

Youth at Risk

BACKGROUND

Research identifies a multitude of *risk factors*—that is, circumstances, influences, or behaviors in a youth's life that put him/her at risk of not growing into a well-adapted adult. The sources of risk for youth may be simplistically categorized as *external* or *internal*.

GLOSSARY

Asset

In reference to youth, a factor considered essential to good growth and development—e.g., caring family, safe school, positive peer influence.

Juvenile delinquency

Illegal behavior by a minor; includes both "status" offenses (pertain only to minors, e.g., truancy) and "index" offenses (pertain regardless of age, e.g., breaking and entering).

Medicaid

A federal/state program that pays for health care services delivered mainly to eligible low-income people.

Poverty threshold

The amount of household income below which it is believed a family cannot meet basic food, shelter, clothing, and other needs; the level is adjusted annually by the federal government and varies by family size. In 2002 for a family of four, the amount is \$18,100.

Risk

In reference to youth, a circumstance, influence, or behavior that mitigates against a young person's growing up with the cognitive, social, emotional, and physical ability to be a well-adapted adult.

Youth, young people

In this article, persons aged 0–18. The definition of adolescence varies by program and study.

- External factors include growing up impoverished, having inadequate health care, being abused or neglected, or residing in an unsafe neighborhood.
- Internal factors relate to lifestyle decisions made by a young person and include deciding to smoke, abuse substances, become sexually active at an early age, or engage in violent or criminal activities.

Despite this distinction, internal and external risk factors are linked. Positive and negative external factors affect young children greatly and can influence the rest of their life, including their later lifestyle decisions. Poverty, for example, is found by numerous studies to be associated with youth being abused or neglected and with their experiencing such difficulties as reduced school readiness, dropping out of school, teen pregnancy, and behavior problems.

Advances in the fields of child development, brain science, and social science are changing how risk among youth is studied and understood. First, risk now is understood to be complex—that is, it involves environmental, neurological, and social factors rather than single or separable factors, behaviors, and outcomes. Moreover, there is growing consensus that identifying, preventing, and ameliorating risk must begin in early childhood rather than waiting until later, when the results manifest themselves.

Adolescent-behavior research supports focusing on the importance of youth having "assets" in their life—that is, protective factors (e.g., a caring and stable family, a safe school, positive peer influences) that increase their resiliency and reduce the likelihood that they will engage in high-risk behavior. The Search Institute (Minneapolis) has surveyed more than one million youth nationwide and is at the forefront of this approach. Many Michigan communities are making efforts to measure the existence or absence of assets in the lives of their young people.

The risk factors presented here are those of current public policy concern in Michigan: poverty, infant and child mortality, access to health care, abuse and neglect, teenage parenthood, crime and delinquency, and tobacco use. Another, substance abuse, is addressed elsewhere in this book.

DISCUSSION

Youth Poverty

Compared to others, youngsters living in poverty are at higher risk than others of dying in infancy, being in poorer health, having lower academic achievement, and, as adults, earning less income. The U.S. Census Bureau estimates that more than 350,000 Michigan children and youth live in households with income below the poverty level. This is 14 percent of all children, down from 19 percent in 1990 and lower than the national

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figure of 17 percent. Exhibit 1 displays the household distribution of childhood poverty. Despite the fact that the number of poor children has dropped, the Children's Defense Fund indicates that a child is more likely to be poor today than was the case 20 or 30 years ago.

Poor children are most likely to be living in a female-only headed household, but many live in two-parent homes; the lowest incidence is in male-only headed households. Although the risk factors discussed below may exist independently of a youth's financial circumstances, it is widely agreed that poverty often is a significant factor.

