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Division for Vital Records and Health Statistics  
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Division of Epidemiology Services  
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Special Education Services  
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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, independent voice for children and their families that works with lawmakers, business leaders and communities to make Michigan a place where all children have the opportunity to thrive.

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The Michigan Data Book 2005 is available as

- A book for $17 plus sales tax (shipping and handling $3) from the Michigan League for Human Services (bulk rates available).
- A PDF file on the League website: www.milhs.org

For copies of the book, further information or presentations, contact:

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Introduction

This year’s data book contains some changes in the key well-being indicators reviewed, as well as a review of the indicators by metropolitan and non-metro county groups; policy options to improve the chances of youngsters in specific indicator areas; and a focus on adolescents at highest risk of faltering in their transition to adulthood. High-risk youth include those who have become parents as teenagers, dropped out of high school, “aged out” of foster care, or spent time in the juvenile justice system. An expanded “Adolescence” section provides an overview of issues and the current situation in Michigan for these high-risk groups.

Changes in Indicators

Two key trend indicators that monitor adolescent well-being have been changed in order to maintain consistency with the national Kids Count data book, and the Michigan Education Assessment Program test results for counties have been eliminated. County-level MEAP results are rarely used in planning or policy evaluation as opposed to the district and building data, according to feedback from a wide range of users and analysts. MEAP test results by school district and even school building are widely publicized and readily available.

In line with other national data book changes, the previous rate of teen death by injury indicator has been expanded to include deaths from disease, also a concern. The prior focus on teen deaths strictly from injuries reflected the fact that most (70-80%) teen deaths result from an injury caused by an accident, homicide or suicide.

The teen birth measure now includes births to teens, aged 15-19, not just those to 15-17 year-olds. This expansion reflects the fact that two-thirds of all teen births occur to 18 and 19-year-olds and that national analyses are showing that outcomes for babies born to these older teens hardly differ from those born to younger teens. Child poverty rates for children born to older teens were 36 percent compared to 38 percent for those born to teens under age 18, and the risk of living in a single-parent family was also essentially the same (43-44%). Limiting the measure to younger teens thus understates the scope of the problem in Michigan.

National data show that in most teen births (80%) the mother is unmarried, but even if a teenager is married at the time of a birth, there exists a high probability that the marriage will end before the child completes elementary school. Roughly half (48%) of marriages involving women under age 18 last less than 10 years, (40% for 18 and 19 year-olds), compared to 24 percent for women over age 25.

County Groups

The county group analyses classify counties based on their metropolitan status and location. The “metropolitan” designation reflects analysis of commuter traffic patterns and population levels reported in the 2000 census by the U.S. Census Bureau. All metropolitan counties are located in the southern half of the state’s Lower Peninsula where the state’s child population in Michigan is concentrated, with four of every five children residing in this county group.

For the purposes of this report and analysis, the non-metropolitan counties are divided by geography into: Southern, Northern, and the Upper Peninsula (UP). The compilation of regional averages and trend analyses for these non-metropolitan areas allows less densely populated counties to have a more helpful comparison of their status on some measures than the state average, which is driven by the metropolitan counties. It is noteworthy that the non-metropolitan county groups have fewer children in the entire region than are located in only one of the largest metropolitan counties. For example, as many children live in Ingham County as live in the entire UP, and the total number of children in each of the other two non-metro groups does not exceed the child population of Oakland, the state’s second most densely populated county.

Policy Recommendations

In this year’s discussion selected policy recommendations are included for the key trend indicators. They are intended to highlight the connection between state and federal policies and outcomes for children and families. State policy decisions make a difference in regard to the level of resources available to maintain and enhance child and family well-being, the strength and efficacy of programs aimed at this goal, and the level of services to be provided. A recent analysis found that the level of public expenditures in a state has an impact on a wide range of indicators including child mortality, elementary school test scores and adolescent behaviors. Approximately half of the child outcomes in the analysis were significantly affected, with Medicaid and education spending having the most pronounced effect.

In recent years resources at both the national and state level have been severely reduced by extensive tax cuts with no replacement revenue identified or collected. As a result of these cutbacks in revenue, funding for health, education and other human needs programs has been eroding. The impact has been most strongly felt by the most vulnerable children and their families. If public expenditures continue to short-change the level of resources available to maintain and enhance child and family well-being, the strength and efficacy of programs aimed at this goal, and the level of services to be provided. A recent analysis found that the level of public expenditures in a state has an impact on a wide range of indicators including child mortality, elementary school test scores and adolescent behaviors. Approximately half of the child outcomes in the analysis were significantly affected, with Medicaid and education spending having the most pronounced effect.

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Executive Summary

This year’s data book provides an analysis of the indicators by metropolitan and non-metro county groups; policy options to improve the chances of youngsters in specific indicator areas; and a focus on adolescents at highest risk of faltering in their transition to adulthood.

Youth in Transition

Adolescence is a time of profound physical and mental transformation as the body and mind mature. Research with new technology has revealed that the physical capacity of the adolescent’s brain to make plans, control impulses and apply reason to decision-making is still in development. Those without consistent positive connection to a caring adult or strong family network are particularly vulnerable, and some youth tragically even lose their lives. Youth who become parents, drop out of high school, age out of foster care, or get placed into the custody of the juvenile justice system face the most barriers in making a successful transition to adulthood.

Youth who lose their lives: The death of a teen reverberates throughout a community as well as within the family. The rate of teen deaths reflects the safety of the environment as well as the emotional and physical health of teens and the capacity of the larger community to protect its youth. Roughly 430 Michigan teens, ages 15-19, died in 2003. The death rate for teens was three times higher than that of children, ages 1-14. Accidents, most involving a motor vehicle, accounted for almost half of all teen deaths. The death of a teen costs. By the time a youth is injuring himself or others in the community to the point that the juvenile authorities become involved, the behaviors and attitudes can be entrenched. Once identified with the juvenile justice system, young people will have a record that can compromise educational and employment opportunities, limit their life chances, and also cost them the opportunity to build a positive peer network during these critical years. Youth of color, especially African-American youth, are likely to experience more severe treatment than their white peers at every stage of the juvenile justice process—putting them at a “cumulative disadvantage.”

Youth who drop out of high school: Roughly 23,600 youth dropped out of high school in Michigan in the 2003-04 school year. But dropout rates tell only part of the story. Many youth who end up in the juvenile justice system could have been better served by another system or agency at an earlier stage and at less cost. By the time a youth is injured himself or others in the community to the point that the juvenile authorities become involved, the behaviors and attitudes can be entrenched. Once identified with the juvenile justice system, young people will have a record that can compromise educational and employment opportunities, limit their life chances, and also cost them the opportunity to build a positive peer network during these critical years. Youth of color, especially African-American youth, are likely to experience more severe treatment than their white peers at every stage of the juvenile justice process—putting them at a “cumulative disadvantage.”

Youth who become parents: Although Michigan has one of the lowest teen birth rates in the nation, ranking 14th among the 50 states, the United States has by far the highest teen birth rate among industrialized nations. Teens who become parents are less likely to complete their high school education than other teens. Only one-third of teen mothers in the U.S. graduate from high school. Their academic difficulties may be as much a cause as a result of their parenthood: high school girls in the bottom 20 percent of students in basic reading and math skills are five times more likely to become mothers as teens than those in the top 20 percent in these skill areas.

Youth who age out of foster care: In Michigan roughly 1,300 foster youth age out of the system every year, that is they are no longer eligible for maintenance payments from the state’s child welfare system. Too many of these youth lack the academic credentials, financial resources, and social supports that will allow them to establish themselves independently. Youth aging out of foster care encounter multiple barriers to attaining post-secondary education or finding a decent job. Unlike most youth who receive some form of financial assistance and other kinds of support from their parents, foster care youth generally do not. Additionally, foster care youth are commonly unaware of resources that may be available to them.

Youth in the juvenile justice system: Many youth who end up in the juvenile justice system could have been better served by another system or agency at an earlier stage and at less cost. By the time a youth is injured himself or others in the community to the point that the juvenile authorities become involved, the behaviors and attitudes can be entrenched. Once identified with the juvenile justice system, young people will have a record that can compromise educational and employment opportunities, limit their life chances, and also cost them the opportunity to build a positive peer network during these critical years. Youth of color, especially African-American youth, are likely to experience more severe treatment than their white peers at every stage of the juvenile justice process—putting them at a “cumulative disadvantage.”

Policy Strategy

Lack of attachment to school and investment in the education process are risk factors for engaging in unprotected sex. Strengthening public education, particularly in schools with large numbers of low-income students, would address the needs of youth at risk of academic failure. Getting teens involved with positive peer groups and activities has also proven to be a successful approach.

Policy Strategy

High quality early care and education can substantially boost high school completion rates for disadvantaged children. Early environments have a major long-term impact on ability and achievement. Preschool interventions with enriched environments and qualified teachers can provide cognitive and emotional stimulation that will reduce the school-readiness gap.

Policy Strategy

The services offered to foster youth aging out of the child welfare system need to be reorganized into “user-friendly” networks at the community level and enhanced by an active mentoring program. In many counties, foster youth must navigate a disjointed system in order to get their needs met. Due to the high turnover in caseworkers and the ruptures within their family structures, many youth lack an adult mentor to sustain them through the process of transition.

Policy Strategy

Develop a comprehensive analysis and response to the over-representation of children of color in the child welfare and delinquency systems. A focused effort must be directed at developing policies to address the problems of poverty, community disorganization, social and ethnic discrimination, inadequate education, and lack of mental health and social services in communities of color. The majority of African-American parents in Michigan are single mothers who must work—many at low-wage jobs situated a substantial distance from their homes. This situation increases the risk of neglect and denies their children the opportunity to grow up in a reasonably safe, secure and supportive environment.

1 The majority of foster youth in Michigan “age out” at age 18. Some extending circumstances such as special needs or if the youth is still in high school or attending college allow for youth to continue to receive assistance past the age of 18.

2 Michigan Assemblies Project, Welfare Reform: How Families are Faring in Michigan’s Local Communities (Detroit, MI, October 1998.)
**The Status of Children in Michigan**

All areas of child well-being for children except adolescence registered mixed trends between 1996 and 2003. The largest and most consistent improvements occurred among adolescents. The area of child safety reflected worsening trends on all but one measure, out-of-home care for delinquency. Improvements in maternal and infant health have stalled despite a slight decline in the share of pregnant women who do not receive adequate prenatal care. During this same period the state has cut back on prevention programs; similarly funding for programs to mitigate the effects of poverty for the state’s most vulnerable families and children has eroded.

**Improvements**

- **Juvenile arrest rates for index crimes declined by roughly 40 percent** between 1996 and 2003. In 1996 there were 19 arrests per 1,000 youth ages 10 through 17 compared to 1.6 in 2003. The rate of juvenile arrests for violent crimes dropped by one-half and for property crimes by roughly 40 percent. In 1996 the juvenile arrest rate for violent crime was 3.4 arrests per 1,000 youth compared to 1.6 in 2003 while that for property crime dropped from 19 to 12 per 1,000 youth.

- **High school dropout rates plummeted by one-half** between 1996 and 2004. In 2002, the rate had dropped to 3 percent compared to 6 percent in 1996.

- **Births to teens dropped by 30 percent**—from 51 to 36 births among every 1,000 female teens, ages 15-19, between 1996 and 2003. Roughly 12,600 teenagers in Michigan gave birth in 2003. One of five was a second or third birth.

- **Teen death rates declined by 29 percent**—from 86 to 60 deaths among every 100,000 youth, ages 15-19, between 1996 and 2003. Roughly 430 teens lost their lives in 2003.

- **Child deaths dropped by 19 percent**—from 26 to 21 deaths per 100,000 children ages 1-14. Roughly 430 children died in 2003.

**Challenges**

- **Confirmed child victims of abuse and neglect rose by 43 percent**—from 8 to 12 victims per 1,000 children between Fiscal Years 1995 and 2004. Roughly 29,700 children were found to be victims of abuse or neglect in 2004.

- **Children in out-of-home care for abuse or neglect rose by 17 percent**—from 7 to 8 children per 1,000. Approximately 17,300 children in Michigan were in out-of-home care for abuse or neglect in 2004.

- **One in three of the state’s school children lived in a family with income 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 2004. A total of 609,000 school-aged children were affected.

