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.

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

The Michigan Data Book 2006 is available as

- A book for $17 plus sales tax (shipping and handling $3) from the Michigan League for Human Services (bulk rates available).

- On the web:
  - www.milhs.org — a PDF of a county profile or any other part of the book
  - www.kidscount.org — Michigan county data can be found at the national Kids Count project site in the online data. Go to CLIKS: Community-Level Information on Kids to view data in a county profile, or create a line graph, a map, or a ranking table.

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

**Kids Count in Michigan**
Michigan League for Human Services
1115 S. Pennsylvania Ave., Suite 202
Lansing, MI 48912
Phone: 517/487-543
Toll Free: 800/837-543
Web: www.milhs.org

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At a Glance

Child Well-Being in Michigan

This review of changes in child well-being in Michigan reflects mixed results. Of the 14 core indicators tracked by the Kids Count in Michigan project, the state made progress on seven, lost considerable ground on four, and saw little or no change at all on another three. Outcomes for adolescents showed improvement while maternal and infant well-being and child safety weakened.

Progress

- Declining teen birth and death rates: Between 1997 and 2004, teen birth and death rates in Michigan dropped by roughly one-quarter. Almost 12,000 teens gave birth in 2004 versus 16,000 in 1997. The rate declined from 48 to 34 of every 1,000 teenaged girls, ages 15–19. Roughly 100 fewer teens died—441 versus 542. The rate dropped from 80 to 61 deaths per 100,000 teens, ages 15–19.
- Almost 12,000 teens gave birth in 2004 compared to roughly 16,000 in 1997. The rate declined from 48 to 34 of every 1,000 teenaged girls, ages 15–19.
- Roughly 100 fewer teens died in Michigan in 2004 compared to 1997—441 versus 542. The rate dropped from 80 to 61 deaths per 100,000 teens, ages 15–19.
- Lower child death rates: 2004 child death rates in Michigan were 17 percent lower than in 1997. The rate dropped from 48 to 34 of every 1,000 teenaged girls, ages 15–19. Roughly 100 fewer children died—409 versus 510.
- Fewer youth going into out-of-home care for delinquency: The rate dropped by 43 percent between 1997 and 2005. Roughly 2,000 youth were in such care in 2005 compared to 4,000 in 1997.

Challenges

- More children living in low-income families: Participation at free or reduced prices in the National School Lunch Program among K-12 students in public schools rose by 17 percent between 1997 and 2005. Roughly two of every five students (623,000) participated at free or reduced prices in 2005. These children lived in families with incomes only marginally above poverty with financial resources still inadequate to meet basic needs. While child poverty in Michigan in 2003 (15%) was lower than in 1997 (18%), more recent data for the state from the American Community Survey showed child poverty stood at 19 percent in 2005, higher than the 1997 rate.2
- More child victims of abuse or neglect: Roughly 28,000 children in Michigan were confirmed victims of abuse or neglect in 2005 compared to almost 21,000 in 1997. The rate rose by 43 percent—from 8 to 11 child victims per 1,000 children, ages 0–17. These children suffered harm from the failure or inability on the part of their parents or guardians to protect them or provide for them. The rate of children going into out-of-home care due to abuse or neglect was also up—by 16 percent, and the rate of children in families investigated—by 13 percent.

- No improvement in maternal and infant well-being: In 2004 roughly 10,700 babies in Michigan were born at low-birthweight (less than five and one-half pounds), putting them at risk for chronic disease, disability and even death. The 2004 rate of 8.2 percent barely changed from the 1997 rate of 7.7 percent. The state’s infant mortality rate (8 deaths per 1,000 live births) meant that roughly 1,000 infants died before their first birthday in 2004.

What can we do to improve the economic security of children? As Michigan struggles to adapt to the loss of manufacturing jobs and erosions in wages and benefits for workers, implications of the impact on families with children must be considered as policy alternatives are developed. For many families wages from a job do not provide enough income to meet the basic needs of the family.

While the state and federal government sponsor an array of programs such as cash assistance, food stamps, and child care subsidies to assist low-income families, these programs routinely have stringent income eligibility ceilings that prevent many needy families from qualifying to receive the benefits. In several programs, the benefits end well before families have the means to meet basic needs. State and federal fiscal policies have eroded the capacity to assist vulnerable families.

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1 These annual rates and numbers are based on three-year averages: 2002-04 and 1995-97.
2 These more recent data from the American Community Survey are available only for the state and the 28 counties and 21 places in the state with population over 65,000.
Introduction

Each year the Kids Count in Michigan project at the Michigan League for Human Services compiles a report of the latest and most reliable information about children and their families. The annual data report is the project’s ongoing effort to assist decision-makers at the local and state level as they develop policies and programs affecting the well-being of children in Michigan.

Over the past 14 years, the project has documented substantial improvements, particularly among the state’s teenagers. As well, some health measures reflect better conditions for the children in Michigan. In the area of economic well-being, however, improvements have not persisted, and the public programs that mitigate the effects of poverty on children have been sharply curtailed.

As the state struggles to adapt to the loss of manufacturing jobs and erosions in wages and benefits for workers, it is key that the implications of the impact on families with children remain in the forefront as policy alternatives are developed. This year’s data book focuses on economic security for children by reviewing trends in poverty and participation in the key programs that address the basic needs of children whose families have insufficient income to meet those needs.

While the state and federal government sponsor an array of programs, such as cash assistance, food stamps, and child care subsidies to assist low-income families, many of these programs employ stringent income eligibility ceilings that prevent many needy families from qualifying to receive the benefits. In several programs, the benefits end well before the parents reach an earnings level which would allow the family to purchase the goods or services necessary to sustain the household. The overarching problem remains the very low benefit levels, particularly in the state’s child care and cash assistance programs.

This year’s report contains some new data. The latest child poverty data from the 2005 American Community Survey (ACS) for the state and the 28 counties with a total population over 65,000 are included. (The latest child poverty data for all counties are the 2003 Small Area and Poverty Estimates from the Census Bureau.) Although trends from the ACS cannot be reviewed this year, every year the ACS will provide Michigan communities with updates of the social and economic conditions for children and their families. This information will be invaluable to community and state planning.

In 2008 and again in 2010 the ACS will begin releasing data for counties with smaller populations.

Also new this year is the immunization data for toddlers, aged 19-35 months, for all counties from the Michigan Care Improvement Registry. While some counties may be registering relatively low rates due to lack of timely provider reporting, this problem does not occur in most counties.

For the first time this year’s report will not include high school dropout rates. In response to the findings of the Auditor General about the unreliability of high school dropout rates currently reported by the Center for Educational Performance and Information (CEPI), those rates have been eliminated from the data and trend page profiling state and county experience. Many of the data problems cited in the audit will be resolved with the change from the current accounting system to an individual student record, which will be effective for the class of 2007, according to CEPI.
Economic Security

Families with economic security in their lives have adequate income to provide for the basic needs of their families. While policymakers commonly use child poverty rates as the key measure to assess the vulnerability of children, it vastly underestimates the extent of economic fragility among the nation’s marginal families. Poverty is measured by a national standard while living costs vary dramatically across the country and within states. Although the federal poverty level is adjusted for inflation each year, it has not kept up with overall changes in the U.S. standard of living since the 1960s. A family of four in Michigan would be hard-pressed to meet its most basic needs with poverty level income of less than $20,000 a year—or less than a full time job paying $10 an hour.1

The state and federal government have put in place a number of programs such as Food Stamps and Child Care Subsidies to assist families with incomes below and marginally above the poverty level, but eligibility for these benefits ends long before families have the means to provide for their needs. Usually the benefit amount also declines significantly as family income approaches the eligibility standard. Several programs end at 130 percent or 150 percent of poverty so the impact on the family budget for multiple needs occurs at nearly the same time. Families that participate in one program often receive other benefits. For example, 95 percent of families that are income-eligible for the Child Care Subsidy in Michigan also received other benefits, typically food stamps and/or Medicaid.

