

# Women's Health Policy in Michigan

Karen Patricia Williams, Ph.D.  
Department of Obstetrics, Gynecology, and  
Reproductive Biology  
Michigan State University

Harold Sauer, M.D.  
Department of Obstetrics, Gynecology, and  
Reproductive Biology  
Michigan State University

Waseya Cornell  
College of Human Medicine  
Michigan State University

Teresa Hill  
Office of the Dean  
College of Human Medicine  
Michigan State University

July 21, 2003



Online at [www.ippsr.msu.edu/AppliedResearch](http://www.ippsr.msu.edu/AppliedResearch)

# About the Research

This research was funded by a grant from Michigan State University's Applied Public Policy Research Program (MAPPR) facilitated by the Institute for Public Policy and Social Research (IPPSR). This program is made possible through funding allocated by the State of Michigan to develop expertise for Michigan's policymaking community. The MAPPR database of reports is available at [www.ippsr.msu.edu/AppliedResearch](http://www.ippsr.msu.edu/AppliedResearch).

For more information on this report, contact Karen Williams at [willi168@msu.edu](mailto:willi168@msu.edu). For more information on this Michigan Applied Public Policy Research Program, contact IPPSR at (517) 355-6672.

# Women's Health Policy in Michigan

Karen Patricia Williams, Ph.D.  
Department of Obstetrics, Gynecology, and  
Reproductive Biology  
Michigan State University

Harold Sauer, M.D.  
Department of Obstetrics, Gynecology, and  
Reproductive Biology  
Michigan State University

Waseya Cornell  
College of Human Medicine  
Michigan State University

Teresa Hill  
Office of the Dean  
College of Human Medicine  
Michigan State University

© Michigan State University, July 2003

## **Table of Contents**

Executive Summary.....	2
Introduction.....	4
Clinical Perspective.....	5
Profile of Michigan’s Women.....	6
<b>Cardiovascular Disease (CVD)</b> .....	6
Overview.....	6
Clinical Guidelines and Cardiovascular Disease .....	7
Risk Factors, Incidence and Mortality .....	8
Policy, Programs and Funding .....	9
Recommendations .....	10
<b>Breast and Cervical Cancer</b> .....	10
Overview.....	10
Clinical Guidelines for Breast and Cervical Cancer.....	11
Risk Factors, Incidence and Mortality .....	12
Breast Cancer Risk Factors and Screening.....	12
Cervical Cancer Risk Factors and Screening.....	13
Policies, Programs and Funding.....	15
Recommendations .....	18
<b>Violence Against Women</b> .....	18
Overview.....	18
Clinical Guidelines Regarding Violence Against Women.....	19
Crime Reporting.....	20
Programs and Funding.....	23
Legislation and Policy.....	34
Recommendations .....	36
<b>Overall Recommendations</b> .....	36
References.....	39
Notes.....	45

## **EXECUTIVE SUMMARY**

Fueled by the recognition that the health status of women is reflected in health policy and is an important social issue, Michigan State University's Institute for Public Policy and Social Research funded faculty in the Department of Obstetrics, Gynecology and Reproductive Biology to examine women's health policy in the state of Michigan. Limitations of time and resources forced the team to look at three specific health issues that universally impact women's health -- cardiovascular disease, breast and cervical cancers, and violence against women -- over the period of 1997 through 2000.

Cardiovascular disease (CVD), diseases of the heart, was selected because in Michigan and nationally, it is the number one killer of women ages 35 years and older. The stereotype regarding CVD is that it is a men's disease, even though the number of CVD deaths for females exceeds males (American Heart Association 2003a). This thinking has often led to a disparate standard of care for women and minorities (Schulman et al. 1999). As a state, Michigan has not created a legislative policy to address this public health issue, which affects women and their families. Some women, including African Americans, the elderly, those living in rural communities, and those with limited financial and medical resources are disproportionately affected. Although not all CVD is fatal, various forms of pulmonary circulation can be devastating, impacting the necessities of daily living and limiting access to various routine and emergency health services for women who typically live longer than men and have fewer economic resources.

Breast and cervical cancers are thought to be women specific, although a small percent of men are diagnosed with breast cancer. Fortunately, for these cancers, there are screening procedures, such as mammograms and Papanicolaou (Pap) smears that are aids in early detection. With the support of federal funding, considerable efforts have been undertaken to develop outreach programs for Michigan women. While no screening procedure is completely accurate, these are the best methods offered to women at this time. In recent years, women have received mixed messages pertaining to the age to get a baseline mammogram and their reliability and purpose. Public health messages need to be consistent if the cancer burden of women and their families is to be lowered. These messages are especially confusing to women who have limited resources and other social barriers that prohibit them from being full partners in their health care. In the meantime, women should be cautioned not to rely solely on any one procedure but continue to be vigilant.