Infant and Youth Mortality

In Michigan from 1990 to 2000, the infant mortality rate (i.e., deaths among children under age one) fell from 10.7 to 8.2 deaths per 1,000 live births. The overall decline belies the fact that most of it occurred in the first half of the decade, and the rate actually increased slightly in 2000 (from 8.0 in 1999). From age one to adolescence, the leading cause of death is unintentional injury. Among adolescents, the three leading causes are motor-vehicle accidents, homicide, and suicide. Actions proposed to address infant and youth mortality in Michigan include

- establishing a MI Family health insurance plan that would extend coverage to 200,000 more people and increase low-income women's access to pre- and

post-natal care, which would reduce risk of infant mortality;

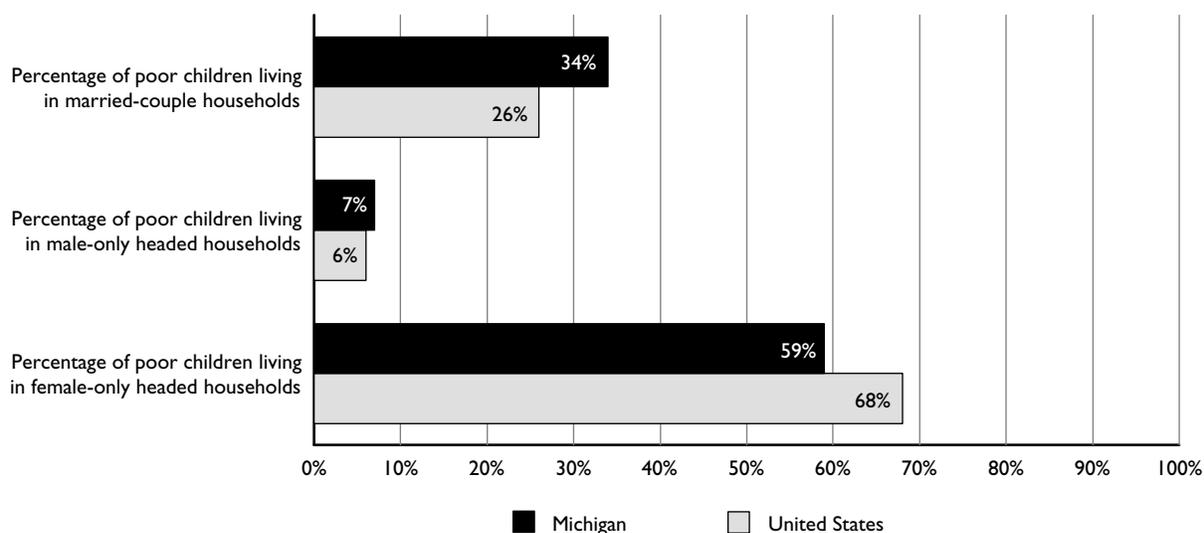
- enacting legislation that holds gun owners responsible if a child or youth gains access to an improperly or unsafely stored firearm; and
- standardizing laws governing firearm safety features such as trigger locks.

Access to Health Care

Inadequate access to health care means that youngsters do not receive regular checkups, immunizations, treatment, and early intervention for health or development problems. Adequate access can help prevent developmental delays and other long-term effects of undetected or untreated health and development problems. Michigan's efforts at providing health insurance for all children have been quite effective: According to the Census Bureau, only 6 percent of all Michigan children are not covered by health insurance.

Among poor Michigan children—for this purpose, defined by the state as those living in households at or below 200 percent of the poverty level—about 129,000 (more than 4 percent of all Michigan children) are believed to be uninsured. In Michigan, there are two main sources of insurance for low-income children: MIChild and Medicaid. MIChild was created in 1998 as a safety net for children aged 1–18 who were ineligible for public assistance

EXHIBIT 1. Child Poverty, by Type of Household, Michigan and the United States, 2000



SOURCE: Public Sector Consultants, Inc., using U.S. Census data.

NOTE: Children living below the poverty level comprise 14 percent of all Michigan children and 17 percent of all U.S. children.

and Medicaid. Modeled after private insurance, families pay a monthly premium (\$5) for coverage. An indirect effect of MICHild has been to increase children's Medicaid enrollment because a high percentage of adults applying for MICHild coverage for their children are eligible for Medicaid.