Eligibility for all the programs that assist low-income families to meet their basic needs or support their work efforts ends well below the amount of earnings needed to cover their basic needs.2 Eligibility for the cash assistance program ends before family earnings even reach poverty level (as indicated by the eligibility for Head Start in the chart at right). An analysis by the National Center for Children in Poverty showed that as wages increase, low-income parents actually lose the ability to cover the costs of the family’s basic needs because of phase outs and complete termination of benefits before the family income is sufficient. The major problem is that income eligibility ceilings are way below the level of family earnings required to purchase basic goods and services.

Estimates, based on the latest data in 2004, showed a single parent with two children in Michigan would need an annual gross income of close to $35,000 to be self-sufficient—to work full-time at $17.50 an hour—to have adequate income to meet all the family’s basic needs for housing, food, health care, child care, clothing, and transportation.3 This gross income represented roughly 230 percent of the poverty level for a family of three in 2004.

The following discussion highlights several key programs that assist low-income families meet their basic needs. An overview of the participation, benefits and eligibility requirements of these programs will examine the important role they play in keeping low-income children healthy and safe. Without these programs, many parents in low-wage jobs could not provide for the basic needs of their children. The discussion begins with a review of the trends for the key indicators of the economic well-being of children.

<table>
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<th>Poverty Income Levels — 2005</th>
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<tr>
<td><strong>FEDERAL POVERTY LEVEL (FPL)</strong></td>
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<td>Single Parent Family (with 2 children)</td>
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<td>Annual</td>
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<td>Monthly</td>
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1 Federal poverty levels are based on the number and ages of family members.

2 The self-sufficiency calculation includes only estimated average costs for housing, food, child care, health, transportation, clothing, household, personal and phone, no money for savings or recreation.

Child poverty in Michigan was lower in 2003 than 1997.
One in seven children in Michigan lived in a family with income below the federal poverty level in 2003, despite a 17 percent improvement in the child poverty rate between 1997 and 2003 (from 18% to 15% of all the state’s children). All counties improved or did not experience a change with the exception of Ottawa, according to U.S. Census estimates. Overall, approximately 377,000—one-third of a million—Michigan children in 2003 were growing up in such dire economic circumstances that their very health and safety were threatened.

Among Michigan counties child poverty rates ranged from a low of 5 percent in Livingston County to 28 percent in Lake County, one of three west Michigan counties with child poverty rates considerably above the state median. Other counties with child poverty rates above the state median in 2003 were mainly on the eastern side of the state. Most counties with child poverty rates well below the state median are considered “suburban” and border the urban counties of Wayne, Ingham or Kent or are concentrated in the Grand Traverse area.

The latest data available from the American Community Survey (ACS), showed child poverty in the state climbing to 19 percent in 2005. This extensive economic deprivation among the state’s children is not necessarily rooted in unemployment.

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4 These Small Area Income and Poverty Estimates (SAIPE) provide the only source of child poverty data for all Michigan counties. The latest available data are for 2003. More current information (2005) from the American Community Survey are only available at this time for the state and counties with population over 65,000.

5 See note 4.
Economic Security

6 Economic Security

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as in almost half (44%) of these families at least one parent was working. Low wages and part-time work play a role, as do single parenthood and low educational attainment.

Analysis of national child poverty trends suggests increases in child poverty between 2000 and 2004 were rooted in the decreasing real value of the minimum wage, which had not been adjusted in over a decade, and local unemployment rates.6 Michigan has suffered from unemployment rates relatively higher than those of the rest of the nation beginning with the downturn in the state’s economy that began in 2000. In Michigan the minimum wage was raised for the first time in almost a decade in October 2006, from $5.15 an hour to $6.95 for workers over the age of 17.

Children in families without a full-time worker are at the highest risk of poverty. However, while unemployment and job loss can devastate a family’s financial well-being, those with only part-time or part-year work also suffer from economic insecurity. In Michigan one of three children lived in a family where no parent had full-time, year-round employment in 2004.7

A national study shows that the poverty rate for white children in families without a full-time worker was 49 percent in 2004, compared to 70 percent for African-American and Hispanic children in this situation.8 The availability of only one wage earner in the family compounds the problem for African-American children who are roughly three times more likely to live in single-parent households than white children in Michigan. The economic downturn that began in 2000 disproportionately affected African-American families, according to the analysis, due primarily to restrictions in Unemployment Insurance coverage that favors full-time workers and does not address the work situations of many single parents.

Overall young children and minority children in Michigan had much higher rates of poverty.9 In 2004, children under the age of five had a poverty rate of 20 percent, compared to 16 percent for school-aged children, ages 5-17. Analysts make the point that this difference by age group may reflect the fact that when children are in school, parents are able to work more hours, and they don’t have the expense of full-time child care.

The differences in the shares of children under severe economic stress in Michigan are even more pronounced by race and ethnicity. Child poverty for African-American children was more than triple that of white children (39% versus 12%) in Michigan, and Hispanic children had almost double the white rate. Almost half (46%) of young African-American children under the age of five were in poverty, and one-third (31%) of young Hispanic children, compared to 14 percent of white preschoolers.

These major differences in economic well-being largely result from several inter-related factors: inequities in access to education and employment, compounded by discriminatory housing and banking practices. Most African-American families live in urban areas where unemployment rates tend to be much higher, and transportation constraints limit access to job opportunities in the outlying suburban areas. Rural poor families

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8 Austin Nichols. Op cit.

9 Poverty rates for racial/ethnic groups are from the ACS; they are not available from the SAIPE child poverty estimates presented on the county profile pages.
suffer similar problems: available low-income housing is in the outlying areas while jobs are in the cities and small towns, and public transportation is unavailable.

Participation at free or low-cost in the school lunch program rose to 37 percent in school year 2005-06. Recognizing the plight of children in families with income only marginally above the poverty level, the federal government in the 1960s put into place several programs, including the National School Lunch Program, to ensure that minimal health and nutritional needs of children were met regardless of family income. The National School Lunch Program is the oldest and the largest child nutrition program in the country. When the program was reauthorized in 2004, several improvements were enacted to make it easier for eligible children to receive free or reduced-price meals. For example, children in households receiving food stamps are now automatically enrolled for free school meals.

Students qualify for a free meal in the National School Lunch Program if their family income falls below 130 percent of the federal poverty level ($25,155 for a family of four in 2005). Four of five Michigan student participants have family income below this level. Students in families with income between 130 and 185 percent of the federal poverty level (up to $35,798 for a family of four in 2005) may obtain a reduced-price meal—with their share of the cost not to exceed 40 cents, according to federal guidelines. While children in families with incomes above 185 percent of poverty pay the full price, their meals are also subsidized to some extent through the National School Lunch Program.

Well over half a million (623,000) students in the public K-12 system in Michigan participated in the school lunch program at free or reduced price in 2005-06. Over half (54%) of the roughly 8.5 million lunches served in Michigan schools through the program that year were provided at no or low-cost to participating families—almost two of every five Michigan students qualified for these subsidies. Among Michigan counties participation ranged from 11 percent in Livingston County to 86 percent in Lake County.

Between 1997 and 2005 the percentage of Michigan public school students qualifying for a free or low-cost lunch rose from 32 percent to 37 percent of students—an increase of 17 percent. All of the increase occurred after the year 2000 when the state experienced a dramatic economic reversal. The increase was widespread with all but two Michigan counties showing higher rates of participation in the National School Lunch Program at free or reduced prices, and in those two counties the decline was minimal—less than 4 percent.