- **Maternal and infant health continued to stall.** The state’s 2003 infant mortality rate remained at essentially the same level as in 1996—8 of 1,000 Michigan infants did not live through their first birthday. The share of babies born at low-birthweight rose slightly—8 percent of all births or roughly 10,600 infants at elevated risk of developmental delay and chronic disease.

**State policy decisions make a difference.**

They determine the level of resources available to maintain and enhance child and family well-being, the strength and efficacy of programs aimed at this goal, and the level of services to be provided. A recent analysis found that the level of public expenditures in a state has an impact on a wide range of indicators including child mortality, elementary school test scores and adolescent behaviors. Approximately half of the child outcomes in the analysis were significantly affected, with Medicaid and education spending having the most pronounced effect.

In recent years resources at both the national and state level have been severely reduced by extensive tax cuts with no replacement revenue identified or collected. As a result of these cutbacks in revenue, funding for health, education and other human needs programs has been eroding. The impact has been primarily borne by Michigan’s most vulnerable children and their families. If public expenditures continue to shortchange the next generation, the state will face not only immediate costs to child well-being, but long-term consequences in decreased earnings and increased crime, imprisonment, and dependency among its adult citizenry.

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**Policy Strategies**

**Expand supports to families.** Prevention is a critical strategy to create better outcomes for children. Family poverty, mental illness, depression, and unrelenting stress increase the vulnerability of parents to abusive or neglectful behavior toward their children. By providing services and resources to mitigate the factors associated with poverty and the mental health of parents, Michigan could substantially reduce the conditions that lead to the maltreatment of children.

**Increase opportunities for low-income wage earners to access education and training programs.** Parents need good wages in order to support their families, and the path to good wages lies through education and training. Michigan’s public assistance policies should encourage education and training, and the state workforce development policies should specifically target low-wage working families.

**Extend the Nurse Family Partnership.** An expansion to all eleven Michigan communities with the highest infant mortality rates in the state and at least six locations in the city of Detroit would focus the state’s limited resources. The Nurse Family Partnership has three decades of research that demonstrate its long-term benefits to mothers and their children.

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Economic Security

Economic security in a family means that the household has access to sufficient financial resources to meet the family’s basic needs. While the federal poverty threshold has been used since the 1960s to gauge the economic well-being of the nation’s citizens, most researchers and economists acknowledge that families with incomes significantly above this poverty threshold experience considerable financial hardship. An alternate measure, the self-sufficiency standard, calculates the amount of income a family would need to meet its basic need for food, housing, utilities, health care, child care, transportation, household and personal needs, and payment of taxes with no assistance from public federal or state programs. This standard does not allow for any extraordinary needs such as savings to meet emergencies or longer term asset accumulation for retirement. Calculations for Michigan families show that living at the bare self-sufficiency standard would require income at more than double the poverty level.

In recognition of the fragility of families even when they have incomes above the poverty threshold, several state and federal income support programs provide benefits to “near poor” families—those with low income at varying levels above poverty. For example, families may qualify for food stamps with income up to 130 percent of poverty, a subsidy for child care up to 150 percent, and health insurance for their children with family income up to 200 percent of poverty.

In the table below, we see the percentage of families in poverty across Michigan counties by metro status and region for the year 2002.

### Children in Poverty (2002)

**Michigan Counties by Metro Status and Region**

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<tr>
<td>Meosta</td>
<td>18.6</td>
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Source: U.S. Census (SAIPE)

The Family Independence Program (FIP) cash assistance program, however, provides benefits only to a family of three with a gross monthly income of less than $773, significantly below the poverty level for a family of that size. Since grant levels and income eligibility ceilings have not been adjusted since 1993 in Michigan, inflation has cut the purchasing power of cash assistance by over one-third. While roughly half the families receiving cash assistance who are expected to work are employed and use the grant to supplement their low wages, many parents have not been able to find jobs in Michigan’s recessionary economy. Families forced to live on the assistance grant alone face considerable hardship. For example, the maximum grant amount of $459 a month for a parent with two children to meet all their non-food needs represented only 57 percent of the average cost of a two-bedroom dwelling in Wayne County in 2005.

The lack of economic security deeply affects all areas of child well-being including health, education, and safety. Family support programs such as FIP cash assistance, food stamps, child care subsidies, and Medicaid play a critical role in enhancing access to basic necessities for children in poor and near poor families. Unfortunately, the gradual erosion in federal and state funding for these critical programs has contributed to widespread and severe economic insecurity among fragile families with children.

The economic downturn that began in 2000 has further affected many Michigan families. The state has been one of the hardest hit in the nation as reflected in its unemployment rates over this period, some of which are reflected in the data below.
the highest in the nation. Child poverty in Michigan continued to climb in 2004 for all age groups. The youngest children who are also the most developmentally vulnerable to the harsh effects of poverty had the highest rates—one of every five of Michigan’s young children was poor in 2004. The poverty rate among school-aged children was the lowest (16.1%), possibly reflecting the parents’ ability to work more hours without incurring child care costs.

Traditionally unemployment insurance has cushioned workers through recessionary periods when jobs are scarce, but Michigan’s eligibility rules have not adapted to reflect changes in the labor market. The state has some of the strictest standards in the nation to qualify for benefits. In 2003 the majority of Michigan’s unemployed did not qualify for benefits. Unemployed parents of minor children can turn to the state cash assistance program if they cannot access unemployment benefits, but only those families with extremely low incomes—almost one-third below the poverty level—will qualify.

**Children in Poverty**

Child poverty represents the number and the percentage of the children living at or below the federal poverty threshold, which varies according to family size and composition. Poverty thresholds are adjusted for inflation each year.

**Why does poverty matter?**

Income below the poverty level means the family has an inadequate level of financial resources to meet the costs of such basic needs as food, housing, health care, and transportation. Children who spend their growing up years in such households are at higher risk of abuse and neglect, teen pregnancy, high school dropout, and depression. They commonly live in neighborhoods or communities where schools have fewer resources and offer limited options for early education and care, which often leads to lower academic performance in later years. Impoverished children also are more likely to suffer from health problems, including malnutrition and asthma, than their counterparts in families with more adequate resources. Their health problems are exacerbated by exposure to environmental toxins such as lead in poorly maintained housing and a lack of access to health care.

**What is the situation in Michigan?**

One in seven children in Michigan lived in a family with income below the federal poverty level in 2002, the last year for which data are available for every county in the state. Roughly 360,000 Michigan children in the state were growing up in this compromised living situation. The overall child poverty rate had improved by 2002, as compared to 1995 when child poverty affected one in five children in the state. Every county in the state experienced a decline in child poverty between 1995 and 2002.

The northern counties in Michigan had the highest child poverty rate, according to the 2002 estimates, with roughly 16 percent of children living in impoverished households. The other three county regions, however, did not lag far behind with rates of 13-14 percent.

The Michigan child poverty rate for 2003 ranked the state 25th among the 50 states, according to the 2005 national Kids Count data book. The states ranking first and second in the nation—New Hampshire and Minnesota—boasted poverty rates of less than 10 percent, roughly half that of Michigan.

Since 2003, child poverty in Michigan has worsened. Between 2003 and 2004, rates rose from 15 to 18 percent of children, according to the American Community Survey. For those seven Michigan counties for which updated child poverty rates were available, all but two sustained an increase in 2004. (Data from the 2004 American Community Survey are only available for counties with population over 250,000.) In 2004, Wayne County had the highest child poverty rate among the seven most populous counties in the state, six times higher than the lowest rate in Oakland County (30% vs. 5%). Between 2003 and 2004 Oakland County experienced a substantial decline (53%) in child poverty while Kent County sustained the largest increase (40%).

Even by national standards, the child poverty in Michigan’s largest county and city was acute in 2004.Wayne County had the 12th highest child poverty rate among the nation’s counties and, among the largest cities in the nation, Detroit had the second highest child poverty rate with roughly half its children living below the poverty level.

**Students Receiving Free/Reduced Priced School Lunches**

Students with family income below 130 percent of the federal poverty level may receive a school lunch at no cost, and those with family income between 130 and 185 percent of the federal poverty level may purchase lunch at a reduced price. This federal program provides nutritional support to children from low-income families.

**Why do school nutrition programs matter?**

Children who grow up in poor or near poor families commonly suffer similar kinds of deprivation, and the school meals program helps them all to meet their nutritional needs. In recent years several programs designed to alleviate hardship for struggling low-income families in Michigan’s most populous counties.

**Children in rural northern Michigan are most likely to live in economically vulnerable families.**

**Students Receiving Free/Reduced Priced Lunch**

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<th>Region</th>
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* school-aged children in families with income below 185% poverty

Source: US Census (SAIPE) 2002; Michigan Department of Education 2004-05 school year
families such as Emergency Services have been eliminated or benefits severely restricted. Student participation in the school lunch program at free and reduced prices provides counties an estimate of the number and share of children in families under economic duress.

Shelter costs represent an increasing share of the family budget in low-income families as housing costs have increased faster than wages, and the burden of escalating energy costs crowds out other needs. Low-wage workers rarely have access to such employment-based benefits as health care insurance for themselves, much less their families, so they and their children are more likely to suffer a health crisis due to lack of access to preventative care. Families usually have little savings to cover a crisis such as an illness, a major car repair or a substantial increase in home heating costs. Families living with economic insecurity routinely experience pressures that create high levels of stress and depression.

What is the situation in Michigan?

Fully one in three school children in Michigan lived in a poor or near poor family in 2004-05 school year when 36 percent of all students in the state’s K-12 schools participated in the School Lunch Program at free or reduced prices. This participation rate represented an 18 percent increase from the 1995-96 school year when the rate was 31 percent. The share of children in low-income families in Michigan rose over the trend period in all but three counties.

Michigan’s northern counties and the Upper Peninsula had the largest shares of students qualifying for free or reduced prices in the School Lunch Program, between 39 percent and 42 percent—roughly two of every five school children.1

What can Michigan do to improve economic security for families with children?

Increase opportunities for low-wage earners to access education and training programs. Parents need good wages in order to support their families, and the path to good wages lies through education and training. Too many low-income parents lack adequate educational and skill levels and therefore are unable to compete successfully in today’s labor market for jobs that pay family-supporting wages. Michigan’s public assistance policies should encourage education and training, and the state workforce development policies should specifically target low-wage working families.

Enact a state Earned Income Tax Credit (EITC): The federal EITC is one of the most highly effective tools to reduce poverty because it provides a supplement to the earnings of low-wage workers. Sixteen other states have enacted a state tax credit program based on the federal structure to provide targeted assistance to working families. A state EITC can be easily administered because it would be directly linked with the federal program. The refunds that the workers receive would be spent locally, thus boosting the local economy.

Adjust the child care subsidy rate to current market rates: Michigan has not adjusted its child care subsidy to market rates since 1994. The cost of child care represents a substantial expense for all families, but low-income workers are particularly vulnerable since such a large share of their wages is consumed by child care costs. The Child Development and Care Program of the Michigan Department of Human Services does provide child care subsidies for low-income workers, but the payment structure and amount severely limit child care options.

Increase the grant amount and adjust eligibility standards in the state’s cash assistance (FIP) program. As the income eligibility ceiling for FIP has been frozen at the same dollar amount of $775/month for over a decade, more and more poor families no longer qualify for the program. Michigan has one of the lowest eligibility ceiling reductions in the country, substantially below those of the other midwestern states—most of which are over $1,000. The maximum grant amount, $459 per month, has not been increased in over ten years. During that time its purchasing power has eroded by over one-third. In 2004 the assistance grant for a family of three was 62 percent below the federal poverty level. Two-thirds of cash assistance grantees are children whose life potential is compromised by living in such dire economic privation during their formative years. With unemployment so high in the state, a parent’s struggle to find a job does not always bear fruit, particularly among those with no regular source of transportation.

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1. Michigan counties were divided into four groups based on their metropolitan status and location. Non-metropolitan counties are grouped into Southern, Northern and the Upper Peninsula.

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Source: Michigan Department of Education

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* Rate could not be calculated.
Child Health

The health of a child is inextricably linked to the overall well-being of that child’s family and its ongoing access to health care, as well as to the general well-being of the community in which the family resides. The degree of economic security enjoyed by the family is also integral to the physical and mental health of children.

