DATA BOOK 2004

KIDS COUNT IN MICHIGAN

County Profiles of Child and Family Well-Being

a focus on young children

kids count in Michigan

Acknowledgments

The *Kids Count in Michigan Data Book 2004* was developed by Jane Zehnder-Merrell of the Michigan League for Human Services (MLHS) with the assistance of League and project staff and the support of the Advisory Committee.

Many thanks to the reviewers, which included the following: Ann Marston and Sharon Parks from the Michigan League for Human Services; Michele Corey from Michigan's Children, Beverley McDonald from the Kids Count Advisory Committee. We are also grateful to the several reviewers who commented on specific sections as well as to Debra Yamron, Wayne State University intern for her painstaking editing of references. Thanks also to other members of the Kids Count in Michigan Advisory Committee who have given time and expertise to shape the book and other project activities. The process of collecting and compiling the data represents the collaborative efforts of numerous individuals, including Jason Martin, Megan Reynolds, and Jim Lunday who obtained the data with the assistance of the following:

Michigan State Police
Central Records Division
- Wendy Easterbrook

Michigan Department of Community Health
Division of Epidemiology Services
- Elizabeth Wasilevich

Division for Vital Records and Health Statistics
- Michael Beebe
- Glenn Copeland
- Sharon Crawford

Childhood Lead Poisoning Prevention
- Bob Scott

Michigan Center for Educational Performance and Information
MEIS Data Analysis and Reporting Services
- Carol Jones

Michigan Department of Education
Director's Office, School Support Services
- Dawn Harris

Special Education Services
- James Nuttal

Office of Educational Assessment and Accountability
- Paul Bielawski

Michigan Family Independence Agency
Children's Protective Services
- George Noonan
- Pat Wilson
- Ted Forrest·

Policy Analysis Division
- Terry Drum

Child Development and Care Program
- Sean O'Keefe

Library of Michigan
State Demographer
- Kenneth J. Darga

State Census Data Coordinator
- Darren E. Warner

Michigan 4 Cs
- Mark Sullivan

Wayne County Department of Community Justice
Juvenile Justice Services Division Information System
- Dan Chaney

Special recognition is accorded support staff at the Michigan League for Human Services:
- Tillie Kucharek for her creativity and care in the production of the county pages.
- Jackie Benson, Phyllis Killips, Mary Logan and Melanie Burnell for their assistance on other aspects of the project.

This report was funded by the Annie E. Casey Foundation, Skillman Foundation, and the Blue Cross and Blue Shield of Michigan Foundation, as well as United Ways. We thank them for their support but acknowledge that the findings and conclusions presented are those of the author, and do not necessarily reflect the opinions of these foundations.

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Kids Count in Michigan is part of a broad national effort to measure the well-being of children at the state and local levels, and use that information to shape efforts to improve the lives of children.

The partners in the Michigan project include:

- **Michigan League for Human Services**
  A statewide citizens' research and advocacy organization that works for effective policies to improve the economic security of low-income people.
- **Michigan's Children**
  A statewide, multi-issue, independent, broad-based advocacy group which works with policy-makers, other organizations and the public to improve the quality of life for children and their families.

The state project is part of a nationwide network of state projects supported by the Annie E. Casey Foundation of Baltimore, Maryland. The Detroit-based Skillman Foundation, as well as the Blue Cross Blue Shield of Michigan Foundation, and local United Ways also provide funding for the Michigan project.

The Michigan Data Book 2004 is available as

- A **book** for $15 plus sales tax (shipping and handling $3) from the Michigan League for Human Services (bulk rates available). Call or e-mail Jackie Benson (jbenson@mlan.net) at the Michigan League for Human Services – 517/487-5436 or toll free 1/800/837-5436
- A **PDF file** on the League website: www.milhs.org

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Suggested Citation: Zehnder-Merrell, Jane. *Kids Count in Michigan Data Book 2004: County Profiles of Child Well-Being- A Focus on Young Children*. Lansing, MI: Michigan League for Human Services. 2004.

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Young Children in Michigan

Federal and state policies have focused on the goal of *all* children attaining a set standard of proficiency on math and reading tests. Since the capacity to succeed in school is developed in the early years of life, the case for ensuring an environment that enables the development and learning necessary for children to experience later success has become even more compelling.

If more children are to arrive at kindergarten "ready to learn," early investments must be made to assure a better start in life for disadvantaged children in all the state's communities. These investments include: meeting the basic needs of infants and children; ensuring their physical health; addressing their social and emotional needs; guarding their safety; and guaranteeing access to high-quality care and education.

Meeting the basic needs of young children is the threshold measure as it has an impact on a child's physical health, socio-emotional needs, safety, and quality care and educational needs. All are compromised by the living conditions of a family mired in poverty.

- In 2003 roughly one in five young children in Michigan lived in poverty.
- Roughly half of young children in single mother families in Michigan lived below the poverty level.

Ensuring the physical health of infants and young children has been addressed in some aspects in Michigan. The state has a relatively low rate of children without health insurance and toddlers without all their immunizations when compared to the national averages, but several other measures raise concerns.

- The rates of well-child check-ups among Medicaid-enrolled children in 2003 were below the national averages.
- Michigan's annual average hospitalization rate (49 per 10,000) for asthma among young children in the three-year period 2000-02 is almost double the *Healthy People 2010* target of 25 per 10,000.
- While Michigan has been making steady progress in the numbers of children being tested for lead poisoning, only 19 percent of children ages one and two were tested in 2003. Undetected lead poisoning causes irreparable damage to the central nervous system in young children.

Addressing the social and emotional needs of young children is critical to success in school and life. Security and attachment in the early lives of children are grounded primarily in the emotional health of parents and their ability to respond with sensitivity to their children. Two of the major family pressures that interfere with this interactive process include poverty—the daily pressures of meeting basic needs—and domestic abuse. Children in the foster care system as a result of confirmed abuse or neglect are also at high risk of social and emotional problems.

- Parents of kindergarteners in poverty had double the risk for depression as parents with incomes above the poverty threshold—27 percent compared to 13 percent.
- Mental health services to meet the needs of children and families is lacking in the majority of Michigan counties.

Guarding the safety of young children involves providing a wide range of supports that fragile families need to stay together and raise children in a secure and stable environment. One strategy for preventing child abuse and neglect, particularly in the early years, involves such activities as parent education, home visitation, parent support groups, and connecting the family to additional supports such as emergency services, child care subsidies, substance abuse or mental health treatment, or cash assistance. To successfully integrate these supports on a timely basis, coordination and an early detection system are critical.

- Infants and toddlers in Michigan were roughly twice as likely as all children to be confirmed victims of abuse or neglect. Among every 1,000 children under age two, 19 were confirmed as victims of abuse or neglect in fiscal year 2003 as compared to 10 among all children.
- Most deaths from maltreatment occurred among young children. Of the 52 Michigan child fatalities that resulted from maltreatment in 2002, over half (56%) were infants under the age of one, and one-quarter were children between the ages of one and four.

Guaranteeing access to high-quality care and education provides young children a safe and stimulating environment where caregivers offer responsive supervision, verbal and cognitive stimulation, individualized attention, and opportunities for stable relationships. While the positive interaction between caregivers and children is key to quality, structural components such as a low ratio of children to caregiver (one of the most vital components of high quality care), staff trained in early childhood development, and adequate staff wages and benefits also have an effect.

- Michigan is the only state in the nation that has not instituted basic training requirements for the providers of child care.
- Almost half of the state's children in higher income families (300% of poverty or above) attended preschool in 2000 compared to just over one third of poor children. Many poor or low-income children who qualify for Head Start or the Michigan School Readiness Program cannot attend because of limited program capacity or parental employment schedules.
- While child care subsidies help low-income families cover the cost of child care so parents can work, the hourly payment structure and relatively low rates restrict parental options for care.

The Status of Children in Michigan

All areas of well-being for children in Michigan registered some improvement between 1995 and 2002. The largest and most consistent gains occurred among adolescents where the rates of teen birth, teen injury death, and high school dropout showed steep declines. Economic security improved, with the state and all of its counties experiencing substantial decreases in child poverty between 1995 and 2000. However, one-third of the state's children continued to live in families only marginally above the poverty level as evidenced by the share of students eligible to participate in the School Lunch Program at free and reduced prices in 2003.

Most measures of child health improved or worsened only slightly except for the child death rate that dropped by 19 percent. Of particular concern is the fact that while the state's infant mortality and low-birthweight rates have not worsened, neither have they improved over the trend period—between 1994-96 and 2000-02.

The area of child safety reflected worsening trends on all but one measure, out-of-home care for delinquency. The rates of children in families investigated for neglect and abuse, confirmed victims, and children in out-of-home care all increased over the trend period—1995 compared to 2002. During this same period the state has cut back on prevention programs, and funding for programs to mitigate the effects of poverty for the state's most vulnerable families and children has eroded. With the implementation of the "category" system in Children's Protective Services, a third of cases where abuse or neglect has been confirmed received no state services in 2003.

Improvements

- **High school dropout rates plummeted** between 1996 and 2002—with a decline of 40 percent. In 2002, the rate had dropped to 4 percent compared to 6 percent in 1996. A growing body of research suggests that dropping out of school results from a combination of individual risk factors and the organizational features of schools.
- **Poverty among children dropped by almost one-third** between 1995 and 2000—from 20 percent to 14 percent of children, ages 5 through 17. During the economic boom between 1995 and 2000, Michigan had the largest decrease in child poverty among the 50 states, according to the U.S. Census Bureau.[1] The latest available poverty data show that rates began to climb in 2001-2002; and by 2003 child poverty in Michigan stood at 15.2 percent. (2003 data were not available for all the state's counties at the time of publication.)
- **Teen births to high school-aged teens dropped by over one-third**—from 30 to 20 births among every 1,000 teens. Only three counties experienced an increase in teen birth rates between 1994-96 and 2000-02. The roughly 4,200 teens who became parents each year before they were 18 are at higher risk of smoking during their pregnancy and receiving less than adequate prenatal care.
- **Teen injury death rates declined by almost one-third**—from 66 to 46 deaths among every 100,000 youth, ages 16-19. The homicide death rate for teens declined by 60 percent between 1994-96 and 2000-02. More Michigan teens died from auto accidents in 2002 than the total caused by homicide and suicide combined.

Challenges

- **Child victims of abuse and neglect rose by over one-quarter**—from 8 to 10 victims per 1,000 children. Roughly 26,700 children were found to be victims of abuse or neglect in 2003. Most Michigan counties experienced an increase in their rates; in 12 counties rates more than doubled.
- **Children in out-of-home care for abuse or neglect rose by almost one-fifth**—from 6 to 7 children per 1,000. Roughly 17,500 children in Michigan were in out-of-home care for abuse or neglect in 2003.
- **Low-income children need access to safety-net programs.** One-third of the state's school-aged children live in families with income below 185 percent of poverty. Many of these families struggle to meet their basic needs. In recognition of this fact eligibility for several family support programs is set to include families at income levels above poverty, excluding direct cash support in unemployed households, which is currently set at two-thirds the poverty line. In recent years these programs have been cut or benefits eroded due to the crises in the state and federal budgets.
- **High school students not meeting proficiency standards in the MEAP math test increased by one-quarter**—rising from 31 to 40 percent of the Class of 2003. Only five counties experienced improvement in meeting the high school math MEAP standard for the Class of 2003 as compared to 2001.

[1] The 2000 Small Area Income and Poverty Estimates are the latest child poverty data for counties.

INTRODUCTION

This year's data book reviews progress on child well-being in Michigan between the mid-1990s and 2002. For most measures the latest data reflect 2002 so the trend period contrasts the years when the state's economy began to surge with the years of its decline.

Measures are grouped in five key areas of a child's life: economic security, health, safety, adolescence, and education. The reality of life does not divide so neatly; outcomes in one area often affect those in another. For example, a health outcome such as low birthweight, can result in developmental delay or chronic disease that raises the risk of family stress, child abuse or neglect or special education.

The measures used in this report represent the latest data available for the state and all its 83 counties in September 2004. Some information may be more current than others, and trend periods may differ due to data availability. For example, the latest child poverty rates for Michigan counties are estimates for the year 2000, at the peak of the economic boom; more current estimates are available from the American Community Survey, but only for the state and some of the most densely populated counties. Results of the Michigan Educational Assessment Program (MEAP) math tests could be compared for only two years because of testing and scoring changes.

In the discussion of the indicators the highest and lowest rates for all counties are cited, as well as the counties affected by the largest changes. In most cases the counties with the smallest populations have the largest changes since relatively small numbers of incidents can make a large impact on the rate. For that reason, the highest and lowest rates and changes are also provided for the ten most populous counties with the largest number of children.

Child Population of the Ten Most Populous Counties in Michigan

County	Children, Ages 0-17	% total State Child Population
Michigan	**2,538,920**	**100.0**
Wayne	564,093	22.2
Oakland	295,900	11.7
Macomb	191,836	7.6
Kent	163,226	6.4
Genesee	117,994	4.6
Washtenaw	73,390	2.9
Ottawa	67,709	2.7
Ingham	64,979	2.6
Kalamazoo	57,258	2.3
Saginaw	53,881	2.1
	1,650,266	65.0

Source: US Census, Population Estimates 2003

This year's special section focuses on the early years of childhood with more in-depth analysis of the trends for young children raised by some Kids Count indicators. The analysis takes on added significance because the first years of a child's life provide the bedrock for physical well-being, as well as social and cognitive capacity throughout life. While these early years represent the period in a child's life with the most potential, they also pose the most peril.

The Michigan data book will be available on the web (www.milhs.org), and selected data are also available from the County-City-Community Level Information on Kids (CLIKS) at the national KIDS COUNT website (www.kidscount.org). CLIKS allows users to create maps, graphs, and rankings for specific indicators as well as produce a profile of a city or county.

The book is presented as a tool for policy makers at the state and local levels to use to inform their decisions about ways to improve the lives of children and families in Michigan and its communities.

YOUNG CHILDREN IN MICHIGAN

Children begin to learn as soon as they are born, and experiences in their early years provide a foundation for their physical and emotional well-being throughout their lives. Science has documented the extensive development of the brain that occurs in the first three years of life. It has also examined the impact of deprivation, trauma or abuse on the structure of the brain during that critical time. While this period represents an opportunity for positive development, children in their very early years are also the most vulnerable to other threats to their health and safety. In this section the status of young children under the age of five in Michigan will be reviewed in several key areas.

With federal and state policies focusing on the goal of *all* children attaining a set standard of proficiency on math and reading tests, the importance of ensuring an environment that enables the brain development and learning necessary to later school success in the early years of life has become even more compelling. Many studies have confirmed the linkages of early childhood well-being to an ability to succeed in school and the workplace. If more children are to arrive at kindergarten "ready to learn," early investments must be made to assure a better start in life for more children. Some of these investments include:

- Meeting the basic needs of infants and children;
- Ensuring their physical health;
- Addressing their social and emotional needs;
- Guarding their safety; and
- Guaranteeing access to high-quality care and education.

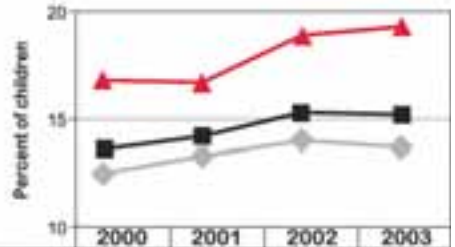
The following discussion will review how Michigan is performing in each of these critical areas from the measures now available.

Meeting the Basic Needs of Infants and Young Children

Meeting the basic needs of young children is the threshold measure as it has an impact on a child's physical health, socio-emotional needs, safety, and quality care and educational needs—all are compromised by the living conditions of a family mired in poverty. Young children living in families with incomes below poverty are at high risk of having their most basic needs unmet. Families with incomes below poverty level struggle to afford the costs of shelter and transportation. Those who must purchase child care in order to work face another substantial expense. Young children under five years old in Michigan are more likely to live in families with incomes below the poverty level than school-aged children—their parents can't work as easily or profitably as those with school-aged children. In 2003 roughly one in five young children in Michigan lived in poverty compared to one in seven school-aged children, according to the latest data from the U.S. Census.

Children under the age of five living with a single mother are at the highest risk of poverty; almost one of every two of these children lived below the poverty level, according to the 2000 Census. Among the state's children under the age of three, one in four lived in a single parent family, mostly with a single mother, and were thus disproportionately vulnerable to living in an impoverished household. Young children in single mother

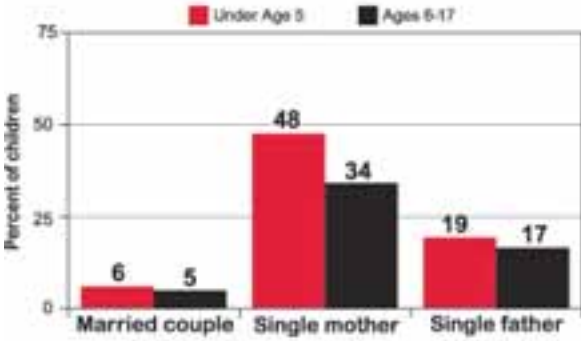
Child poverty in Michigan worsened between 2000 and 2003, particularly for young children.



	2000	2001	2002	2003
Young Child Poverty (under age 5)	16.8	16.7	18.9	19.3
Child Poverty (under age 18)	13.6	14.2	15.3	15.2
School-Age Child Poverty (ages 5-17)	12.5	13.3	14.0	13.7

Source: US Census Bureau, American Community Survey

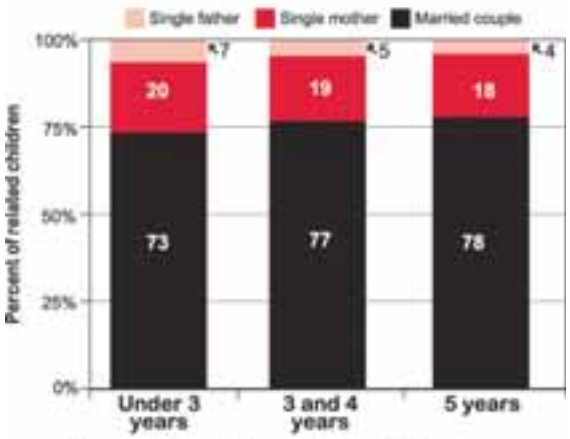
Almost half of young children in Michigan's single mother families lived in poverty.



Source: US Census 2000 (www.kidscount.org)

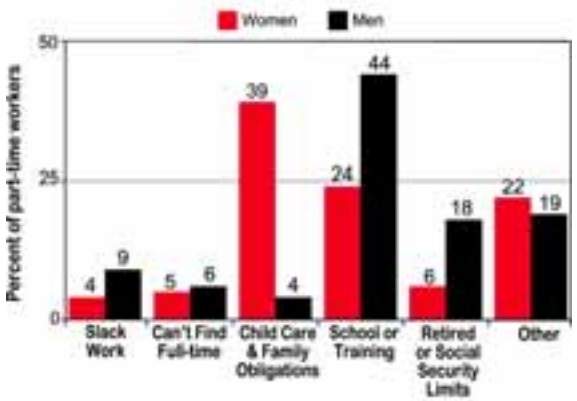
families were significantly more likely to live below poverty than children of school age in the same living arrangement (48% vs 34%). This spread was much smaller for single father families and married couple families. Single mothers with under school-aged children are disadvantaged economically in that women

Roughly one of four infants and toddlers in Michigan lived with a single parent.



Source: American Community Survey 2002

Michigan women are ten times more likely than men to work part-time due to family responsibilities or child care.



Source: Bureau of Labor Statistics Geographic Profiles of Employment and Unemployment, Table 13, 2002

generally earn less than their male counterparts so they are less likely to be able to afford child care costs in order to work profitably outside the home. Overall women are more than twice as likely as men to work part-time in Michigan, and almost 40 percent of those women cite child care and family obligations as the reason for part-time work compared to 4 percent of men.

Compounding the problem are the changes in supplemental public programs such as cash assistance, emergency services, and subsidized child care, which mitigate the effects of poverty. Such programs have been compromised over the last decade by actual cuts or a lack of adjustment for inflation. The current ballooning operating deficits at the federal level and a structural deficit in the state budget may result in further erosion to such programs that address the needs of the most vulnerable children.

Physical Health of Infants and Young Children

Most infants and young children in Michigan are physically healthy. Michigan has a relatively low rate of children without health insurance and toddlers without all their immunizations when compared to the national averages, but several other measures of the physical health of Michigan's young children raise concerns. The state's relatively high infant mortality rate has essentially stagnated since 1994. Between 2000 and 2002 one in four infants was born to a mother who had not received adequate prenatal care. During this same period over 10,000 of Michigan's infants were born each year weighing less than five and a half pounds, which puts them at risk for developmental delay or chronic health problems. (These indicators are discussed in more detail in the Child Health section.) Other measures available for review of the physical health of young children include the rates of well-child visits, hospitalizations for asthma, and lead testing among children insured by Medicaid.

Access to Health Care and Well-Child Visits

The first and most important key to the physical health of a child is the parent. The educational level attained by the mother plays a particularly critical role in the physical health of children in their early years. Parents without basic literacy and math skills often lack the necessary "health literacy" to adequately care for the health needs of young children. Well-child visits and annual checkups represent the key to maintaining a child's health and preventing illness. They provide an opportunity for the health provider to identify conditions a parent may not detect, monitor developmental or physical problems, counsel parents about their concerns, and promote positive parenting techniques and understanding of the child's age-appropriate needs and behaviors. These visits can also establish relationships between families and the health care system so that crises are less likely to occur. Families where parental education was less than high school were the least likely to have taken their children for a well-baby visit in the previous year—77 percent of young children whose parents had less than a high school education had received a well-child check-up in the previous year compared to 88 percent of college graduates.[1] A major contributing factor also related to insurance coverage—children without health insurance were the least likely to have had a well-child visit in the prior year (71%).

In Michigan the rates of well-child check-ups among Medicaid-enrolled children in 2003 were below the national averages and showed no improvement from the previous year.[2] These rates reflected visits for children in the first 15 months of life, as well as those ages three through six years. Deepening the concern in this area, for well-child visits for children ages three through six, twelve of the eighteen Michigan health plans serving Medicaid children had rates below the national average, and four were in the lowest performance category.[3]

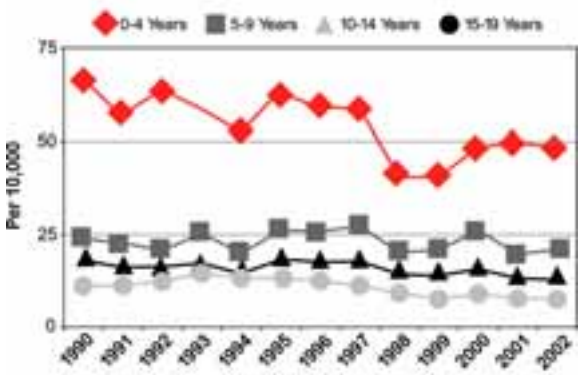
To identify the barriers to well-child visits for Medicaid-enrolled children in the state, the Michigan Department of Community Health in collaboration with the Medicaid managed care plans, Michigan Association of Local Public Health and the Institute for Health Care Studies at Michigan State University held a series of focus groups with Medicaid beneficiaries and clinicians in an effort to develop communication strategies and office practices to address the problem. Focus group findings showed that few parents or guardians were familiar with the concept and importance of well-child services, and most reported not being informed about the availability or

[1] Brett Brown and Michael Weitzman, *Early Child Development in Social Context: A Chartbook*. (Washington, D.C.: Child Trends, 2004), 65, Chart 6-1 Developmental Screening and Well-Child Visits.