Other Public Programs for Children in Need
Several other federal and state programs address the basic needs of children in low-income families. The largest numbers of poor and near-poor children are served by the Food Assistance Program—roughly half a million. The Office of Child Support serves over 600,000 children in the state by collecting and distributing funds from non-custodial parents to provide for children, mostly living in female-headed households at high risk of poverty—38 percent compared to 5 percent in married couple families in Michigan. Other programs discussed in this section include the Family Independence Program or cash assistance and the Child Day Care Subsidy. These programs play an important role in helping families meet the critical needs of their children during their growing up years.
2005 Child Poverty Rates in Michigan Counties

The American Community Survey (ACS), which was fully implemented in 2005, essentially uses what was previously called the “long form” census questionnaire to gather information from randomly selected households on an ongoing basis. This continuous collection and release of information through the ACS will mean that communities will be able to review demographic, social and economic changes in a much more timely way than was possible with reports once every ten years.

The 2005 data from the American Community Survey (ACS) were available only for counties, cities and townships with populations over 65,000. Included in this year’s release is updated information about child poverty for 28 of Michigan’s 83 counties.

Among these 28 counties in Michigan, Livingston County has the lowest poverty rate, at 6.3 percent with a margin of error (MOE) of 2.5 percentage points, that is, the actual child poverty could range from a low of 3.8 to a high of 8.8 percent. Counties with the smallest populations, such as Van Buren and Midland had relatively large margins of error—9 and 7 percentage points respectively, compared to the more populous counties such as Wayne and Oakland where the child poverty estimates are much more reliable with an MOE of roughly two percentage points.

Although Berrien County had the highest child poverty rate among the 28 counties in 2005, its rate of 30.6 percent had a MOE of plus or minus 5.9, meaning that the county child poverty rate could be as high as 37 percent or as low as 25 percent. The second highest county child poverty rate, in Wayne County, was estimated at 29.1 percent.

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1 The 2005 data did not include group quarters due to funding constraints, but group quarters have been included in 2006.
Among the 28 counties, 17 had child poverty rates that were significantly different than the Michigan average of 18.5 percent. Among these counties, Berrien County’s child poverty rate was 12 percentage points above the state average while those of Clinton, Livingston, and Ottawa counties were 12 percentage points below it.

Beginning in 2006, annual data from the ACS will be released every year for geographic areas with a population of 65,000 or more. In Michigan, that includes these 28 counties and 21 municipalities (cities and townships). These data should continue be used with some caution. As has been noted, the margin of error for small counties can be quite large, and for most counties comparable data from previous years are not available from the ACS. While some reports have compared the ACS child poverty rates to those of the 2000 Census, the U.S. Census Bureau does not recommend this approach because differences may simply reflect those in the way the data were collected and the sample population.

Next year these same counties and places will receive 2006 data. Starting in 2008, the ACS will release data in three-year averages (2005-07) for another 36 Michigan counties, with a population 20,000-65,000. Finally, in 2010, the ACS will begin to report data averaged over five years (2005-09 in the first year) for geographic areas with a population less than 20,000. In Michigan 19 counties fall into that group.
Food Assistance Program (Food Stamps)
The federal Food Stamp Program was inaugurated in the 1960s in recognition that individuals in families with income at or near poverty are likely to suffer from nutritional deprivation. A lack of vital nutrients during the growing up years is particularly dangerous as it compromises the development of physical and cognitive capacity.

This major nutritional support program for struggling families is called the Food Assistance Program (FAP) in Michigan, formerly called food stamps. Roughly half of the more than one million participants in the state were children in 2004. Individuals with household income below 130 percent of poverty qualify for this program with some recognition of shelter and child care costs in determining eligibility and benefit levels. The average participant receives a benefit of 88 cents a meal or a total of $237 a month for a family of three.10

The state has a substantial share of children who depend on the program to meet their every day nutritional needs. The percentage of all children, ages 0–18, participating almost doubled between 2000 and 2005—growing from 10 to 19 percent. Not surprising, food assistance participation trends reflect changes in unemployment and poverty. Among Michigan counties, participation rates in 2005 ranged from 5 percent of children in Livingston County to 33 percent in Lake County.

Participation rates for young children are the highest with almost one-quarter of all the state’s young children under the age of five in the program. In some counties the rate rises to 45 percent of young children who depend on the program to meet their nutritional needs.

Youngest children have largest share participating in Food Assistance Program.

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<thead>
<tr>
<th>Ages 0-4</th>
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<td>24</td>
<td>21</td>
<td>17</td>
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Source: Michigan Department of Human Services December 2005

Child Care Subsidy
After housing, child care costs represent the second largest expense for those families who need to purchase full-time care for their children. In Michigan the cost of infant care averaged $536 per month in 2006, and for school-aged children roughly $472. The average cost of infant care constitutes 16 percent of the 2004 average wage per job in Michigan ($38,737). Low-income workers earning $6 or $7 an hour cannot afford full-time child care for even one child.

With the changes in the federal welfare law in the mid-1990s that emphasized working outside the home as the primary responsibility of parents, federal and state governments devoted more resources to supporting parental employment by strengthening the child care subsidy program for low-income families. Michigan’s child care subsidy caseload more than doubled between 1995 and 2000, jumping from roughly 25,000 families to

10 Benefits are no longer distributed as “stamps” but through an Electronic Benefit Transfer system, similar to a debit card.
almost 67,000. In Michigan, roughly 151,000 children in 65,000 families relied on the child care subsidy in 2005. The average monthly payment per family was $636 or $324 per child.

These payments represent costs well below current market rates for child care because the maximum subsidy is based on the 1997 market survey (1996 rates). Michigan is one of only two states that have failed to update its child care reimbursement rates since 1997.11 For a four-year old in Wayne County, there is a $320 shortfall between the subsidy rate for center care and the 2005 market rate of $758 per month—a difference that must be made up by low-income families or providers.12 The difference between the reimbursed amount and the 2005 market rate in Wayne County is the second largest in the nation, behind St. Louis, Missouri, and tied with Clark County (Las Vegas), Nevada.13 Michigan’s low subsidy rates also partially explain why the lowest cost providers, relatives and aides, supply almost two-thirds of subsidized care in the state.

Eligible day care providers include the following: Centers, Group Homes (up to 12 children), Family Home (up to six children), Relatives and In-Home Aides.14 The first three groups are regulated by the Department of Human Services (DHS) while relatives and aides who receive a state subsidy for providing care are “enrolled” by staff at the county DHS office.

The maximum subsidy amount is based on an hourly rate and varies by the shelter area, the provider type, and the age of the child.15 (Shelter areas are groups of counties initially established to reflect variations in living costs but the areas have not been adjusted to reflect changes in the last two decades.) For example, the maximum hourly rate for infant/toddler care ranges from a high of $2.85 an hour in a Center (in Shelter Area IV) to a low of $1.35 for a Day Care Aide (in Shelter Areas I through III). Only families in the cash assistance program (Family Independence Program) or in transition from FIP receive the maximum hourly amount.16

While parent(s) can qualify for the child care assistance program if they attend high school, work or are involved in an approved treatment program for child welfare purposes or approved employment related activities, almost all participant families qualify based on their employment. Eligibility is based on family size and income—for example, a family of three with income below $1,944 per month (148 percent of poverty level) qualifies.

12 Ibid.
13 Ibid.
14 An aide may be no younger than 18 years of age, effective January 2005 as approved by the Department of Health and Human Services as an amendment to the state plan.
15 Higher rates are paid for children who are under 30 months old, also referenced as infant/toddler care.
16 Transition means having left the FIP caseload within the last three months.
Most children in subsidized child care (71%) are income-eligible, and their subsidy is adjusted to reflect their family income. Michigan families of three with income below $1,847 a month (approximately 140 percent of the poverty level) qualify for 95 percent of the department’s maximum payment. Once that family’s income crests at 140 percent of poverty, a monthly change in income of roughly $50 moves the recipient precipitously down the reimbursement scale. A family of three with a parent in a full-time job making $11.50 an hour no longer qualifies for a subsidy. As a result, a single parent with two children needing care would need to find a way to cover a child care cost of $300-600 per month although her monthly income has risen by roughly half that amount: $131.