• Only two of three poor children in Michigan were considered to be in very good health in 2003, according to the National Survey of Children’s Health.
• Among the state’s low-income families, children were significantly less likely to have very good health compared to children in higher income group, and they were three times more likely to suffer from a moderate to severe health problem than their higher income counterparts.

Not only are the children in Michigan’s poor families in more compromised health, so are their parents. The state’s poor children were almost five times more likely to have a mother in tenuous health than their more affluent counterparts in 2003 (19% vs. 4%).

Poor and low-income children in Michigan were significantly less likely to be in very good health than higher income children.

Low-wage workers are less likely to receive employer-provided health insurance than higher wage workers, and thus more likely to have limited access to care and suffer from health problems. Michigan parents and guardians generally qualify for Medicaid at incomes of only 35 to 50 percent of the poverty level unless they are disabled or over 65. While the children in many low-income families qualify for Medicaid or MiChild, research has consistently shown that children in families where parents do not have insurance coverage are much less likely to receive necessary health care services, regardless of whether they are eligible for a public program.

Health insurance coverage is critical to access to care, particularly preventive care for children. Since 1990 Michigan has had consistently lower rates of uninsured children than the national average although the margin has narrowed in recent years. In both the state and the nation the share of children without insurance coverage rose steadily between 1990 and 1998 as health care costs increased, and employers cut back on private insurance. After the federal Children’s Health Insurance Program (S-CHIP) was implemented in the late 1990s, states extended eligibility for publicly funded health care insurance at higher income levels and increased their outreach. In Michigan the MiChild program extended coverage to children in families with incomes up to 200 percent of poverty. The outreach resulted in many more children gaining access to health coverage. More than one-third of the Michigan families applying for MiChild for their children actually qualified for Medicaid because their incomes were under 150 percent of poverty. Nonetheless in 2003, children in Michigan families with income under 200 percent of poverty were still more than twice as likely to lack insurance as children in higher income families (9% vs. 4%). Their health care coverage was also less consistent: children in the state’s very poor and other low-income families were three times more likely to be uninsured or have experienced periods of no coverage during the previous year than the most affluent children (16% vs. 5%).

These disparities in health insurance coverage are reflected in unequal access to care between poor and affluent children. Poor children were less likely to have a “medical home” as defined by the American Pediatric Association. Roughly two-thirds of poor and other low-income children lacked a care giving center or office with a “personal doctor or nurse from whom they received family-centered, accessible, comprehensive, culturally sensitive and coordinated health care,” compared to 42 percent of children in families in higher income brackets (incomes over 400 percent of poverty). Children who do not have access to consistent care commonly end up suffering preventable medical emergencies. For example, children in poor families were much more likely to have been hospitalized for asthma than their more affluent peers who would have better access to timely effective outpatient care and adequate medications, according to a recent analysis.

Not surprisingly, children in Michigan’s poor and other low-income families were much more likely to have been hospitalized for asthma not to have access to timely effective outpatient care and adequate medications, according to a recent analysis.

The share of children without health insurance* in Michigan and the US dropped sharply in the late 1990s.

Source: US Census (Current Population Survey), Calculations by the Population Reference Bureau

% at any point during the year


calculated by the Population Reference Bureau


1 All data cited in this introductory section are from this survey <www.nschdata.org> For the purposes of this narrative, “very good health” indicates very good or excellent health, and “tenuous health” indicates fair or poor health in the National Survey of Children’s Health.

2 Poor families have incomes below the federal poverty level, and low-income have income between 100 and 199 percent of the poverty level.
Poor children in Michigan were more likely to lack consistent health insurance and access to a regular care giver, and suffer from compromised health than higher income children.

While many measures can be reviewed from survey data available for the entire state, data for all individual counties are more limited. Of the four indicators that assess child health across Michigan counties reflect maternal and infant well-being at the onset of life: prenatal care, low-birthweight, and infant mortality. Only one measure, the child death rate, reflects the well-being of children after infancy. It should be reviewed in tandem with available data on county rates of chronic health problems—incidences of lead poisoning and asthma hospitalizations. Child health in Michigan counties should also be viewed in the context of child poverty levels in light of findings from the National Survey of Children’s Health.

Less Than Adequate Prenatal Care

No health care visits during the pregnancy at all or care that started after the first trimester or care that did not include the requisite number of visits based on the length of the pregnancy.

Why does prenatal care matter?

Prenatal care that includes education, support and monitoring by health professionals increases the likelihood of a healthy pregnancy and birth. Mothers who receive timely prenatal care are also less likely to deliver babies with health problems. During prenatal care visits, expectant mothers receive information about health and nutrition, and care providers diagnose and treat medical problems, as well as advice and referrals on other issues such as domestic violence or depression that may compromise maternal and infant health. Mothers who fail to receive timely and regular prenatal care are at higher risk of delivering a low-birthweight baby or having their infant die before his/her first birthday.

Adequate prenatal care is one of the most effective strategies for preventing costly extensive hospital stays for mothers and infants for conditions that could have been detected and prevented. While the prenatal and early nutritional experience do not dictate health outcomes, they can affect vulnerability to disease. Recent research is documenting how single nutrients, toxins, or any number of environmental exposures can cause biochemical responses that interfere with genetic responses in an embryo or fetus. Babies born with health problems may require special services and extensive time and attention.

There are several reasons why a pregnant woman might not receive timely and regular prenatal care. Mothers who lack insurance are less likely to seek and obtain prenatal care because of concerns about cost or a lack of connection to the health care system. Many low-income pregnant women do not realize they qualify for Medicaid at 185 percent of the federal poverty level once they are pregnant. The mothers at highest risk are those living in poverty, high school dropouts, and young adults, ages 18-24— those least likely to have health insurance. Depression about the pregnancy can also keep women from seeking medical attention, as well as an employment situation or other time constraints if the source of the care is in a clinic or office environment that is crowded, involves long waiting periods and offers limited options for appointments outside regular office hours.

What is the situation in Michigan?

Despite the relatively large share, one in five, (22%), of Michigan women giving birth who did not have adequate prenatal care in 2003, the situation improved over the 1996-2003 trend period. Of Michigan mothers who gave birth in 1996, 25 percent had not received adequate prenatal care. Roughly 28,500 infants born in 2003 were affected.

While the share of mothers not receiving adequate prenatal care varied only slightly among the county groups—19 to 22 percent, among Michigan counties the range was quite dramatic—from 7 to 51 percent.

All county groups experienced improvement in their rates of pregnant women not receiving adequate prenatal care between 1996 and 2003, but the northern area saw the largest decline (21%) while the Upper Peninsula experienced a drop of only 5 percent. The trends for most Michigan counties reflected declines or minimal increases; only nine counties suffered rate increases that exceeded 10 percent.

source: National Survey of Children's Health

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5 All references to 1996 and 2003 actually represent three-year averages of 1994-96 and 2001-03, respectively.
Less Than Adequate Prenatal Care  
(Average 2001-03)  
Michigan Counties by Metro Status and Region

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<th>%</th>
<th>COUNTY</th>
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Source: Michigan Department of Community Health, Vital Records and Health Data Development Section

What can Michigan do to make sure more pregnant women get adequate prenatal care?

Support outreach and advocacy to the at-risk population. Strategies include providing mentoring and support for families to assure use of health services, and incorporating community-based health workers in service provision. Public health and community-based health care resources can be more easily accessed by at-risk populations.

Increase availability and quality of services to pregnant women. Improvements in maternal health is key to reducing the incidence of premature delivery and low-birthweight. Efforts should be made to broaden access to care; co-payments and premiums pose barriers to the women at highest risk of poor birth outcomes.

Expand access to family planning. The prevention of unintended pregnancies to women who are not prepared to have children would ensure more women were financially, emotionally and physically prepared to have children. Women who are depressed about their pregnancy and not prepared to have a child are less likely to seek prenatal care.

Low-Birthweight Babies

Babies born weighing less than five and one-half pounds.

Why does low-birthweight matter?

Babies born at low-birthweight are much more likely to suffer from developmental problems, serious illness, and even death during infancy. Estimates from the National Public Health Service suggest that almost three of five infant deaths result directly from low-birthweight.

Those children born at low-birthweight who survive infancy are more likely to have health problems during childhood and adolescence than those born at normal weight. They are also more vulnerable to adverse conditions in their environment and may suffer from several medical problems. Low-birthweight has also been linked to coronary heart disease, diabetes, hypertension, stroke and even osteoporosis in adults.6

Low-birthweight infants can represent significant costs for the family and community. They may need extensive hospital stays and the kind of parental attention and time that can curtail employment outside the home and destabilize family income. Babies born at very low birthweight may stay in neonatal intensive care for as long as three months at a cost of roughly $2,000 per day.

What is the situation in Michigan?

Michigan experienced little change (5%) in its rate of low-birthweight babies between 1996 and 2003. In 2003, roughly 10,600 babies were born weighing less than five and one-half pounds. They represented about 8 percent of all babies born that year. The state’s 2002 low-birthweight rate ranked in the bottom half of the states—27th among the 50 states.

Little variation is reflected among Michigan’s four county groups in their low-birthweight rate that ranged from 6 to 8 percent. While all county groups sustained worsening trends between 1996 and 2003, Northern Michigan and the Upper Peninsula had the most substantial changes with increases of 12-13 percent. Despite improvements in the share of mothers without adequate prenatal care in the county groups, low-birthweight continued to worsen over the same trend period.

Several other factors such as stress or chronic hypertension affect the incidence of low birthweight, and many expectant mothers have problems that cannot be solved in nine months.

6 Duke University Medical Center. Op cit.
KIDS COUNT IN MICHIGAN | DATA BOOK 2005

CHILD HEALTH

What is the situation in Michigan?
In 2003 eight babies of every 1,000 in Michigan died before their first birthday, for a total of 1,080 infant deaths. The Michigan rate continues to be higher than the national rate, mainly because the state’s African-American mortality rate is significantly higher than the national average (16.5 vs. 13.9 per 1,000 births). Among the ten core Kids Count child well-being indicators, Michigan earned its worst ranking (38th) among the 50 states for its 2002 infant mortality rate.

Among Michigan counties the incidence of low-birthweight ranged from 4 to 11 percent of live births. Most counties experienced increases in their rates of low-birthweight babies over the trend period; in fact, only 10 counties experienced a decline of more than 10 percent in their rate.

What can Michigan do to lower the rate of low-birthweight babies?

**Use tobacco settlement funds to extend access to smoking cessation programs.** Mothers who smoke are more likely to have children born with low-birthweight, and they are likely to continue smoking after their children are born. The cost of smoking cessation programs and products pose a barrier for low-income smokers who want to quit. Smokers who are fully covered for smoking cessation by their health insurance are one and one half times more likely to quit.

**Streamline procedures for enrolling in and receiving food stamp benefits.** A contributing factor for low-birthweight is poor maternal nutrition—pregnant women need to ingest 200 more calories per day than non-pregnant women. Food stamps can be an important resource for low-income women, but many who are eligible do not participate. Food high in nutritional value can be expensive and studies have documented that families with food stamps are more likely to have diets with higher nutritional value.

**Infant Mortality**

**The death of an infant during the first 12 months of life.**

**Why does infant mortality matter?**
Infant mortality is often considered a proxy for overall child health. It is a simple and sensitive barometer of the health conditions in a community as well as of families’ resources and the environments in which they function. Infant mortality is widely used as a “quality of life” measure because it reflects an outcome from a variety of factors including economic well-being, the emotional and physical health of the mother, the involvement and support of the father, the strength of the health care system, the level of access to maternal and infant care and support services, and community safety. Poverty is a key factor according to national studies—the mortality rate for children born into U.S. families with incomes below the poverty level is 50 percent higher than that of families with income above that level.

**Michigan county groups experienced similar trends in low-birthweight and prenatal care between 1996 and 2003.**

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

**What is the situation in Michigan?**
In 2003 eight babies of every 1,000 in Michigan died before their first birthday, for a total of 1,080 infant deaths. The Michigan rate continues to be higher than the national rate, mainly because the state’s African-American mortality rate is significantly higher than the national average (16.5 vs. 13.9 per 1,000 births). Among the ten core Kids Count child well-being indicators, Michigan earned its worst ranking (38th) among the 50 states for its 2002 infant mortality rate.