[2] National averages represent the 50th percentile from 2002. *Michigan Medicaid HEDIS* [Health Plan Data and Information Set] *2003 Results Statewide Aggregate Report* (Phoenix, AZ: Health Services Advisory Group, December 2003), 3-20: Figure 3-12, HEDIS is a set of performance data accepted by the managed care industry as standards of performance.

[3] Ibid., 3-20.

Despite declining rates, Michigan's youngest children continued to suffer from highest rates of hospitalization for asthma between 1990 and 2002.



Source: Michigan Department of Community Health

importance of such services nor requested to schedule such a visit.[4] Those making regular visits for a chronic condition such as earaches or asthma assumed well-child services were included in such visits.[5]

Hospitalizations for Asthma

The rate of hospitalization for asthma provides another baro--meter of access to health care. Many hospitalizations for asthma could be prevented with better access to care. Asthma is the most common chronic illness among children, and the leading cause of preventable hospitalizations. A chronic disorder of the airways, asthma is characterized by wheezing, shortness of breath, tightness or discomfort in the chest, and/or a cough.[6] Factors that can trigger an asthma attack include allergens, infections, exercise, abrupt changes in the weather, or exposure to airway irritants, such as tobacco smoke or mold.

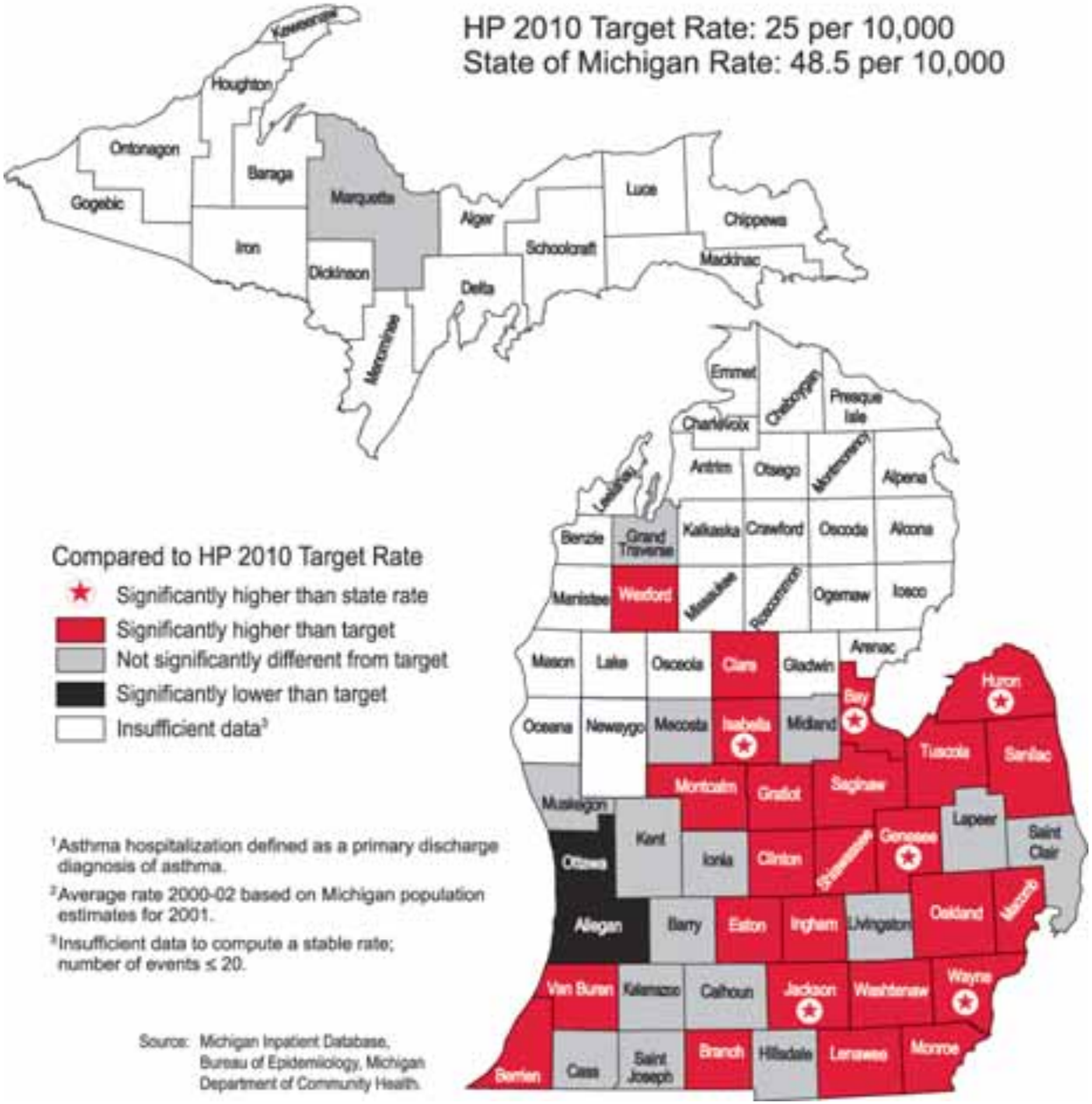
[4] A report by the Institute for Health Care Studies (IHCS) at Michigan State University in collaboration with the Foundation for Accountability (FACCT) and the Michigan Department of Community Health (MDCH). *Medicaid Focus Groups: Early and Periodic Screening, Diagnosis and Treatment (EPSDT): Beneficiary Perspectives on Well Child Care. Executive Summary* September 2002, <http://www.healthteam.msu.edu/imc/MCH/Medicaid%20Focus%20Groups.doc> (October 5, 2004).

[5] Ibid.

[6] Elizabeth Wasilevich and Sara Lyons-Callo, *Epidemiology of Asthma in Michigan 2004 Surveillance Report* (Lansing, MI: Michigan Department of Community Health, June 2004).

Meeting the Target:

Asthma Hospitalization[1] Rate[2] Among Children, Ages 0-4, in Michigan Counties versus Healthy People 2010 Target



Hospitalization of Children, ages 0-4, due to Asthma in Michigan and its Counties

	County	Average Annual Count 2000-02	Rate per 10,000		County	Average Annual Count 2000-02	Rate per 10,000
	Michigan	**3,212**	**48.5**	22	Oakland	293	37.1
1	Ottawa	32	17.6	23	Branch	11	40.3
2	Allegan	13	17.8	24	Sanilac	11	40.9
3	Calhoun	19	21.3	24	Montcalm	16	40.9
4	Ionia	9	22.0	26	Berrien	45	42.8
5	Barry	9	24.8	27	Shiawassee	20	43.9
6	Kent	117	25.8	28	Tuscola	15	44.7
7	Livingston	29	26.3	29	Clare	8	45.5
8	St. Clair	28	26.4	30	Eaton	30	47.2
9	Muskegon	32	27.4	31	Lenawee	30	49.2
10	Grand Traverse	13	27.5	32	Ingham	90	49.8
11	Kalamazoo	44	28.5	33	Washtenaw	108	52.8
12	Mecosta	7	29.2	34	Saginaw	76	54.7
13	Marquette	9	30.1	35	Monroe	53	57.0
14	St. Joseph	14	30.4	36	Jackson	59	58.3
15	Lapeer	18	31.4	37	Genesee	185	59.3
16	Macomb	164	32.4	38	Gratiot	15	62.2
17	Midland	17	33.0	39	Wexford	13	68.4
18	Hillsdale	10	34.8	39	Bay	45	68.4
19	Cass	10	35.0	41	Wayne	1,250	83.6
20	Van Buren	19	36.3	42	Huron	16	85.0
21	Clinton	15	36.4	43	Isabella	29	86.4

Source: Michigan Inpatient Database, Bureau of Epidemiology, Michigan Department of Community Health

[1] Based on Michigan population estimates for 2001.
[2] Hospitalization with primary discharge diagnosis of asthma
~ Only counties with sufficient data to compute a statistically stable rate are included in the ranking.
(Total number of events must exceed 20 or a total population of 5000 over three-year period.)

Michigan's youngest children, those under the age of five, were more likely to be hospitalized for asthma than any other age group: young children were twice as likely as 5-9 year olds to be hospitalized for asthma in the period 2000-2002, four times more likely than 10-14 year olds, and six times more likely than older youth. In Michigan the average length of stay in the hospital for young children with the primary diagnosis of asthma was two days in 2001.[7]

[7] Ibid.

Hospitalization rates for asthma reflect profound health disparities by income and race. Young children in low-income families were twice as likely to be hospitalized for asthma as their middle income counterparts (91 vs. 42 per 10,000) and almost four times as likely as high-income children (91 vs. 25 per 10,000).[8] Young African-American children were three to four times more likely to be hospitalized for asthma than their white counterparts in Michigan.[9]

Michigan's annual average hospitalization rate (49) for asthma among young children in the three-year period 2000-02 is almost double the *Healthy People 2010* target of 25 per 10,000. Of the 43 counties where a rate could be calculated for this age group during this period, well over half (25) were significantly higher than the 2010 target. Six of these counties were significantly higher than the state rate. Wayne, Huron, and Isabella counties had the highest rates among the counties with 84-86 young children per 10,000 having been hospitalized for asthma. Only two counties, Allegan and Ottawa, with 18 hospitalizations for asthma per 10,000 young children met the *Healthy People 2010* goal.[10]

Michigan trends in hospitalization rates for asthma among children show a decrease for all age groups between 1990 and 2002 with most of the decline occurring after 1995. National data also reflect downward trends in hospitalization and death rates since 1995, but the rate of outpatient visits and emergency department visits for asthma escalated.[11] (Asthma deaths among children are relatively rare—0.3 per 100,000 children compared to 2.1 among adults aged 18 and over.[12]) These trends may reflect changes in the health care system as well as the more effective treatments available for asthmatic symptoms for children who have health insurance and access to care.

[8] Wasilevich et al., *op. cit.*, 44, Figure 4.9. High income was top 20% of zip codes by median household income (US Census 2000) and low income was bottom 20%, all the rest were designated middle income.

[9] Ibid., 42, Figure 4.7.

[10] Although two other counties had rates below 25, they were not significantly below the target rate, that is, with their margin of error, their rate could exceed 25.

[11] Center for Disease Control, *Surveillance for Asthma — United States, 1980—1999,* 29 March 2002, <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5101a1.htm > (1 October 2004).

[12] National Center for Health Statistics, Centers for Disease Control and Prevention. *Asthma Prevalence, Health Care Use and Mortality, 2000-2001,* <http://www.cdc.gov/nchs/products/pubs/pubd/hestats/asthma/asthma.htm> (5 October 2004)

Michigan's strategies to reduce hospitalizations among young children include educating child care providers through the Coordinated Community Child Care system (4Cs); distributing asthma education resource kits to primary care providers, including pediatricians and family practitioners; and providing case management to children with asthma and their families.[13]

[13] For more information about asthma in young children and efforts to control it in Michigan, go to *www.GetAsthmaHelp.com.*

Childhood Lead Poisoning

Lead poses another threat to the physical, mental and emotional health and development of children. Young children also have the most vulnerability to lead. Since the most active period of development and growth of the central nervous system occurs during the first three years of a child's life, and children absorb lead more readily than adults, young children are particularly susceptible to its devastating effects. For the most part, these effects on a child's nervous system, hearing, vision, cognitive development, and behavior during the early years are not reversible:[14] Their impact is long-term and can be severe. Childhood lead poisoning compromises a child's physical and mental health and limits lifelong earning and relationship potential.

Number and percent of infants and toddlers tested for lead rose significantly in Michigan between 1998 and 2003.

Source: Michigan Department of Community Health, Childhood Lead Poisoning Prevention Program

Lead paint in housing is the primary source of childhood lead poisoning. Children ingest lead through flaking, chipping, peeling lead-based paint or inhale dust-borne particles generated from friction on multiple layers of paint, particularly on windows. Housing built before 1978 poses the greatest risk, particularly if the structure has not been well-maintained, and the paint has deteriorated. Because young children explore the world through taste and touch, paint dust, flakes or chips can easily get into their systems. Children in poor or low-income families are more likely to live in poorly maintained older housing, and their diets are also less likely to be rich in foods that supply the iron, calcium, and adequate caloric intake that help to prevent absorption and use of lead in the child's body and brain and make the ingestion of paint chips and non-food items that are covered in fine lead dust less likely.

Since most children with lead poisoning do not exhibit any symptoms, blood tests, particularly in the first two years, are essential. Michigan has been making steady progress in the numbers of children being tested for lead in their early years; the number being tested has risen steadily since 1998. In Michigan 19 percent of all children, ages one and two, were tested for lead in 2003, compared to 13 percent in 1998. Of the children tested in 2003, 3 percent (1,687) were found lead poisoned with 10 or more micrograms of lead per deciliter of blood. The Healthy People goal for the year 2010 is the elimination of childhood lead poisoning.

There is considerable concern about children with even low levels of lead in their systems, as recent research has suggested an impact on cognitive development at lead levels of 5 micrograms per deciliter. In Michigan roughly 16,000 children under the age of six were identified as having blood lead levels between five and nine micrograms per deciliter of blood in 2003.

The testing of all children under six for lead has been recommended, but young children in poor or low-income families have roughly three times the risk of lead poisoning so it is particularly important that they be tested. Many of these children are eligible for Medicaid enrollment; federal guidelines require blood lead tests for Medicaid-enrolled children at 12 and 24 months, and the requirement may not be waived. Current quality assurance standards for Michigan health plans serving Medicaid-enrolled children consider only whether a Medicaid-enrolled child has been tested for lead at least once on or before the ages of two or three. (Thus a child who had been tested at age one but not at age two would be counted.) In 2004 the state legislature instituted a requirement that Michigan's lead testing rates of Medicaid-enrolled children be in "substantial" compliance with federal standards beginning October 1, 2007.[15]

The Governor's 2003 Call to Action Task Force (on childhood lead poisoning) as well as several bills in the legislature and growing concerns about lead levels in city water systems have focused more public attention on lead poisoning and its effects. Without substantial improvements in testing young children in order to make timely interventions and in reducing lead hazards in the housing stock, Michigan will not reach the 2010 Healthy People goal of eliminating lead poisoning among children.

[14] A Joint Report of Michigan State University and Michigan Department of Labor and Economic Growth and Michigan Department of Community Health, *2003 Annual Report on Blood Lead Levels in Michigan* (Lansing: MI, 2004).

[15] 2004 PA 55.

Social and Emotional Needs

Social and emotional skills and competence are as critical to success in school and life as cognitive ones. While 60 percent of children enter school with the cognitive skills necessary for success, only 40 percent have the age-appropriate social and emotional skills.[16] Positive interactions with caregivers in the early years of life help a child develop the capacity to form and value caring and intimate relationships. The sense of security and attachment that flows from the early positive interactions allows a child to meet emotional needs constructively. Infants and toddlers who feel emotionally connected through daily routines with their caretakers, usually their parents, thrive physically and demonstrate a curiosity and interest in the world. As they grow, they gradually acquire the ability to manage their emotions, their behavior, and their learning.

Security and attachment in the early lives of children is grounded primarily in the emotional health of parents and their ability to interact with their children. Emotionally healthy parents can demonstrate the responsiveness and sensitivity that enables their children to get their needs met, to learn life skills and to feel good about themselves. Two of the major family pressures which interfere with this interactive process include poverty—the daily pressures of meeting basic needs—and domestic abuse, which heighten the parental stress and depression that inevitably affect their interactions with their children.

Children at Risk

Young children with depressed parents are more likely to have socio-emotional and behavior problems, difficulties in school, and problems with self-control than other children. Parents of kindergarteners in poverty had double the risk for depression as parents with incomes above the poverty threshold—27 percent compared to 13 percent.[17] While it is difficult to separate the cause and effect of depression and poverty, clearly better access to mental health and other family support services, including infant mental health services, for low-income families would ameliorate the effects of parental depression on children.

Other risks for mental health problems among young children include biological factors such as premature birth, as well as family mental and emotional capacity, stresses, and supports. Little information exists about the prevalence of social and emotional difficulties among young children. Pediatricians do not characteristically screen for maternal depression and not surprisingly, young children and their parents are also not likely to receive timely or appropriate treatment.[18]

Another group of children at high risk of social and emotional problems are those in the foster care system as a result of confirmed abuse or neglect. They suffer not only from the abuse or neglect but also the loss of their family. Half to two-thirds of foster children ages 0-6 score in the problem range in their developmental status according to national studies.[19] Although African-American children are disproportionately represented in the child welfare system, nationwide African-American and Hispanic children are the least likely to receive mental health services. The vulnerability of these children to emotional distress is revealed in national survey data. Less than half of children living with neither biological parent were able to control their behavior in kindergarten regularly or most of the time compared to 72 percent of children living with two parents (biological or adopted) and 58 percent living with one parent.[20]

Mental Health Services

Systems to meet the mental health needs of children in Michigan are plagued by a lack of services and limited resources.[21] The mental health continuum of care works poorly or extremely poorly, according to over two-thirds of county Family Independence Agency offices responding to a March 2004 survey.[22] Service gaps were cited though the entire continuum, from preventive services, including counseling for parents and families, to beds for long-term hospitalizations and psychiatric services. In the long list of service needs, respondents noted the need for more services provided outside normal business hours and offices, more qualified therapists and psychologists willing to treat Medicaid-enrolled children, and services for preschool children. Unmet mental health needs make foster care placements difficult to find and sustain for children with emotional problems and can lead to multiple placements causing further distress.

Intervention to assure the social and emotional health of children during their early years makes sense because that is the period of most growth. Neurological development at that time outpaces any other period in the life cycle. As children age, behaviors and attitudes get more entrenched so addressing potential problems as early as possible tends to be more effective. Mental health disorders have relatively the same prevalence in younger children as among older children, according to current studies, but most young children do not receive any treatment unless their problems are severe. Estimates suggest 6 to 10 percent of children in child care settings are expelled or at risk of expulsion because of anti-social behavior or emotional disturbance.[23]

[16] Michigan Department of Community Health: Division of Mental Health Services to Children and Families. *Social-Emotional Development in Young Children* (Lansing: MI, revised 12/03), 12.

[17] B. Brown et al., *op cit*., 59. Chart 5-1 Parental Depression.

[18] Neal Halfon, *Preschool and Identification of Mental Health Needs* from Report of the Surgeon General's Conference on Children's Mental Health, (U.S. Dept.of Health and Human Services).

[19] John Landsverk, *Child Welfare and Identification of Mental Health Needs* from Report of the Surgeon General's Conference on Children's Mental Health (U.S. Dept.of Health and Human Services).

[20] B. Brown et al., *op cit*., 15, Chart 1-2.

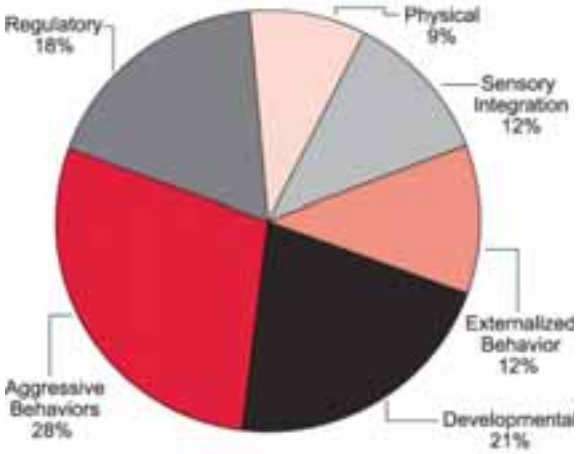
[21] Charles Jones to Marianne Udow, Memo Re: Mental Health Survey (Lansing, MI: Office of Performance Excellence and Disability Determination Service: Family Independence Agency, March 26, 2004).

[22] Ibid.

[23] Betty Tableman, *Presentation to Elkins Task Force on Early Education and Care*, (Lansing, MI: November 3, 2003).

Most children at risk of expulsion from care exhibited more than one problem.

(N=224 children/521 behaviors)



Source: Michigan Child Care Expulsion Prevention Projects Evaluation Report for Oct 02-Sept 03 (June 2004)

In a limited number of sites, through collaboration between state mental health and child welfare systems, young children in Michigan child care settings may get assistance as part of a Child Care Expulsion Prevention project (C.C.E.P.) when they are exhibiting problematic or "challenging" behaviors. (Challenging behaviors by a young child are defined as those that interfere with learning, development or success at play; that harm the child or others; or that put the child at high risk for later social problems or school failure.)[24] C.C.E.P. and other similar projects provide support for adults to enable them to nurture social and emotional development of children in their care, increase access to mental health services for children and their families, and promote retention or appropriate relocation of children in child care settings.[25] Project consultants take a comprehensive approach—addressing the home and child care environments as well as the needs of the child.

[24] Michigan Department of Community Health: Division of Mental Health Services to Children and Families, *Social-Emotional Development in Young Children* (Lansing, MI: revised 12/03), 23.

[25] Sharon Field and Mary Mackrain, *Michigan Child Care Expulsion Prevention Projects: Evaluation Report October 2002 through September 2003* (MCCEPP, August 2004), 5.

In fiscal year 2003 Michigan had 18 C.C.E.P. programs with services available in 26 counties across the Upper Peninsula, Detroit and Wayne County, Kent County, as well as the greater Lansing area.[26] Although a relatively small number of children (224) were referred, the intervention affects the child, but provider staff, family members, and other children in the child care facilities. At the end of the program, problem behaviors among referred children had decreased in number and intensity. The majority of children served were able to remain in or graduate from their child care setting (69%) or transfer to a more appropriate setting (15%). Before the programs started in 1999, one survey found that during a single year nearly 2 percent of the children in a single Michigan county had been expelled from child care programs.[27]

Children were most frequently referred for aggressive behavior (e.g. biting, hitting, swearing, bullying) or developmental problems (e.g. clinging, problems focusing, not listening to the teacher, crying for mother).[28] The average number of problems identified for each child was two. The average age of children referred was three years and four months, and most (75%) were boys.[29] Since the program is designed for and marketed to child care centers or preschools, it is not surprising that they were the source of almost all (82%) referrals.[30]

To increase awareness of the importance of social-emotional development and improve services the Department of Community Health developed and distributed a guide on the topic for practitioners such as child care providers and Community Mental Health staff. It outlines signs of social and emotional well-being and behaviors signaling potential distress among young children. It also categorizes the developmental needs of young children at different stages with age-appropriate activities and outlines specific strategies agency personnel can take to promote social and emotional well-being among its young charges.[31]

[26] Ibid.

[27] Elena Cohen and Roxanne Kaufmann. *Early Childhood Mental Health Consultation* (Washington, DC: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, April 2000), vii.

[28] Sharon Field and Mary Mackrain., *op cit*., 3.

[29] Sharon Field and Mary Mackrain, *op cit.,* 5.