The department has estimated that the increase to $6.95 in October 2006 and to $7.15 in July 2007 will result in roughly 1,800 income-eligible families losing access to child care assistance from the state. The rise in the minimum wage will have an impact on child care provider costs, particularly Group Homes that employ two or more helpers, according to the DHS.

Most Michigan children in subsidized care are cared for by relatives or in-home aides. Many parents rely on relatives or aides for child care because their frequently fluctuating work schedules do not mesh with the availability of care in licensed settings where providers have a need for predictability. In 2002 a national study showed that 28 percent of young children under age six in a single-parent home had a parent working non-standard hours.

Michigan’s minimum wage increase will also affect eligibility for child care since the eligibility chart is not adjusted annually by the Legislature for inflation or higher minimum wage schedules.

Currently the DHS is considering ways to enhance the quality of care among these relative and in-home aides by requiring an orientation session, providing training, increasing payment rates for those with training, encouraging these providers to become licensed, and improving standards. A concern with these initiatives, however, is that they may destabilize the supply of child care providers available to low-income families.

Two-thirds of children in Michigan in subsidized care rely on aides or relatives.


Children represent two-thirds of the individuals dependent on the state cash assistance program, also known as “welfare” or the Family Independence Program (FIP), to sustain minimal subsistence levels. In December 2005, roughly 155,000 children in Michigan received cash assistance from FIP, a program partially funded by the federal Temporary Assistance for Needy Families (TANF) block grant. One in twenty of the state’s children aged 0–18 (7%), met some of their basic needs through this state and federally funded safety net program. Among Michigan counties, the percentage of children assisted by the program ranged from a low of less than 1 percent in Livingston County to 12 percent in Wayne County.

Over the past ten years program access and benefit levels have eroded. The maximum benefit of $459 for a family of three in Wayne County remained unchanged for the 13-year period between 1993 and 2005 thereby losing substantial value in real buying power due to inflation. In May 2006 the Department of Human Services standardized payments across the state to $489 to reflect the level of the highest housing costs of the six shelter areas in the state. Although many families realized an increase of $1 a day, the boost did little to bring the assistance level back to its purchasing power of the early 1990s. The total new grant amount represents less than two-thirds of the rental cost of the average two-bedroom unit in Wayne County, but is expected to stretch to cover food not covered by the food assistance allotment (calculated to cover two-thirds of a family’s minimum nutritional needs), cleaning materials and paper products, personal hygiene items, clothing, transportation, telephone, school supplies, and other necessities of daily living. The state’s assistance policy assumes that the $489 monthly grant will be enhanced by parental earnings up to $810 a month, the absolute income eligibility ceiling for any cash supplement to the family.

After five years of extending the original Temporary Assistance to Needy Families (TANF) block grant level and requirements, Congress reauthorized TANF in 2006 as part of the Deficit Reduction Act. While TANF funding was reauthorized for another five years at the same funding level as allocated in 1996—actually a 23 percent cut in real value due to inflation, the Act instituted additional work requirements for parents, mostly single mothers.19

The new stricter requirements will have a heavy impact on Michigan’s dependent families with children, as they will in many other states. The state’s employment rate among parents in all single-parent families receiving any level of assistance is 23 percent, 26 percentage points less than required under the new federal requirements (50%). The state’s two-parent rate (26%) is 64 percentage points short of the new 90 percent federal requirement. Failure to meet the higher work participation rates could result in total penalties to Michigan of $83.6 million in Fiscal Year 2009. The only families that are exempt from work requirements by federal law are mothers with infants less than 12 months old, but Michigan has opted to exempt only those mothers with infants less than 12 weeks old.

To avoid penalties, the DHS is focusing on the hurdles faced by the families in the Michigan caseload who work for a matter of months but find themselves in need of assistance again within a year. Responding to the multiple barriers faced by such parents the Department launched the Jobs Education and Training (JET) program to match work preparation activities to individual abilities and needs; offer training in a range of skills, including personal, basic, and job-related; and strengthen support for job advancement and retention.

19 Since the dollar amount of the block grant is frozen again for the next five years, its actual value will erode further.
The new strategy reflects the findings of a long-term study of a representative sample of Wisconsin welfare applicants in 1999, which found that more than four of five parents applying for assistance reported at least one potential barrier to employment and over half had two or more.20

Such barriers included disability of the applicant parent or a disabled family member; poor or fair health; no high school diploma or general equivalency diploma; mental health, alcohol or other drug problems; or involvement in a physically abusive relationship. While some of these issues can be addressed with more individualized caseworker support and oversight, many cannot be solved in a matter of days or weeks. Typically low-income workers do not have flexible schedules, health care or education benefits, nor sick leave or vacation time to address these barriers and remain employed. Another problem already noted is the phase-out of employment support benefits and termination of all eligibility for work support programs at an unrealistically low earnings level.

Child Support
Over half a million (654,305) children had child support orders in Michigan in 2005. Almost one of every four children in the state depends on the child support collection system to receive payment from a non-custodial parent. In October of 2005 the average amount of monthly support provided for one child was $135. More than one in three children who were owed support under a court order had received none during the previous six months.

Among Michigan counties, the percentage of children with a child support order ranged from a low of 9 percent in Keweenaw to a high of 37 percent in Calhoun. Muskegon, Genesee and Berrien counties also had one of three children with child support orders. The average monthly payment ranged from $78 in Lake County to $265 in Livingston County. Only 11 percent of children with a support order had not received a payment in the last six months in Leelanau County compared to 54 percent in Wayne County. Non-custodial parents in counties with high unemployment and poverty rates face more difficulty supporting themselves and meeting their child support obligations than do those in counties with a more stable economy.

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Children Not Receiving Support

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Source: Michigan Department of Human Services, Office of Child Support, October 2005
A new threat to the stability of families and children looms as a result of the federal Deficit Reduction Act of 2006, which cuts state and county resources for child support enforcement by about 20 percent for fiscal year 2008 and beyond. This reduction in funding for Friends of the Court, Prosecutors and the Office of Child Support could result in a $300 million loss in child support collections for Michigan families over the next five years, causing more families to turn to the TANF program. Ironically, if the state is unable to meet federal child support performance standards because of the budget cuts, it could also incur penalties that would reduce its TANF block grant amount.

What can be done to improve economic security for children in Michigan?

- **Raise eligibility limits in the cash assistance (FIP) and the Child Day Care Subsidy programs.** Many low-income families need work supports to continue until their toehold in the job market is more secure. As the current income eligibility ceiling for the FIP program ($810 gross monthly income) denies assistance to families with income well below poverty, they are unable to gain the necessary stability to maintain enduring employment. Parents with inadequate income to pay for housing, transportation and clothing, to maintain a home base and a consistent school base for their children, makes it impossible for many to take care of the family’s personal needs and maintain a steady work schedule. The income eligibility ceiling for child care assistance cuts families off the program before they have adequate earnings to replace the subsidy.

- **Phase out benefits more gradually.** The benefit amount for the child care subsidy drops sharply with every additional $50 per month in earnings. A more gradual decline in reimbursement would help families maintain child care arrangements—disruptions in child care can have a negative impact on children, especially young children who need stable routines; they also greatly compromise the parent’s ability to meet work schedules.