One major aspect of Medicaid coverage for children and youth is preventive health care focused on developmental assessment and identifying health problems, which is accomplished through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program. Critics assert that the state's effort in ensuring this care has been uneven. For example, a review of 1999 data from the Michigan Department of Community Health (MDCH) reveals that despite the high incidence of insurance, older youth are less likely than infants to receive basic preventive care such as physical examinations, immunization review, vision and hearing tests, and developmental assessment (see Exhibit 2).

Federal targets for EPSDT screenings are set at 80 percent. Michigan has not reported a screening rate that exceeds 51 percent. To respond to the state's need to address participation in screening programs, some advocate for

- providing incentives to parents and providers to obtain/provide the screenings;
- establishing service-delivery and data-collection standards consistent with EPSDT standards;
- changing the name of the program to something more engaging and compelling; and
- making the program mobile, so that screenings can occur where children and youth are gathered.

Abuse and Neglect

A great deal of research links abuse and neglect suffered as a youth with later delinquent and criminal behavior. The National Institute of Justice finds that childhood

abuse/neglect increases the odds of future delinquency or criminal behavior by almost 30 percent.

In FY 1999–2000, nearly 129,000 allegations of abuse/neglect were made, and, after investigation, the state removed 3,750 children from their home to protect them from continued abuse/neglect. In each case the child is assessed for future risk, and if deemed to be of high or intensive risk, on-going services to deal with the risk must be offered. Participation in services may be voluntary or court ordered.

Michigan's Child Protection Law requires a number of professionals to report suspected abuse/neglect; failure to report results in a fine (the maximum was increased by Public Act 14 of 2002) and possible imprisonment. Most reports are made by law-enforcement personnel, school counselors and administrators, and hospital/clinic and FIA social workers. Of those not required to report suspected child abuse/neglect, most reports come from an anonymous source or a relative, friend/neighbor, or a parent/caretaker outside the home.

Public policy options currently under consideration to address the neglect/abuse risk factor include

- improving accountability of the child-protection system through annual audits of the Michigan Family Independence Agency's (FIA) child-protection and foster-care services;
- extending whistle-blower protection to FIA child-protection and foster-care workers;
- standardizing training for professionals mandated by law to report abuse/neglect;
- ensuring better continuity of legislative oversight; and
- providing and expanding early-childhood programs to include parenting classes.

EXHIBIT 2. Percentage of Medicaid-Enrolled Michigan Children Receiving EPSDT Preventive Services, by Service Category, 1999

Age	Immunization Review	Vision Screening	Hearing Screening	Developmental Assessment	Physical Examination
0 – 2	85%	49%	49%	65%	70%
3 – 6	71	45	50	47	60
7 – 12	48	37	49	35	45
13 – 21	58	29	52	30	39

SOURCE: Michigan Department of Community Health (1999), "EPSDT Review."

Crime and Delinquency

Juvenile justice and delinquency services are the concern of both the Michigan Department of Corrections (MDOC) and the FIA Bureau of Juvenile Justice (BJJ).

The MDOC handles juvenile offenders who have been waived into the adult corrections system—in July 2000, about 519 youths—mostly in “boot camps.” In 1999 the MDOC opened the Michigan Youth Correctional Facility, a 450-bed prison for males aged under 19 who are convicted of a violent or assault crime. The facility is run by contract with a private corrections corporation, which has evoked some controversy. A legislative committee investigated numerous complaints, including understaffing, inadequate officer training (95 percent had no previous corrections experience), a high number of suicide attempts, and the absence of certified special-education teachers. Public Act 41 of 2001 requires the MDOC to report quarterly to the legislature on such matters as offender-control incidents, suicides, attempted suicides, assaults, fights, weapons use, and various staffing and program matters.