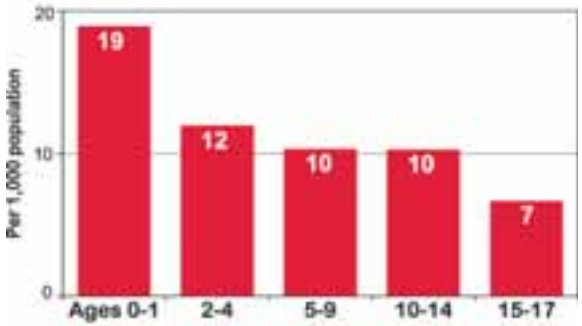
[30] Sharon Field and Mary Mackrain, *op cit.,* 3.

[31] Michigan Department of Community Health: Division of Mental Health Services to Children and Families, *Social-Emotional Development in Young Children* (Lansing, MI: revised 12/03)

Safety of Infants and Young Children

When children are not safe in the care of their families, the state's child welfare system is required to intervene. Nationally and in Michigan young children have the greatest risk of involvement in the state child welfare system— children under the age of two have the highest confirmation rate of abuse or neglect in Michigan.[32] Among every 1,000 children under age two, 19 were confirmed as victims of abuse or neglect in fiscal year 2003, compared to 12 among 1,000 children ages 2-4, and 10 among children ages 5 to 9.

Youngest children in Michigan had highest rates of confirmed abuse or neglect.

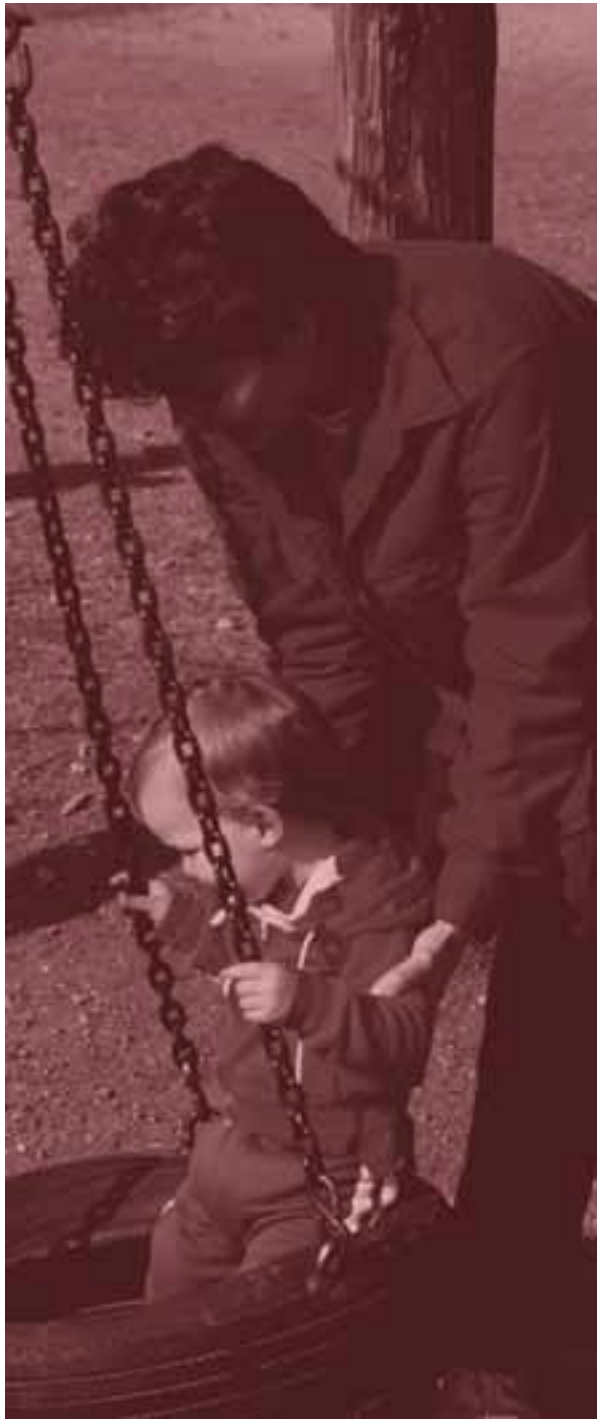


Source: Michigan Family Independence Agency/Calculations by Kids Count

Infants and young children are also at the highest risk of death from maltreatment; they are the most vulnerable because of their dependency and inability to defend themselves.[33] Of the 52 Michigan child fatalities that resulted from maltreatment in 2002, over half (56%) were infants under the age of one, and another one-quarter occurred to children between the ages of one and four. National data reflect similar patterns, reporting that most children (75%) who die from maltreatment are under the age of four.[34] According to national statistics, almost 40 percent of all fatalities from maltreatment resulted from neglect where the mother is most often held responsible while the 30 percent from abuse often involve fathers or other male caretakers.[35]

Child deaths as a result of abuse or neglect may be twice as high as the numbers suggest. Recent studies in Colorado and North Carolina have estimated that at least half the deaths caused by maltreatment are not identified, particularly in cases involving neglect. In Michigan the findings of local Child Death Review teams that examined roughly half of all child deaths in the state in 2001 determined that almost half of these were preventable if an individual, groups of individuals, or the community had intervened at crucial points.[36] (Local teams set their own criteria for determining which records to review.) Teams have made recommendations about state and local policy, services, and programs to prevent future child deaths. Unfortunately many of these initiatives have not been implemented because of funding constraints in the state budget.

One strategy for preventing child abuse and neglect, particularly in the early years, involves such activities as parent education, home visitation, and parent support groups. Such efforts can help parents better understand and meet their child's emotional, physical, and developmental needs, as well as develop nonviolent discipline techniques, and connect the family to additional supports. Without adequate funding for these additional supports such as emergency services, child care subsidies, substance abuse or mental health treatment, or cash assistance, abuse and neglect will continue to threaten children. A major part of keeping children safe involves providing a wide range of supports that fragile families need to stay together and raise children in a secure and stable environment. To successfully integrate these supports on a timely basis, coordination and an early detection system are critical.



[32] 1975 PA 238, Abuse involves harm or threatened harm to a child's health or welfare by a parent or legal guardian that occurs through non-accidental physical or mental injury. Neglect occurs when a parent or legal guardian harms or threatens to harm the child through negligent treatment by failing to provide adequate food, clothing, shelter or medical treatment or placing the child at unreasonable risk.

[33] Michigan Child Death State Advisory Team, *Child Deaths in Michigan*: *Fourth Annual Report*, (Lansing, MI: Michigan Child Death State Advisory Team Spring 2004), 5. They also represent the largest share of all child deaths – 69 percent of child deaths in Michigan in 2001 were children under the age of five.

[34] US Health and Human Services: Administration for Children and Families, *Child Abuse and Neglect Fatalities: Statistics and Interventions*, < http://nccanch.acf.hhs.gov/pubs/factsheets/fatality.cfm > (5 October, 2004).

[35] Ibid.

[36] Michigan Child Death State Advisory Team, *Child Deaths in Michigan*: *Fourth Annual Report*, (Lansing, MI: Michigan Child Death State Advisory Team Spring 2004), Teams examined records for half (854 of the 1,760) the deaths of children, 0-17, in 2001.

Access to Education and High-Quality Care

Parents are the first teachers of children, and the quality of those parent-child relationships shapes the world of young children. For parents to do their job well, they need the support of their families, neighborhoods, and the larger community. The most vulnerable children have often been found to live in families with insufficient support, particularly those in neighborhoods with high levels of poverty and unemployment. Society has a vested interest in assisting such disadvantaged parents of young children to increase the likelihood of these children reaching their potential as adults. A key strategy for state intervention in early childhood is to ensure access to quality child care and early education programs.

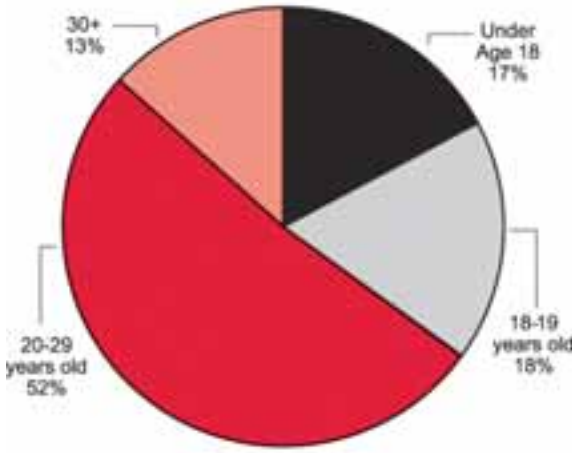
Most Michigan children now spend time in the care of someone other than their parent in their early years. National data show that three of five young children, ages six and under, spent some time in non-parental care in 2001.[37] In most households all parents work, and 85 percent of children in homes where a mother works full-time (35 or more hours a week) spend time in child care. Rarely can parents arrange their work schedules to accommodate the care of children unless part-time work is an option financially and professionally. Many low-wage part-time jobs in retail or other services actually offer less flexibility and scheduling options than full-time work where employees are more likely to have sick time, vacation time, or family time benefits.

Maternal Education

Children born to a mother who has not completed a high school education are vulnerable in several ways—economically, physically, and emotionally. In 2002, one of every six newborns in Michigan had a mother who had not completed 12 years of education. These 21,770 infants, 17 percent of all births, were at higher risk of not getting their basic needs as well as their developmental needs met, particularly in the formative early years when mothers play such a crucial role in child development as well as basic care. In 22 Michigan counties, including two counties with some of the largest concentrations of children, a fifth of mothers of newborns had not completed high school. Over half of Michigan mothers with less than a high school education were in their 20s, another 40 percent were teens, and 70 percent were single parents. Unfortunately, the education level of the parents usually affects the family's capacity to provide for not only the basic physical needs but also the social-emotional and cognitive needs of children.

Recent studies have revealed that young children from families with low parental education levels are less prepared for school in terms of their intellectual development. For example, only 38 percent of kindergarten children whose mothers lacked a high school degree could demonstrate proficiency at recognizing letters—the first step to reading—compared with 86 percent of kindergarteners whose mothers had graduated from college.[38]

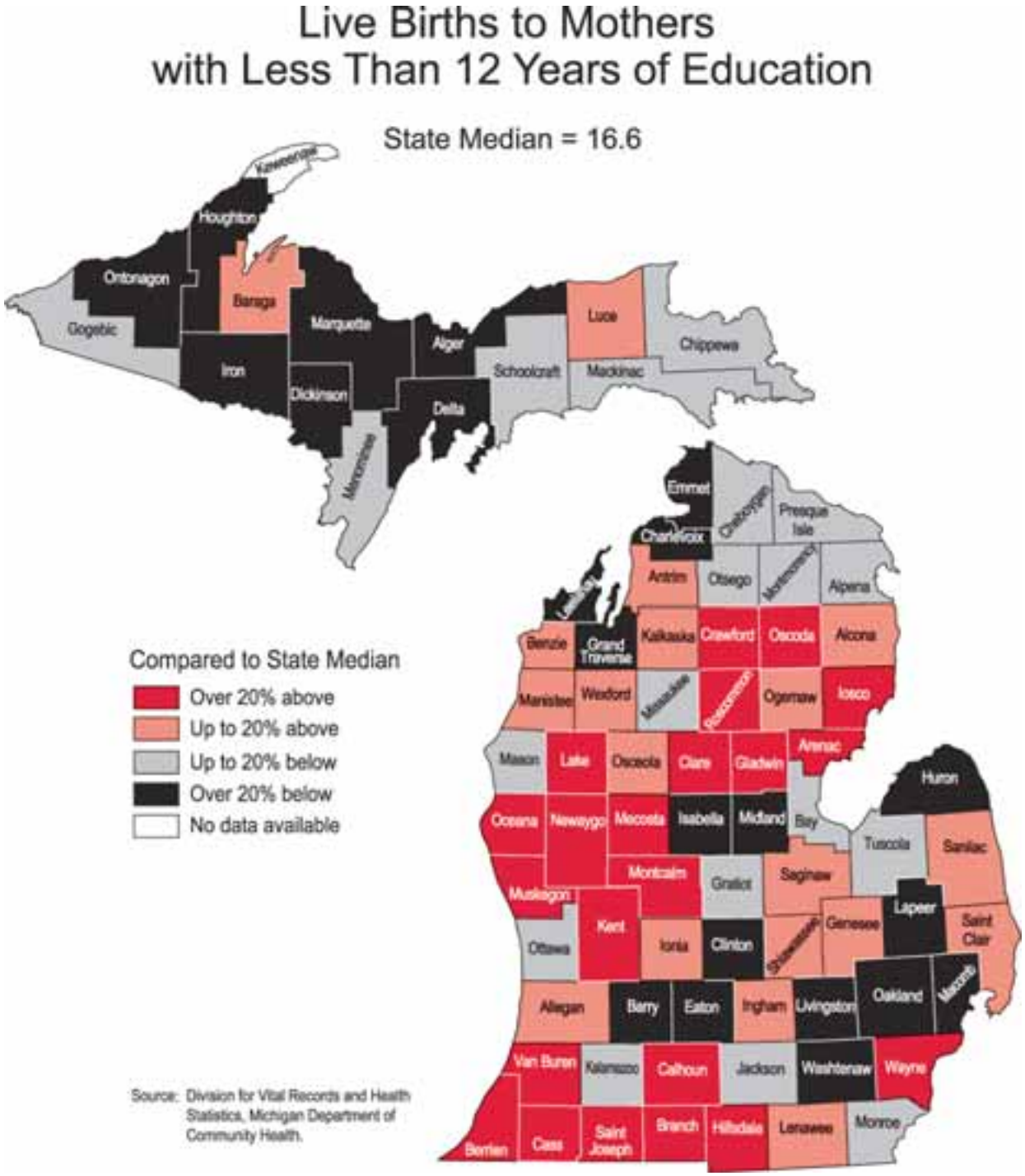
The majority of mothers without a high school education in Michigan were in their 20s or older.



Source: Vital Records and Health Data Development, Michigan Department of Community Health, 2002

[37] B. Brown et al., *op cit.*, 82

[38] Ibid., 21 (Chart 2-1)



Importantly, these reading readiness deficits at an early age tend to persist over the elementary school years. Strengthening the quality of child care options and other supports available to low-income mothers would help address the disparity in cognitive skills among entering kindergarteners.

Quality Concerns

The well-being of children in non-parental care and education programs is a matter that concerns the state. Michigan provides oversight of child care facilities to insure that the basic health and safety needs of young children are protected. However, Michigan is the only state in the nation that has not instituted any basic training requirements for the providers of child care. In the past several years, as caseloads have increased for the state's licensing consultants, concern has grown about the capacity of the state to monitor even the most basic health and safety requirements.

While child care has many positive effects such as early socialization with peers, positive relationships with other adults, and a potentially rich environment for early learning, national studies suggest that only 10-15 percent of current child care could be considered "high quality." A safe and stimulating environment where caregivers offer responsive supervision, verbal and cognitive stimulation, individualized attention, and opportunities for stable relationships characterize high quality care.[39] While the positive interaction between caregivers and children is key to quality, structural components such as a low ratio of children to caregiver (one of the most vital components of high quality care), staff trained in early childhood development, and adequate staff wages and benefits also have an effect.[40] As the impact of the quality of early care on children's later achievement is more widely appreciated, public policy advocates are examining ways to increase quality care options and broaden access for more children.

[39] Lynn Davey, *Early Childhood Development: What Matters MOST?*, Child Development and Public Policy Issue Brief. Vol. 1 No. 1 (Augusta, Maine: Maine Children's Alliance, Summer 2003).

[40] Ibid.

Supply of Child Care

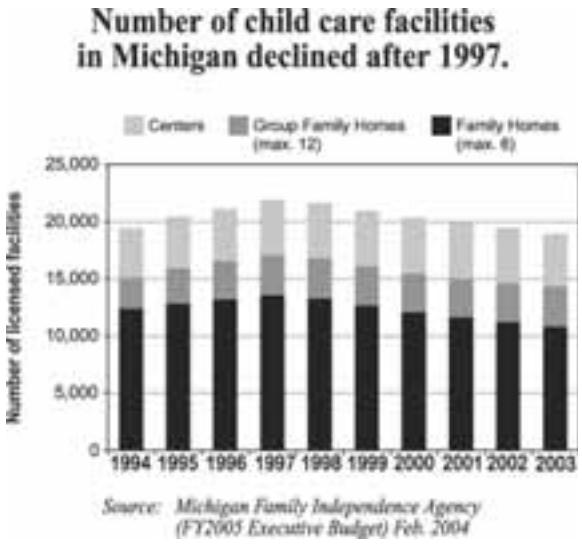
In Michigan the total number of licensed facilities providing child care grew between 1994 and 1997 as the state economy boomed. Capacity peaked in 1997 at 23,856. By 2003 the total number of facilities had dropped to 18,925—below the 1994 supply.

Regulated child care is provided at the following types of facilities:

- Family homes with a maximum capacity of six children,
- Group family homes with a maximum of twelve children, and
- Centers, which range from 12 to over 300 children

Of the three types of facilities, the recent decrease in supply occurred primarily among family homes where the number dropped by 21 percent—from roughly 13,590 to 10,800 between 1997 and 2003. During that period the number of group family homes (3,500) and centers (4,600) remained essentially the same.

This steep decline in licensed family home providers may have resulted from the backlog in processing licensing renewals. The backlog represented 2,000 facilities in March 2003, and roughly 930 at the end of January 2004. Early retirements



of state workers at the end of 2002, precipitated by budget deficits, reduced the Child Day Care Licensing workforce by a quarter. Between 2001 and February 2004 the caseload per consultant swelled from 240 facilities to 300.[41] These constrictions in the state licensing and inspection capacity can have negative effect on the supply and the quality of care of regulated child care facilities.

Cost of Child Care

The cost of full-time child care represents a substantial expense in the household budget. The average cost of full-time child care in Michigan ranges from $510 per month for infants to $468 for preschoolers. These costs would consume 15-16 percent of Michigan's average wage per job ($37,512 annually or $18 an hour) or 21 percent of income at Michigan's median wage ($29,577 annually or $14.22 an hour).[42]

Costs vary quite dramatically across counties and types of care. For example, in Osceola County the $346 cost of infant care is roughly half of the $666 in Oakland or Washtenaw counties. The cost of full-time infant care takes almost a quarter of the average wage per job in the counties of Livingston and Leelanau counties compared to 15 percent in Hillsdale and Midland counties.

The average wage is well above what most female-headed families would earn. Most parents in the low-wage market earn less than half the average wage per job so full-time child care, particularly for infants, would consume almost a third of their income. Families with more than one child requiring full-time care face even steeper costs. For this reason the child care subsidy by the state has proved a critical work support for families, but its steady decline in purchasing power limits child care choices.

Child Care Subsidy

Child care subsidies help low-income families cover the cost of child care so parents can work. The Child Development and Care Program of the Michigan Family Independence Agency provides subsidies for the number of hours care actually provided as confirmed by the provider. This policy limits child cares choices for parents because almost all licensed child care providers charge by the week, not by the hour, for child care. Low-income parents would not have the financial resources to make up the difference, and part-time workers with unpredictable schedules would be at a particular disadvantage in purchasing care at regulated facilities.

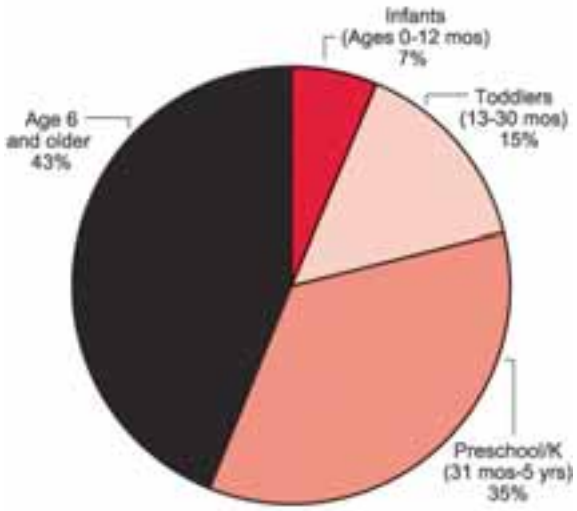
Even families who qualify for the maximum payment may be liable for a significant difference between the actual cost and the subsidy payment. The last increase in basic subsidy rates in 1997 was based on the 1996 market rate survey—now lagging by eight years in cost of care. Since 1996 there have been two adjustments in the minimum wage, which has created financial pressures for providers who often use minimum wage workers. In October of 2000 an "Infant Toddler Incentive" increased reimbursement for care to children under the age of two and a half to all providers, including relatives and aides if they had completed 15 hours of approved child care instruction.

Recent changes in the subsidy program have limited either payment or eligibility. In fiscal year 2003 a 6 percent decrease was levied on payments to relatives, and the income eligibility

[41] Family Independence Agency, *Fiscal Year 2005 Executive Budget: Office of Children and Adult Licensing Programs* (Lansing, Michigan: Presentation to the House Appropriations Subcommittee for the FIA Budget, February 18, 2004).

[42] Lawrence Mishel et al, *The State of Working America 2004-05* (Washington D.C.: Economic Policy Institute-ILR Press, 2003), 371. Median wage data are not available for Michigan counties.

Three of five children in subsidized child care in Michigan were below the age of six.



Source: Michigan Family Independence Agency, Oct-Nov 2003

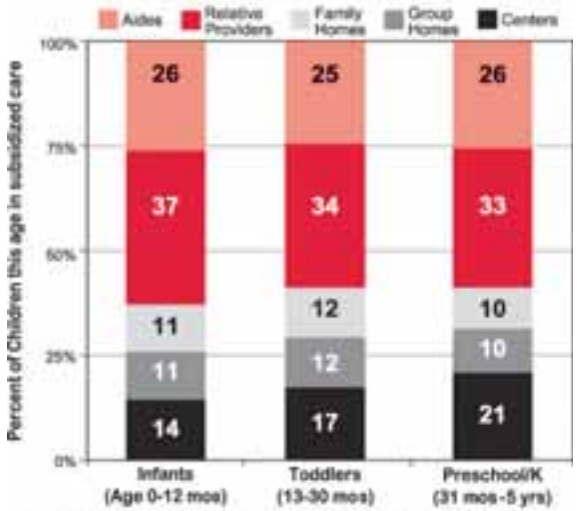
ceiling for care subsidies was lowered from family income below 185 percent poverty to below 150 percent of poverty. In fiscal year 2004, the maximum subsidized hours of care per child during a two-week pay period was limited to 100.

A total of 67,086 families received assistance with child care costs in fiscal year 2003.[43] In fiscal year 2003 the average monthly subsidy payment per child was $317, and the average payment per family was $601. (These lower than average monthly payments reflect the predominant use of unregulated care and associated substandard rates paid by the state.) Three of every five children whose non-parental care is supported by the subsidy in Michigan are in unregulated care provided by relatives or in-home aides.[44] This pattern does not change substantially across age groups for children under age six. Infants are only slightly more likely to be in relative care than toddlers and preschoolers (37% vs. 33%). Parents of infants often prefer to rely on providers with fewer children to limit exposure to illness or infection.