- **Increase subsidy level for cash assistance and child care.** While the cash assistance grant was adjusted for about 70 percent of recipients in 2006, the increase represented roughly $1 a day. A more substantial increase in the basic grant would allow more stability in housing and basic care of children as well as provide a better income base for those families deferred from the work requirements. The current maximum grant amount of $489 per month fails to cover even the Fair Market Rent for a two-bedroom residence in any Michigan county. Michigan’s child care subsidy amount was last adjusted based on the 1997 market rate survey. Family choices for safe and quality child care arrangements remain limited by the low subsidy amounts.

- **Address discriminatory housing, education, employment, and banking practices that disproportionately affect families in segregated minority group communities.** Well-documented discriminatory housing and banking practices have resulted in concentrations of minority groups and poverty in the state’s older cities. These concentrations of poverty in turn affect neighborhood stability and place strains on resources in the local health delivery system and the school district.
Child Health

One of the least costly but most beneficial public policies is to assure access to health care for children. In recognition of that fact, policy makers expanded public health insurance for children in 1997, and provided federal funding to the states to increase access for near-poor children. With this support, Michigan offers coverage, with some restrictions, to children in families with incomes up to 200 percent of poverty through the Medicaid and MIChild programs ($39,612 for family of four in 2005). Most children in the state public programs are covered by Medicaid, which limits income eligibility to 150 percent of the poverty level for children.

Health Insurance

Michigan has had one of the lowest uninsured rates among children in the nation—7 percent compared to the national average of 11 percent in 2003. Nonetheless, this percentage means that roughly 200,000 children in the state remain uninsured—one in 14, and without insurance coverage they are less likely to get the preventive and primary care needed to avoid emergency room visits, hospitalizations, acute or chronic health problems, or long-term disability. Providing adequate access to health care has clear benefits for children, their families, their schools, their communities, and society.

The most recent county estimates of uninsured children are for the year 2000. At that time the west Michigan counties of Barry and Ottawa had the lowest rate (5%) of children without any health insurance while Oscoda County had the highest (13%). Some of the poorest counties had the highest rates of children without health insurance. The latest state data showing the percentage of children uninsured by family income indicate that low-income children in families with income less than 250 percent of the poverty level are twice as likely to lack health insurance as children in more affluent Michigan families.1

Between 1999 and 2005, the number of children covered by Medicaid in the state climbed from roughly from 579,000 to 859,000—an increase of almost 400,000 children. In part due to the diminishing coverage of children in private employment-related insurance programs, the percentage of children dependent on Medicaid for access to health care rose from 21 percent to 32 percent—one in three—of the state’s children under 19 years of age. Outreach for MIChild between 1999 and 2002 brought many eligible children into Medicaid, but even after funding for that effort was eliminated, child enrollment rose by another four percentage points. Across Michigan counties the percentage of children insured by Medicaid ranged from a low of 12 percent in Livingston County to a high of 51 percent in Lake County.

The supplemental MIChild program, which limits participation to children in families with income between 150 and 200 percent of poverty, serves roughly one percent of all children in the state. Unlike the consistently rising Medicaid participation of children, participation in MIChild leveled off at roughly 34,000 in 2004 and 2005 after peaking at 36,000 in 2003.

The cost of health care for children is much less than for other populations, particularly among those dependent on Medicaid for their health insurance. While children represent more than half of all Michigan residents participating in Medicaid, their costs are only 20 percent of total Medicaid spending. In fact, among the 50 states Michigan had the lowest average cost per Medicaid-covered child at $971 in 2003-04, roughly one-quarter the cost in Maine, which had the highest cost per child ($3,570).2 While state officials maintain these low costs represent efficiencies, others express concerns about low provider reimbursement rates that result in limiting access to care.

The core of Medicaid services for children is the Early Periodic Screening Diagnostic and Treatment (EPSDT) program. Federally mandated preventive services include the following six components, as well as referrals to the appropriate practitioner for treatment as needed:

- Comprehensive health and developmental history and assessment
- Comprehensive physical examination
- Immunizations
- Laboratory tests, including mandatory lead screening
- Vision, hearing, and dental screening
- Health education and anticipatory guidance.


A review of the annual Early Periodic Screening Diagnostic and Treatment (EPSDT) program participation report for Michigan suggests relatively low access to services, particularly during the critical teenage years. One in three or fewer adolescents who were eligible actually received the comprehensive physical exam required by the federal Medicaid law, while half of eligible elementary school-aged youngsters received such an exam.

Share of Medicaid children receiving periodic comprehensive health exam drops sharply after infancy.

Access to oral health services for children insured by Medicaid is another concern since most dentists in the state do not accept Medicaid payments. Six years ago the Michigan legislature allocated roughly $11 million additional dollars to increase access to oral health services for children in rural counties. With the funds the Michigan Department of Community Health developed a Healthy Kids Dental program in a contract with the Delta Dental Plan. In 37 counties the plan assured dentists payment at 85 percent of their premier rate for Medicaid-eligible children under 21. Effective May 2006, the program expanded to an additional 22 counties for a total of 59 rural counties. The program covers all of the counties in the Upper Peninsula and northern Michigan, as well as many of the southern non-metropolitan counties. Unfortunately children in the large urban counties, which have the largest concentrations of poverty, do not have access to the program, and department analysts estimate $45 million would be needed from the General Fund in order to extend the program to all 83 counties.

Childhood Lead Poisoning

An area where Michigan has made substantial improvements in Medicaid services has been in increasing the number of toddlers tested for lead-based poisoning. Young children under the age of three are particularly vulnerable to the damaging effects of lead since their nervous systems are still developing, and their hand-to-mouth behaviors result in their ingesting lead dust or chips. Poor children with nutritionally deficient diets, especially those lacking adequate iron and calcium, also are more susceptible to the lead-based paint in their housing—an element prevalent in the past and still present in the many older Michigan homes constructed before 1970 when lead paint was banned.

In 2005 roughly one-quarter of Michigan toddlers, ages 1 and 2, were tested for lead and 2 percent had elevated blood lead levels, that is more than 10 micrograms of lead per deciliter of blood. (Recent studies have shown that damage occurs at much lower levels as well.) To target the most vulnerable, Michigan has focused its testing efforts on Medicaid-


4 These percentages take into account the variation in exam schedules recommended for different age groups.
The immunization rate for Michigan reflects children ages 19-35 months old who had received a series of at least 15 vaccinations as of December 2005. This series is the required level of immunizations for entry into Michigan preschools or kindergartens. For the first time this year the data book includes the immunization rates for toddlers, ages 19 through 35 months old, in all Michigan counties, according to records in the Michigan Care Improvement Registry (MCIR) previously known as the Michigan Childhood Immunization Registry. The registry has been in operation for roughly eight years, but it has taken a while to get enough providers using it on a regular basis so that localities can rely on the results to assess immunization rates.

The state immunization rate for this series from the MCIR in 2005 was substantially lower than that estimated from the National Immunization Survey (NIS) conducted by the Centers for Disease Control and Prevention: 64 percent compared to 81 percent (NIS) conducted by the Centers for Disease Control and Prevention: 64 percent compared to 81 percent. Results from the NIS show Michigan

As of June 2006 over half of Medicaid-eligible toddlers had received at least one blood lead test by the age of two. Although Michigan is making steady progress, it still falls far short of federal standards that require all Medicaid-enrolled children be tested at ages one, and again at age two, or once between the ages of three and six if they have not been previously tested. Early detection and intervention are critical because many lead-burdened children exhibit no clear symptoms until the lead burden is quite high, and the damage is often irreversible. Data show that Wayne County had the highest rate of tested children with elevated blood lead levels. Roughly one in 20 of Wayne County’s toddlers tested for lead suffered from lead poisoning, the most common preventable health problem for children.