Among the four county groups, the Upper Peninsula had the lowest infant mortality rate. Among the 54 counties with a large enough incidence of infant death to calculate a rate, the infant mortality rate ranged from 4 deaths per 1,000 infants to 18.

Trends in Michigan’s four county groups showed some variation with rates remaining essentially the same between 1996 and 2003 in the metropolitan area and Northern Michigan while declining slightly in the UP and rising slightly in the Southern non-metropolitan area. The majority of the 54 counties where trends could be assessed experienced worsening infant mortality rates; only 11 counties saw improvements of over 10 percent in their rates.
What can Michigan do to prevent infant deaths?

Improving the infant mortality rate represents an ongoing challenge for Michigan. A statewide summit on strategies to reduce the gap in infant mortality identified the following three broad areas for state policy initiatives.

- **Extend the Nurse Family Partnership.** An expansion to all eleven Michigan communities with the highest infant mortality rates in the state and at least six locations in the city of Detroit would focus the state’s limited resources. The Nurse Family Partnership has three decades of research that demonstrate its long-term benefits to mothers and their children. Some of the documented effects include reductions of 79 percent in child abuse and neglect, 56 percent in emergency room visits, 44 percent in maternal problems due to substance use, and 32 percent in subsequent pregnancies.

- **Improve the capacity to collect and analyze data.** Reliable data are necessary to direct state and local efforts most strategically. Better birth and death certificate data, particularly the reporting of race, ethnicity, smoking and alcohol use would assist efforts to identify risks and target resources. A critical component of the analysis and use of data involves the state support of local Fetal Infant Mortality Review Teams (FIMR) that merge the data with the in-depth review of birth and death certificates by community partners.

- **Reduce associated risks for infant mortality.** Providing options in the Work First requirements would allow new mothers time to focus on their infant during the first year of life. Most low-wage jobs do not allow flexibility in scheduling or sick/vacation time to accommodate the needs of infants thereby creating extraordinary stress on parents, particularly single mothers. Increased access to family planning would reduce the incidence of unintended pregnancy. One clear message of safe sleep position and environment for infants would enhance its effectiveness in preventing infant deaths caused by suffocation.

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**Michigan county groups saw improved child death rates, while infant mortality worsened in UP and Southern non-metro counties.**

<table>
<thead>
<tr>
<th>Infant Mortality (Average 2001-03)</th>
<th>Michigan Counties by Metro Status and Region</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COUNTY</strong></td>
<td><strong>AVERAGE ANNUAL #</strong></td>
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<td>Eaton</td>
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<td>Newaygo</td>
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<td>Lapeer</td>
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<td>Macomb</td>
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<td>328</td>
</tr>
<tr>
<td>Genesee</td>
<td>70</td>
</tr>
</tbody>
</table>

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**Child Death (per 1,000) | Infant Mortality (per 100,000)**

- **Metro**
  - Infant Mortality: 8.4
  - Child Death: 21.7

- **Non-Metro South**
  - Infant Mortality: 7.4
  - Child Death: 7.4

- **Non-Metro North**
  - Infant Mortality: 7.0
  - Child Death: 22.8

- **Non-Metro UP**
  - Infant Mortality: 5.5
  - Child Death: 19.5

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

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*Rate could not be calculated.*

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*The complete report can be found on the Michigan Department of Community Health website at [http://www.michigan.gov/mdch/0,1607,7-132-3942_4911-51049—,00.html](http://www.michigan.gov/mdch/0,1607,7-132-3942_4911-51049—,00.html).*
What can Michigan do to prevent child deaths?

Reestablish outreach for Medicaid and publicize the streamlined enrollment process. Publicizing the streamlined application process can increase healthcare coverage rates for children, thereby reducing the likelihood of death by treatable disease. The enrollment procedure for Medicaid benefits can be intimidating and time-consuming. Many families with children who are eligible for benefits do not apply.

Promote the use of child safety restraints. One of the best ways to prevent injury deaths in motor vehicles is the use of appropriate restraints such as car seats or seatbelts. Three of five of Michigan child deaths involving motor vehicles in 2002-03 reflected the lack or incorrect use of restraints, according to the Child Death Review report. Of those, 39 percent had not used any restraint at all, and 21 percent had used one incorrectly.

Promote safety and supervision for young children. One-third of child injury deaths in 2003 resulted from an accident from causes other than a motor vehicle, such as fire and drowning. Preschoolers were at particularly high risk. A critical prevention strategy is a functional smoke detector and regular inspections of rental properties.
Child Safety

The safety of children is the responsibility of all members of a community. Supportive personal and community networks all play a vital role in the community’s ability to protect children from harm. As well, broad-based prevention initiatives in all community and state programs focusing on families function to keep children safe. While parents have the legal responsibility to nurture and protect their children, they need the support of extended family, friends, neighbors, and other community members in that task. Parents all have their own physical, mental, financial, and emotional challenges. Without access to supportive networks and community services, these personal issues can interfere with the ability to parent; they can result in endangering a child’s healthy development and, in the extreme, a child’s life.

A total of 52 infant and child deaths in Michigan resulted from child abuse or neglect in 2002, according to the Citizen Review Panel on Child Fatalities, a subcommittee of the Child Death State Advisory Team.1 Before the panel’s review, only 12 of these deaths had been identified on death certificates as caused by abuse or neglect. The largest share (33%) of the 52 deaths resulted from neglect, or the responsible person’s not attending to the child’s basic needs. On death certificates such deaths may be coded as malnutrition, dehydration, hypothermia or an infectious disease, but in the main they flowed from parental neglect or living in unsafe housing or other impoverished environments. The victim was an infant in over half the deaths. In roughly two-thirds of the abuse or neglect deaths identified by the Child Death Review Teams in 2002-03, maltreatment had previously been confirmed by the Michigan Department of Human Services (DHS).

The DHS follows up on reports of harm or threatened harm to a child’s health or welfare strictly in cases where the adult, usually a parent or guardian, has responsibility for the child. Reports involve either non-accidental maltreatment (child abuse) or negligence (child neglect). Other adults who harm or threaten to harm a child are referred to the criminal justice system for prosecution. The capacity of the DHS to ensure the safety of children is affected by the resources allocated to adequately train staff who provide prevention services, investigate reported abuse or neglect, respond appropriately to family and community needs, and effectively monitor the well-being of children identified as victims. Caseworkers are called upon to make momentous decisions about the risk of maltreatment or even death for a child. The consequences of removing children from parental care must be weighed carefully.

Steady erosion in staffing has compromised the capacity of the DHS to respond effectively to rising levels of abuse and neglect. Current caseworkers are struggling with caseloads numbering between 25 and 40, well beyond the 15 recommended by the Child Welfare League of America. In addition to home and court visits, caseworkers must spend substantial time maintaining records. A large percentage of case files lacked documentation that children in care had received the required annual health and dental examinations, according to the latest audit report.2 While this may be more an issue of failure to maintain records, without proper documentation it is impossible to assess if these children had received the health care they need.

Despite staffing constraints, the state has performed well by national standards in several areas. In 2001 the U.S. Children’s Bureau launched a review process of state welfare systems to assess a number of outcomes such as safety and overall well-being of children in the system and timely achievement of permanency.3 According to the Child and Family Services Review, Michigan has met several of the national goals in the areas of recurring abuse for confirmed victims, the victimization of children in foster care, and percent of adoptions completed within two years. One of the most serious challenges identified for Michigan was the state’s lack of timeliness in the reunification process. Only 30 percent of children in Michigan who were scheduled to be reunited with their families returned home within 12 months; the national goal is 76 percent. The DHS is hoping to remedy the situation through broader implementation of the Family to Family Initiative.

The mission of the Family to Family Initiative is to strengthen family and community partnerships to care for children. The goal is to place children with a stable family within the child’s community until reunification with the birth family or an adoption can occur. In this approach the child remains within his/her school, as well as the familiar networks of family and friends. Often this results in placements with extended family or kin. The initiative focuses on increasing family involvement and responding more effectively to the needs of individual families. The approach involves facilitated team meetings with birth and foster parents, as well as community members, to address the placement and service needs of the children. One result is to strengthen the linkages of the child and the birth or foster family to a system of support within the extended family and community. The approach, implemented in several other states to improve outcomes for foster care children and youth, has been fully established in Wayne County and will expand to 20 additional Michigan counties in 2006.4

As more children in out-of-home care live with relatives, many states have created subsidized guardianship programs to ease the financial burden on these caregivers who often may not be eligible for other subsidies. National studies indicate that over half of kinship care families have incomes below 200 percent of the poverty level and the majority (55%) are headed by a single caregiver over the age of 50 (52%).5 Michigan and its communities have an obligation to ensure that children are safe. This discussion focuses on some of the measures related to children who come to the attention of the DHS. In order to monitor and track the state’s success in ensuring child safety, three measures are reviewed—the number and rate of children in families where an allegation of abuse or neglect is investigated, the number and rate of confirmed child victims, and the number and rate of children who are subsequently removed from parental care and placed in foster care or with relatives.

Children in Investigated Families

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 Department of Human Services. An investigation involves face-to-face contact with the parents and a visit with the child or children to assess alleged injuries and risk to the child. Visits to the child’s school and medical exams may also be part of the investigation.

3 Permanency refers to a child returning to live with their birth family, being adopted, or living with a relative through guardianship—all intentioned as a permanent living arrangement for the child or youth.
4 DHS director says department has made significant strides to protecting children and families; calls for strong action on behalf of children and families Press release quoting DHS director Marianne Udow (Sept 6, 2005) <http://www.michigan.gov/dhsb01607%207-124-5458_7691_7752-125598--M_2005_9,00.html>.
Why does the prevention of child abuse and neglect matter?
The devastating, long-term effects of child abuse and neglect have been well documented. Outcomes include compromised physical conditions and mental health problems such as depression, chronic fatigue syndrome, eating disorders, and post-traumatic stress disorder for the victims. Maltreated children are also more likely than other children to engage in high-risk behaviors such as unsafe sex and drug use in later life. Childhood abuse or neglect also heightens the risk of attempted suicide, sexually transmitted diseases, and alcoholism.

Some research suggests these negative outcomes also plague children in cases where the alleged neglect or abuse has never been confirmed. The lack of a “preponderance of evidence” required to confirm maltreatment does not necessarily mean the children under scrutiny are safe. One study indicated that school and delinquency outcomes do not differ substantially between children with unconfirmed and confirmed maltreatment.6

What is the situation in Michigan?
In Fiscal Year 2004, 157,693 or 62 of every 1,000 children in Michigan lived in families investigated for child abuse and neglect; this rate represented an increase of 15 percent when compared to the 1995 rate. Northern Michigan had the highest rate of children in investigated families—75 children per 1,000 children, and the UP the lowest rate. 58.7 While rates of children in families investigated for abuse and neglect increased between 1995 and 2004 in all Michigan county groups, the largest jump in rates (21%) occurred in the non-metro counties of Southern Michigan.

Although 25 of the state’s counties saw a decrease in the rate of children in families investigated for abuse or neglect, 38 counties sustained increases of 20 percent or more.

Children in Investigated Families (Fiscal Year 2004)

<table>
<thead>
<tr>
<th>County</th>
<th>Rate per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michigan</td>
<td>62.1</td>
</tr>
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<td>Metropolitan</td>
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<td>Ottawa</td>
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<td>Monroe</td>
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<td>Isabella</td>
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</table>

What can Michigan do to prevent child abuse and neglect?
Expand supports to families. Prevention is a critical strategy to create better outcomes for children. Family poverty, mental illness, depression, and unrelenting stress increase the vulnerability of parents to abusive or neglectful behavior toward their children. By providing services and resources to mitigate the factors associated with poverty and the mental health of parents, Michigan could substantially reduce the conditions that lead to abuse or neglect of children.

Enhance efforts to educate parents. Parents sometimes lack information about the stages of child development and good parenting skills. Frustration is commonly experienced and can result in abuse. Community agencies and support services can help parents prepare for the stresses of parenting in a variety of ways; home visits and family planning programs are two examples.

Implement follow up and preventive services. These services can reduce the rate of future abuse or neglect. The risks and challenges facing those children whose cases are found to be unsubstantiated must also be considered in service programs. Funding cutbacks have virtually eliminated DHS prevention services targeted to this vulnerable group.