Between 1998 and 2003, the number of subsidized children in unregulated care rose. Relative care rose 22 percent, and aide care by 7 percent. Among licensed facilities only group family homes experienced an increase (12%) in the number of subsidized children. Licensed child care centers, family homes or group family homes are often not readily available in low-income neighborhoods. Transportation, variable or night/weekend work schedules, registration fees, and payment norms may also present barriers for low-income families to the licensed care market for their children while they work.

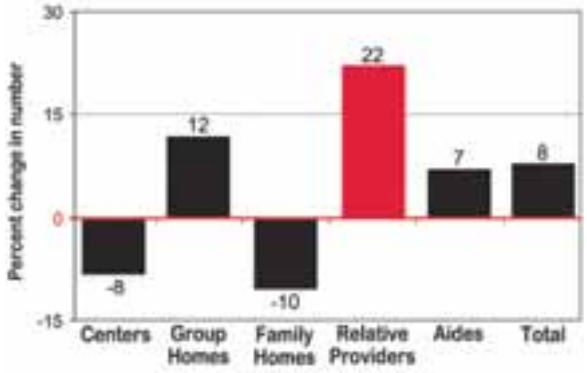
Provider turnover among relative providers and aides registered for subsidies in Michigan is relatively high. Only 40 percent of aides and 47 percent of relatives receiving payment in May 2003 were still receiving a payment a year later, compared to 79 percent of centers, 76 percent of group homes, and 60 percent of family homes. These changes suggest relatively rapid disruptions in child care arrangements with their consequent impact on a child's sense of security and attachment. The institutional stability in centers and group homes masks their turnover in child care workers, estimated to be about 20 percent per year.

Most children in subsidized care in Michigan were in unregulated care regardless of age.



Source: Michigan Family Independence Agency, Oct/Nov 2003

The number of children in subsidized care cared for by relatives jumped by 22 percent between 1998 and 2003.



Source: Michigan Family Independence Agency 1998 vs. 2003

Preschool

Preschool programs usually defined as primarily serving four-year-olds although some programs also target three-year-olds, mostly offer only part-day, part-week school-year services. Michigan was ranked 10th in the nation for access to preschool programming for four-year-olds, but as the worst state in the nation (50th) for access for three-year-olds. While there is a large private market for preschools, the costs are generally prohibitive for low and moderate income families. In addition, part-day, part-week preschool programs do not match work schedules for parents with full-time or variable employment schedules.

Programs with comprehensive services targeted to low-income children and their families have been shown to improve children's health, reduce grade retention and placement in special education, and increase high school graduation rates.[45] They also encourage and increase parental involvement in their child's learning.

[43] Family Independence Agency, *Fiscal Year 2005 Executive Budget Overview and Administrative Issues* (Lansing, Michigan. Presentation to the House Appropriations Subcommittee for the FIA Budget, February 18, 2004).

[44] Family Independence Agency, *Day Care Aide Requirements*, <http://www.michigan.gov/fia/0,1607,7-124-5453_5529_7148-15175—,00.html> (October 7, 2004). An aide provides care in the child's home and must be at least 16 years old.

[45] Ron Haskins and Isabel Sawhill. *The Future of Head Start*: Policy Brief Welfare Reform & Beyond #27 (Washington D.C.: The Brookings Institute, July 2003), 3.

Michigan Three- and Four-Year-Olds Attending Preschool

Rank		% in Preschool	Rank		% in Preschool
	Michigan	**48.9**	42	Lake	42.2
1	Baraga	66.3	43	Arenac	42.1
2	Iron	64.3	43	Grand Traverse	42.1
3	Oakland	61.4	45	Emmet	41.9
4	Washtenaw	58.9	46	Roscommon	41.2
5	Luce	55.5	47	Wexford	41.0
6	Alcona	52.3	48	Lapeer	40.8
6	Alpena	52.3	49	Calhoun	40.7
8	Wayne	51.8	50	Ionia	40.5
9	Manistee	51.5	51	Charlevoix	40.2
10	Livingston	51.2	52	Hillsdale	40.0
11	Midland	50.3	53	Barry	39.9
12	Bay	50.1	53	Mecosta	39.9
13	Ingham	49.7	55	Ontonagon	39.5
14	Mackinac	49.4	55	Schoolcraft	39.5
15	Macomb	49.2	57	Cheboygan	39.0
16	Muskegon	49.0	57	Clinton	39.0
17	Saginaw	48.4	59	Van Buren	38.4
18	Benzie	47.6	60	Iosco	38.1
19	Shiawassee	47.5	61	Osceola	37.9
20	Kalamazoo	47.4	62	Alger	37.6
21	Huron	47.1	62	Newaygo	37.6
22	Genesee	47.0	62	Ogemaw	37.6
22	Kent	47.0	65	Clare	37.4
24	Chippewa	46.9	65	Montmorency	37.4
25	Gogebic	46.7	67	Dickinson	37.2
26	Saint. Clair	46.2	68	Antrim	37.1
27	Isabella	46.1	69	Cass	36.4
28	Mason	45.9	70	Tuscola	36.1
29	Leelanau	45.4	71	Montcalm	36.0
30	Menominee	45.3	72	Kalkaska	35.4
31	Monroe	44.7	73	Oceana	35.3
32	Branch	44.6	74	Houghton	34.9
33	Jackson	44.3	75	Keweenaw	34.8
34	Lenawee	44.1	76	Sanilac	34.5
35	Oscoda	43.9	77	Gladwin	34.3
36	Berrien	43.8	78	Saint. Joseph	34.1
36	Presque Isle	43.8	79	Missaukee	34.0
38	Ottawa	43.6	80	Allegan	33.8
39	Eaton	43.5	81	Gratiot	33.5
40	Delta	42.7	82	Otsego	32.6
41	Marquette	42.3	83	Crawford	30.9

Source: US Census 2000

Highest income children in Michigan were most likely to attend preschool.

Source: US Census 2000, Tabulations from Library of Michigan

Roughly half of all three- and four-year-olds attended a nursery or preschool program in Michigan, according to the U.S. Census 2000.[46] Among Michigan counties the Upper Peninsula counties of Baraga and Iron had the largest share of children attending preschool with roughly two of every three attending. In Gratiot, Otsego and Crawford counties only a third of three- and four-year-olds attended a preschool program. Among the ten most populous counties, the share attending preschool ranged from 47 percent in Kent to 61 percent in Oakland.

Higher income children were more likely to attend preschool in Michigan than poor or low-income children.[47] Almost half of the state's children in higher income families (300% of poverty or above) attended preschool in 2000 compared to just over one third of poor children. Many poor or low-income children who qualify for Head Start or the Michigan School Readiness Program cannot attend because of limited program capacity or parental employment schedules.

Head Start

Head Start, the federal early education program, has offered comprehensive services for low-income children and families since 1965. Research has documented that comprehensive services to address the emotional, social, health, nutritional, and educational needs of low-income preschoolers make a significant difference in the well-being of those children and their success as adults. A recent review found that children in Head Start were more likely to: have received more screenings for medical conditions than other Medicaid-enrolled children (86% vs. 28%), have a higher level of immunizations than other children (93% vs. 72% of poor children), and have received more dental treatment than other low-income children (78% vs. 20% of poor children)[48]

In Michigan 35,512 children participated in Head Start in 2002-03. Three of four children lived in families with incomes below the federal poverty level, and one-third were enrolled for their second year. Most (64%) attended a center-based four-day part-day program. It is estimated that half of eligible children in Michigan participate in Head Start.

Michigan School Readiness Program

To meet the needs of other vulnerable children not eligible for Head Start, the state sponsors the Michigan School Readiness Program (MSRP) that began serving four-year olds at risk of school failure in 1985. A total of 22,891 four-year-olds participated in the 2002-03 school year. To be eligible a child must have two of 25 identified risk factors, and more than 50 percent of the children in each site must come from low-income families.[49] Most children (57%) qualified by income, 37 percent came from a single-parent family, 30 percent lived in rural or segregated housing, and 27 percent had a family history of academic failure. Half the children in the MSRP program had more than three risk factors.

Each class has a certified teacher and a trained assistant for a maximum of 16 children. Services are provided primarily by school districts (84% of enrollment) with another 16 percent served by nonprofit organizations selected in a competitive grant process.[50] A total of 467 school districts and 65 community agencies participate. Although a few children received full-day or home-based services, almost all children (94%) in MSRP attended a part-day program, with most of these (73%) children attending a part-day program administered by a school district.[51]

[46] Census respondents were directed to include "only nursery school or preschool.

[47] US Census 2000, Tabulations from Library of Michigan.

[48] Kate Irish et al., *Head Start Comprehensive Services: A Key Support for Early Learning in Poor Children*. CLASP Policy Brief No. 4 (Washington D.C.: Center for Law and Social Policy January 2004), 1.

[49] Low-income is defined as meeting the eligibility for free or reduced prices in the School Lunch Program with income below 185 percent of the federal poverty level.

[50] Marijata Daniel-Echols, *2002-2003 Michigan School Readiness Program Statewide Data Report: Risk Factor and Program Quality Profiles* (Ypsilanti, Mich.: High/Scope Educational Research Foundation. September 2003), 6.

[51] Ibid. Table 3.

Program evaluation findings showed that children who participated in MSRP were better prepared when starting school and continued to do better in school than non-participating children with similar socio-economic characteristics and age.[52] The majority of MSRP children received significantly higher ratings in cognitive and socio-emotional skills when entering kindergarten. Their parents also demonstrated a much higher level of involvement in the school and their child's learning than those of non-participants. These positive effects persisted through elementary grades with a significantly larger share of MSRP participants passing the MEAP in the fourth grade. Unfortunately 16,000 of Michigan's children are eligible but do not participate each year—they go without services because the program lacks classroom space and funding. Children of working poor families in rural communities are particularly disadvantaged in gaining access to the program because of transportation restraints.

[52] The full evaluation report is available at the High/Scope web site: http://www.highscope.org/research/MsrpEvaluation/msrpmain.htm

Summary and Conclusions

Michigan faces many challenges in improving the lives of its young children. In order to ensure that more children arrive at school ready to learn, the state must target more investment in the early years of children's lives. During that developmental stage, focused interventions can make a large impact on a child's future. Unfortunately the structural deficits in the state budget and a lagging economy have placed more children at risk. Poverty among young children in Michigan has increased between 2000 and 2003, and programs designed to mitigate its effects have been severely weakened at the federal and state level.

The physical and socio-emotional well-being of children as well as their safety and the quality of their care and education are all jeopardized by these trends. The basic needs of children cannot be met with family income below poverty, and even families with income double the poverty level struggle with the costs of shelter, transportation, and child care. The roughly 28,000 babies born each year to mothers without a high school education represent a group at high risk of poverty in an economy where post-secondary skills are required in most cases to earn a living wage.

Intervention strategies for these vulnerable families include access to health care, particularly well-child visits, high-quality child care and early education options, mental health and substance abuse treatment, and adequate and accessible child care subsidies. These strategies would help improve the well-being of young children and their families. They would also address the relatively high rates of preventable hospitalizations for asthma among 0-4 year-olds, and the share of children afflicted by lead poisoning.

Broadened recognition of the importance of the quality of the relationships in the early years, primarily based on interactions with caregivers, especially parents, has emphasized the need for adequate and accessible supports for vulnerable families. The daily routine of caretaking shapes a child's sense of self, capacity for empathy and emotional regulation. These capacities in the development of the child are as important as cognitive skills for success in school and life. Supports for parents, the first caregivers, are key to improvements in this area, as are increased awareness and sensitivity among child care providers and other workers who come into contact with young children and their families to the socio-emotional needs of young children.

The national agenda has expressed a determination to leave no child behind in educational performance, but the effort to achieve this goal must begin at birth, intensify in the early years, and be maintained throughout the child's formal educational period. But the threshold issue remains: the child's basic needs must first be met if the state and nation are to fulfill their promise to children.

ECONOMIC SECURITY

Despite improvement in child poverty over the late 1990s during some of the best economic times the state had seen in decades, the economic security of families since 2000 has been eroding. During the economic boom between 1995 and 2000, Michigan had the largest decrease in child poverty among the 50 states, according to the U.S. Census Bureau.[1] These data reflect the situation for Michigan families at the height of the economic expansion that occurred over the late 1990s. The downturn in the summer of 2000 and the "jobless" recovery that followed adversely affected the financial stability of many families. In March 2004, Michigan had the second highest unemployment rate in the country. Between 2001 and 2003 participation in the Food Stamp Program, the nation's major nutrition support program, escalated by 44 percent among Michigan residents. The latest available poverty data show that in 2003 child poverty in Michigan stood at 15.2 percent—up from 13.6 from 2000.[2]

Michigan Rankings for Economic Security Indicators

Michigan Rank*	Indicator	Percent**
20	Children in extreme poverty (below 50% of poverty level)	6
29	Female-headed Families receiving child support or alimony***	36
26	Children in families where no parent has full-time year-round employment	25
22	Children in Poverty (2000 estimate)	14
22	Families with children headed by single parent	28
14	Median Income Families w/ Children	$55,800

Source: Kids Count Data Book 2004: State Profiles of Child Well-Being

* a rank of "1" is best

** Data are a 2000-02 average from 2001-03 Current Population Survey or SAIPE Estimate (for child poverty)

*** includes partial payments received in the previous calendar year (2001)

[1] The 2000 Small Area Income and Poverty Estimates are the latest child poverty data for counties as of September 2004.<http://www.census.gov/hhes/www/saipe/> (5 October 2004).

[2] US Census Bureau, *American Community Survey 2003 Data Profile, table 3,* 18 October 2004, <http://www.census.gov/acs/www/Products/Profiles/Single/2003/ACS/Tabular/040/04000US263.htm> (20 October, 2004).

Poverty Thresholds 2003

	Two Children Annual	Two Children Monthly	Three Children Annual	Three Children Monthly
100% Poverty				
Two Parent	$18,660	$1,555	$21,959	$1,830
Single Parent	14,824	1,235	18,725	1,560
150% Poverty				
Two Parent	27,990	2,333	32,939	2,745
Single Parent	22,236	1,853	28,088	2,341
200% Poverty				
Two Parent	37,320	3,110	43,918	3,660
Single Parent	29,648	2,471	37,450	3,121

Source: US Census Bureau.

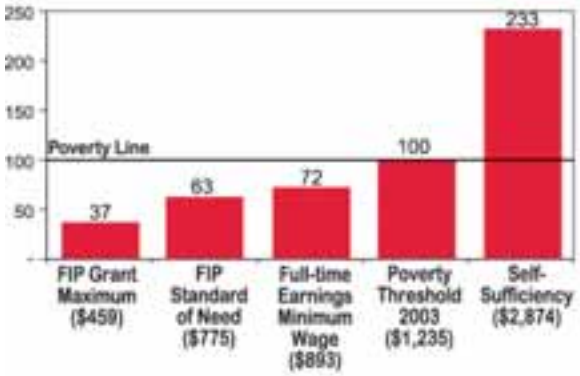
The poverty threshold has been used to measure economic well-being since the 1960s. While it is adjusted annually for inflation, the standard represents a profound level of deprivation in modern America. In 2003 the poverty threshold for a family of four with two children was $18,660 or a gross monthly income of $1,555. The 2003 shelter costs ($771) of a two-bedroom unit in Wayne County, as estimated by the U.S. Department of Housing and Urban Development[3] would consume half of the before-tax family income of a family living at the poverty threshold. The remainder of roughly $700 would have to cover all other expenses including the cost of food not covered by the food stamp allotment, transportation, telephone, clothing, personal needs, medical expenses, school supplies, and child care.[4] Even more troubling, roughly one of every 17 children in Michigan lived in "extreme" or abject poverty, where family income is less than half the poverty threshold.

[3] Fair Market Rent as calculated annually by the U.S. Department of Housing and Urban Development includes all utilities except telephone. It represents the 40th percentile for rents in the area; that is, 40 percent of the area rents are lower while 60 percent are higher. US Department of Housing and Urban Development, *Fair Market Rents* (Washington D.C.: HUD, 2004).

[4] The food stamp allotment was calculated as a supplement, to cover two-thirds of the food budget, not adequate for all food expenses. When "poverty" was calculated in the 1960s, child care, now the second largest expense for families with preschool children, was not part of the average family household budget. <http://www.fns.usda.gov/fsp/faqs.htm#12> (5 October 2004).

Program benefits and poverty level income do not reflect real income needs of families.

(Monthly income for single parent with two children)



Source: Michigan League for Human Services, Economic Self-Sufficiency in Michigan

In recognition of the inadequacies of poverty income as an indicator of need, eligibility for several family support programs is set to include families at income levels above poverty. For example, children are eligible for Medicaid in Michigan with family income at 150 percent of poverty and for reduced prices on the School Lunch Program at 185 percent of poverty. Children in low-income families are at high risk of nutritional deficiencies and deferred medical care.

In recent years more researchers and economists have focused on calculating a "self-sufficiency" standard of income, where basic needs can be met on available income without reliance on any government or non-profit programs. A recent self-sufficiency analysis for Michigan revealed that a family of four with both parents working, and two preschool children, would require combined annual earnings of $38,394.[5] A single parent with two children under the age of six would require $34,485. At the current minimum wage a single adult working full-time (40 hours a week) year-round earns $10,712—less than one-third of the requisite income for such a single parent family to be economically self-sufficient.

[5] Michigan League for Human Services *Economic Self-Sufficiency in Michigan: A Benchmark for Ensuring Family Well-Being*. March 2004.

Child Poverty

The latest poverty estimates for all Michigan counties are available only up to the year 2000, when child poverty in Michigan had dropped by almost a third (32%) as compared to 1995.[6] In 1995, 20 percent of children in the state lived below the poverty line but by 2000 the share declined to 14 percent. Since 2000 the national and state economy took a sharp downturn, and child poverty in the state increased in the state by 12 percent between 2000 and 2003. Unfortunately updated information is available only for the state and a few of the most densely populated counties so the following discussion reflects the data for the year 2000.

Among the state's 83 counties the share of children living below poverty ranged from 4 percent in Livingston County to 30 percent in Lake County. Among the most densely populated counties, Ottawa County had the lowest child poverty rate (6%) followed closely by the southeastern counties of Oakland and Macomb at 7 percent. The share of disadvantaged children in Wayne County was three times as large (21%).

All Michigan counties experienced declines in the shares of their children living in poverty between 1995 and 2000. The drop was less than 10 percent in several counties in the northeast, such as Crawford and Alcona, and in the Upper Peninsula, such as Ontonagon and Mackinac. Among all counties, Wayne, the state's most densely populated, experienced the steepest decline (37%) in child poverty. Among the ten most populous counties, Ottawa had the smallest improvement (14%).

Free and Reduced Priced School Meals

A more current measure of need may be represented by the number of eligible school children who enroll in the state's means tested school meals program. In the 2003-04 school year, just over a third of Michigan student enrolled in public K-12 schools participated in the School Lunch Program at free and reduced prices. Such participation increased by 13 percent between 1995 and the 2003, rising from slightly less than one-third (31%) of K-12 public school students to over one-third (35%). Over half a million (588,400) students in Michigan were eligible for free or reduced-priced school lunches last year.

Across Michigan, the share of students participating in the School Lunch Program at free and reduced prices ranged from 9 percent in Livingston County to 58 percent in Oceana County. Among the most populous counties, Oakland County had the lowest participation rate—one in five children participated (18%) while in Wayne County almost half of school-aged children were of income low enough to qualify (48%).

Only six counties experienced a decline in the share of students qualifying. Lake County reflected the largest decline (37%), but in the other five counties the drop was 5 percent or less. The populous counties of Ottawa and Macomb counties had the largest increases (45-50%) in participation. Among the populous counties all reflected an increase in participation, but Washtenaw County had the smallest (6%).

Family Support Programs

A variety of programs provide nutritional, cash, or medical benefits to low-income families. Each program has its own eligibility criteria and application process. Families living below 130 percent of the poverty level may qualify for food stamps while children in families up to 200 percent of the poverty level ($36,000 for a family of four) may be eligible for health insurance. Direct or cash support, however, is provided to families at much lower income ceilings.

Food Assistance Program

The purpose of the Food Stamp Program, known as the "Food Assistance Program" in Michigan, is to address hunger and improve nutrition and health.[7] The program increases the nutritional value of household food supplies by 20 to 40 percent, according to research studies.[8] Households with incomes below 130 percent of poverty may qualify for a monthly allotment to purchase food. Benefits amount to roughly 79 cents a meal per person in a qualifying household. This benefit is now accessed electronically by means of a debit card. Although state governments administer the program and share in the administrative costs, the benefits are totally funded and their delivery primarily regulated by the federal government, where benefit levels and eligibility criteria are also determined.

In December 2003, one of every seven children in the state (409,384) relied on the program to meet some of their nutritional needs. Participation in 14 Michigan counties, including Wayne, Saginaw, and Genesee, climbed to at least a fifth of the child population.

Family Independence Program

The Family Independence Program (FIP), the state's cash assistance program often referred to as "welfare," assists some poor families with children with direct support. A parent with two children must have gross monthly income (earnings and FIP supplement) below $775 to qualify. This income ceiling for participation has not changed for over a decade despite roughly a 33 percent change in the cost of living over that time period. Families that have incomes too high to qualify for cash assistance subsist at levels substantially below the poverty level ($1,235 a month for a single parent with two children). As the poverty level continues to be adjusted upward to reflect cost of living increases and the FIP standard remains static, the struggle of Michigan families ineligible for any cash supplement to help cover the basic needs of their children becomes more desperate—their meager earnings cannot keep pace with rising costs.

In Michigan in 2003, roughly 147,000 or 5 percent of the state's child population depended on FIP. The maximum monthly cash assistance of $459 for a family of three has not been adjusted for over a decade for families whose head is expected to work. The eligibility income represents an income almost 40 percent below the poverty level for a family when work is unavailable.[9] In every Michigan county the maximum cash assistance level barely covered or fell far short of shelter costs as measured by the Fair Market Rent (FMR) for two-bedroom housing in 2003. In Wayne, for example, the FMR of $771 was almost 70 percent higher than the maximum cash assistance level of $459. When parents are not able to find the employment that would allow

[6] Small Area Income and Poverty Estimates (SAIPE) from the U.S. Census Bureau. The U.S. Census 2000 reflected income in 1999. <http://www.census.gov/hhes/www/saipe/ > (5 October 2004).

[7] The Food Nutrition Service is considering renaming the federal program since the term "food stamps" dates back to 1939 when a national welfare program actually issued orange and blue stamps that could be traded for food. In the early 1960s when the current program was established, participants were provided with paper coupons. Federal Register, Vol 69, No 119.

[8] The Food Research and Action Center. *Federal Food Programs* <http://www.frac.org/html/federal_food_programs/programs/fsp.html#History> (5 October 2004).

[9] Grant levels vary among six "shelter" areas designated by the Family Independence Agency. Figures quoted in the text are for Wayne County because it is the county with the most children in the state. It is in shelter area IV. Family Independence Agency, *FIP Monthly Assistance Payment Standards PRT* 210 (Lansing, MI: FIA 2000).