Immunizations for Toddlers

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As of July 2006 the name change also heralds a change in policy to maintain the records in the registry through adulthood authorized by Public Act 91 of 2006. The change will affect only children born after 1993, and those who agree to participate in the program. The system will also be enhanced to connect to other child health data bases involving lead and newborn vision and hearing screenings.

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The state immunization rate for this series from the MCIR in 2005 was substantially lower than that estimated from the National Immunization Survey (NIS) conducted by the Centers for Disease Control and Prevention: 64 percent compared to 81 percent (NIS) conducted by the Centers for Disease Control and Prevention: 64 percent compared to 81 percent. Results from the NIS show Michigan

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had the ninth highest coverage among the 50 states in 2005 due in large part to a significant increase in immunization levels in city of Detroit. The state immunization rate reflected by the MCIR tends to be lower because provider participation is lowest in southeast Michigan where half the child population resides. As participation in the MCIR extends more pervasively among providers, the two rates should be closer.

Each of the six MCIR regions develops its own provider outreach and training plan, as well as policies and procedures regarding noncompliant provider sites. Local and state health departments, as well as the regional MCIR advisory board, are involved in shaping these policies and plans. Turnover in provider office staff can often be the problem in MCIR compliance. Recently some health plans have been offering financial incentives to providers based on the number of children they have in the MCIR with up-to-date immunizations.

Among Michigan counties the percentage of toddlers fully immunized ranges from 91 percent in Ontonagon to 49 percent in Wayne. Oakland County, with the second highest child population in the state, had an immunization rate of 52 percent, according the MCIR. As noted, the relatively low immunization rates for the southeastern counties apparently results from low participation by providers. Among the large urban counties Kalamazoo and Ottawa had the highest immunization rates with roughly 78 and 76 percent of their toddlers immunized.

Less than adequate prenatal care affects almost one-quarter of new babies.

In Michigan in 2004, roughly 28,350 mothers who gave birth had not received adequate prenatal care that started in the first trimester and included the number of visits recommended throughout the pregnancy. Numerous research studies have documented better delivery and birth outcomes for both mother and baby who receive adequate prenatal care. Studies suggest that a woman who has received less than adequate prenatal care is twice as likely to have a low-birthweight baby as one receiving adequate care.

In recent years the state improvement on this measure has been minimal. Between 1997 and 2004 the Michigan rate of new mothers receiving less than adequate prenatal care dropped only slightly (by 9%) from 24 to 22 percent of all mothers giving birth. While most Michigan counties showed declines in their rates of pregnant mothers not receiving adequate care over this trend period, some large counties such as Ingham and Macomb reflected substantial increases.

Access to prenatal care in Michigan varied dramatically by race/ethnicity and geography. The share of women not receiving adequate prenatal care ranged from a low of 8 percent in Otsego County to a high of 46 percent in Jackson County.

Almost two in five pregnant African-American women did not receive adequate prenatal care in 2004; the rate declined only minimally between 1997 and 2004—from 40 percent to 38. Although Hispanic women had the largest decline in their rate—a drop of 16 percent over the trend period, almost one in three pregnant Hispanic women did not receive adequate prenatal care in 2004, compared to 18 percent among their white counterparts.

Minority women in Michigan continued to have much higher rates of pregnant women receiving less than adequate prenatal care.

8 References to 2004 in the child health section for the trend indicators actually represent the annual three-year average for 2002 through 2004. Similarly references to 1997 represent the annual three-year average for 1995-97.

9 Less than adequate prenatal care encompasses both intermediate and inadequate care, according to the Kessner Index.
Most women recognize the value of beginning prenatal care in the first three months of pregnancy. Almost half of Michigan mothers of newborns (43%) who started care in the second trimester and over three-quarters (77%) in the third trimester would have preferred to have started care earlier, according to data from Michigan’s Pregnancy Risk Assessment Monitoring System (PRAMS) survey.\(^\text{10}\) Reasons cited by these women for not starting prenatal care earlier included lack of awareness of pregnancy (33%), cost issues (30%), inability to get an earlier appointment (28%), and not having an insurance card (23%). Roughly half of these women experienced at least two or more such barriers.

The women most likely to be starting care after the first trimester were 18–21 years of age (41%); lacked health care insurance (39%); were African Americans (38%); or lacked a high school diploma (38%). These women are also the most socio-economically vulnerable and at highest risk of having babies born too early and too small. Most observers agree that addressing barriers to health care, including family planning and prenatal care, among these groups would greatly reduce risky pregnancies and births.

The relatively high rates of women without health insurance during their prime child-bearing years means that many Michigan women must rely on Medicaid for prenatal care and delivery. However, because they only become eligible for coverage once they are pregnant, these women face delay in getting prenatal care. This policy also means that women are less likely to have a regular medical provider and had any health concerns addressed before they become pregnant.

Healthy babies are much more likely to be born to healthy mothers. Mothers who have received adequate prenatal care, starting in the first trimester with regular visits throughout the pregnancy are much more likely to deliver a healthy infant. Timely prenatal care with sustained monitoring and support results in early detection of health problems, providing opportunities for early intervention.

Low-birthweight babies represent 8 percent of all births.

Babies born weighing less than 2,500 grams (five and one-half pounds) are at substantially higher risk of infant death—roughly eight times that of babies weighing in at a higher level. The lower the birthweight, the higher the risk of disease or death is for an infant. More than one-quarter of Michigan’s babies with extremely low-birthweights (under three pounds five ounces), do not survive their first year.

The percentage of low-birthweight babies born in Michigan in 2004 was 8.2 percent, up slightly from the 1997 rate of 7.7 percent.\(^\text{11}\) The 2004 rate represented roughly 10,700 low-birthweight babies in Michigan. African-American babies had double the risk of being born with low-birthweight as white infants, 14.6 percent versus 7.0 percent. Hispanic infants have the lowest risk of low-birthweight (6.3%).

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African-American babies also suffer a much higher risk of being born with extremely low-birthweights. Among white infants one of every six low-birthweight infants weighed in at extremely low levels, less than three pounds five ounces, compared to one of every five low-birthweight African-American infants.

Among Michigan counties the percent of babies born at low-birthweight ranged from 4 percent in the Upper Peninsula County of Alger to 12 percent in Alcona and 10.5 percent in Wayne. In Wayne County that rate represented roughly 3,000 infants at risk. The rising rates of low-birthweight were widespread in the state with almost three-quarters of Michigan counties experiencing increases in their rates. This trend means more children will suffer from developmental delays and chronic disease in the majority of Michigan counties.

Michigan’s infant death rate remains above the national average. In Michigan the infant mortality rate was 8 deaths per 1,000 live births in 2004 with roughly 1,050 infants dying before their first birthday. The state infant mortality rate has remained essentially the same for almost a decade and earned the state its worse ranking among the key trend indicators in the recent national Kids Count reports.

In the 2006 national report and rankings, Michigan’s infant mortality rate put the state at a new low in the rankings, placing it 43rd among the 50 states in the nation (2003 data). Only six other states had an infant mortality rate worse than Michigan’s, which matched that of Georgia, and was not significantly different than those of Alabama and Arkansas.