Highest rates of confirmed abuse or neglect victims occurred in Northern Michigan in 2004, but out-of-home placement rates for victims were higher in metro areas.

Source: Michigan Department of Human Services

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7 Michigan counties were divided into four groups based on their metropolitan status and location. Non-metropolitan counties are divided into Southern, Northern and the Upper Peninsula.
Confirmed Victims of Abuse or Neglect
These children are confirmed to have been threatened with harm or actually harmed through the intention or negligence of those responsible for their care, usually a parent or guardian.

Why does child abuse and neglect matter?
Children can suffer long term disability or even death as a result of abuse or neglect. Victims will experience life long impacts that will likely affect their functioning as responsible adults and citizens. As young people they are more at risk when the family is challenged daily by poverty and the continuing stress that flows from it. These families do not have the resources to address situational or personal problems, which often result from their economic insecurity. Michigan children living in such households are more likely to have mothers with compromised mental health than those living in families with higher incomes; this situation is exacerbated when low-income parents lack access to health care coverage and mental health services. Federal, state and local agencies have sustained substantial cuts in programs that address the housing, child care, health and mental health needs of poor families.

Other vulnerable children, for example those with disabilities, are also at high risk for maltreatment. Not only are they three times more likely to suffer abuse than children without disabilities, the maltreatment itself has been cited as a major contributing factor to disability in roughly two of five confirmed cases, according to a national survey of caseworkers. Behavioral disorders and mental retardation are the most common disabilities resulting from abuse or neglect, but an estimated one in ten cases of cerebral palsy may be linked to physical abuse.

What is the situation in Michigan?
There were 29,737 confirmed victims of child abuse or neglect in Fiscal Year 2004 for a rate of 12 for every 1,000 children in Michigan. Between 1995 and 2004, the rate of confirmed child victims increased by 43 percent—roughly triple the increase in investigations.

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2 Jerry Manders, Abuse Intervention - Preventing the Maltreatment of Youth with Disabilities (project summary) University of Georgia, Institute on Human Development and Disability <http://dev.addup.org/index.cfm?section=projects&action= show ProjectDetail&id=654578>
Out-of-Home Care

Only those child victims of abuse or neglect who are considered to be at risk of further harm are removed from their homes, as are delinquent youth who pose a threat to themselves or others.

Why does placing children in out-of-home care matter?

Children need a safe place in which to grow and be nurtured, and they naturally turn to their parents as their primary caregivers. Despite the trauma that they may have endured, child victims of abuse or neglect who are placed in out-of-home care hold fiercely to the desire to go home. This desire compounds the stress that often accompanies the transition to foster care, making an out-of-home placement an upsetting experience. Roughly one-third of confirmed victims of abuse or neglect are placed in out-of-home care in order to ensure their safety, although most of these children return home at a later date.

Once the state has removed children from their parents, the state has a responsibility to provide adequate resources and support to ensure that children achieve a stable and permanent home as soon as possible. During the time children reside in foster care, the DHS must have adequate resources and staff to monitor their well-being, provide appropriate services and supports, and document and monitor all interactions with vigilance and care. These children must not be neglected by the very system designed to provide for their safety and well-being.

What is the situation in Michigan?

Roughly 20,000 children were placed in out-of-home care in Fiscal Year 2004—17,304 due to abuse or neglect and 2,509 youth as a result of delinquency. Eight children per 1,000 were in out-of-home care in 2004, representing an 8 percent increase over 1995. While the rate of placement due to abuse or neglect increased by 17 percent—from 6 to 7 children per 1,000—youth in 2004.

What can Michigan do to reduce child abuse and neglect?

Provide adequate funding to protect the safety of children. Without adequate funding DHS is forced to operate with an insufficient number of staff and systemic support while children’s very lives are at stake. Continued and adequate funding is needed in order to implement fully the Service Worker Support System—Child Protective System (SWSS-CPS). By creating a single location that integrates all information relevant to each case, this database will streamline the information used by caseworkers and allow them to better serve vulnerable children.

Institute programs and policies that reduce poverty or its impact. The majority of all child victims suffer from neglect, which is strongly related to poverty. Many poor families live in crowded households in high-crime neighborhoods with limited child care options. Their housing may be poorly maintained and may have many health and safety hazards such as lead paint. Creating further pressure on the family are making the family’s resources available for heat and food.

Implement best practice strategies. State and local programs can improve their effectiveness in prevention and intervention by employing the latest strategies that have proven effective and providing adequate resources for accountability.

Children in Out-Of-Home Care

(Fiscal Year 2004)
while children over the age of five averaged at least double that amount of time before adoption. These averages underestimate the actual length of time most of these children have actually spent in care as they would already have spent time in foster care as Temporary Court Wards before the termination of parental rights.

Most Michigan children designated as Temporary Court Wards had spent well over a year in foster care in 2004. Problems that occasion the removal of children such as substance abuse cannot be resolved in a matter of weeks or, in some cases, months. Among Temporary Court Wards the youngest children also spent the least amount of time in foster care. Roughly 80 percent of children under the age of two spent less than one year in care compared to roughly 60 percent of children ages 2-12, and 41 percent of the oldest children, over age 12. Youth over the age of 12 comprised two-thirds of the 11,410 children who were in care as Temporary Court Wards more than 23 months.

As the capacity of other systems to address the problems of poverty, lack of affordable housing, mental illness, and disability have been compromised by decreased funding, the numbers of children at risk of abuse and neglect will rise. For example, cutbacks in respite care for children with disabilities elevate the stress on parents who often face enormous difficulties finding care for their children.

The metropolitan counties had the highest rate of children in out-of-home care for abuse or neglect in 2004 with 8 children per 1,000. The non-metropolitan counties in Southern Michigan had the lowest rate at 5 children per 1,000. Northern Michigan experienced the greatest increase in children in out-of-home care between 1995 and 2004 (38%) rising from 5 to 6 per 1,000 children.

What can Michigan do to improve the lives of children in foster care?

Create a subsidized guardianship program. In recognition of the increase in children being raised by relatives, often their grandparents, many states have instituted subsidized guardianship programs to provide income support for these families and permanency for the children. Relative caregivers willing to become legal guardians sometimes lack adequate resources to provide for the children placed in their care. While Michigan has committed to the Family to Family Initiative in order to place more siblings together, reduce the number of placement changes, curb re-entries into the system, and improve the likelihood of permanency, the state has not instituted a subsidized guardianship program—one of only 15 states that has not. Subsidized guardianship is a promising permanency option for children as demonstrated by Illinois, where permanent placements for over 600 children were supported by subsidized guardianships in 2004.

Enhance the capacity of the Department of Human Services to monitor delivery of services by private agencies under contract. DHS is mandated to oversee the private agencies that provide placement and monitoring (of foster care homes) services for nearly 40 percent of the foster care in the state. Staffing reductions due to early retirements in 2002 have resulted in only five staff to oversee 87 agencies with 200 separate contracts. The frequency of oversight activities deemed appropriate would require doubling the staff—from five to ten analysts.

Ensure monthly visits by DHS caseworkers to children in foster care. Inadequate staffing hinders agency capacity to achieve this goal. A manageable caseload ratio of 15 foster children to 1 caseworker as recommended by the Child Welfare League of America would require an additional staff of 160—a 20 percent increase in current capacity. (Current caseloads range from 25 to 40 per caseworker.) Steady cutbacks over several years to the DHS budget have hindered this effort.
Adolescence: Youth in Transition

During adolescence youth gain skills and expand their social networks to transition into the adult world as workers or students or both. This period is also a time of physical and mental transformation as the body and mind mature. Research with new technology has revealed that the physical capacity of the brain to make plans, control impulses and apply reason to decision-making is still developing during adolescence. The processing of emotions actually shifts into a different area of the brain during these years, allowing the adolescent more reasoned perceptions and improved ability to assess emotional responses in others.

Also during this critical time youth are not fully capable of assessing the consequences of their choices or actions. Many serious problems can result from their innocence, inexperience, or inability to control their behavior and emotions. Youth without strong connections to a caring adult or strong family network are particularly vulnerable as they are less likely to seek or receive the advice and nurturing that will guide and protect them. Some situations are more unforgiving than others, and the consequences can irrevocably compromise the future of a young person. Some youth tragically even lose their lives.

Youth who become parents, drop out of high school, age out of foster care, or get placed into the custody of the juvenile justice system are particularly vulnerable in making the transition to adulthood. Some may find a way to get back on track to complete their education and gain the skills they need to function in the workplace successfully, but they face a bigger challenge than those youth without these liabilities. Youth in poor or low-income families that lack the financial resources or social connections to address these barriers to a successful transition often suffer the most dire consequences.

The following discussion begins with a review of the three key adolescent measures traditionally included in Kids Count—teen births, teen deaths, and high school dropout—and then examines the issues of other at-risk Michigan youth—those aging out of foster care and those in the juvenile justice system.

Births to Teens, Ages 15-19

The rate of teen births is based on the number of births per 1,000 teen females, ages 15-19.

Why do teen births matter?

Teens who become parents are less likely to complete their high school education than other teens. Only one-third of teen mothers in the U.S. graduate from high school. Their academic difficulties may be as much a cause as a result of their parenthood; high school girls in the bottom 20 percent of students in basic reading and math skills are five times more likely to become mothers as teens than those in the top 20 percent in these skill areas.

As high school dropouts, teen mothers are more likely to be unemployed, work fewer hours, and earn less than high school graduates. Thus, they are at high risk for poverty and jobs that provide no benefits and few opportunities for training or advancement. They are also more likely to need assistance from government programs to provide for their children and themselves.

Teen mothers not only lack adequate financial resources, but are less likely to have the social supports and parenting skills enjoyed by women who delay parenthood into their 20s. Children born to teen parents are more likely to live in poverty, suffer poor health, experience learning and behavior problems, spend some time in prison, and become teen parents themselves.

Teen mothers are more likely to be or become single parents, heightening their risk of poverty. Four of five teen mothers are unmarried at the time of the birth of their baby. Teen mothers who marry have double the risk of divorce as women who delay marriage into their late 20s. Almost half of teen mothers who are married when their babies are born will divorce before their child completes elementary school, compared to one-quarter of women who delay parenthood into their 20s. Teen mothers not only lack adequate financial resources, but are less likely to seek or receive the advice and nurturing that will guide and protect them. Some situations are more unforgiving than others, and the consequences can irrevocably compromise the future of a young person. Some youth tragically even lose their lives.

What is the situation in Michigan?

Roughly 12,600 Michigan teens, ages 15-19, gave birth in 2003. The birth rate for teens in this age group dropped by 29 percent between 1996 and 2003—from 51 of every 1,000 teen females in 1996 to 36 in 2003.1 Michigan’s teen birth rate in 2002 earned the state one of its best rankings—14th among the 50 states. (A ranking of 1 is the best.)

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1 All references to 1996 and 2003 actually represent three-year averages of 1994-96 and 2001-03

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Michigan Counties by Metro Status and Region

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* Rate could not be calculated.

Source: Michigan Department of Community Health, Vital Records and Health Data Development Section
The United States, however, continues to have by far the highest teen birth rate among industrialized nations. The teen birth rate in the U.S. is more than double that of the United Kingdom, ten times that of the Netherlands or Japan, and 17 times that of South Korea.

In Michigan as elsewhere in the country, teen birth rates varied dramatically by race and ethnicity. African-American teens had the highest teen birth rate in 1996—95 of every 1,000 teen females, ages 15-19. By 2003 that rate had dropped to below that of Hispanic youth. The sustained decline in births to teens may explain some of the improve-ment in high school dropout in the state as pregnancy and birth are major barriers to high school graduation for high school girls. Among the four major racial/ethnic groups, Hispanic teens had the least improvement in their rates.

In Michigan one of five teen births was to a teen who was already a mother. Despite the significant improvement in the births to teens overall between 1996 and 2003, the share of Michigan teen births that were a second or third child declined by only 9 percent. This group represents an extremely vulnerable population that will face substantial barriers to completing their education and the necessary post-secondary training to secure a family-sustaining job.

Michigan’s African-American and Hispanic teens continued to have the highest birth rates in 2003 despite dramatic declines.

Michigan: 36 births per 1,000 teens (2001-2003 average)

Compared to State Average

- 10% or more above state average
- At or near state average
- 10% or more below state average
- Rate cannot be calculated

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

1 Right Start in Michigan 2005. <www.milhs.org>
The rate of teen deaths is based on the number of deaths from all causes per 100,000 teens, ages 15-19.