Shelter Costs and Cash Assistance (FIP) Grant Levels in Michigan Counties

County	Fair Market Rent (FMR)	FIP Grant	FMR as % of Max. FIP Grant	County	Fair Market Rent (FMR)	FIP Grant	FMR as % of Max. FIP Grant
Alcona	$446	$444	100	Lake	446	434	103
Alger	446	424	105	Lapeer	771	474	163
Allegan	632	459	138	Leelanau	530	474	112
Alpena	446	459	97	Lenawee	785	474	166
Antrim	446	459	97	Livingston	785	489	161
Arenac	446	434	103	Luce	446	424	105
Baraga	446	424	105	Mackinac	446	444	100
Barry	506	474	107	Macomb	771	489	158
Bay	543	474	115	Manistee	446	434	103
Benzie	446	444	100	Marquette	446	459	97
Berrien	538	459	117	Mason	446	444	100
Branch	449	459	98	Mecosta	446	424	105
Calhoun	572	459	125	Menominee	446	424	105
Cass	448	459	98	Midland	543	474	115
Charlevoix	481	459	105	Missaukee	446	444	100
Cheboygan	446	444	100	Monroe	771	489	158
Chippewa	446	434	103	Montcalm	528	444	119
Clare	446	459	97	Montmorency	446	459	97
Clinton	645	474	136	Muskegon	632	444	142
Crawford	456	444	103	Newaygo	447	444	101
Delta	446	434	103	Oakland	771	489	158
Dickinson	468	444	105	Oceana	446	434	103
Eaton	645	474	136	Ogemaw	446	444	100
Emmet	488	459	106	Ontonagon	446	434	103
Genesee	584	489	119	Osceola	446	434	103
Gladwin	446	444	100	Oscoda	446	434	103
Gogebic	446	424	105	Otsego	483	474	102
Grand Traverse	584	474	123	Ottawa	632	474	133
Gratiot	446	459	97	Presque Isle	446	424	105
Hillsdale	446	444	100	Roscommon	446	459	97
Houghton	446	434	103	Saginaw	543	474	115
Huron	446	424	105	St. Clair	771	489	158
Ingham	645	489	132	St. Joseph	446	459	97
Ionia	480	459	105	Sanilac	446	444	100
Iosco	446	434	103	Schoolcraft	446	424	105
Iron	446	424	105	Shiawassee	466	459	102
Isabella	493	459	107	Tuscola	488	459	106
Jackson	543	444	122	Van Buren	572	474	121
Kalamazoo	572	474	121	Washtenaw	785	489	161
Kalkaska	447	444	101	Wayne	771	459	168
Kent	632	474	133	Wexford	462	444	104
Keweenaw	446	424	105				

Source: U.S. Department of Housing and Urban Development (2003 FMR), Michigan Family Independence Agency

* Grant amounts vary by shelter areas designated by the FIA.

Note: FIP grant amount represents the maximum allowed to an "employable" parent

them to subsist on a mix of earnings and state supplemental support, they are less likely to find stable housing, putting the children at serious risk of moving frequently and often having to change schools. Recent high unemployment levels in the state have resulted in a substantial increase in the percentage of cases without earnings. Between May 2001 and May 2003 the share of cases expected to work that had no earned income doubled—from one-third to two-thirds. Among deferred cases where parents are not expected to work because of disability or illness, the legislature approved a modest increase in their cash assistance grant, roughly $18 a month for a family of three.

The continuing erosion of the capacity of public programs to mitigate the effects of poverty on vulnerable children and their families also takes its toll on other sectors—it raises costs for education, mental and physical health, substance abuse, and child welfare. Such minimal benefits place children in these vulnerable families at heightened risk of physical neglect, increase the burden on the Child Protective Services (CPS) system, and may lead to disruptions in their families, community networks, and education. A recent analysis of confirmed child victims of abuse or neglect in 2003 revealed that roughly three-quarters of the victims and their families were poor enough to meet the stringent standards for receipt of public assistance within the 12 months preceding the initial CPS investigation. (Public assistance includes one or more of the following; FIP, State Disability Assistance, Food Assistance Program, or Child Day Care subsidy.) Three-quarters of these confirmed cases involved the neglect flowing from inadequate resources as opposed to abuse.

Child Support

In Michigan almost one million children (990,000) depended on the child support system in 2004. Since the 1970s every state has operated a program to help locate absent parents and to establish paternity, as well as establish, periodically modify, and enforce child support orders. As a result of divorce and an increased number of never-married parents, more children than ever before depend on the effective functioning of the child support system. Child support payments provide a vital source of income to single parent families, mostly headed by women who make significantly less than their male counterparts. Michigan has one of the largest wage gaps in the country between men and women workers, it earned a ranking of 45th among the states. When custodial parents who tend to be women do not receive child support payments, these families are at great risk of poverty.

Roughly two of every five children under 18 in the state have a support order. The share of children with a support order ranged from a low of 15 percent in Keweenaw County to 57 percent in Calhoun County, one of six counties where more than half the children relied on a child support payment. Among the most populous counties, Oakland and Macomb had the smallest shares (22%) of children with a support order while Wayne had the largest (54%).

In April of 2004 the average monthly payment per child in Michigan was $133 per month. Among all counties the payment ranged from $77 in Lake to $224 in Leelanau County, one of six counties where payments were above $200 a month. Wayne County children received one of lowest average payments—$95.

Of the non-custodial parents in Michigan obligated to provide financial support to minor children in May 2004, roughly half had not made any payment during the previous six months while over a quarter (28%) had paid in each month since December. The erosion in earnings for male workers, particularly among those with a high school education or less and the recent high unemployment in the state have increased pressures on non-custodial parents, most of whom are fathers. The percentage of non-custodial parents not making a payment climbed from 49 percent in July 2002 to 52 percent in May 2004.

The continuing erosion of the capacity of public programs to mitigate the effects of poverty on vulnerable children and their families also takes its toll on other sectors—it raises costs for education, mental and physical health, substance abuse, and child welfare.

CHILD HEALTH

The health status of children in Michigan is measured by a broad array of indicators. The state compares favorably with other states on some, but on others its experience does not stand up well against that of other states. For example, the state's child death rate earned the ranking of 21st among the 50 states (with first the "best" rate) and the state immunization rate for toddlers (84%) in 2002 ranked 8th in the nation.[1] (The state immunization rate in 2003 showed no improvement from 2002 and earned the state a ranking of 23rd.)

In contrast, Michigan's infant mortality rate placed the state at 38th, and its share of babies born with a low birth weight at 32nd among the 50 states. The state's poor position on maternal and infant health indicators may largely be explained by the striking health disparities, some of the largest in the nation, between African-Americans, the state's largest minority population, and white non-Hispanics. Many of the state's efforts in addressing maternal and infant health were cut as the state revenues dropped due to tax cuts and a lagging economy. State general funds allocated for maternal and child health programs declined by 66 percent between fiscal years 2001 and 2004.

Health Insurance

Despite cuts in health programs, Michigan has made a significant effort to cover uninsured children: 7 percent of the state's children are uninsured compared to 12 percent in the nation. In 2003 almost three-quarters of a million of the state's children qualified for Medicaid; children and youth, ages 1-18, were eligible in families with incomes below 150 percent of poverty, as were infants in families below 185 percent of poverty. MIChild, the coverage program for children established by the federal State Children's Health Insurance Program law (SCHIP), has much narrower income eligibility standards—family income must fall between 150 and 200 percent of the poverty level.

Children with health insurance are significantly more likely to get the preventive care they need in their critical developmental stages. The number of Michigan children who depend on

Michigan Rankings for Child Health Indicators

Michigan Rank***	Indicator	Percent*
8	Immunized Two-Year-Olds (4:3:1)	84
9	Children Without Health Insurance	7
32	Low Birth-Weight	8
		Rate
38	Infant Mortality (per 1,000 infants)	8
21	Child Deaths (per 100,000 children)	22

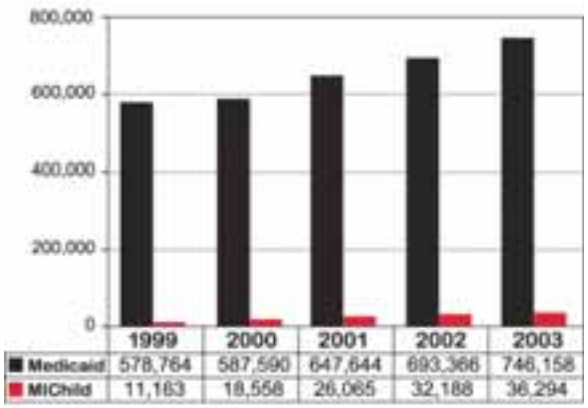
Source: Kids Count Data Book 2004: State Profiles of Child Well-Being

* Data are for 2002 (immunizations) or a 2000-02 average from 2001-03 Current Population Survey

*** a rank of "1" is best

Medicaid rose sharply in recent years The number jumped by a third between 1999 and 2003, mostly as a result of the sustained community outreach for the MIChild program which identified and enrolled many Medicaid-eligible children.[2] Job loss, stagnating wages and eroding benefits, combined with

Between 1999 and 2002 the number of children in Michigan dependent on public health insurance rose sharply.



Source: Michigan Family Independence Agency

large increases in health care costs, left many working families without health insurance. Even for those families where coverage is still offered, premiums and other cost-sharing requirements may exceed the family's financial capability. At the same time the rising costs of health care, higher Medicaid caseloads, and erosions of federal support are creating pressures in the state budget to curtail Medicaid expenditures that now represent 29 percent of the state's general fund outlays.[3] While children, ages 0-19, represented roughly 60 percent of the Medicaid population in 2001 they accounted for less than 20 percent of the expenditures.[4] The annual per capita expenditures for their health care of roughly $1,200 saw modest growth rates in the 1990s, according to national analysis.[5]

Less than Adequate Prenatal Care

While most pregnant women in Michigan receive adequate prenatal care as defined by the Kessner Index, almost one-quarter (23%) does not. Optimally, prenatal care begins in the first three months of the pregnancy and involves one or two visits each month thereafter. Prenatal care that includes education, support, and monitoring, increases the likelihood of a healthy pregnancy and birth for both mother and baby.

Roughly 30,450 Michigan mothers who gave birth each year in the 2000-02 period did not receive adequate prenatal care. Michigan has shown minimal (8%) improvement on this measure between the base years of 1994-1996 and the most recent period, 2000-2002. Most counties (59) experienced some improvement over the trend period. Alcona, Montmorency and Otsego had the largest decline in their share of women with less than adequate prenatal care; their rates dropped by roughly half. In Bay County with the largest increase, rates jumped by 70 percent during the trend period. Among the ten most populous counties, Saginaw showed the largest

[1] As derived from the Centers for Disease Control and Prevention's 2002 National Immunization Survey that provides state estimates of vaccination coverage levels among children ages 19 to 35 months in the states and large metropolitan areas. The figures here reflect the percentage of children who have "4:3:1 Series Coverage"; that is, four or more doses of Diphtheria and Tetanus Toxoids and Pertussis Vaccine, three or more doses of oral Poliovirus vaccine, and one or more doses of Measles-Mumps-Rubella.

[2] Children who are eligible for Medicaid cannot participate in the MIChild program. <http://www.mdch.state.mi.us/MSA/mdch_msa/manual.htm> (5 October 2004).

[3] Gongwer News Service, Inc, "Govs Ponder Options for Long-Term Care, Health." *Michigan Report #137*. July 19, 2004.

[4] Centers for Medicare and Medicaid Services, *Table 5 Medicaid Expenditures - Fiscal Year 2001 by type of Service and Age Group* <www.cms.hhs.gov/medicaid/msis/o1mi.pdf> and Michigan Department of Community Health, Medical Services Administration. *Who is Eligible for Medicaid in Michigan?* (January 2004) <www.michigan.gov/documents/59-178_msa_ar_find_96525_7.indd.pdf> (7 October 2004).

[5] Centers for Medicare and Medicaid Services, Medicaid Statistical Information System, *Table 3.26 Average Real Medicaid Payments per Person Served, 1978-1998 <http://www.cms.hhs.gov/charts/healthcaresystem/chapter3.asp> (5 October 2004).*

improvement—22 percent—while Macomb County worsened at the same rate. Kent, Washtenaw, and Ottawa counties showed little or no improvement on this critical measure.

Overall, the incidents of births with less than adequate prenatal care in Michigan counties ranged from an average of 7 to 53 percent of births each year between 2000-2002.[6] The three rural counties that showed the greatest improvements also reflected the lowest rates—under 11 percent—while Oscoda, Lake and Mason counties had the highest rates with roughly one-third of new mothers having received less than adequate prenatal care. Among the most populous counties, almost one-third of mothers of newborns in Wayne County gave birth without adequate prenatal care compared to only 12 percent in Oakland County.

Low-Birthweight Babies

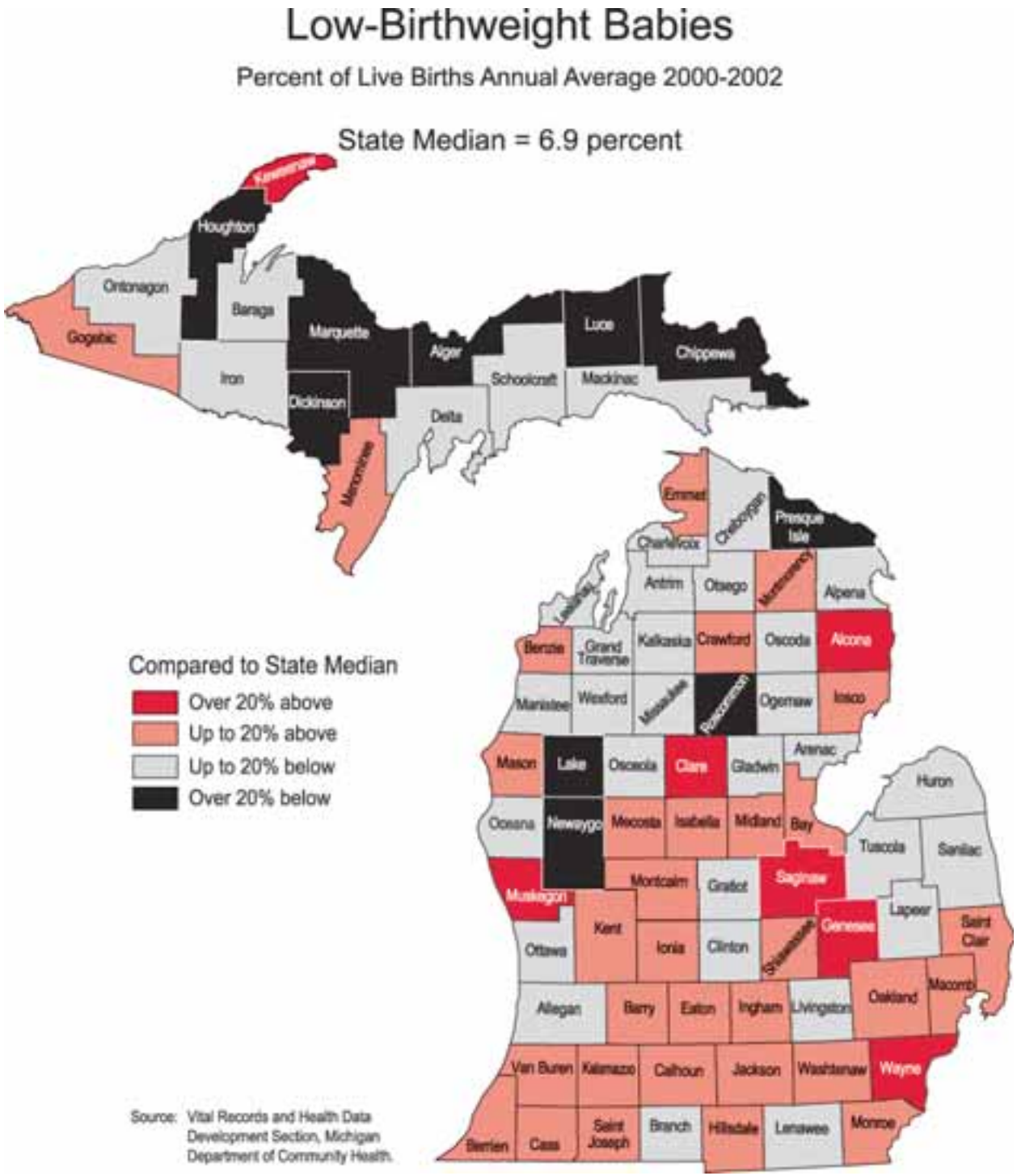
Low-birthweight babies, those weighing less than five and a half pounds at birth, are more vulnerable to developmental delays or chronic health problems as well as being at much higher risk of dying before their first birthday. The risk of death during infancy for these small babies is nearly 25 times greater than for those born at normal weight, 58.6 deaths per 1,000 compared to 2.4 for normal weight infants.[7]

Roughly 10,600 Michigan infants were born too small each year in the 2000-2002 period. The share of babies born at low-birthweight has remained essentially the same in Michigan since the mid-1990s: 8.0 percent of all births in Michigan in 2000-2002 were born at low-birthweight, up from 7.7 percent over the 1994-96 period.

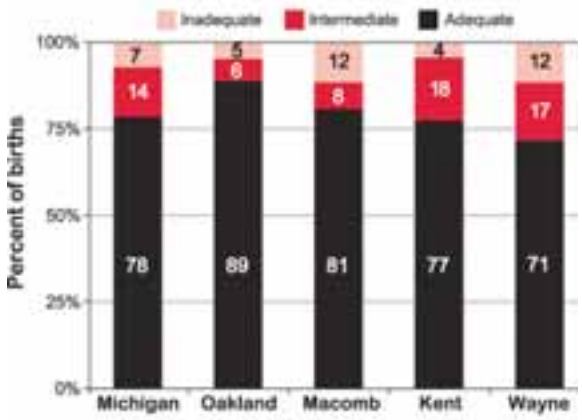
Across Michigan's counties, the share of low-birthweight babies ranged from a low of 4 percent in Houghton to a high of 10 percent in Wayne. Most counties (52) saw their shares of low-birthweight babies climb over the decade. Alcona and Mackinaw counties sustained the most dramatic increases with their rates doubling, while Lake County experienced the largest decline (43%). The most populous counties showed little or no improvement. Most of the ten counties with the lowest incidence of infants born at low-birthweight were located in the Upper Peninsula.

[6] Numbers may be artificially high in some counties because of data coding problems in 2000.

[7] Annie E. Casey, *Kids Count Data Book: State Profiles of Child Well-Being 2004* (Baltimore, MD: The Annie E. Casey Foundation, 2004), 34.



Michigan counties with most births reflected diverse levels of prenatal care in 2002.



Source: Michigan Department of Community Health, Vital Records and Health Data Development Section

Infant Mortality

Eight of every 1,000 babies born in Michigan between 2000-02 died before their first birthday—roughly 1,100 each year. The state's infant mortality rate remained essentially the same between 1994-96 and 2000-02—dropping only two-tenths of a percentage point from 8.3 to 8.1 deaths per 1,000 infants.

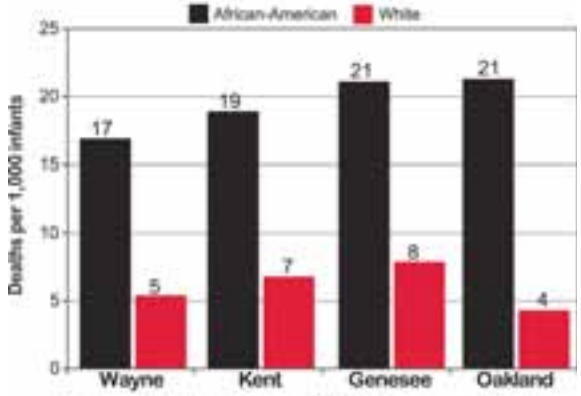
While a long-term decline in infant mortality has occurred for both white and African-American infants, the gap between the two rates has widened steadily since 1981. In 1970 Michigan's African-American infant mortality rate was double that experienced by white infants, but by 2002 the rate for African-American infants was three times that of white infants. In 2002 most births to African-American mothers occurred in four Michigan counties—Wayne, Oakland, Genesee, and Kent (86%). In Oakland County, which has the second largest number of African-American infants, the African-American infant mortality rate was five times higher than that of white infants.

Infant mortality rates ranged from a low of 4 per 1,000 infants in Eaton County to 17 per 1,000 in Crawford County. Among the ten most populous counties, Genesee had the highest infant mortality rate (11.6) and Oakland the lowest (6.3), but the two counties had the same mortality rate (21) for African-American infants.

In most Michigan counties the infant mortality rate worsened. Only 14 of the 49 counties with a large enough incidence of infant mortality (at least six deaths over each three-year period) to calculate a change experienced an improvement between 1994-96 and 2000-02. In Sanilac County the infant mortality rate declined by almost half while in Iosco County the rate doubled. Among the most populous counties, Ingham County reflected the largest decrease (9%) in its infant mortality rate, while Kalamazoo sustained the largest increase (44%).

In 2003 the state launched a home-visiting initiative in a small number of communities with high infant mortality rates, but it is still too early to measure outcomes of the initiative. Maternal health is a critical component in the high infant mortality rates and women during their prime child-bearing years often lack health insurance coverage despite the higher income ceilings (185% of poverty) established in the Medicaid program to address the pre- and post-natal health care needs of low-income mothers and their babies.

Racial gaps in infant mortality rates persisted in counties with the largest numbers of African-American births.



Source: Vital Records and Health Data Development Section, Michigan Department of Community Health

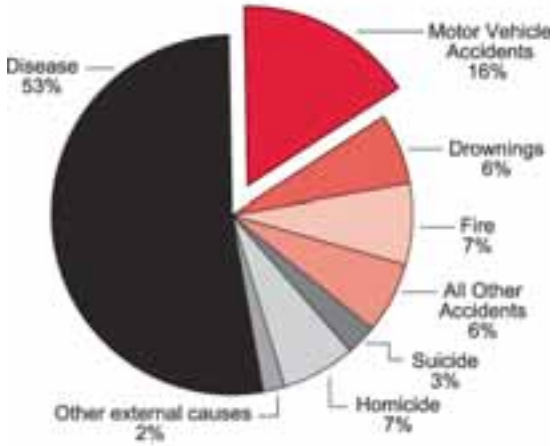
Child Deaths

The child death rate in Michigan declined by roughly one-fifth between 1994-96 and 2000-02. It dropped from roughly 26 of every 100,000 children, ages 1-14, to 22 per 100,000. An average of 434 children died each year from all causes in the 2000-02 period. Roughly half of all child deaths in Michigan resulted from an injury, and almost one-third of those involved a motor vehicle.

The child death rate ranged from a low of 10 per 100,000 children in Livingston County to a high of 45 in Mason County. Among the most populous counties, Genesee County had the highest child death rate (27) compared to the lowest in Saginaw County (15).

Of the 35 counties where a change in the child death rate could be calculated most (23) experienced a decline in their rates. Child death rates dropped by half or more in Midland, Lenawee, Berrien, Eaton, and Van Buren counties. Lapeer County suffered the largest increase: its rate tripled over the trend period. Among the most populous counties Washtenaw County had the largest increase in its child death rate—it rose by over half.