The final issue examined here is violence against women, an issue that has garnered the attention of the public and only recently has been considered a health issue rather than a mere social ill. Michigan does not have the infrastructure to administer violence against women programs. Law enforcement agencies collect data regarding the types of crime perpetrated against women; however, the data are not uniform across the state. When examining catalysts for violence against women, other health issues surfaced such as alcohol and drug abuse and mental health issues.

Statistical sources for this paper were gleaned from the Michigan Department of Community Health (Largo et al. 1999), Michigan State Police Reports (Michigan State Police 2000) and Centers for Disease Control (Anderson 2002). Where appropriate, interviews were conducted with key informants. The clinical guidelines came from the American College of Obstetrics and Gynecology Compendium (American College of Obstetricians and Gynecologists 2001). Whenever possible, the standard set by Making

the Grade on Women's Health, a national state report card developed by the National Women's Law Center, was used to make comparisons to other states (National Women's Law Center 2000).

## INTRODUCTION

During the decade of the 1990s the U.S. Congress passed various pieces of legislation, which specifically addressed women's health issues including the Women's Health Equity Action of 1996, which addressed questions of service delivery, health care access and research. The interest in women's health also manifested itself as an Office on Women's Health, located within the U.S. Public Health Services in the Department of Health and Human Services, and the Office of Research on Women's Health, at the National Institutes of Health. Taking its lead from the federal government and the ever-growing consumer interest in women's health, the Michigan Department of Community Health launched a women's health initiative that became known as the *Year of Women's Health (1997-1998)*. The *Year of Women's Health* steering committee coordinated statewide and local activities with community-based organizations, and public and private sectors with a vested interest in women's health. Although Michigan was the first state to develop the idea of dedicating a year to focus on women's health, other states embraced the idea through the National Governors Association's Governor's Spouses Program.

From this successful initiative, a retrospective examination of women's health policy was launched in Michigan from 1997 to 2000. A select research team in the Department of Obstetrics, Gynecology and Reproductive Biology, in the College of Human Medicine at Michigan State University (MSU) examined the policies that govern three specific areas in women's health in the state of Michigan: cardiovascular disease, breast and cervical cancer, and violence against women. These areas were selected because they were among the ten issues focused on during the Year of Women's Health Initiative. In addition, these three areas of concentration were among the Healthy People 2000 goals and objectives for the nation set by the U.S. Department of Health and Human Services.

The findings of the MSU investigation showed that Michigan is moving in the right direction but it is moving very slowly. The state has failed to take advantage of the momentum built after the conclusion of the *Year of Women's Health* initiative. While it was a leader forging this new initiative, it appeared to miss the mark by not harnessing women's health programs within a single office like many other progressive states. In addition, available state resources that are critical to the life of women in Michigan have not been earmarked, instead creating dependency on federal resources. If the state matched the federal resources for cardiovascular disease, women's cancers, and violence against women, the state could better its ranking of *unsatisfactory* by the National Women's Law Center's national state-by-state report card, *Making the Grade on Women's Health*. Michigan ranked 38 out of 51 in key causes of death for women and the overall health of women. In relation to wellness and prevention measures, such as Pap smears to detect cervical cancer or mammograms to detect breast abnormalities for women in Michigan, the state has either no policy or a weak policy. On the other hand, with regard to the violence women have experienced, Michigan women are 25 percent below the national statistics (National Women's Law Center 2000).

It should be noted the Women's Health Policy project was conducted prior to the adoption of Michigan's FY 2003 which has significantly impacted some of the programs included in this report.

To move the state forward, Michigan should invest in sustained funding, research, and uniform and consistent data collection in the areas of violence toward women, cardiovascular disease and breast and cervical cancers.

## **CLINICAL PERSPECTIVE**

The paradigm for medicine in the past has been to take care of illness as it happens. Unfortunately, this fails to catch illness in its earliest, and most easily treated forms. Public health involvement in the form of screening, both of populations in general and of those at high risk, has long been shown to be a successful and cost-effective intervention. However, without central coordination and funding, ideally at the state level, these efforts do not become initiated or may break down.

Spearheaded by the *Year of Women's Health*, sponsored by the Michigan Department of Community Health in 1997 to 1998, women's health issues in Michigan were noted on the state's political radar screen. Studies of conditions are now available for state-by-state comparison. Individual data as well as numeric state rankings show us that progress in women's health care has been made, but that we still have a long way to travel before approaching an ideal situation. Michigan, in particular, ranks below the mean for all U.S. states in almost every women's health category compared (National Women's Law Center 2000).