Why do teen deaths matter?
The death of a teen reverberates throughout a community as well as within the family. The rate of teen deaths reflects the safety of the environment as well as the emotional and physical health of teens and the capacity of the larger community to protect its youth.

What is the situation in Michigan?
A total of 431 Michigan teens, ages 15-19, died in 2003, compared to 566 in 1996. The teen death rate in 2003, 60 deaths for every 100,000 teens, was 30 percent lower than in 1996. Even with this substantial decline, the death rate for teens was three times higher than that of children, ages 1-14.

Accidents, most involving a motor vehicle, are the leading cause of deaths among Michigan teens, accounting for almost half of all deaths—motor vehicle deaths alone represented over one-third of all deaths. A major risk factor for fatal car accidents for teen drivers is the lack of teens’ experience and skills under less than ideal driving conditions. Teens are much more likely to be at fault in poor weather driving conditions and on gravel roads, according to some Michigan child death review teams.

One-quarter of teen deaths result from a homicide or suicide—52 youth perished from homicide, and 49 from suicide. These deaths are often the result of anger, aggression or depression. Youth are vulnerable to volatile emotions and may act impulsively without realizing the dire consequences to themselves or others.

What can Michigan do to prevent teen births?
Provide health education that is informative, timely, and realistic. A key risk factor for teen pregnancy is the insufficient understanding of the importance of avoiding pregnancy, childbearing, and STDs. Informative, timely, and realistic health education can give teenagers the knowledge and resources they need to make good decisions. Research has demonstrated that health education that discusses contraception does not hasten the onset of sexual activity, increase its frequency, nor increase the number of sexual partners.

Develop teen programs that address issues of school involvement, motivation to stay in school, and vision for a future. Lack of attachment to school and investment in the education process are risk factors for engaging in unprotected sex.

Strengthening public education, particularly in schools with large numbers of low-income students, to address the needs of youth at risk of academic failure would be a key strategy. Getting teens involved with positive peer groups and activities has also proven to be successful approach.

Focus resources on adolescents at greatest risk of unwanted pregnancy. Teens who give birth are most likely to live in disadvantaged families and communities. When poverty is persistent and pervasive, the risks increase. Girls whose mothers or sisters were teen mothers are at the highest risk. Strengthening community kinship and friendship networks can help protect teens from early pregnancy and birth.

The Upper Peninsula had the lowest teen birth rate with 28 births per 1,000 teens. Although all Michigan county groups showed improvement in their teen birth rates, the metropolitan counties and Northern Michigan reflected the largest improvements with teen birth rates roughly one-third lower in 2003 as compared to 1996.

Among the 82 counties with a teen birth rate, rates ranged from 8 to 57 births per 1,000 teens. The counties with rates of teen births 10 percent or more above the state average concentrated in western and northern Michigan and along the southwestern border. Most counties in the UP, in the central state, the thumb, and among the southeastern suburbs had rates 10 percent or more below the state average. In all but four counties the teen birth rate declined between 1996 and 2003, and only two of those four counties experienced increases of more than 2 percent.

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Michigan’s metropolitan area had the lowest teen death rate with 57 deaths per 100,000 teens, while non-metropolitan Southern Michigan had the highest rate with 73 deaths per 100,000. Northern Michigan and the metropolitan counties had the largest declines in teen deaths over the trend period with rates dropping by roughly one-third between 1996 and 2003.

Among the 46 counties where rates could be calculated, the teen death rate ranged from 23 to 233 deaths per 100,000. (Rates based on small numbers of events and small populations can vary dramatically.) The teen death rate dropped in 29 of the 39 counties where a trend could be calculated.

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

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Teen Deaths, Ages 15-19

Why do teen deaths matter?
The death of a teen reverberates throughout a community as well as within the family. The rate of teen deaths reflects the safety of the environment as well as the emotional and physical health of teens and the capacity of the larger community to protect its youth.

Michigan counties were classified into four groups based on their metropolitan status and location. Non-metropolitan counties are divided into Southern, Northern and the Upper Peninsula.

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Accidents continued to be the major cause of death for Michigan teens in 2003.

Northern and metropolitan counties experienced most improvement in teen births and deaths between 1996 and 2003.

Deaths to Teens, Ages 15-19 (Average 2001-03)
Michigan Counties by Metro Status and Region

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*Rate could not be calculated.
Source: Michigan Department of Community Health, Vital Records and Health Data Development Section

What can Michigan do to prevent teen deaths?

Require driver education programs to address high-risk weather and road conditions. Teen drivers need experience and training in how to drive in less than ideal weather and road conditions before they become licensed. With fewer schools involved in driver education programs, the Michigan Department of State should take a more active role in making sure curricula in private agencies adequately prepare new drivers.

Expand access to family mental health services geared to adolescents. Mental health services are often not covered by insurance, or are only covered for a set amount of office visits. Expanding access to mental health services would give more youth the resources they need to address anger, aggression, and depression.

Eliminate harassment at school and in the neighborhood.
Homicide and suicide comprised one-quarter of adolescent deaths. One of the risk factors for teenage homicide and suicide is related to bullying behavior. These situations can escalate into violent aggregation or reprisals by the bully or the victim.

High School Dropouts
A dropout is a youth who leaves high school before graduating. The dropout rate as reported by Michigan school districts is based on the number of students enrolled in grades 9-12 in the fall who do not return in the fall of the following year and are not accounted for as graduated, retained or transferred out of the district.

Why do high school dropouts matter?

Dropping out of high school has severe consequences for the individual, the family, the community, and the state. The consequences for the student of dropping out of high school include a higher risk for unemployment; lower earnings over a life time; dependency on public assistance; and incarceration.

Only about one-half the nation's high school dropouts hold down regular jobs, compared with 69 percent of those whose academic achievement includes a high school diploma and almost three-quarters
of those who graduate from college. Hispanic and African-American students have significantly higher dropout rates than white non-Hispanic students. As the demographic shifts continue with minority populations becoming a larger share of the state and national population, this lack of educational attainment among minority youth can be projected to undermine the nation’s economic growth and increase social costs at every level.

The earnings gap continues to widen among those with different levels of education. Between 1964 and 2004, the earnings for a high school dropout declined from 64 cents to 37 cents for every dollar earned by an individual with at least a high school diploma. High school dropouts who are employed earn an average of $12,000 per year—$6 an hour for a full-time job—roughly one-half the amount earned by high school graduates. The average earnings of adults with bachelor’s degrees ($33,701) are almost three times more per year than dropouts. High school dropouts are also half as likely as high school graduates to have employee benefits such as health insurance and a pension plan.

Poor academic performance is a key issue for youth who drop out of high school. Retaining students at grade level has not proved an effective intervention strategy as students who are held back a grade are twice as likely to drop out as those who are not. Ongoing problem behaviors such as truancy, absenteeism and tardiness also elevate the risk of dropping out, but poverty is the single strongest family and community-related predictor of dropout. Research has also linked the risk of dropout to student employment, especially if work hours exceed 14 to 20 hours a week.

What is the situation in Michigan?

Roughly 23,600 youth dropped out of high school in Michigan in the 2003-04 school year—3 percent of all public high school students in a single year. The dropout rate for the state fell by one-half from 6 percent in the 1995-96 school year. These trends are mirrored in survey data for the state that show similar declines in the share of teens, ages 16-19, who were not enrolled in school nor had they graduated (or earned a GED) between 2000 and 2003.

Michigan’s metropolitan counties had the highest dropout rate, with 3.5 percent of all public high school students leaving school without graduating. The Upper Peninsula had the lowest rate—1.7 percent.

Trends were the same among the county groupings with the dropout rate declining by roughly one-half in each.

Among counties the dropout rate ranged from 0.9 to 7.1 percent of high school students among the 77 counties where a rate was calculated. In 65 of the 75 Michigan counties with a calculable percentage change, the dropout rate declined.

While these rates and numbers reflect district reports to the Michigan Department of Education, debate continues about the reliability of dropout and graduation rates. Michigan is one of 39 states that do not report graduation rates by race/ethnicity. Using district race/ethnicity enrollment numbers submitted to the federal government, a recent study estimated that just over one-third of the state’s Hispanic students earn diplomas, while the African-American rate could not be calculated due to the unreliability of available data. The analysis highlighted dramatic gaps in graduation rates between the 93 percent of Michigan districts with a majority of white students and the 7 percent with a majority of minority students. Michigan’s majority white districts had an average graduation rate of 77.4 percent compared to 44.4 percent in the majority minority districts.

### Dropout rates declined by roughly one-half in all Michigan county groups.

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*Rate could not be calculated.

Source: Microsoft Department of Education
**Youth “Aging Out” of Foster Care**

The normal developmental throes of adolescence are compounded for youth who spend these formative years in foster care. These youth are too often plagued by instability, with no place to call home for very long and no ongoing relationship with a reliable adult. This lack of stability at a time of major life changes can compromise the develop-mental needs of youth if they are to successfully transition to adulthood.

A significant share of these youth has survived multiple out-of-home placements and suffers from lack of trust in adults, many of whom have failed them. Although foster care youth have a series of adults such as caseworkers, attorneys, judges, advocates, teachers, involved in their lives, they are often missing the one adult who is always there for them. As a result, youth already beset with a sense of isolation can feel emotionally adrift. Some foster youth will have been living on their own since the age of 16, a situation which, in most cases, further limits their interaction with supportive adults.7 Youth who spend a substantial amount of time in foster care often run away—estimates on the share of foster care youth who become runaways range from 23 percent to 73 percent, according to studies in other states.8

When foster youth turn 18 in Michigan, most are no longer eligible for maintenance payments from the state—they are “aging out” of the child welfare service system. The need, however, continues; too many of these youth lack the academic credentials, financial resources, and social supports that will allow them to establish themselves independently.9 Since their foster family has no further obligation to assist them, most foster care youth who age out of care must find another place to live as they begin their adult lives. Only one in ten such youth reported living with their foster family at age 19, according to a Chapin Hall study.10 They often turn to their birth and extended family as evidenced by the fact that one-third of these youth reported living with their biological parents or relatives. Studies have shown that youth who are forced to exit foster care at age 18 have worse outcomes than those who remain in care longer.11

**Why do youth aging out of foster care matter?**

Most foster care youth who age out of the child welfare system do not have adequate skills or resources to meet their material needs. In the 21st century, few American youth can survive economically on their own at age 18. Their parents and other family members commonly continue to help them out in a variety of ways well into their twenties. Parents who have economic and social resources provide assistance to the young adults in their family in many ways: in obtaining a car, completing post-secondary education or training, maintaining housing or locating a job. Parents also are available to help in the event of an emergency. Foster youth, however, are less likely to be able to rely on a similar parental or familial “safety net,” making their situation much more tenuous.

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7 Michigan offers an Independent Living allowance of just over five-hundred dollars a month to foster youth ages 16, 17 or 18 who live in their own residence. They do not receive a semi-annual clothing allowance as do children in the care of foster parents.


9 The majority of foster youth in Michigan “age out” at age 18. Some extenuating circumstances such as special needs or if the youth is still in high school or attending college allow for youth to remain in the system and continue to receive assistance past the age of 18.

10 Mark Courtney, et al. Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 19 (Chicago, IL: Chapin Hall, 2005)

11 News Advisory: Study Shows Broad Challenges for Young Adults Leaving Foster Care (Chicago, IL: Chapin Hall, 2005).
These youth encounter multiple barriers to attaining post-secondary education or finding a decent job. Unlike most youth who receive some form of financial assistance from their parents, foster care youth generally do not. Such tasks as completing lengthy applications, applying for loans or choosing a career path can be bewildering even for more privileged youth. Additionally, foster care youth are commonly unaware of resources that may be available to them as these opportunities aren’t well publicized. Without help, frustration can lead to resignation regarding their ability to continue their education or get a decent job.

Children in foster care are at increased risk for a variety of conditions that further impede their successful transition to adulthood. They are four times more likely to have a disability than children who live with a parent. Foster youth are also more likely to experience mental health problems; one study showed that over half of foster care alumni reported some kind of mental health disorder, disorders brought on or exacerbated by the abuse or neglect in their background. Children with disabilities and those with mental, emotional or behavioral health problems often need intensive and continuous services and thus experience considerable risk and hardship at the termination of these services when they “age out.” Foster youth face particularly dire outcomes without necessary transitional services.