One in six child deaths in Michigan resulted from a motor vehicle accident in 2002. (N=431)



Source: Vital Records and Health Data Development Section, Michigan Department of Community Health

Children are safe when their parents, guardians or other persons responsible for their well-being provide them with adequate food, clothing, shelter and medical care and protect them from harm. When parents fail to provide this minimal care, family or community members can make a report to Child Protective Services (CPS) at the Family Independence Agency (FIA). Other reports of this failure come from several professional groups such as social workers, teachers, doctors, and nurses who are mandated by law to report suspected abuse or neglect of children.

Of the 136,603 reports of abuse or neglect submitted in FY 2003, the majority resulted in an investigation (56%). One in four reports that resulted in an investigation of child abuse or neglect in fiscal year 2003 originated with family, friends, or neighbors (24%). Social workers (21%) and school personnel (18%), both of which are mandated by law to report suspected abuse or neglect, were the next two largest groups that made an investigated report.

In roughly one in five (22%) of the approximately 76,000 cases investigated in FY 2003 caseworkers found enough evidence to confirm that abuse or neglect had occurred. Cases may involve only one child victim in a family or several children; the average confirmed case usually includes two child victims.

Investigated Cases by Category

The number of investigated and confirmed cases tells only part of the story about the maltreatment of children. Starting in 1999, Michigan drastically changed the way it classified investigated cases of child abuse and neglect.[1] Prior to 1999, after an investigation CPS workers classified the allegation as either substantiated (confirmed) or unsubstantiated. Services were provided to the family in substantiated cases to remedy identified safety factors; unsubstantiated cases were closed.

Overview of Five-Category System

In 1999 a five-category system was implemented to focus the scope of CPS intervention and responsibility more narrowly on the highest risk cases of abuse and neglect, while referring lower risk families to available community services for support and intervention. The probability of future harm to the child is based on a risk assessment, which assigns the risk as high, moderate, or low based on a number of factors.[2] With some exceptions, the level of future risk dictates the assignment to a specific risk category and the corresponding level of state intervention.

Cases where abuse or neglect has been confirmed are assigned to categories I through III, while cases in categories IV and V reflect either insufficient or no evidence. In roughly 22 percent of investigated cases in Michigan in 2003, caseworkers confirmed that the alleged abuse or neglect had occurred. These cases were evenly divided among the first three categories—each representing roughly 7 to 8 percent of the total investigated cases.

Among cases where child abuse or neglect was not confirmed, those with insufficient evidence are classified as Category IV, and those with no evidence were designated a Category V. Over half of the investigated cases in the state fell into Category IV,

[1] 1998 PA 484. On December 31, 1998, the Five-Category system was signed into state law as Public Act 484 and took effect July 1, 1999.

[2] By assigning a numerical score to several factors determined to be highly correlated to maltreatment, a summative score is calculated, which translates into the level of future risk of harm to the child. Family Independence Agency, *Disposition and Structured Decision Making*, <http://www.michigan.gov/fia/0,1607,7-124-5452_7119_7194-15399—,00.html> (7 October 2004).

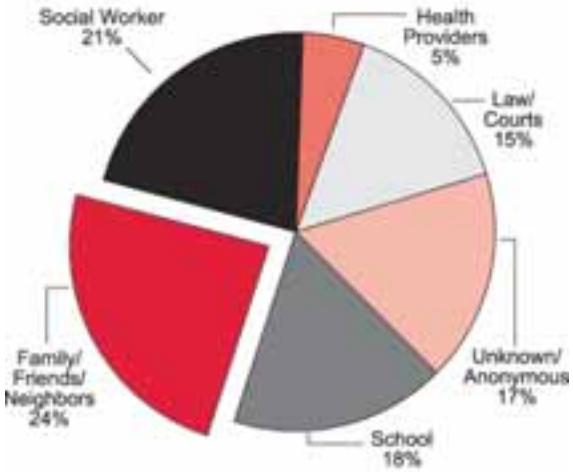
Victims of Child Abuse and Neglect by Category in Michigan and its Counties

County	% of Victims Cat. I	Cat. II	Cat. III	County	% of Victims Cat. I	Cat. II	Cat. III
Michigan	**34**	**34**	**32**	Delta	48	20	32
Baraga	28	12	60	Kalkaska	36	32	32
Gladwin	6	35	59	Montmorency	11	58	32
Alpena	32	11	57	Charlevoix	33	35	31
St. Joseph	13	31	56	Wexford/ Missaukee	31	38	31
Houghton	23	22	55	Ionia	16	54	30
Montcalm	37	12	51	St. Clair	27	43	30
Livingston	28	22	50	Saginaw	34	36	29
Sanilac	26	26	49	Menominee	57	14	29
Clinton	30	22	48	Berrien	42	30	28
Washtenaw	22	30	48	Kalamazoo	40	33	27
Benzie	19	34	47	Cass	36	37	27
Eaton	23	31	46	Mecosta	51	22	27
Macomb	25	30	46	Dickinson	44	30	27
Oakland	33	22	45	Wayne	40	34	26
Huron	27	29	44	Arenac	34	41	25
Iosco	25	32	43	Schoolcraft	43	32	25
Alger	13	43	43	Ingham	39	36	25
Emmet	25	31	43	Calhoun	36	39	25
Newaygo	31	26	43	Cheboygan	32	44	24
Ogemaw	28	29	43	Roscommon	35	42	24
Barry	13	45	42	Osceola	55	21	24
Ontonagon	41	18	41	Bay	32	45	23
Midland	31	29	41	Mackinac	19	59	22
Hillsdale	24	36	40	Ottawa	33	47	21
Presque Isle	26	34	40	Gratiot	69	10	20
Otsego	40	20	40	Allegan	44	35	20
Manistee	33	27	39	Muskegon	39	41	20
Tuscola	36	25	39	Monroe	35	46	19
Marquette	33	28	38	Lenawee	22	59	19
Gogebic	40	21	38	Grand Traverse	54	28	18
Oceana	35	27	38	Luce	27	55	18
Isabella	46	16	37	Iron	22	63	15
Kent	24	40	37	Shiawassee	51	34	15
Branch	32	32	36	Van Buren	31	58	11
Jackson	33	32	36	Mason	44	48	8
Lapeer	30	35	35	Lake	55	38	7
Genesee	33	34	34	Oscoda	88	*	*
Crawford	46	20	34	Alcona	*	*	*
Chippewa	31	35	33	Leelanau	*	*	*
Antrim	23	44	33	Keweenaw	*	*	*
Clare	39	28	33				

Source: Michigan Family Independence Agency, FY2003

* Percent not calculated because of small numbers.

One of four reports of child abuse or neglect that resulted in an investigation originated with family, friends, or neighbors.



Source: Michigan Family Independence Agency FY2003

and almost 20 percent into Category V. When the category system was first proposed, families in Category IV would have received preventive services to decrease the likelihood that these children would later become confirmed victims of abuse and/or neglect; but as the legislation was passed, and the program functions today, no preventive services are provided to this group.

For Category I cases where children are at the highest risk of harm, caseworkers must seek a court petition for removal from the home. Category II cases that reflect that the child is assessed at high risk of future abuse or neglect require continued services to the family through CPS workers. In Category I and II cases the name of the perpetrator(s) must be listed on the Central Registry, which is used to screen individuals seeking employment in settings with children, such as child care centers.

Category III cases where children have a relatively low risk of future abuse or neglect are referred to community agencies for services. The perpetrator's name does not get placed on the Central Registry. If the family does not "voluntarily" participate in the services, the case may be elevated.

Currently, the FIA has no systematic way to record or keep track of Category III perpetrators. Feasibly, a person could be identified as the perpetrator of child abuse or neglect on more than one occasion and not be identified on the Central Registry. When a case is classified as Category III, it means, "services are needed" to reduce the likelihood that the children will be re-victimized. If the parent does not choose to seek recommended community services, the Michigan Child Protection Law requires CPS to consider elevating the case. Although FIA policy requires CPS to refer the family to community services, it does not require workers to keep a Category III case open to monitor a parent's participation or progress. This makes it difficult to fulfill the legal requirements of the FIA. In fiscal year 2003, 4 percent of cases originally classified as III were raised to Category I or II.

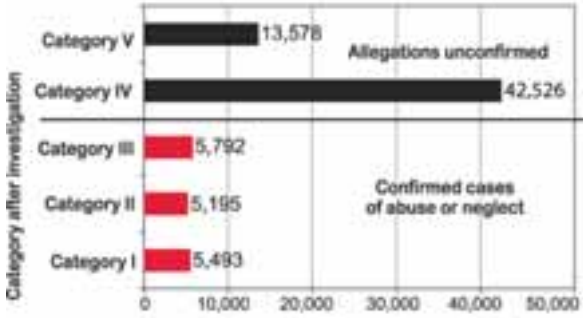
Victims by Category in Counties

Among the seven counties with over 1,000 victims of abuse or neglect in FY 2003 (all children in categories I through III), those with similar rates of child abuse or neglect may have a significantly different distribution of victims among the categories. For example, although Wayne and Kent counties both had roughly 10 victims per 1,000 children, 40 percent of victims in Wayne County were in Category I where the child would be removed from the home, compared to only 24 percent in Kent. Ingham and Kalamazoo counties also had relatively large shares (40%) of their child victims in Category I, whereas in Oakland and Macomb counties almost half (44-45%) of all confirmed victims were classified as Category III, at lowest risk. In these counties there would thus be a relatively high demand for community services to meet the needs of families referred for preventive services. In counties with the largest concentration of confirmations in Category I, demand for foster care homes would be much larger.

The ten counties with 300 to 900 victims of abuse or neglect also showed quite dramatic differences in the categorization of confirmed victims. St. Clair, Muskegon and Berrien counties had the largest shares—roughly 40 percent—of victims in Category I. Eaton and Washtenaw counties had classified almost half (46-47%) of victims in Category III whereas only 11 percent of victims in Van Buren County fell into that category.

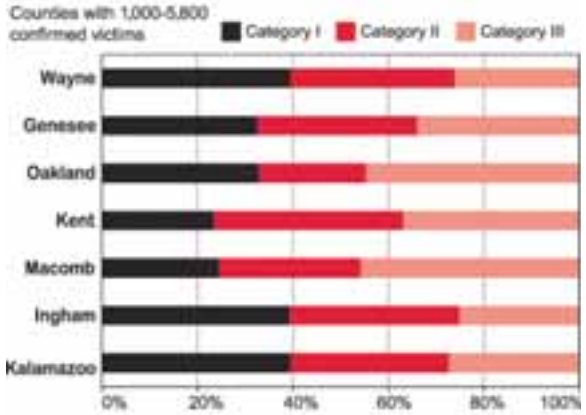
Among the nine counties with between 200 and 300 child victims, Shiawassee County had almost half of child victims in Category III, compared to only 14 percent in St. Joseph County where over half the victims were in Category I. These two counties had very similar rates of child victimization but the distribution of victim by category reflect very different outcomes for families and children. It is not clear what explains these striking differences in the category assignment among the counties. Availability of community services may be a factor.

Confirmed cases of abuse and neglect in Michigan were distributed quite evenly across categories I-III in 2003.



Note: Case can include more than one child.
Source: *Michigan Family Independence Agency*

Two of five victims of abuse and neglect in Kalamazoo, Ingham, and Wayne Counties were in Category I.

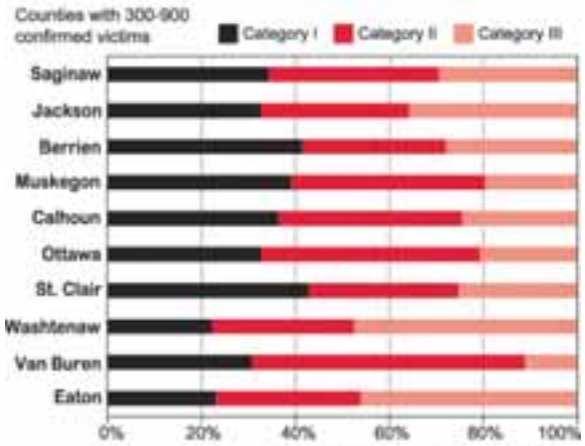


Source: *Michigan Family Independence Agency FY2003.*

Children in Families Investigated for Abuse or Neglect

In Michigan roughly 170,104 children lived in a family where an investigation of child abuse or neglect occurred in fiscal year 2003—66 of every 1,000 children in the state. This rate is 23 percent higher than the 1995 rate of 54 per 1,000 children. Policy changes requiring that more reports be investigated may explain some of the increase in investigations as well as extensive publicity on high-profile tragedies that elicit more careful attention to abuse and neglect reports. The level and expertise of FIA staff, as well as community expectations can affect the share of complaints of child abuse and neglect that are investigated, although efforts have been made to standardize decision-making across counties. When a case of child abuse or neglect is investigated, all children in the family are interviewed.

Most victims of child abuse or neglect in St. Clair and Berrien Counties were in the most serious category.



Source: Michigan Family Independence Agency FY2003.

The lowest investigation rate in the state was in Livingston County; its rate of 30 children among 1,000 in investigated families was less than half the state average. Kalkaska County had the highest rate (155), more than double the state average. Among the most populous counties, Washtenaw County had the lowest rate (35) of children involved in an investigation of abuse or neglect, and Genesee County the highest (99) rate.

Most Michigan counties (59 of 83) experienced increases in their rates of children involved in an abuse or neglect investigation, with the steepest rise occurring in Benzie County where rates jumped by almost eightfold. Alcona County had the sharpest decline with its rate dropping by half over the trend period. All the ten most populous counties reflected increases in their rates of children involved in investigations of abuse or neglect except Washtenaw and Wayne counties, which showed essentially no change over the trend period. The largest change occurred in Ingham County where the rate jumped by 80 percent.

Substantiated Victims of Abuse or Neglect

The rate of children who were confirmed victims of abuse and neglect increased by 27 percent between 1995 and 2003, rising from eight to ten of every 1,000 children. Roughly 26,700 children were found to be victims of abuse or neglect in 2003.

Rates of confirmed victims varied widely across the counties. Among all Michigan counties, Alcona had the lowest rate of confirmed victims of abuse or neglect (3 of every 1,000 children) and Antrim (28) the highest. Among the populous counties, Washtenaw had the lowest rate (4 of every 1,000 children), while Genesee had the highest (20).

Most Michigan counties (62) experienced an increase in their rates of substantiated victims of abuse or neglect. Rates more than doubled in 12 counties including one of the most populous, Kent. Improvement was most pronounced in Menominee County where the rate dropped by almost two-thirds over the trend period. Among the most populous counties, the largest improvement occurred in Wayne, which experienced a slight decline (4%) in its rate of confirmed child victims.

Out-of-Home Care

Only those child victims of abuse or neglect who are considered at risk of further harm are removed from their homes, as are delinquent youth who pose a threat to themselves or others. In Michigan roughly 20,000 children resided in out-of-home care, including kinship care, in fiscal year 2003—eight of every 1,000 children, ages 0-17. Overall the rate for children in out-of-home care rose by 8 percent between fiscal years 1995 and 2003.

Almost all children in out-of-home care in the state were removed because of abuse or neglect (90%). While the rate for children in out-of-home care for abuse or neglect rose by 17 percent between 1995 and 2003, the rate of children placed for delinquency fell by almost one-third (32%). Several factors have influenced the sharp decrease in delinquency placement rates among juveniles. A substantial decline in juvenile arrest rates for both violent and property crimes has occurred, and more youth, particularly in Wayne County, are being referred to community-based alternatives instead of state residential facilities. In some counties youth are being waived as adults into the state prison system rather than juvenile facilities.

Out-of-Home Care due to Abuse or Neglect

Among Michigan counties, Lapeer and Livingston counties had the lowest rate (1 of every 1,000) of children living in out-of-home care due to abuse or neglect, and Lake County the highest: 18 of every 1,000 children. Among the most populous counties, Ottawa had the lowest rate (2) and Wayne the highest with 12 children of every 1,000 in out-of-home care for abuse or neglect. All but 13 of the 75 Michigan counties with a change that could be calculated experienced higher rates of children placed in out-of-home care for abuse or neglect in 2003 than in 1995. In several counties the risk of out-of-home placement for abuse or neglect essentially doubled over the trend period, and in seven counties tripled. The largest decline (36%) in placement occurred in Gladwin County. Among the most populous counties, Washtenaw had the largest decline (27%) in out-of-home placements for abuse or neglect while the rate increased by two and a half times in Genesee County.

Out-of-Home Care Due to Delinquency

Out-of-home placement for delinquency was fewer than one per 1,000 in 38 counties in 2003, with only 51 Michigan counties having enough incidences to calculate a reliable rate. Bay, Washtenaw, Muskegon, and Montcalm had the lowest rates while the Upper Peninsula County of Gogebic had the highest—seven of every 1,000 children. Wayne County had the highest rate (2 of every 1,000 children) among the most populous counties.

Out-of-home rates for delinquency declined in the majority of Michigan counties where change could be calculated (44 counties). The rates of children in out-of-home care for delinquency dropped most dramatically—almost three-quarters—in Bay County. In five counties the rate doubled. Among the most populous counties, Ottawa County's rate jumped the most—by more than half—while those in Genesee and Kalamazoo counties dropped by two-thirds.

Michigan Rankings for Indicators of Adolescent Well-Being

Michigan Rank*	Indicator	Rate**
16	Teen deaths by accident, homicide and suicide (per 100,000 teens)	46
20	Births to teens, ages 15-17 (per 1,000)	20

Source: Kids Count Data Book 2004: State Profiles of Child Well-Being

* a rank of "1" is best
** Data are for 2001

Michigan made substantial improvement over the late 1990's and earned some of its best rankings when compared to other states in the nation on indicators of well-being among adolescents. The state's injury death rate for teens, ages 15-19, ranked 16th among the 50 states, and its birth rate to teens, ages 15-17, ranked 20th, according to the latest national Kids Count data book. (Number 1 is the "best" state ranking.) Most Michigan youth were doing well, and were more likely to postpone parenthood and escape fatal injuries, but one in six young adults, ages 18-24 was disconnected from opportunities to make a successful transition to adulthood, according to the national report.

"Disconnected" young adults are those without a degree beyond high school, who are not enrolled in school or working. Generally, these disconnected young people did not have access to the critical education and skills to make a successful transition to adulthood. The youth at highest risk of lacking the connections to make a successful transition to adulthood included: teens aging out of the foster care system; youth involved in the juvenile justice or corrections system; teen parents; and youth who had not completed high school.

In Michigan in 2001, roughly 4,400 youth aged 15-19 were in foster care and another 3,500 were detained, incarcerated or placed in residential facilities. Despite the downward trends in teen births, roughly 12,200 teenagers (under the age of 20) in Michigan gave birth in 2002.

National estimates indicate that at current birth rates over one-fifth of 20-year-olds will have given birth while in their teens. The U.S. still maintains a teen birth rate significantly higher than other industrialized nations in the world, more than ten times that of the Netherlands or Japan. Young mothers are much less likely to complete their K-12 education than their peers. Only one-third of teen mothers in the United States obtain their high school diploma compared to roughly three-quarters of youth who do not play the dual role of parent and student in their high school years

In addition to teen moms, other high-risk youth are also more likely to drop out of high school. Dropout rates among foster care youth have been reported as high as 55 percent by some studies.[1] One longitudinal study of a group of ninth graders found that roughly half of all formerly incarcerated youth returned to school after their release and high school completion rates were as low as 15 percent.[2]

Teen Births

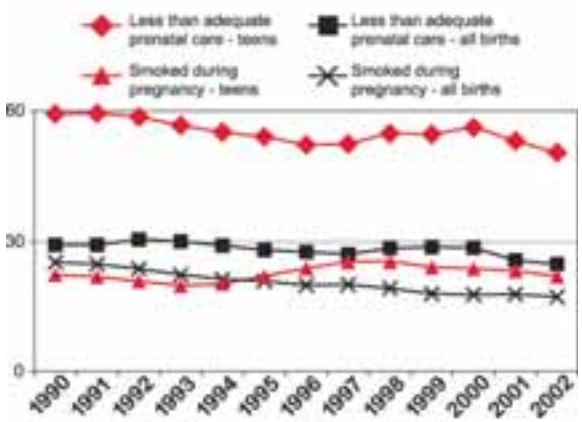
One of every 50 teens ages 15-17 gave birth in Michigan each year between 2000 and 2002. The rate dropped by one-third from the 1994-96 period when one of every 33 teens gave birth each year. Roughly 4,200 Michigan high school-aged teens gave birth annually in the 2000-02 period compared to almost 6,100 each year in 1994-96.

Younger teen mothers who become parents before they are 18 are at higher risk of not completing their K-12 education and having another child during their teen years than those ages 18-19. They also are more likely to have higher risk pregnancies than the average, with double the rate of less than adequate prenatal care than the average new mother in Michigan. Almost half of them started care after the first trimester or had an inadequate number of visits during the pregnancy. They were also more likely to smoke during their pregnancy. In 2002 almost a fifth (19%) of these at risk teen mothers under age 18 smoked during pregnancy compared to 15 percent of new mothers of all ages.

Among Michigan counties, Livingston and Huron counties had the lowest rate of teen births (7 births per 1,000 teens) for this age group, and Muskegon County the highest (34). Of the 80 counties where a change could be calculated, all but four—Leelanau, Midland, Manistee, and Branch—reflected a decline in their teen birth rates. The largest decline—a two-thirds drop—occurred in Charlevoix County

Among the ten most populous counties, Wayne had the highest rate (29 births per 1,000 teens) and Macomb and Oakland the lowest (9) over the 2000-2002 period. Among these counties Washtenaw had the largest decline in its rate, which dropped by half while Ottawa County experienced the smallest improvement (14%).

Teen mothers, ages 15-17, were half as likely to get adequate prenatal care as the state average.



Source: Michigan Department of Community Health, Vital Records and Health Data Development Section

[1] *Kids Count Data Book 2004: State Profiles of Child Well-Being* (Baltimore, MD: Annie E. Casey Foundation, 2004), 7-8.

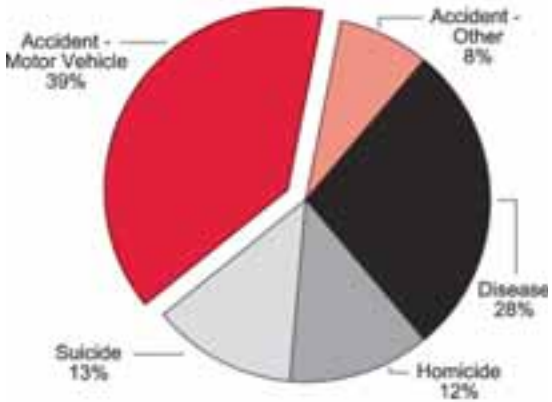
[2] Ibid., *7-8*

Teen Injury Deaths

The injury death rate from accidents, homicides and suicides among teens aged 15-19 dropped by almost one-third in Michigan between 1994-96 and 2000-02. On average between 2000 and 2002, 46 of every 100,000 teens in this age group died from an injury compared to 66 in the mid-1990s. The recent year rate represented a total of 333 Michigan youth suffering a fatal injury annually compared to 440 each year in the mid-1990s.