### Low-Birth Weight Babies: Rates for Selected Counties by Race/Ethnicity

| COUNTY    | WHITE  |  |  |  |  |
|-----------|--------|  |  |  |  |
|           | LBWT # | %  | LBWT # | %  | LBWT # | %  |
| Michigan  | 6,573  | 7.0 | 3,262  | 14.6 | 491   | 6.3 |
| Berrien   | 103    | 7.5 | 55     | 11.6 | 12    | 7.8 |
| Calhoun   | 99     | 7.0 | 36     | 12.8 | 9     | 4  |
| Genesee   | 356    | 8.2 | 279    | 16.7 | 4     | 4  |
| Ingham    | 197    | 7.9 | 90     | 15.7 | 15    | 6.6 |
| Jackson   | 149    | 8.1 | 25     | 13.2 | 4     | 4  |
| Kalamazoo | 145    | 6.2 | 82     | 16.0 | 16    | 8.9 |
| Kent      | 472    | 7.1 | 167    | 14.9 | 68    | 5.3 |
| Macomb    | 564    | 6.8 | 92     | 14.2 | 18    | 5.6 |
| Muskegon  | 111    | 6.7 | 68     | 14.3 | 8     | 4  |
| Oakland   | 805    | 7.2 | 233    | 12.5 | 62    | 8.1 |
| Ottawa    | 182    | 6.2 | 6      | 4    | 36    | 8.1 |
| Saginaw   | 118    | 7.2 | 100    | 14.2 | 15    | 5.6 |
| Washtenaw | 173    | 6.2 | 82     | 11.4 | 15    | 6.8 |
| Wayne     | 890    | 7.1 | 1,907  | 15.0 | 115   | 6.0 |

| COUNTY    | AFRICAN-AMERICAN |  |  |  |  |
|-----------|------------------|  |  |  |  |
|           | LBWT # | %  | LBWT # | %  | LBWT # | %  |
| Michigan  | 6,573  | 7.0 | 3,262  | 14.6 | 491   | 6.3 |
| Berrien   | 103    | 7.5 | 55     | 11.6 | 12    | 7.8 |
| Calhoun   | 99     | 7.0 | 36     | 12.8 | 9     | 4  |
| Genesee   | 356    | 8.2 | 279    | 16.7 | 4     | 4  |
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| Ottawa    | 182    | 6.2 | 6      | 4    | 36    | 8.1 |
| Saginaw   | 118    | 7.2 | 100    | 14.2 | 15    | 5.6 |
| Washtenaw | 173    | 6.2 | 82     | 11.4 | 15    | 6.8 |
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Source: Michigan Department of Community Health, Vital Record and Health Data Development, 2002-04

Among Michigan counties with enough African-American births to calculate a valid percentage (more than nine in 2004), Washtenaw had the lowest percentage (11.4%) of African-American infants born at low-birthweight while Genesee (16.7%) had the highest. Among counties with adequate numbers of Hispanic births for reliable calculations, the low-birthweight rate ranged from 5.3 percent in Kent to 8.9 percent in Kalamazoo.
Among the 52 Michigan counties with a measurable infant mortality rate in 2004, Marquette had the best ranking with its relatively low rate of 3 deaths per 1,000 infants, while Leelanau had the worst rate (14). Half the counties where change could be calculated experienced an increase in rates. Large counties with the most total births showed little change in their rates.

Almost half of the state’s infant deaths in 2004 occurred within the first 24 hours, and another 26 percent before the end of the first month. Only seven percent of all deaths among infants in the state occurred between 6 and 12 months of the infant’s life. These patterns emphasize the need for targeted comprehensive interventions in high risk communities and the importance of maternal health before and during pregnancy.

Infant mortality differed dramatically by race. African-American infants died at roughly triple the white rate—18 deaths per 1,000 live births among African-Americans versus 6 among whites. This disparity persisted across all the more highly populated counties that had sizeable numbers of African-American births. Ingham County had the lowest infant mortality rate for African-American infants (13) and Genesee County the highest (23). Genesee County also had a substantially higher white infant mortality rate (8) than most other large counties, almost double that of Ingham County, which had the lowest mortality rate for white infants (4) among the large counties.

The death rate among children declined. In 2004 Michigan’s child death rate stood at 21 deaths per 100,000 children ages 1-14. These deaths resulted from all causes, including disease and injury. The state rate dropped by 17 percent between 1997 and 2004—from 25 deaths per 100,000 to 21 in 2004. The total number of child deaths in the state declined by roughly 100—from 510 in 1997 to 409 in 2004.

Among Michigan counties the child death rate ranged from a low of 12 deaths per 100,000 children in Bay County to the high of 44 in Osceola County. Most (26) of the 37 Michigan counties with calculable rates over the trend period experienced improvements in their child death rate.

The child death rate varied dramatically by race/ethnicity in Michigan. African-American children suffered almost double the risk of death from age 1 through 14 as their white counterparts—31 deaths per 100,000 versus 16 for white children. These stark differences in child mortality reflect higher levels of poverty, compounded by health and safety risks among African-American children.
Child Safety

Children are totally dependent on their parents or guardians for their basic needs, particularly during the critical early days, months and years of life. Child maltreatment occurs when a parent or caretaker acts or fails to act in such a way that a child is seriously harmed. Child abuse or neglect can result in developmental delay, long-term emotional damage, physical disability, injury, or even death.

Programs such as cash assistance and subsidized child care have a key role to play in preventing neglect as they provide vital support to financially fragile families. Roughly 70 percent of child maltreatment in Michigan occurs due to neglect rather than abuse—the parent fails to meet the child’s basic needs for shelter, food, education or health care. Unfortunately over the past decade appropriations for supportive basic needs programs have not been adjusted for inflation, and eligibility has been restricted.

When children are harmed or threatened with harm by a parent or a guardian, the state must take steps to protect them. Reports of abuse or neglect originate primarily from family members, friends and neighbors, as well as social workers, school teachers and administrators, who are required by law to report suspected cases of abuse or neglect. Allegations of child abuse or neglect are investigated and addressed by the Child Protective Services Division of the Michigan Department of Human Services. (Other individuals who harm children are prosecuted through criminal courts.)

If the report is considered credible and fits within the state’s legal definition of abuse or neglect, state Child Protective Services (CPS) workers are obliged to conduct an investigation to determine whether the allegation is supported by a “preponderance of evidence,” that is most of the evidence confirms that abuse or neglect has occurred.

When the investigation is completed, the caseworker must assign the case one of five categories to reflect the findings of the investigation as well as a judgment regarding future risk to the child. Categories are assigned on a descending level of severity, with Levels One through Three for confirmed cases of abuse or neglect. Level One is the most severe and often involves the immediate removal of the child from the home. Cases assigned a Level Three category are deemed at low-risk of future maltreatment: families are referred to services in community agencies, and the perpetrator’s name is not added to the state’s central child abuse registry as in the more severe cases.1 Cases assigned a Level Four do not have enough evidence to confirm abuse or neglect, and a Level Five reflects unconfirmed abuse or neglect.

In Michigan of the roughly 72,000 complaints of child abuse or neglect that were investigated, one-quarter were confirmed in 2005. The confirmed cases were fairly evenly divided among the three categories with 28 percent in Level One, and 36 percent in each of the other two categories.

While data on the numbers of children in families investigated and those confirmed as victims reflect children involved in the child welfare system, changes in the rates of child abuse or neglect in counties should be interpreted with caution as they represent only an estimation of the scope of the problem. Despite state protocols governing the screening of reports and conducting of investigations, inexplicably wide variation occurs among counties in the percent of reports investigated and confirmed.

1 Individuals whose names are on the central registry are not allowed to work with children in child care centers or schools or other occupations where they may be unsupervised in close contact with children.
Many cases of abuse or neglect may never come to the attention of the state, and the capacity of the system to address the problem of child maltreatment is influenced by the resources available, especially staffing levels. Changing regulations and policies may also affect how many cases are investigated and addressed. Media attention to a particularly tragic case can also have an impact on public responsiveness and state policy.

The best public policy would be to prevent child abuse or neglect from ever occurring, but the current federal approach, which allows open-ended funding only for foster care, shortchanges prevention strategies and family interventions. Further, the federal funding source for foster care under Title IV-E has eroded over time as it is available only to vulnerable children in families with an income level that would have made them eligible for Aid to Families with Dependent Children (AFDC) in 1996. In Michigan, this eligibility level is income of less than 67 percent of the poverty level or roughly $10,500 for a family of three. Cuts in federal funding of child welfare services that were approved by Congress in the Deficit Reduction Act in early 2006 will place even more pressure on Michigan’s state budget for child welfare services.