Cardiovascular disease, which affects more women in Michigan than the other areas studied combined, is detected by screening for blood pressure and lipids including cholesterol. The message of necessity for screening is reaching its intended public in a spotty and sporadic fashion.

In the area of breast disease and its early detection, Michigan has fared well above the national mean in promoting the use of mammography (National Women's Law Center 2000). Despite recent opinion and data disputing the use of mammography as a screen, it remains a standard for the early detection of breast malignancies. Recommendations for regular screening promulgated by the American Cancer Society, among others, remain in effect. The use of mammography and the incidence of breast cancer are discussed in the data presented here. Despite the encouraging statistics about mammography use in Michigan, breast cancer remains a major health concern, and statistics demonstrate racial and economic disparities.

Cervical cancer, though much less prevalent than 30 or 50 years ago due to Pap smears, remains a problem for women who are not screened. Accessibility to screening varies among population groups, both on an ethnic as well as on an economic basis. The concern here, in addition to access, is one of education, as many women feel that Pap smears are no longer needed or needed less frequently after a certain age. Thus, preventable cancer cases and deaths persist.

One key issue in the area of domestic violence is the availability of uniform, consistently reported data. It is impossible to pinpoint the gender and ethnic backgrounds of victims on any consistent basis, and the reported data have varied from year to year in terms of what is reported and what different categories of reporting mean. Without adequate demographic data, prevention efforts are doomed to ineffectiveness.

Ethnic and racial disparities are of major concern. African-American women are generally at greater risk of suffering and dying from the conditions studied, yet screening and preventive efforts have failed to reach them equitably. Hispanic women and those in



other underserved groups have been inadequately targeted, and studies have failed to take their presence into account as demographic groups of importance.

It is time to reassess how Michigan can build a system that reaches out to women and improves the quality and duration of their lives. This analysis addresses these issues and serves as an initial template for the future of women's health in Michigan.

## **PROFILE OF MICHIGAN'S WOMEN**

According to the 2000 U.S. Census, the State of Michigan has 5.1 million women out of its total population of nearly 10 million. Among Michigan women, 80 percent are white, 15 percent are Black, three percent are Hispanic, and two percent are Asian and Pacific Islander. Some 38 percent of the women are in the 18-44 years age group; 25 percent are under 18 years of age. Slightly under ten percent of Michigan women are without health insurance and 13 percent live in medically underserved areas. The median age of female residents in Michigan is 35, and the median earnings for women are \$24,000. More than 80 percent of women in Michigan reside in urban areas (Bureau of the Census 2000). The percentage of preventable hospitalizations for female is significantly higher for women than men (56 percent compared to 44 percent) (Michigan Department of Community Health 2002). Preventable hospitalizations are for conditions where timely and effective ambulatory care can decrease hospitalizations by preventing the onset of an illness or condition, controlling an acute episode of an illness or managing a chronic disease or condition.

## **CARDIOVASCULAR DISEASE (CVD)**

### **OVERVIEW**

Cardiovascular disease (CVD) refers to a group of diseases related to the heart and arteries. Within the domain of CVD are two primary diseases: coronary heart disease and stroke. CVD is the number one cause of death for women in Michigan across all racial and ethnic groups (American Heart Association 2003a). Although heart disease and stroke are the leading causes of death for women, they are still seen as 'men's diseases.' American Heart Association studies have noted the lack of knowledge among women concerning heart disease and stroke. According to the American Heart Association's *Know Heart and Stroke Survey* in 2000, only eight percent of women perceive heart disease as their greatest health threat and a majority of women are unable to identify the warning signals associated with stroke (American Heart Association 2000).

Not only do women themselves underestimate their own risk and relation to heart attack and stroke, but medical professionals are guilty of this as well. The adverse consequences of this view are increased when one adds to the situation that the symptoms and presentations for these diseases differ for men and women. For instance, when a patient presents with any of the common heart attack symptoms such as chest pain, pain in the arm, shortness of breath, and chest tightness, further diagnostic tests such as chest radiography, electrocardiogram, stress testing, or echocardiography are indicated. Because of the common bias on the part of the patient and the medical profession to link men to heart disease, these symptoms will most often indicate the need for these important tests in male patients, but not necessarily female patients. Compounding this already negative

situation is the fact that the less common heart attack symptoms, nausea and fatigue, are more common in women than in men, and are often attributed, when presented by a female patient, to other causes such as menopause. The effect of both of these situations is that women are often not seen by medical professionals to be in need of further diagnostic tests for heart attack. Women, due to their own lack of knowledge concerning the threat of CVD, are apt not to attribute these symptoms to a heart attack either. On an individual basis this can have dire consequences—a woman who goes to her doctor or the emergency room with some of the symptoms, common or uncommon, of a heart attack will often not get the standard workup for possible heart disease. Because many women do not believe they will get heart disease and because many physicians are not looking for the disease, it is not being prevented or treated early. According to a recent study, women, on average, receive only 64 percent of the medical care recommended for hypertension (Asch 2001). According to the Centers for Disease Control and Prevention (CDC), the heart disease death rate is declining more slowly for women than for men. This can be attributed at least in part to the barriers described above (Anderson 2002).