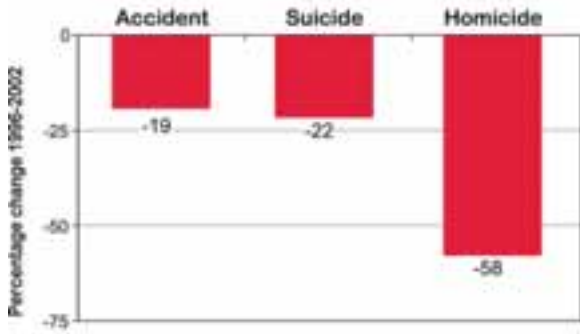
More Michigan teens (176) died from auto accidents than the total caused by homicide and suicide combined (114). The teen injury death rate due to homicide dropped by 58 percent in the trend period compared to only 19 percent decline in the rate due to accidents. In 1994-96 the teen homicide rate was 20 deaths per 100,000 youth compared to 8 in 2000-02; the suicide rate dropped from 10 to 8 deaths per 100,000 youth; and accident death rates from 37 to 30 deaths per 100,000 youth. Teen injury death rates understate the full impact on the lives of youth and their families from injury. National data show that for every youth killed in an auto accident another 85 were injured and lived.

Two of five deaths among older youth in Michigan resulted from a motor vehicle accident (N=452).



Source: Michigan Department of Community Health, Vital Records and Health Data Development Section

The rate of injury death from homicide reflected the most dramatic decline for older teens in Michigan.



Source: Michigan Department of Community Health, Vital Records and Health Data Development Section

Adolescent drivers are at high risk of fatal injury death in automobiles. Roughly 65 of every 100,000 drivers, ages 16-20, were involved in a fatal accident in 2001, compared to 46 per 100,000 among 21 to 24-year-olds, according to national data.[3] While Michigan has instituted several restrictions on licenses for teen drivers to address the high accident rate in this age group, the state legislature also ended support for driver education training in early 2004 and authorized moving driver education support staff from the Department of Education to the Department of State. While 80 percent of schools in the state still offered driver education in 2004, the average course fee is now roughly $250 per student. In areas where schools no longer offer driver education because of increased budgetary pressures, the only option for student drivers may be a driver education school with average costs of $350. For many low-income families this financial burden may prove prohibitive, and without public transportation alternatives more unlicensed and uneducated drivers may be on the road. Students with special needs such as emotional impairment will also need to be accommodated in this transition, and staff in driving schools may not have adequate training to address the needs of this population.

[3] U.S. Department of Transportation, National Center for Statistics and Analysis (NCSA) of the National Highway Traffic Safety Administration, *Traffic Safety Facts 2002*: *Young Drivers* (Washington, D.C.: NCSA, 2002).

In Michigan's counties in the latest years reviewed, the average rate of injury death among teens, ages 15-19, ranged from a low of 22 per 100,000 youth in Washtenaw County to 129 in Cheboygan County. These rates for teen injury deaths can vary dramatically from year to year since the numbers of deaths are very small in most Michigan counties. Among the most populous counties in the recent report period, Saginaw had the highest rate—60 deaths per 100,000 youth.

Among the 35 counties where changes in the teen injury death rate could be calculated, 25 experienced declines in their teen injury death rates. The largest improvement occurred in Tuscola and Eaton counties where rates dropped by roughly half or more while Ottawa County suffered the largest increase, with its rate jumping by almost three-quarters. The largest change among the most populous counties occurred in Wayne with a decline of 45 percent on this measure.

High School Dropout

The high school dropout rate has improved in Michigan over the trend period. Between the 1995-96 and 2001-02 school years the high school dropout rate declined by 40 percent. The share of high school students leaving school without a diploma decreased from 6 percent in the 1995-96 school year to 4 percent in 2001-02. In 2002 roughly 17,200 Michigan high school students left high school without having obtained a diploma.

Among Michigan counties high school dropout rates ranged from roughly 1 percent in Charlevoix, Mecosta, and Newaygo counties to 7 percent in Wayne. Most (56) of the 76 counties where change could be calculated reflected improvement in their dropout rates. The most substantial declines occurred in Wexford and Charlevoix counties where the dropout rate dropped by roughly three-quarters. Among the most populous counties Wayne County showed the most improvement with dropout rates cut in half over the trend period while Kalamazoo County with one of lowest dropout rates (2%) reflected essentially the same rate.

Earning a high school diploma or its equivalent has become an essential first step to securing employment, which carries the potential to provide an individual or family the kind of income that allows them to be self-sufficient

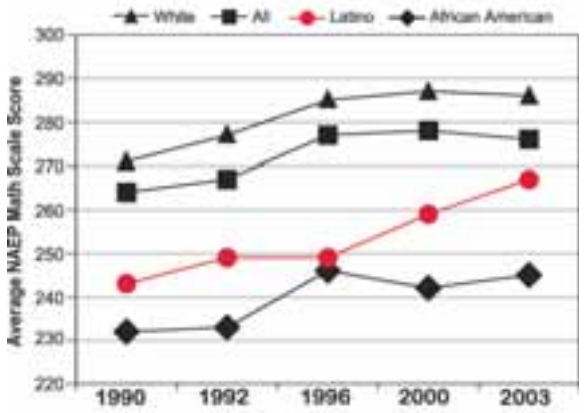
Math Achievement

Math skills are key to the nation's economic engines of the 21st century—science and technology. They are also essential to an individual's financial well-being in adulthood and required for success in many vocations, such as health care and the building trades. Funding in the federal No Child Left Behind (NCLB) statute is tied to math and reading scores, which are also used for the state school accreditation program ("Education Yes!"). Beginning in the fall of 2005, Michigan students will be tested in math and reading each year between the third and eighth grade.[1] The NCLB mandates specific penalties for those schools whose students do not show "adequate yearly progress" in these subjects for two or more consecutive years.

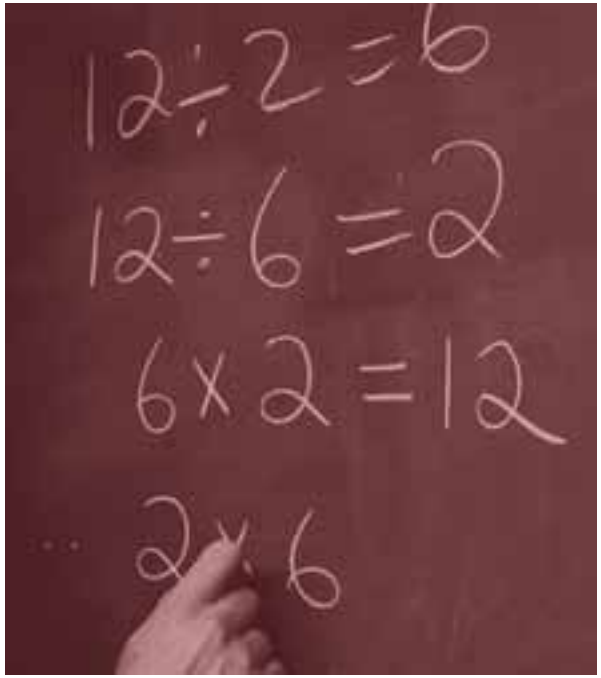
Math achievement is measured in Michigan by two tests—the National Assessment of Educational Progress (NAEP) and the Michigan Educational Assessment Program (MEAP). All students in the state are required to take the MEAP tests, while the NAEP is given only to a sample of the state's students. The MEAP provides the standard for achievement for state accreditation and the NCLB goals. The NAEP, also known as "the Nation's Report Card," provides a continuing overall assessment of what America's students know and can do in various subject areas. Results are not available for individual students or schools—but since 1990, test results have been available for participating states.

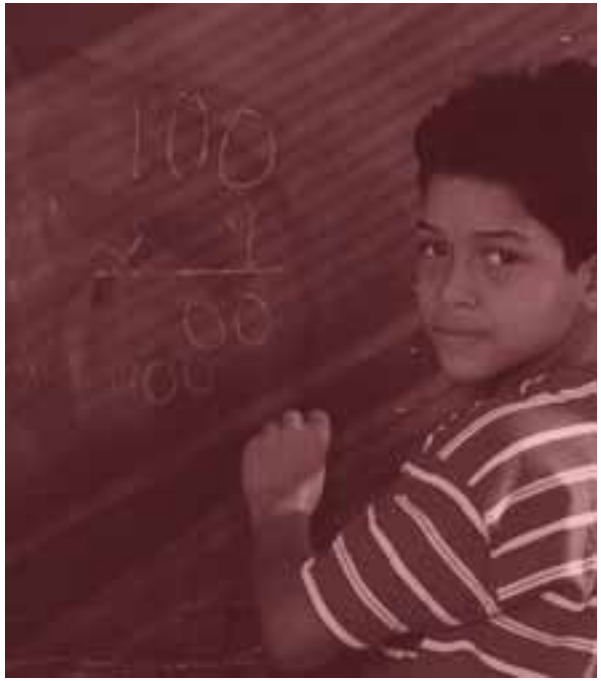
Comparison of the results of the national and the Michigan tests provides a perspective on the level and rigor of the state's assessment as well as a standard by which the state results can be compared to those in other states. The latest available comparisons for NAEP are based on the 2003 test while the state MEAP discussion that follows reflects state and county trends on the 2004 test.

In Michigan only Latino eighth graders continued to make gains on national math tests after 1996.



Source: The Education Trust, Education Watch: Michigan (Spring 2004)





Reading and Math Test Results for Michigan Fourth and Eighth Graders

Michigan Rank*	NAEP Test	Percent below Basic Level
28	4th Graders	36
28	8th Graders	25
30	4th Graders	23
30	8th Graders	32

Source: Kids Count Data Book 2004: State Profiles of Child Well-Being

* a rank of "1" is best

** Data are from the 2003 National Assessment of Educational Progress (NAEP). It uses three proficiency categories: Advanced, Proficient, and Basic.

National Assessment of Educational Progress (NAEP)

While slightly over half of the state's eighth graders met or exceeded the standard on the MEAP math test in 2003, only 28 percent scored "proficient" or above on the NAEP. *Proficient* is the level of performance on the NAEP test considered to demonstrate student competency.[2] Eighth graders scoring proficient or above on the NAEP are able to "apply mathematical concepts and procedures consistently to complex

[1] For NCLB tests for reading and math will be required for six grades—three through eight; currently Michigan tests only two grades in that spectrum. No Child Left Behind Act, HR 1, January 8, 2002.

[2] Ed Watch, <http://66.43.154.40:8001/projects/edtrust/navfiles/databookdef2.html#scores> (6 October 2004).

problems in the five NAEP content areas: 1) number sense, properties, and operations; 2) measurement; 3) geometry and spatial sense; 4) data analysis, statistics, and probability; and 5) algebra and functions."[3] Without adequate skills in these content areas, eighth graders will struggle to succeed in their high school coursework.

Proficiency Categories

Although the NAEP uses three proficiency categories: Basic, Proficient, and Advanced, *basic* performance is defined as "partial mastery of prerequisite knowledge and skills that are fundamental for proficient work at each grade." Forty percent of Michigan eighth graders scored at a basic level on the math NAEP in 2003.

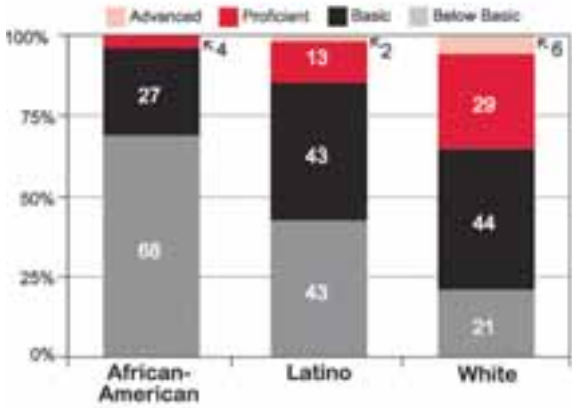
In 2003 Michigan fourth and eighth graders fell into the bottom half of the states in performance on math and reading. The state ranked 28th in the share of students scoring *below* basic level in reading among the 50 states, and 30th in the share scoring below basic level in math. One of four Michigan fourth graders and one of three eighth graders had not mastered basic skills in mathematics, according to NAEP 2003 results.

Achievement Gaps

NAEP results also allow comparison with other states in the test results for the various demographic groups. In an equitable system wide differences in achievement would not be aligned by race and income. In Michigan as in the nation, math test results for eighth graders reflected dramatic variation by race, ethnicity, and income levels as measured by participation in the means tested School Lunch Program. This variance, which is calculated as the difference between the average score of white and minority students or poor and non-poor students, defines the "achievement gap."

Michigan, with one of the most racially segregated school systems in the nation, also had one of the largest achievement gaps in the nation for African-American students, and–while not negligible—one of the smallest for Latinos. The gap between Michigan's African-American and white eighth graders in the 2003 NAEP math was 41 points. (Oregon's achievement gap, one of the smallest among the states, was half that of

Minority eighth graders in Michigan were two and three times more likely to perform below basic level than white students on NAEP.



Source: The Education Trust, Education Watch: Michigan *(Spring 2004)*

Michigan.) Since each ten-point difference represents roughly a year of learning, this gap suggests the average eighth grade African-American student in Michigan is proficient in math at the fourth grade level. Latino eighth graders in Michigan suffered a two-year lag in math skills, and poor students of every ethnic background were almost three years behind their non-poor peers.

Achievement Gaps for Eighth Grade Math in Michigan (NAEP 2003)

Michigan Rank*	Students	Average Score
26	White	286
46	African-American	245
4	Latino	267
35	Low-Income	257
		Size of Gap**
47	African-American	41 points
3	Latino	19 points
32	Low-Income	28 points

Source: The Education Trust, Education Watch: Michigan *(Spring 2004)*

Note: Sample size was too small to calculate a reliable estimate for other racial/ethnic groups.

* a rank of "1" is best

** The gap is the difference from the average score for white or non-low-income students; ten points is roughly equal to a year of learning.

Changes in school funding under Proposal A have had a negative impact on the state's larger urban school districts with concentrations of African-American students.[4] A recent analysis of the consequences of Proposal A found that the 25 school districts in Michigan where African-American students comprise more than a third of the students had the smallest increases in their per pupil funding (foundation allowance) between 1994 and 2002—smaller than the increase in the top fifth of districts with the highest median family income that had been targeted to receive less increase as a result of financing changes.[5]

Michigan Educational Assessment Program (MEAP)

Test scores for Michigan's MEAP tests are divided into four levels: Those in the two groups who "meet" or "exceed" the standard are considered "proficient" while those in the two groups where performance is scored as "basic" or "apprentice" are not. The 2004 MEAP math test results showed that proficiency decreased at the higher-grade levels. Roughly one-fourth of the state's fourth graders compared to one-third of eighth graders did not meet the math standards. Among high school students an even larger share was unable to meet the standard: 40 percent of the members of the Class of 2003 did not demonstrate proficiency.

In a similar pattern, trends between 2002 and 2004 in the share of students not demonstrating proficiency deteriorated over the grade levels. Among elementary students the share of fourth graders unable to meet the math MEAP standard dropped by 24 percent between 2002 and 2004, compared to a 20 percent drop among eighth graders. Among the high school class of 2003 the share unable to meet the math standard rose by 26 percent.

[3] National Center for Education Statistics, *Mathematics,* <http:www.nces.ed.gov/nationsreportcard/mathematics/achieveall.asp> (8 October 2004).

[4] Proposal A, as approved in a March 1994 special election, shifted the funding of public education from local property taxes to state revenues primarily from an increase of two percentage points in the sales tax.

[5] David Arsen and David N. Plank, *Michigan School Finance Under Proposal A: State Control, Local Consequences* (East Lansing, MI: The Education Policy Center at Michigan State University. November 2003).

Fourth Graders

Outcomes varied dramatically among the counties for fourth graders taking the math test in 2004. In the Upper Peninsula counties of Schoolcraft, Alger, and Ontonagon only ten percent of fourth graders did not demonstrate proficiency compared to roughly 40 percent in the central counties of Gladwin, Lake, Clare, and Alcona. Among the ten most populous counties the share of fourth graders not meeting the math standard in the MEAP ranged from 16 percent in Oakland County to 35 percent in Wayne County.

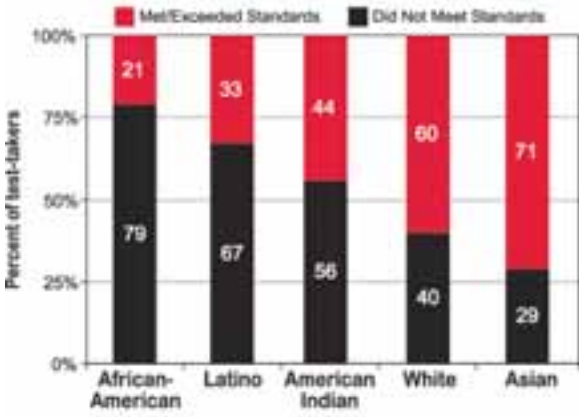
All but four counties experienced improvement in the MEAP math performance among fourth graders between 2002 and 2004. The top performing counties also tended to be those with the largest improvements. Their shares of fourth graders not demonstrating proficiency dropped by roughly 60 percent. Performance deteriorated over the trend period most dramatically in Alcona and Iron counties, which experienced the largest increases in their share of fourth graders not meeting the standard. Among the most populous counties all showed improved results, but the range of improvement varied substantially. Genesee and Kent counties improved by only 11 percent while Washtenaw County improved by roughly one-third.

Eighth Graders

Alger County experienced the best performance on the eighth grade math MEAP with 88 percent of eighth graders demonstrating proficiency. In contrast, half or more of eighth graders in Alcona, Wayne and Lake counties performed below the standard. Among the most populous counties, Oakland and Ottawa had the "best" performance for eighth graders with three-quarters of eighth graders meeting the state standard on the MEAP math test.

All but two counties—Alcona and Oscoda—experienced a decrease in their shares of eighth graders not meeting the math standard. The largest improvements occurred in Alger, Montmorency, Emmet, and Otsego counties. Among the most populous counties Oakland led the way with a 26 percent decline in its non-proficient rate while Kalamazoo and Saginaw counties improved by only half as much.

MEAP math results for 2003 showed large achievement gaps among eighth-graders by racial/ethnic group.



Source: The Education Trust, Education Watch: Michigan (Spring 2004)

High School Students

Midland and Gogebic counties had the smallest share (24%) of students in the Class of 2003 not meeting performance standards on the high school math MEAP test while Kalkaska, Osceola, Wayne and Lake counties had half of high school students unable to meet the standard. Among the most populous counties Washtenaw had the smallest share (28%) of high school students not meeting the math MEAP standard.

In contrast to the trends on the math tests for the elementary and middle grades students, only five counties—Baraga, Roscommon, Schoolcraft, Alcona, and Dickinson—experienced improvement in meeting the high school math MEAP standard for the Class of 2003 as compared to 2001. Improvement in these counties was minimal, less than 10 percent for the most part. Another five counties—Emmet, Cheboygan, Missaukee, Leelanau, and Manistee—saw the share of high school students not meeting the standard double over the trend period. Among the most populous counties, Saginaw County experienced the smallest increase (10%) in those not meeting the standard while Kalamazoo County saw its share jump by 46 percent—rising from 22 to 33 percent of the Class of 2003 not meeting the MEAP high school math proficiency standard.

Background Indicators

(in order of appearance on state/county profiles)

Live Births: The number of live births represents live births to Michigan women residents, regardless of where the birth occurred.

Source: Michigan Department of Community Health, Vital Records and Health Data Development Section.

Percent No Listed Paternity (2002): The percent of births with no paternity listed are those infants born to unmarried mothers for whom no father signs a form to accept his parenthood. The percent is based on total live births.

Source: Michigan Department of Community Health, Vital Records and Health Data Development Section.

Birth Defects (1999-2001): The number reflects the annual average number of infants reported with a birth defect who were born in Michigan over the three-year period of 1999 through 2001 and whose mother was a resident at the time of the birth. Conditions are reportable only if identified within the first year of a child's life. This methodology represents a departure from previous years when children with birth defects identified by their second birthday were included. The Department of Community Health has also initiated some quality assurance strategies to improve data reliability. The latest available numbers, as of summer 2004, were for 2001.

Caution must be taken in interpreting these numbers, because birth defects are likely to be underreported, especially in border counties, where some Michigan mothers give birth in nearby states that do not collect birth defect data. Infants in those counties may also be diagnosed or treated for a birth defect in a facility outside the state. Evidence also suggests many facilities may not be submitting all cases nor correcting reports when the original diagnosis changes. The percentage is based on live births. Births by county are based on the residence of the mother.

Source: Michigan Department of Community Health, Michigan Birth Defects Registry.

Toddlers, ages 1-2, Tested for Lead Poisoning (2003): The number and percent of Michigan children, ages 1-2, represent those tested for lead poisoning, not the prevalence of lead poisoning. The percent tested is based on the total number of children ages 1-2 in 2000 (U.S. Census). The percent with lead poisoning is based on the number of children ages 1-2 who were tested, excluding those with elevated capillary tests that were not confirmed by venous blood tests. The numbers reflect blood test results reported by laboratories to the Michigan Department of Community Health (MDCH) during the calendar year 2003. Additional tests on Michigan children may have been conducted but not reported.

Percent [Lead] Poisoned: This percent is based on the number of children tested. "Lead poisoned" children have 10 or more micrograms of lead per deciliter of blood (mcg/dL), according to the current guidelines from the Centers for Disease Control and Prevention (CDC). That standard represents just 10 millionths of a gram of lead in one-tenth of a liter of fluid. Research has shown that even more minuscule lead concentrations disrupt the workings of the brain and nervous system in children enough to impair their ability to think, concentrate, and learn.

Source: Michigan Department of Community Health, Childhood Lead Poisoning Prevention Program, 2003.

Child Care Monthly Costs (2004): The monthly average costs in 2004 for one child full-time in a regulated child care facility reflected those cared for by family providers and group family providers or in centers. Infant and toddler care and center-provided care tend to cost more than the average. Monthly child care costs are calculated as a percentage of the average wage per job for the year 2002.

Source: Provider data from a March 2004 survey of regional Community Coordinated Child Care agencies by the Michigan Community Coordinated Child Care Association. Wage data from the U.S. Department of Commerce, Bureau of Economic Analysis, Regional Accounts Data, Table CA34. (http://www.bea.gov/bea/regional/reis/).

Children in Subsidized Child Care (monthly/2003): This number reflects the number of children ages 0-2½, 2½-6, and 6-12 in child care whose parents were receiving a subsidy payment from the state in October 2003. Eligibility for child care subsidies is based on family participation in the Family Independence Program or earnings below qualifying income levels (in 2003 roughly 150% of the poverty level). Payments are only extended to regulated or "enrolled" child care providers, such as relatives and in-home care aides registered with the state. Subsidies range from 100 to 5 percent of the hourly rate specified by age of child, type of provider and shelter areas as determined by the agency.

Source: Michigan Family Independence Agency, Child Development and Care Program, Monthly Assistance Payments, Child Day Care Children by Age (p. 177) December 2003.

Data Glossary

Rates are calculated when an average of more than five incidents occur in a county. Rates based on small numbers of events and small populations can often vary dramatically and cannot be considered statistically reliable for projecting trends or considering impact. Rates for non-census years are based on population estimates available from the Office of the State Demographer or the Census Bureau; 2002 population estimates were used to calculate rates for data from 2003 and 2002 because the population estimates by age for 2003 were not available in time.