Michigan has implemented several strategies to prevent child abuse and neglect, including home visitation programs, safe havens for abandoned newborns, and integration of family support and child abuse prevention into early childhood education programs. To strengthen its efforts at early intervention and prevention, Michigan sought and received a five-year waiver in the spring of 2006 to redirect some of its federal foster care aid into family preservation and reunification as well as support for relatives providing foster care. Pilot programs providing family support and intervention will be launched in Wayne, Genesee, Kent and Ingham counties in the fall of 2006.

The rate of children in families investigated for abuse or neglect rose slightly.

In fiscal year 2005 just over half (56%) of the roughly 129,000 reports of child abuse or neglect received by the department resulted in an investigation. The others may have been added to an ongoing case, referred to another agency, or rejected because the incident did not fit the legal definition of abuse or neglect or did not come from a person deemed reliable or credible. The likelihood of a complaint being investigated varied dramatically across Michigan counties, ranging from 16 percent in Lapeer County to 99 percent in Wayne County in fiscal year 2005. Saginaw County was the second highest with roughly 82 percent of complaints investigated. Wayne’s unusually high investigative rate may result from its being the only county with a 24 hour intake system staffed around the clock so after-hour complaints are immediately assigned, according to department officials.

Roughly 162,000 children in Michigan lived in families that were involved in an investigation of abuse or neglect in 2005. The state rate rose by 13 percent between 1997 and 2005— from 57 children to 64 children, ages 0–17, per 1,000. Among Michigan counties, the rate of children living in families where an investigation of abuse or neglect occurred ranged from 31 of every 1,000 children in Leelanau to 166 per 1,000 children in Lake County. Most counties (59 of 83) in the state experienced an increase in their rate of children in families investigated for abuse or neglect.
be expected, the rate of confirmed victims rose during the late 1990s in Michigan during the period when economic conditions were improving. However, during this period, several changes in state policies were also implemented.

Of the confirmed cases of child abuse or neglect victims in the state, just over one-third (36%) were designated as Category Three, indicating a low-risk of repeat maltreatment and the family was referred to community services.

The rate of children in out-of-home care due to maltreatment rose.

In Fiscal Year 2005 eight of every 1,000 children in the state were placed in out-of-home care by the state. Children in out-of-home care because of abuse or neglect are usually placed with a relative or in a foster home while those in care due to delinquency are most often placed in residential treatment facilities. Of the 19,280 children who were placed in out-of-home care in Michigan in 2005, nine of ten were removed from their homes because of abuse or neglect. Among Michigan counties the rate ranged from 1 of every 1,000 children placed in out-of-home care in Lapeer County to 16 of every 1,000 in Lake County.

The rate of children in care due to abuse and neglect rose by 16 percent while the rate of those going into care due to delinquency dropped by 43 percent.

Among Michigan counties the rate of confirmed child abuse and neglect victims ranged from 4 of every 1,000 children in Oscoda County to 26 children per 1,000 in Crawford County. Almost all counties experienced higher rates of confirmed child victims in 2005 compared to 1997; in fact, only 11 Michigan counties did not see any increase in their rates over this trend period.
Adolescence

Adolescence is a critical transition period in development. The line between childhood and adulthood blurs, and some youth stumble into situations where the decisions they make change the course of their lives or even bring their lives to an end. Two examples of such outcomes are reviewed in the following discussion about the rates of teen births and teen deaths.

Another critical outcome for this age group is graduation from high school. Unfortunately the data from Michigan school districts to track this outcome suffer from serious flaws, according to a recent performance audit of the Center for Educational Performance and Information (CEPI) by the Michigan Office of the Auditor General so it will not be included in this year’s report.1 CEPI, which has the responsibility for collecting and reporting high school performance indicators, anticipates that many of the data problems cited in the audit will be resolved with the change to an individual student record. This change will be effective for the class of 2007, and Michigan will become one of the first states to use the individual tracking method, as recommended by the National Governors Association Graduation Counts Compact.

The state teen birth rate dropped by one-quarter.

The Michigan teen birth rate in 2003 compared favorably with other states, ranking the state 16th among the 50 states. Michigan, as well as the nation, is experiencing record low teen birthrates as the social norms and economic climate have continued to change. Access to effective contraception, more available health information for young people, and more youth delaying sexual activity have also had a profound impact. The majority of women, whether they marry or not, can now expect to work most of their adult lives and need to spend their teen years getting the education and skills to compete successfully in the job market. The age of first marriage for American women rose to 25 in 2002 compared to 21 in 1970.

Young women who become mothers as teenagers are less likely to complete their high school education and be able to obtain the requisite skills to get jobs with high enough earnings to support themselves or a family. Nearly one in three girls who dropped out of high school in 2004 cited pregnancy as the reason.2 The poverty rate for children born to teenage mothers who have never married nor graduated from high school is 78 percent, compared to 9 percent for children born to women over age 20 who are currently married and graduated from high school.3

Although teen birth rates have dropped in the nation and every state over the last decade, teen parenthood continues to be a major challenge for the


3 Ibid.
United States, which has teen birth rates substantially higher than all other industrialized nations.

Michigan’s teen birth rate dropped by more than one-quarter between 1997 and 2004. In 2004, the state teen birth rate was 34 births per 1,000 female teens aged 15-19, compared to 48 in 1997. Roughly 4,000 fewer Michigan teenagers had a baby in 2004 than in 1997. The total number dropped from almost 16,000 births to teens to roughly 12,000.

However, the annual numbers understate the scope of the problem. In 2003 the state had a total of roughly 22,600 Michigan teenage girls, ages 15–19, who were mothers at a rate of 64 of every 1,000. And while Michigan has made substantial improvements in its teen birth rate over the trend period, the decline has slowed. Since 2001 the rate has dropped only a few tenths of a point each year. Furthermore, the percentage of all teen births that are to a teen who is already a mother has remained almost the same—essentially one of five teen births. Since these mothers face compounded barriers to completing the essential education and training and meeting the needs of their children, these trends suggest the need for more effective interventions to prevent second births to teen mothers.

Among Michigan counties the teen birth rate ranged from a low of 13 births per 1,000 teens in Livingston County to 71 births per 1,000 in Lake County. All but four counties in the state reflected improvement on this measure, and roughly 60 of the state’s 83 counties showed declines of 20 percent or more in their teen birth rates.

The teen death rate declined in Michigan by almost one-quarter.

The teen death rate in Michigan dropped by almost one-quarter between 1997 and 2004—from roughly 80 deaths per 100,000 teens, aged 15-19, to 61. Over the most recent three-year period—2002-04—an average of 441 youth a year lost their lives compared to 542 annually in 1995-97. Most of the improvement, however, occurred in the late 1990s, and the rates for the major causes of injury deaths—accident, homicides and suicides—have leveled off since then.

While most of the state’s youth who lose their lives die as a result of an accident, primarily automobile accidents, African-American youth are most likely to die as the result of a homicide. The risk of a homicide death for an African-American youth in Michigan was roughly 38 times greater than for a white youth in 2004. Overall, however, the homicide death rate for all teens was almost half as high in 2004 as in 1997.

Among the 45 counties with large enough incidence of teen deaths for a rate to be calculated, Washtenaw County had the lowest rate of 26 deaths per 100,000 teens while Missaukee County had the highest with 224. Roughly two-thirds (28) of the counties where the percentage change in rates could be calculated reflected declining rates. Lenawee and Berrien counties experienced the largest declines in their teen death rates over the trend period while Kalamazoo and Shiawassee suffered from the largest increases.