Having already experienced abuse or neglect as children, former foster youth are, unfortunately, likely to experience hardships in their adult lives. They are much less likely to have completed high school than their peers. Over 35 percent of foster youth ages 17-20 are without either a high school diploma or GED. High school dropouts face substantial disadvantage in the current American economy that demands post-secondary skills training for a wage considered sufficient to meet basic needs. Former foster children are more likely to be homeless, to be unemployed and to be involved with the criminal justice system.

In Michigan, as in the rest of the country, children of color are disproportionately represented in the foster care system. In 2004, while African Americans made up only 17 percent of the population under the age of 18, they represented 50 percent of foster care placements or 12,624 children. Caucasian Americans are the majority of Michigan’s population at 75 percent, but they represented only 45 percent (11,262 children) of the foster care caseload. National studies have shown that youth of color in foster care stay in care longer, have less contact with caseworkers, fewer visits with their biological families and fewer written case plans—all of which lead to more long-term damage to the affected youth.

Michigan is serving as a model for other states in developing strategies to encourage leadership and input from foster youth to improve the state capacity to better serve their needs. In 2003, with support from the Jim Casey Youth Opportunities Initiative (JCYOI), the Michigan Department of Human Services (DHS) formed 13 local youth boards representing 17 counties around the state. These boards comprised of current or former youth in foster care work to raise awareness about the issues of older youth in care. Currently a state Youth Policy Board of delegates from the county youth boards meets quarterly in Lansing to advise the DHS on state programs and policy that affect youth in foster care.

Their first recommendation focused on the need to involve foster youth in the decision-making process about their future, particularly changes in placement. One of the most common complaints from runaway youth in Michigan was that they were not consulted about changes in their placements by their caseworker or attorney. The Family to Family Initiative is seeking to remedy that situation with Team Decision-Making Meetings where all stakeholders, including the youth, are involved.

Other issues highlighted by Michigan’s Youth Policy Board include the importance of encouraging youth to maintain positive connections with their birth family, including siblings, and hometown friends; enabling foster youth to get driver’s education and a license; and assisting youth to make connections through nurturing mentors.

Although numerous agencies provide a variety of services to youth aging out of foster care in Michigan, the resources and services are not easily accessed and serve only a small percentage of the eligible

13 Peter Pecora, et al. Improving family foster care: Findings from the Northwest Foster Care Alumni Study (Seattle, WA: Casey Family Programs, 2005).
19 Voice: discussing issues and concerns
20 Rosemary C. Sarri, et al. Juveniles who Run Away from Placement, 44.
population. A lack of collaboration among service providers is common, further complicating the situation for youth who need services. The following programs and services are among those offered through the DHS to youth aging out of foster care in Michigan:

- **The Jim Casey Youth Opportunities Initiative (JCYOI)** is a national effort that includes a wide variety of programs aimed at helping the “aging out” population. JCYOI currently operates in 17 counties in Michigan.
- **Education and Training Vouchers (ETV)** provide up to $5,000 per school year for tuition, room and board, school supplies, or a variety of other school-related expenses. To be eligible for these funds, youth must have enrolled in a post-secondary program before the age of 21, must have been in foster care on or after their 14th birthday because of abuse or neglect or adopted from foster care on or after their 16th birthday. In 2004, only 135 Michigan youth received ETFs.
- **The Tuition Incentive Program (TIP)** pays tuition and fees up to $500 per semester in an associate’s or certificate program and $400 per term in a bachelor’s degree program at a Michigan college or university. Eligible youth must have been on Medicaid for 24 of 36 consecutive months, have attained their high school diploma or GED by age 20, and use program benefits within 10 years of completing high school or their GED.
- **The Youth in Transition (YIT) program** awards federal dollars to foster youth to obtain educational support, job training, independent living skills training, self-esteem counseling, housing, car and car insurance, and other services to help them transition to adulthood. When the total cost of services per youth exceeds $600 (other than housing), the worker must file an exception request. To be eligible for YIT, youth must initiate the request for assistance, be in foster care or have spent time in such care for abuse or neglect or after their 14th birthday. In 2004 DHS processed 1,980 requests for YIT assistance—only a small share of the total youth who would have been eligible.

### Youth in the Juvenile Justice System

**Juvenile Arrest Rate for Violent and Property Index crimes**

The number of arrests of youths ages 10 through 17 is totaled for eight index offenses—murder, rape, robbery, aggravated assault, larceny, burglary, motor vehicle theft, and arson. The first four are considered “violent,” the second four, “property.” The rate per 1,000 is calculated based on the population of youth, ages 10 through 17. Data are based on where the event occurred not the residence of the youth.

**Out-of-home care for delinquency**: The number and rate of youth in out-of-home care for delinquency represents those placed in a facility or foster care or any setting other than with their biological parents.

Youth who come to the attention of law enforcement in the community require various responses based on the seriousness of their offense and their needs. Many vulnerable youth lose their way because of the inadequate response of the systems in place to protect them and the community. Too often youth end up in the juvenile justice system because mental health, substance abuse, academic failure, or abuse or neglect issues have not been addressed.

Several studies have estimated that the majority of youth in the juvenile justice system have a “recognizable” mental health problem, and 20 percent are seriously mentally ill. If these underlying issues are not addressed, these young people will continue their unacceptable behaviors and be come more deeply enmeshed in the criminal justice system.

Youth from the child welfare system are at particular risk of becoming involved in the juvenile justice system. Major concerns have been voiced about the level of “drift” of youth from the foster care system to delinquency status. Particularly vulnerable are those youth with multiple placements and those without an attachment to an adult who can provide stability to their lives. Runaways from foster care are particularly vulnerable as when they are detained, they may be placed in secure facilities with other juveniles detained for criminal offenses.

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25 Ibid. Young people who spent any time in foster care as adolescents, after the age of 13, may be eligible for services even if their cases are closed.
26 The program also supplies a one-time housing allotment limited to $1,000.
Runaway youth often end up on the street without adequate financial resources to survive and may turn to illegal activities to support themselves. Vulnerable and lonely, they are easy prey for exploitation by the unscrupulous.

**Why do youth in the juvenile justice system matter?**

Youth who enter the juvenile justice system will eventually return to their homes and communities. The capacity of the system to address their needs and provide opportunities for them to improve their social and academic skills will affect profoundly the future quality of their lives, as well as those of family and community members.

Many youth who end up in the juvenile justice system could have been better served by another system or agency at an earlier stage and at less cost to the state, the community, the youth, and their families. By the time a youth is injuring himself or others in the community to the point that the juvenile authorities become involved, the behaviors and attitudes can be entrenched. Once identified with the juvenile justice system, a youth will have a record that can compromise educational and employment opportunities, limit his/her life chances, and also cost them the opportunity to build a positive peer network during these critical years.

Youth with disabilities, particularly developmentally disabled youth, are at high risk of receiving inequitable treatment in the juvenile justice system. They have poorly developed social skills and lack the ability to understand the questions and warnings. For example, youths with mental retardation may not understand their rights, say what they think another person wants to hear, respond inappropriately to lawyers and court personnel, and not be recognized as mentally retarded.

Significant bias has been shown to exist in the juvenile justice system. Youth of color, especially African-American youth, are likely to experience more severe treatment than their white peers at every stage of the juvenile justice process—putting them at a “cumulative disadvantage.” While self-reported behaviors reflect little difference between white and African-American youth in many delinquent behaviors, arrest rates display striking differences. For example, African-American and white students report being in a physical fight at a similar rate as white students (37% vs. 33% for whites), according to the annual Youth Risk Behavior Survey, yet they were arrested for aggravated assault at a rate nearly three times that of whites (137 per 100,000, versus 48 per 100,000).  

**Michigan’s African-American youth experienced roughly double the risk for arrest in 2003.**

![Graph showing Michigan’s African-American youth experienced roughly double the risk for arrest in 2003.](image)

Source: Michigan State Police

**What is the situation in Michigan?**

Juvenile arrest rates vary widely across the state and by minority status. Law enforcement in some communities is more apt to make arrests as an early intervention strategy while in other communities arrests are not viewed as the appropriate first option.

In Michigan, African-American youth and young males are disproportionately involved in the juvenile justice system. While they are half of the adolescent population, male youth represented roughly 80 percent of juvenile arrests for violent offenses, and 67 percent of the juvenile arrests for property offenses in 2003. The only offense where female arrest rates approached those of males is for larceny (6 per 1,000 for females vs. 9 for males). African-American youth comprise 17 percent of the youth population but 44 percent of all juvenile arrests for violent offenses, and 33 percent of arrests for property offenses.

The overall rate of juvenile arrests for index crimes declined dramatically—by roughly 40 percent—between 1996 and 2003. In 1996 there were 19 arrests per 1,000 youth ages 10 through 17 compared to 12 in 2003. Counties with juvenile arrest rates 10 percent or more above the state average were concentrated along the southern border, central northern Michigan and the Upper Peninsula. Although there is much attention directed to the occurrence of violence among youth, they are much more likely to be arrested for property offenses.

Roughly 86 percent of all arrests of youth in this age group were for property offenses, primarily larceny, often shoplifting.

Trends in juvenile arrests for both violent and property offenses were similar across Michigan. The juvenile arrest rates for violent and property crimes both declined dramatically over the trend period. The rate of juvenile arrests for violent crimes dropped by one-half, and for property crimes by roughly 40 percent. In 1996 the juvenile arrest rate for violent crime was 3.4 arrests per 1,000 youth compared to 1.6 in 2003 while that for property crime dropped from 19 to 12. The metropolitan area reflected the most dramatic decline in arrests for violent crime. Among these counties the juvenile arrest rate for violent crimes ranged from 1 to 3 arrests per 1,000 youth.

The Upper Peninsula had the highest rate of juvenile arrests for property crimes in 1996, but the deep decline in its rate in the trend period brought it close to the average of other county groups in 2003. Among Michigan’s counties, property crime arrest rates ranged from a low of 1 arrest per 1,000 youth ages 10-17 to a high of 32.

Youth involved in a serious crime are often placed in a detention or a residential facility. Previous efforts were made in Michigan to limit that option because of its high cost and its ineffectiveness as a placement in many instances. Community-based alternatives have proven both more effective and far less costly but there was public pressure for punishment and control and they were dramatically reduced.

**Juveniles in state’s metropolitan area experienced the largest decline in violent crime arrests between 1996 and 2003.**

![Graph showing Juveniles in state’s metropolitan area experienced the largest decline in violent crime arrests between 1996 and 2003.](image)

Source: Michigan State Police

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Michigan counties experienced the largest declines in juvenile property crime arrests between 1996 and 2003.

Since 1990 many youth in Michigan have been charged as adults and sentenced to the adult prison system. While touted as a solution to youth committing heinous and violent crimes, the majority of children in Michigan’s adult prisons have been convicted of non-violent offenses. Analysis of outcomes for juveniles waived to criminal court revealed that the probability of receiving an adult prison sentence was essentially determined by the county where the youth were tried rather than the crime committed. In some counties funding concerns influenced the decision-making as the state pays full cost for prisons but roughly half for juvenile residential placements. Almost 90 percent of youth transferred to the adult system were minorities, and two of five youth had no previous delinquency charges.

Many of these youth return to their communities from confinement with their successful reentry seriously undermined by the lack of systemic after-care services. Similar to the experience of youth who age out of the foster care system, many of these young people who are placed in out-of-home care as delinquents lack an adequate social and economic support system to make a successful transition once they are released.

Adolescents in foster care who run away from placement constitute a high-risk group for “drift” into the juvenile justice system. When they are found, they are often placed in detention with delinquent youth. In response to several negative incidents and the relatively large numbers of youth absent (from placement) without legal permission (AWOLP) in southeast Michigan, the Wayne County Task Force on AWOLP Children was established in 2003. Members were charged with developing and implementing programs and policies to reduce the numbers of AWOLP youth. The preliminary evaluation found AWOLP youth had experienced multiple placements (a median of five), and roughly half of these youth had at least one experience with a juvenile justice agency. There has now been a concerted effort to address the needs of adolescent youth in the child welfare system more effectively so that there is less likelihood they will drift into the juvenile justice system.