Percentage Change is calculated by dividing the difference between the recent and base year rates by the base year rate: (Recent rate-base rate/base rate). Rising rates indicate worsening conditions for children. Changes on some indicators such as victims of abuse or neglect may reflect state or local policies or staffing levels.

The calculation is based on unrounded rates so calculations based on published rounded numbers may not reflect the same change.

Rank is assigned to a county indicator based on the rounded rate of the most recent year or the average of the three most recent years. A rank of 1 is the "best" rate. Only counties with a rate in the most recent year could be ranked on a given indicator.

Standard measures are used for the various trend indicators:

- **Percentages** for child poverty, participation in free or reduced priced lunch, low-birthweight babies, high school dropout, less than adequate prenatal care, and student MEAP achievement.
- **Per 1,000** for infant mortality, children in investigated families, substantiated victims of abuse or neglect, children in out-of-home care, and births to teens.
- **Per 100,000** for teen deaths (by accident, homicide and suicide) and child deaths.

Children in Preschool (2000): This number of children attending preschool is based on a response by the head of household in the 2000 U.S. Census. The response depends on the parental knowledge or perception of the program.

Source: Census 2000, U.S. Census Bureau

Infants at Risk (1990-2002): Low birthweight and maternal education of less than 12 years are considered risk factors for the physical, as well as social and emotional well-being of an infant. Low birthweight places infants at higher risk for developmental delays, chronic disease, and even death. Mothers with less than a high school education may have literacy difficulties as well as problems gaining further skills or wages sufficient to support themselves and their child. The graph portrays three-year rolling averages from 1990-1992 to 2000-2002.

Source: Michigan Department of Community Health, Vital Records and Health Data Development Section

Population: Total and Child: The estimated population is a calculated number of people living in an area as of July 1. The estimate is calculated from a components-of-change model that incorporates information on natural change (births, deaths) and net migration (net internal migration, net international migration) that has occurred in an area since a Census 2000 reference date. The child population includes total children, ages 0-17, as well as age groups: 0-4, 5-9, 10-14 and 15-19.

Source: U.S. Census Bureau (for 0-17), County Population Estimates; Michigan State Census

Average Wage Per Job (2002): The average wage per job data for the year 2002 is the latest data available. (Median wage per job data were not available for the counties.) Since the Bureau of Economic Analysis bases its estimates on a job count, not a person count, people holding more than one job are counted in the employment estimates for each job they hold.

Source: U.S. Department of Commerce, Bureau of Economic Analysis, Regional Accounts Data, Table CA34. (http://www.bea.gov/bea/regional/reis/).

Unemployment (2003): The average annual unemployment for 2003 is calculated from the monthly unemployment numbers. This rate has not been seasonally adjusted.

Source: U.S. Department of Labor, Bureau of Labor Statistics, Local Area Unemployment Statistics. (http://data.bls.gov/servletmap.servlet.MapToolServlet?survey=la)

Percent Change in Food Assistance Program Participation (2001-2003): The percent change in food assistance program participation is calculated from the average annual total participation for 2001 and 2003. This number is not adjusted for population changes.

Source: Michigan Family Independence Agency, Program Statistics (http://www.michigan.gov/fia/0,1607,7-124-5458_7696_10775—,00.html)

Children with Child Support Order (April 2004): All children legally entitled to child support are counted. The average amount received is the average amount of child support that was actually distributed, not the average amount ordered, to those children with a support order in April 2004. The percent of noncustodial parents making no payment in previous six months includes those parents who have been ordered to pay child support but have not complied over the last six months as of May 2004.

Source: State of Michigan Child Support Enforcement System (MiCSES) April and May 2004 OCS AdHoc Query. U.S. Census Bureau State and County Population Estimates (ages 0-17); Michigan State Census

Children Receiving FIP Assistance: The Family Independence Program (FIP) supplies cash assistance to needy families—roughly two-thirds are children. The 2003 number is children in the program as of December 2003. The percentage of children is based on the number of children ages 0-18 in 2002. Data for three sets of counties are combined: Missaukee and Wexford counties, Grand Traverse and Leelanau counties, and Charlevoix and Emmet counties. The total for each set is reported for each county.

Source: Michigan Family Independence Agency, Assistance Payments. (Table 12: Total Federal FIP: Children and Adults by Program) December 2003. U.S. Census Bureau State and County Population Estimates (ages 0-17) for 2002.

Children Receiving Food Assistance: The monthly number of children participating in the federal Food Stamp Program includes those in families receiving other forms of public assistance, as well as those receiving no other assistance in December 2003. Families qualify for food assistance with incomes below 130 percent of the poverty level. The percent of children is based on the total number of children ages 0-18 in 2002. Data for three sets of counties are combined: Missaukee and Wexford counties, Grand Traverse and Leelanau counties, and Charlevoix and Emmet counties. The total for each set is reported for each county.

Source: Michigan Family Independence Agency, Policy Analysis Division, Report EY 180 for December 2003. U.S. Census Bureau State and County Population Estimates (ages 0-18) for 2002

Students in Special Education: This figure represents the percentage of the enrolled public school students who are diagnosed with a mental or physical condition resulting in their eligibility for special education services. Local school districts report this information to the Michigan Department of Education. The county numbers represent the children served by local and intermediate school districts within the county in school year 2002-03. Children in programs operated by the Michigan Departments of Corrections and Community Health or the Family Independence Agency are not included. The special education count includes all individuals receiving special education services, ages 0 through 26 as of December 1. The rate is based on the percent of school enrollment for K-12 in October as reported by the Michigan Department of Education.

Source: Department of Education, Office of Special Education & Early Intervention Services, Special Education Count By County and By Type Of Disability For December 1, 2003.

Children Receiving Supplemental Security Income, per 1,000: The number reflects children receiving Supplemental Security Income (SSI) in December 2003. SSI is a federal program of the Social Security Administration that provides direct cash payments to low-income aged, blind and disabled persons who have few financial assets. Children under age 18 are eligible if they meet one of the following criteria:

- Have special health care needs as determined by assessment under SSI criteria;
- Require institutional care but can be cared for at home for less cost;
- Are "Department wards," that is, receiving foster care or for whom there is an adoption assistance agreement (Title IV-E).

The criteria for disability include medical proof of a physical or mental condition or conditions that result in marked and severe functional limitations lasting or expected to last at least 12 months or to result in death. As of January 2003, the maximum monthly amount for a child with a disability living at home was $368 plus a $9.33 state supplement. Persons who are eligible for SSI are automatically eligible for Medicaid, and, if they live in a household with only SSI or Family Independence Program (FIP) recipients, food stamps. The rate is per 1,000 children ages 0-17 in 2002 (U.S. Census). Data for three

sets of counties are combined: Missaukee and Wexford counties, Grand Traverse and Leelanau counties, and Charlevoix and Emmet counties. The total for each set is reported for each county.

Source: Michigan Family Independence Agency, Policy Analysis Division, Report EY-180 for December 2003. U.S. Census Bureau State and County Population Estimates (ages 0-17); Michigan State Census

Children Insured by Medicaid: All children covered by Medicaid in December 2003 are included in this total; children qualify through several different programs. Most recipients are in Family Independence Program (FIP) families, who automatically receive Medicaid, or in families with incomes below 150 percent of poverty—$28,088 for a family of three in 2003. Pregnant women and infants are income eligible at incomes below 185 percent of poverty level. These numbers do not include children in the MIChild program (see next note). The count is the sum of children receiving Supplemental Security Income, children receiving FIP assistance, and other children receiving medical assistance as reported by the Family Independence Agency. The percentage is based on the number of children ages 0-18, according to Michigan population estimates for 2002.

Source: Michigan Family Independence Agency, Policy Analysis Division, Report EY-180 for December 2003. U.S. Census Population Estimates 2002.

Children Insured by MIChild: The number reflects the children enrolled in MIChild as of December 2003. MIChild is a federal and state funded program that provides health insurance to children, ages 0-18. Families with income between 150-200 percent of the federal poverty line, roughly $22,000 to $29,000 for a family of three in 2003, would meet income eligibility. The program was developed with funding made available by federal legislation for States' Children's Health Insurance Program (S-CHIP). The percentage is based on the number of children ages 0-18 according to the Michigan population estimates for 2002.

Source: MAXIMUS of East Lansing. MIChild, December 2003 Executive Summary, Table 2. U.S. Census Population Estimates 2002.

Hospitalized for Asthma, ages 1-14 (2000-2002): This number represents the discharges of children ages 1-14 from Michigan hospitals with asthma recorded as the primary diagnosis. It under-represents the prevalence of asthma among children and the incidence of asthma attacks because many children who have asthma may never be hospitalized for the disease. It does reflect those children with symptoms severe enough to warrant hospitalization.

Data are reported by the county of residence of the patient. The number reflects the average annual numbers of hospital discharges of children ages 1-14 during the three-year period 2000-2002. The rate is the annual average number of incidents per 10,000 children ages 1-14. Rates are reported as calculated by the Bureau of Epidemiology, Michigan Department of Community Health using population estimates for the years 2000-2002. Numbers totalling less than six are not reported. Rates are only provided for counties with a three-year total of 20 or more.

Source: Michigan Department of Community Health, Division of Epidemiology Services. (Michigan In-Patient Data Base, 2000-2002)

Juvenile Justice (2002)
Arrests for violent and property index crimes for juveniles aged 10-17 are reported by the county where they occur, not where the youth resides. In Michigan's criminal justice system seventeen year-olds are not considered "juveniles," but they are included here to maintain comparability with national data. The Uniform Crime Report of the Michigan State Police tabulates the number of arrests for eight index crimes. Those eight are divided into "violent" and "property" as follows:

- **Violent Index Crime Arrests:** murder, rape, robbery, and aggravated assault
- **Property Index Crime Arrests:** larceny, burglary, motor vehicle theft, and arson

These offenses are considered "index" crimes because they are consistently defined across the states, not necessarily because they are considered the most serious. For example, larceny arrests include shoplifting. These data should be used with caution because of several sources of error. First, the arrest count reflects numbers of arrests not numbers of youth; each arrest of an individual who was arrested multiple times is included in the count, as well as multiple youth involved in a single incident. Second, many county numbers are based on partial reporting by police jurisdictions in those counties. Variations across counties may be more influenced by local law enforcement and community norms than actual incidents.

The numbers reflect juvenile arrests for index crimes in 2002. Arrests of children younger than 10 are included with 10-year-olds in that age group is estimated to be small enough not to affect the rates. The rates per 1,000 children ages 10-17 are based on the 2002 population estimates.

Source: Michigan State Police, Criminal Justice Data Center, Uniform Crime Reports. As these data are periodically updated, current electronic information may differ from the data in this report.

Trend Indicators

(in order of their appearance on state/county profiles)

Child Poverty, Ages 0-17 and Ages 5-17 (1995 and 2000): The percentages are based on the number of related children, ages 0-17 and 5-17, in 1995 and 2000. Estimated numbers and rates for 1995 and 2000 are taken directly from the Small Area Income and Poverty Estimates (SAIPE).

Poverty rates include only "related" children—defined as "related" to the head of the family by birth, marriage or adoption. Poverty thresholds are applied on a national basis and are not adjusted for regional, state, or local variations in the cost of living. In 2000, the poverty threshold for a family of two adults and two children was $17,463 nationally. Poverty status is not determined for people in military barracks, institutional quarters, or for unrelated individuals under age 15 (such as foster children).

Source: U.S. Census Bureau, Small Area Income and Poverty Estimates (SAIPE), data accessed online at www.census.gov/hhes/www/saipe.html (April 21, 2004)

Children Receiving Free/Reduced Priced School Lunches (1995/96 vs. 2003/04): Students from families with incomes below 185 percent of the poverty level are eligible for free or reduced prices in the federal School Lunch Program. Students from families reporting income between 130 and 185 percent of the federal poverty line are eligible for reduced priced meals, while children from families with incomes below 130 percent of poverty are eligible for a fully subsidized or "free" meal. The percentage is based on total enrollment of K-12 public school students for school years 1995-96 and 2003-04.

Source: Michigan Department of Education, Food and Nutrition Services, Office of Nutrition (1995-96 and 2003-04)

Less Than Adequate Prenatal Care (1994-96 vs. 2000-02): The Kessner Index is a classification of prenatal care based on the month of pregnancy prenatal care began, the number of prenatal visits, and the length of the pregnancy, that is, for shorter pregnancies, fewer visits are considered adequate. For example, adequate prenatal care begins in the first three months of the pregnancy and includes at least nine visits for a 37-week pregnancy. Less than adequate prenatal care occurs when prenatal visits do not start within the first trimester or reach a standard number of visits, based on the length of the pregnancy. Less than adequate prenatal care includes two categories: inadequate and intermediate prenatal care.[1]

This indicator does not reveal the quality of care, and less than adequate prenatal care *per se* does not cause poor birth outcomes. Included in the measure are some cases where data are unknown or missing. Data-reporting problems in some hospitals have compromised the accuracy of this indicator, especially for the large southeast counties of Oakland, Washtenaw, and Wayne. The percent is based on total resident live births. To mitigate random year-to-year variation, average annual rates were calculated using three-year periods, 1994-96 and 2000-02. Births by county are based on the mother's county of residence.

Source: Michigan Department of Community Health, Vital Records and Health Data Development Section (Calendar years 1994-2002)

Low-Birthweight Babies (1994-96 vs. 2000-02): Babies who weigh less than 2,500 grams (approximately 5 lb. 8 oz.) at birth are considered low-birthweight. To mitigate year-to-year random variation, average annual rates were calculated using three-year periods, 1994-96 and 2000-02. Births by county are based on the mother's county of residence. The percentage is based on live births.

Source: Michigan Department of Community Health, Vital Records and Health Data Development Section (Calendar years 1994-2002).

Infant Mortality, per 1,000 (1994-96 vs. 2000-02): Infant mortality numbers include deaths of infants up to one year of age. County totals do not always add up to the Michigan total because the county of residence is missing in some infant death cases. To mitigate year-to-year random variation, average annual rates were calculated using three-year periods, 1994-96 and 2000-02. The rate is the number of infant deaths per 1,000 resident live births. Since an infant death may occur in the calendar year following the birth year, some amount of error is introduced into the rate.

Source: Michigan Department of Community Health, Vital Records and Health Data Development Section (Calendar years 1994-2002).

Three-year averages are used to calculate trends for most health indicators because they are less likely to distort trends than a single year. Rates are calculated for the average number and average population base. Many Michigan counties have small numbers of events for several mortality indicators and small population bases.

Fiscal Years begin on the previous October 1st and end on September 30th. For example, fiscal year 2003 began on October 1, 2002, and ended on September 30, 2003. Indicators such as child abuse and neglect and out-of-home care are reported in fiscal years.

Child Deaths, Ages 1 to 14 (1994-96 vs. 2000-02): The number of child deaths includes deaths from all causes, disease as well as injury. To mitigate year-to-year random variation, average annual rates were calculated using three-year periods, 1994-96 and 2000-02 (U.S. Census 2000 and estimated populations for other years are used). The rate is the number of child deaths per 100,000 children, ages 1-14.

Source: Michigan Department of Community Health, Vital Records and Health Data Development Section (Calendar years 1994-2002). 1994-96 population estimates from the Michigan Information Center, Department of Management and Budget. 2000-02 population estimates from the National Center for Health Statistics (These estimates were developed for NCHS by the U.S. Census Bureau.)

Children in Investigated Families (1995 vs. 2003): These children are in families where an investigation of abuse or neglect was conducted, usually initiated by a complaint or report received by the Child Protective Services Division of the Family Independence Agency during the fiscal years of 1995 and 2003. Families may be investigated more than once in a given year, so these numbers represent a duplicated count. Rates are calculated per 1,000 children ages 0-17 in 1995 and 2002. Data are merged for two sets of counties: Missaukee/Wexford and Grand Traverse/Leelanau.

Source: Michigan Family Independence Agency, Health and Welfare Data Center, Children's Protective Service Management Information, Report PS-31D, Victims by Category of Abuse/Neglect (Fiscal Years 1995 and 2003). Population Estimates for 2002 taken from US Census bureau FactFinder website (http://factfinder.census.gov)

Confirmed Victims of Abuse or Neglect (1995 vs. 2003): These numbers reflect an unduplicated count of children in fiscal years 1995 and 2003 confirmed to be victims of abuse or neglect after an investigation. (These numbers reflect all types of confirmed abuse or neglect.) The operational definitions for child abuse and neglect are found in the *Services Manual* of the Family Independence Agency. Rates are calculated per 1,000 children ages 0-17 in 1995 and 2002. Data are merged for two sets of counties: Missaukee/Wexford and Grand Traverse/Leelanau.

Source: Michigan Family Independence Agency, Health and Welfare Data Center, Children's Protective Service Management Information, Report PS-31D, Victims by Category of Abuse/Neglect (Fiscal Years 1995 and 2003). Population Estimates for 2002 taken from US Census bureau FactFinder website (http://factfinder.census.gov)

"Child abuse" means harm or threatened harm to a child's health or welfare by a parent, legal guardian, or any other person responsible for the child's health or welfare or by a teacher or teacher's aide that occurs through nonaccidental physical or mental injury; sexual abuse; sexual exploitation; or maltreatment.

"Child neglect" means harm or threatened harm to a child's health or welfare by a parent, legal guardian, or any other person responsible for the child's health or welfare that occurs through either of the following:

(i) Negligent treatment, including the failure to provide adequate food, clothing, shelter, or medical care.

(ii) Placing a child at an unreasonable risk to the child's health or welfare by failure of the parent, legal guardian, or any other person responsible for the child's health or welfare to intervene to eliminate that risk when that person is able to do so and has, or should have, knowledge of the risk.

[1] Intermediate prenatal care is defined as having begun during the second trimester with corresponding fewer visits or during the first trimester but with fewer visits than considered appropriate for the length of the pregnancy. Inadequate prenatal care is none at all or care beginning in third trimester or the number of visits was less than the minimal standard, based on the length of the pregnancy, no matter when the visits began.

Children in Out-of-Home Care (1995 vs. 2003): The total number includes children in facilities or placements (other than their own home) where supervised by the Family Independence Agency (FIA) or its agents or the courts, including children placed with a relative or guardian. The number of children in out-of-home care for reasons of abuse or neglect and the number for delinquency are presented separately. The total includes court placements that are not designated by cause. The number of Wayne County children placed out-of-home for delinquency in 2003 was provided by the county's Department of Community Justice, which has jurisdiction over delinquency services for county youth. This number was added to the state total. Since children in mental health facilities or out-of-home placements supervised by the Department of Mental Health or Department of Corrections are not included, these numbers are viewed as an under-count of children in out-of-home care. The rate is calculated per 1,000 children, ages 0-17 in 1995 and 2002 (Population Estimates). Data are from a single month—September.

Source: Michigan Family Independence Agency, Children's Services Management Information System, Report CY-091, Part G, Legal Status by Living Arrangement and Sex (Report Period September 1995 and 2003) and Wayne County Department of Community Justice, Juvenile Justice Services Division Information System, JAIS (Juvenile Agency Information System) for September 2003. Population Estimates for 2002 taken from US Census bureau FactFinder website (http://factfinder.census.gov)

Births to Teens, Ages 15-17 (1994-96 vs. 2000-02): The total number of births to teens between ages 15-17 is an annual average for the three-year periods of 1994-96 and 2000-02. The rate of teen births is based on the number of live births per 1,000 females, ages 15-17 for those periods. Average annual rates were calculated to mitigate year-to-year random variation. (U.S. Census 2000 and estimated populations for other years are used).

Source: Michigan Department of Community Health, Vital Records and Health Data Development Section (Calendar years 1994-2002). 1994-96 population estimates from the Michigan Information Center, Department of Management and Budget. 2000-02 population estimates from the National Center for Health Statistics (These estimates were developed for NCHS by the U.S. Census Bureau.)

Deaths by Accident, Homicide, Suicide, for Teens, Ages 15-19 (1994-96 vs. 2000-02): Only teen deaths caused by accidental injury, homicide, or suicide are included, not those caused by disease. To mitigate year-to-year random variation, average annual rates were calculated using three-year periods, 1994-96 and 2000-02. The rate of teen injury deaths is based on the number of such deaths per 100,000 teens, ages 15-19, for those periods.

Source: Michigan Department of Community Health, Vital Records and Health Data Development Section (Calendar years 1994-2002). 1994-96 population estimates from the Michigan Information Center, Department of Management and Budget. 2000-02 population estimates from the National Center for Health Statistics (These estimates were developed for NCHS by the U.S. Census Bureau.)

High School Dropouts (1995-96 vs. 2001-2002): County dropout rates are calculated from dropout numbers and adjusted enrollments summed across all school districts in a county. The count of dropouts in a given year in a Michigan school district is the sum of students enrolled in the district in grades 9 through 12 on fall count day of one school year who are not accounted for on fall count day of the following school year. Students who were enrolled on the beginning count day are considered accounted for on the ending count day if they are enrolled, have transferred to another district, were retained in grade, or graduated. The calculation does not reflect those who return to an adult education program to complete their diploma requirements or those who drop out prior to the ninth grade.

Source: Data for the calculations were obtained from the Center for Educational Performance and Information. As Department of Education dropout data may be updated from time to time, rates posted by the Department of Education, particularly for more recent years, may differ from the data presented here.

Students Not Meeting Mathematics Standards (Grades 4 & 8 – 2001-02 vs. 2003-04, Class of 2001 vs. Class of 2003): The Michigan Educational Assessment Program (MEAP) is the statewide testing program designed to assess school and student performance and identify educational needs. The MEAP mathematics tests are administered to grades four and eight, and high school students prior to graduation. Most high school students take the exam in the 11th grade. The data for the Classes of 2001 and 2003 include the scores for all students in that graduating class who took the exam, regardless of when they took it.

Mathematics test scores for fourth and eighth grade MEAP tests and for the high school test are reported in four levels. Scores at levels one and two are deemed to meet or exceed Michigan standards. (Additional information about how to interpret and use MEAP scores is available in the *Michigan Educational Assessment Program Handbook*.) The number of students reported as *not* meeting proficiency standards includes only students who scored at levels 3 and 4.

A new high school mathematics test was introduced in spring 2002. The class of 2003 was the first to take this test. Performance standards were deemed comparable to the previous test in scholarship, that is, it was no easier for the class of 2002 to get a scholarship based on their math proficiency than for the class of 2003.

County numbers and rates were calculated by summing total participant numbers and numbers scoring at each level across school districts in each county. Numbers at each level were calculated from the percents and the total number of participants. Thus, in some cases, the numbers reported here might not equal the original totals because of rounding errors. Total number of participants is the number of students in a given grade who took the test.

Source: MEAP website, Merit Award Program, Michigan Department of the Treasury. http://www.meritaward.state. mi.us/mma/meap.htm

Students in charter schools, also known as public school academies, have not been included in the following indicators: participation in free or reduced priced lunch, achievement (as measured by the Michigan Educational Assessment Program) or high school dropout. Many of these schools have not been required to comply with reporting requirements, and they encompass a relatively small share (3%) of all K-12 public education students.

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Mission Statement

To improve the status of children, youth, and families, Kids Count in Michigan collects and disseminates data as a basis for public policy development and community action.

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