The BJJ provides services to youths aged 12–20 who are named by the courts as state wards or who are court wards and assigned to the FIA for care and supervision. At any point in time, there usually are about 5,000 wards in a variety of living arrangements, including six medium-to-high security facilities and four community-based, low-security residential care centers; because of space constraints and other considerations, some youth are sent to out-of-state facilities. In 2001 the Office of Auditor General released a performance audit of BJJ services citing several matters that the department has agreed to address.

- The intake/placement processes of the courts and the FIA need improvement to ensure that proper background information on youths is collected.
- Assessments are not always conducted in accordance with department policies.
- There is insufficient oversight of the out-of-state facilities where some youths are sent.
- Caseloads of probation officers and caseworkers often are too high.
- Youth have insufficient access to prevention services.
- Evaluation of prevention services often is insufficient.

A report by Michigan’s Children notes that while youth violence is declining, the state lacks an overall, coordinated prevention strategy. Most state funding directed at youth violence is aimed at punishing delinquents. Youth-violence prevention monies are dispersed through several state agencies and are significantly smaller than the

amount going to delinquency services. To address the state’s problems of youth delinquency and violence, advocacy groups propose

- establishing a statewide, coordinated effort at violence prevention;
- providing local communities with flexible funding to meet local needs;
- providing more opportunities for adult supervision through before- and after-school programs and other youth programs;
- permitting judges to review cases when a juvenile turns 21, to determine whether s/he requires further intervention; and
- encouraging conflict-resolution strategies, such as peer-mediation programs in local schools.

Teenage Pregnancy

The birth rate among Michigan teenagers has been falling. In 1990, births to women aged 19 and younger comprised 13 percent of all births in the state; by 2000 the percentage had been reduced to 10 percent. Children born of teenaged parents are at risk because they are much more likely than children of others to have low birth weight (a health risk), grow up in poverty, have inadequate health care, develop behavioral problems, and experience physical and developmental problems. A large body of research finds a correlation between poverty and teenage pregnancy.

Public policy options are somewhat divided on how best to prevent or alleviate the ill effects of teenage pregnancy and parenthood.

- Some advocate for greater use of abstinence-only education in schools; others advocate for more education about contraception and abortion.
- Some believe that sex education needs to be brought up to date and made more relevant to today’s youth; others believe that sex education should not be a part of any school curriculum, but left to parents.

Furthermore, funding for services that include contraception and other reproductive health care services are tenuous at best. For example, House Bill 4655 proposes to give priority for state funding to family-planning providers who provide few or no abortion services. This bill stands to cut \$1.8 million dollars in state funding to Planned Parenthood of Michigan, a major provider of family-planning services in the state.

Tobacco Use

According to the 2001 Michigan Youth Risk Behavior Survey, the biennial poll of high school students,

- 30 percent have used a tobacco product at some time,
- 64 percent have smoked at some time, and
- 26 percent had smoked in the month preceding the survey.

These numbers are lower than those found in previous surveys. The Michigan departments of Community Health and Education credit the decline to intensive health education, including the Michigan Model for Comprehensive School Health Education, a state-developed model curriculum that addresses health issues and helps young people to build risk-avoidance skills. More than 90 percent of Michigan school districts use the model.

Since 1998 the state has received approximately \$600 million from the national tobacco settlement. Most of that money has been directed to programs other than tobacco-use prevention and treatment. This is decried by those who believe that the money rightfully should be spent for anti-tobacco purposes and possibly other health-related programs, but it is supported by those who believe that state spending (about \$8 million, according to the MDCH) for this purpose from other sources is adequate. The Michigan Health and Hospital Association is developing a ballot question for November 2002 that if passed would redirect settlement spending from scholarships to health care.

See also Abortion; Children's Early Education and Care; Child Support; Communicable Diseases and Public Health; Crime and Corrections; Domestic Violence; Firearms Regulation; Foster Care and Adoption; Health Care Access, Medicaid, and Medicare; Immigrants: Human Resources Benefits; K-12 Quality and Testing; Substance Abuse; Tobacco Settlement; Welfare Reform: TANF Reauthorization.

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