Overall in Michigan the rate of youth placed in out-of-home care for delinquency declined by 29 percent—not surprising in light of the dramatic decline in arrests, particularly for violent offenses. Northern Michigan was the only area that did not experience a decline in its rate of out-of-home placement for delinquency while non-metropolitan Southern Michigan had the largest decline.


What can Michigan do to serve better the youth in the juvenile justice system?

Develop a comprehensive response to the over-representation of children of color in the child welfare and delinquency systems. A focused effort must be directed at developing policies to address the problems of poverty, community disorganization, social and ethnic discrimination, inadequate education, and lack of mental health and social services in communities of color. The majority of African-American parents in Michigan are single mothers who must work—many at low-wage jobs situated a substantial distance from their homes. This situation increases the risk of neglect and denies their children the opportunity to grow up in a reasonably safe, secure and supportive environment.

Enhance inter-departmental collaboration. Adolescents, especially low-income and minority youth, need better access to prevention and early intervention services, particularly for mental health. For example, African-American offenders are less likely than their white counterparts to have previously received mental health services. Enhanced collaboration among child welfare, mental health, education, and juvenile justice systems could improve service delivery for children, adolescents, and their families.

Cooperative and concerted efforts to empower families can make a dramatic difference for children and youth.

Improve after-care services. Most youth return to their community, and they need support in that transition process. A reentry plan that includes case management and community-based services for at least one year should be created at intake rather than waiting until just before discharge. Subsidies for housing and other needs may be required. The design of the Michigan Prisoner Reentry Initiative from the Department of Corrections could provide the model.

Source: Michigan State Police

References:

Youth of Color in the Juvenile Justice System

Research suggests a "race effect" that accumulates through juvenile justice process leads to higher rates of arrest and detention for minority youth.

Drugs: The largest disparities between African-American and white youth are found in drug arrests and imprisonment: African Americans make up nearly half the youth detained for drug offenses although they use drugs at the same rate as whites. While African-American youth comprise 17 percent of the youth population, African American youth represent 27 percent of all drug violation arrests and 48 percent of the youth detained for a drug offense.

- **Same or higher rate of illicit drug use among white youth.** The rate of current illicit drug use was 11 percent among white youths aged 12 to 17, and 9 percent among African-American youth. In a previous year, the same survey found that white youth aged 12 to 17 were more than one third more likely to have sold drugs than African-American youth. White high school seniors annually use cocaine at 4.6 times the rate of African-American students, use crack cocaine at 1.5 times the rate of African-American students, heroin at the same rate of African-American students, and marijuana at a rate 46 percent higher than African-American youth.2
- **Higher arrests among African-American youth.** African-American youth are arrested for drug offenses at about twice the rate of whites (314 per 100,000 vs. 175 per 100,000 for white youth), and represent nearly half of all the youth incarcerated for a drug offense in the juvenile justice system.

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1 National Survey on Drug Use and Health 2004
2 The Monitoring the Future Survey
If Michigan Were a Village of 100 Children

Their racial and ethnic background
- 73 would be non-Hispanic White
- 17 would be African American
- 5 would be Hispanic
- 3 would be of more than one race
- 2 would be Asian Pacific
- 1 would be American Indian

Their geographic distribution
- 82 would live in the metropolitan counties
- 9 would live in non-metro counties in Southern Michigan
- 9 would live in the Upper Peninsula and rural northern lower peninsula

Their living arrangements
- 66 would live in a married couple family
- 20 would live in a single mother family
- 5 would live in a single father family
- 7 would live in a household headed by a relative
- 2 would live in a household headed by a non-relative

Their economic well-being
- 31 would live in families where no parent has full-time, year-round employment
- 36 would live in a poor or low-income family
- 1 would be in poverty
- 18 would receive food stamps
- 6 would receive cash assistance (FIP)

Their health
- 83 would be immunized before the age of three
- 29 would be insured by Medicaid
- 1 would be insured by MIChild
- 7 would not have health insurance
- 1 would be disabled and receiving SSI

Their safety and security
- 6 would live in a family investigated for child abuse or neglect
- 1 would be a confirmed victim of abuse or neglect

Sources: Kids Count in Michigan Data Book 2005: County Profiles of Child and Family Well-Being-A Focus on Youth in Transition; US Census 2000; American Community Survey 2004
Juvenile Justice (Avg. 1994-96 vs. 2001-03)
Arrests for violent and property index crimes for juveniles aged 10-17 are reported by the county where they occurred, not where the youth resides. In Michigan’s criminal justice system seventeen year-olds are not considered “juveniles,” but they are included to maintain comparability with national data. The Uniform Crime Report of the Michigan State Police tabulates the number of arrests for eight index crimes. (“Index” crimes are so-named because they are consistently defined across the states.) Violent Index Crime Arrests include: murder, rape, robbery, and aggravated assault. Property Index Crime Arrests include: larceny, burglary, motor vehicle theft, and arson. These data should be used with caution. The arrest count reflects arrests not youth; individuals arrested multiple times are counted, as well as multiple youth involved in a single incident. County numbers may be affected by partial reporting by police jurisdictions within those counties. Variations across counties may be more influenced by local law enforcement and community norms than actual differences in incidents. Arrests of children younger than 10 are included with 10-year-olds in the data source, but the number of arrests is estimated to be small enough not to affect the rates. The rate is calculated per 1,000 youth, ages 10-17.
Source: Michigan State Police, Criminal Justice Data Center, Uniform Crime Reports. These data are periodically updated so current electronic information may differ.

The rate reflects the average three-year rate per 1,000 of live births to females ages 15-19.
Source: Michigan Department of Community Health, Vital Records and Health Data Development Section.

Children Receiving FIP Assistance (2004)
The Family Independence Program (FIP) supplies cash assistance to needy families with children under age 18. Families with assets less than $3,000 qualify for assistance at gross monthly income below $775. The percentage is based on the number of children ages 0-18 in 2003.

Children Receiving Food Assistance (2004)
The number reflects child recipients in single month (December 2004). The number of children participating in the federal Food Assistance Program includes those in families receiving other forms of public assistance, as well as those receiving no other assistance. 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 0-17 in 2003. For three county groups—Wexford/Missaukee, Grand Traverse/Leelanau, and Charlevoix/Emmet, the number of children receiving food stamps in each county was prorated on the basis of the total number of food stamp recipients in each county.

Percent No Listed Paternity (2003)
The percent of births with no paternity listed are those infants born to unmarried mothers for whom no father signs a form to acknowledge his parent-hood. The percent is based on total live births.
Source: Michigan Department of Community Health, Vital Records and Health Data Development Section.

Students in Special Education (2004)
This figure represents the percentage of the enrolled public school students diagnosed with a mental or physical condition that qualified them for special education services. Children in programs operated by the Michigan Departments of Corrections, Community Health, and Human Services are not included. The count includes all individuals receiving special education services, ages 0 through 26. The rate is based on the percent of school enrollment for K-12 in October as re-ported by the Michigan Department of Education.
Source: Michigan Department of Education, Office of Special Education & Early Intervention Services, Special Education Count By County and By Type Of Disability (December 1, 2004).
Children Receiving Supplemental Security Income, per 1,000 (2004)
Supplemental Security Income (SSI) is a federal program of the Social Security Administration. 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 rate is per 1,000 children ages 0-17 in 2003.

Birth Defects (2000-02)
The number reflects the annual average number of infants reported with a birth defect. It includes babies born in Michigan over the three-year period of 2000-02 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. 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.

All children covered by Medicaid are included in this total; children qualify through several different programs. The percentage is based on the number of children ages 0-18, according to 2003 population estimates.

Child Care Monthly Costs (2005)
The monthly average costs in 2005 for one child full-time in regulated child care reflect only those cared for by family providers, group family providers or child care centers. Monthly child care costs are calculated as a percentage of the most current average wage per job.
Source: Provider data from a March 2005 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 (2004)
This number reflects the children ages 0-12 in child care whose parents were receiving a subsidy payment from the state in October 2004. Eligibility for child care subsidies is based on family participation in the Family Independence Program or earnings below qualifying levels (roughly 150% of the poverty level in 2004). The percent is based on all children, not just those eligible for the subsidy, by age group.

Trend Indicators
(in order of their appearance on state/county profiles)
Child poverty, Ages 0-17 and Ages 5-17 (1995 and 2002)
The percentages are based on the number of related children, ages 0-17 and 5-17, in 1995 and 2002. Estimated numbers and rates for 1995 and 2002 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 and adoption.
Source: U.S. Census Bureau, Small Area Income and Poverty Estimates (SAIPE), data accessed online at www.census.gov/hhes/www/saipe.html (July 28, 2005)

Children Receiving Free/Reduced Priced School lunches (1995/96 vs. 2004/05)
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 below 130 percent of poverty are eligible for a fully subsidized or “free” meal while children from families with incomes between 130 and 185 percent of the federal poverty line are eligible for reduced priced meals. The percentage is based on total enrollment of K-12 public school students for school years 1995-96 and 2004-05.
Less Than Adequate Prenatal Care (1994-96 vs. 2001-03)
The number represents the mothers who received less than adequate prenatal care as defined by the Kessner Index, which classifies prenatal care based on the month it began, the number of prenatal visits, and the length of the pregnancy. Included in the measure are some cases where data are unknown or missing. The percent is calculated on total resident live births, based on the mother’s county of residence.

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

Low-Birthweight Babies (1994-96 vs. 2001-03)
The number includes those babies who weighed less than 2,500 grams (approximately 5 lb. 8 oz.) at birth. The percentage is calculated on total resident live births based on the mother’s county of residence.

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

Infant Mortality, per 1,000 (1994-96 vs. 2001-03)
The number includes infants who died before their first birthday. The rate is the number of infant deaths per 1,000 based on the mother’s county of residence. 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

Child Deaths, Ages 1 to 14 (1994-96 vs. 2001-03)
The number of child deaths includes deaths from all causes, disease as well as injury. 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

These children reside in families where an investigation of abuse or neglect was conducted. Families may be investigated more than once in a given year, and they would be counted each time. Rates are calculated per 1,000 children ages 0-17. Data are merged for two sets of counties: Missaukee/Wexford and Grand Traverse/Leelanau.


Confirmed Victims of Abuse or Neglect (1995 vs. 2004)
These numbers reflect an unduplicated count of children confirmed to be victims of abuse or neglect after an investigation. 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. Data are merged for two sets of counties: Missaukee/Wexford and Grand Traverse/Leelanau.


The total number includes children in facilities or placements (other than their own home) supervised by the Department of Human Services, its agents or the courts, including children placed with a relative or guardian. The county represents the location where the child is in care. The total includes court placements that are not designated by cause. The number of Wayne County children placed out-of-home for delinquency in 2004 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. Children in mental health facilities or out-of-home placements supervised by the Departments of Mental Health or Corrections are not included.
The rate is calculated per 1,000 children, ages 0-17. Data are from a single month—September.


Deaths to Teens, Ages 15-19 (1994-96 vs. 2001-03)
The number represents the deaths from all causes to teens, ages 15-19, by county of residence. The rate is based on the number of 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 1994-2003).

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, transferred, retained or graduated.

Source: Data for the calculations were obtained from the Center for Educational Performance and Information on July 12, 2005.

Fiscal Years begin on the previous October 1st and end on September 30th. For example, fiscal year 2004 began on October 1, 2003, and ended on September 30, 2004.
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State and Federal Affairs Office
Michigan Municipal League
Michele Corey
Director of Community Advocacy
Michigan’s Children
Jane Zehnder-Merrell
Senior Research Associate
Michigan League for Human Services

Design
CiesaDesign
of East Lansing, Michigan
Printing
Lawson Printers
of Battle Creek, Michigan

Dr. Marvin McKinney
Program Director,
Youth and Education
W.K. Kellogg Foundation

Michigan League for Human Services • 1115 S. Pennsylvania Avenue, Suite 202 • Lansing, MI 48912-1658 • Phone: 517/487-5436 • Toll free: 800/837-5436 • Fax: 517/371-4546 • Web: www.milhs.org
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.

Kids Count in Michigan
Michigan League for Human Services
1115 S. Pennsylvania Avenue, Suite 202
Lansing, MI 48912
Tel: 517.487.5436 or 800.837.5436
Fax: 517.371.4546
Web: www.milhs.org