 have gained (With my Drs. help,) up to 99 pounds.

We do not wish to report him, for fear he might commit suicide. or, harm us again. we want to keep it secret unless, this occurs again.

My letter Sir, is about your proposed bill making it a felony to exploit, or assault an elderly person. and we want "Teeth" in the law if passed which we desire it to be a felony.

We have three sons. two living in Oregon who never harmed us ever. but, our oldest son, indeed has hurt us permanently.

1f your bill passes, 1 would be thankful to know about it Mr. Towe.

1 apologys for the long letter, wishing you the very best always.

Sincerely,

P.S. Our son even attempted to get us to mortgage our home and give him the money. Every word in my letter sir, is precisely true and very real.

My wife doesn't know I write you, you the first I've ever told. I hope this letter reaches you at the address I have.

cc/
Tom Towe

cc/ (CE/)