## **CLINICAL GUIDELINES AND CARDIOVASCULAR DISEASE**

Cardiovascular disease is the number one cause of death among American women. The American College of Obstetricians and Gynecologists (ACOG) recommends that women work with their ob-gyn to control the factors that affect a woman's risk for heart disease (American College of Obstetricians and Gynecologists 2001).

A primary part of ACOG's guidelines and policies concerning cardiovascular disease stresses patient education and empowerment of women to take charge of their health. According to ACOG guidelines for preventive healthcare for women:

- women from ages 12-39 years should receive periodic blood pressure screenings after the age of 21 and be counseled to limit fat and cholesterol in their diets and recognize the importance of physical activity;
- women from ages 40-64 years should receive periodic blood pressure screenings, receive a cholesterol screening every 5 years beginning at age 45, receive nutritional counseling, be advised to practice regular physical activity and informed about the importance of exercise after the age of 40, and be counseled to take a daily aspirin if there is a history of heart disease;
- women over the age of 65 years should receive periodic blood pressure screenings, receive a cholesterol screening every five years until the age of 75 years and then every three to five years, be counseled to limit fat and cholesterol, be advised to practice regular physical activity, and be counseled to take a daily aspirin if there is a history of heart disease. At all ages women should be encouraged to avoid tobacco use or to stop smoking (American College of Obstetricians and Gynecologists 2001).

Men have high blood pressure more often than women in the early and middle adult years, but this is not the case with women after menopause. If high blood pressure is found in a yearly screening, ACOG recommends the woman see a doctor who knows her medical and family history so that she can determine the best course of treatment. ACOG does emphasize the need to make lifestyle changes and thus the importance of women

being educated and more involved in their own health care by partnering with their doctor (American College of Obstetricians and Gynecologists 2001).

**RISK FACTORS, INCIDENCE, AND MORTALITY**

Prevention is key in reducing CVD mortality. A major risk factor for heart disease is age. As age increases so does one’s risk for heart disease. One in three women over the age of 65 years has some form of heart disease (American Osteopathic Association 2001). Race is also an important risk factor. There are ‘controllable’ or modifiable risk factors for CVD. Controllable or modifiable factors for heart disease include smoking, elevated cholesterol level, diabetes, physical inactivity, obesity, and high blood pressure. The uncontrollable risk factors for stroke include age, heredity, and race (Grundy et al. 1999). African-Americans are more likely to have a stroke at some point in their lives than Caucasians. Young African-Americans have a four times greater risk of stroke than their white cohorts (American Heart Association 2003b).

Making the Grade on Women’s Health, a study by the National Women’s Law Center, was a first-ever report card that assessed the overall health of women at the national and state levels. The study looked at various health status indicators and ranked the 50 states and the District of Columbia. According to this study Michigan ranked 48 out of 51 on percent of women who are overweight (36 percent) and percent of women who smoke (25 percent). Michigan was ranked number ten for women who engage in no leisure time activity (23 percent) (National Women's Law Center 2000). Michiganians have higher than average CVD risk factors according to the Michigan Department of Community Health's Michigan Stroke Initiative CVD Health Fact Sheet, but only 65 percent of Michigan adults can identify one or more risk factors for stroke (Michigan Stroke Initiative 2003).

Table 1 and Table 2 show the stroke deaths and death rates and heart disease death rates for the State of Michigan for the years 1997 to 2000.<sup>1</sup> According to Table 1, the death rate for Michigan women from strokes has varied only slightly from 1997 to 2000—from 59.3 to 57.8 (Michigan Department of Community Health 2000). These rates are lower than the comparable national rate for women of 60.8 (American Heart Association 2003a). Even though the state has a lower death rate than the national average, it only ranked 32<sup>nd</sup> best out of 51 for stroke deaths in the Making the Grade study (National Women's Law Center 2000), there is a significant difference between the rates in Michigan by race. In Michigan in 2000, for example, the black female death rate from strokes was 69; the white female death rate was 56.

**Table 1. Michigan and National Stroke Death Rates**

<b>Stroke</b>	<b>Year</b>	<b>Female Death Rate*</b>	<b>White Female Death Rate</b>	<b>Black Female Death Rate</b>	<b>Total</b>
Michigan	1997	59.3	57.3	71.9	3,478
	1998	59.2	57.7	67.3	3,542
	1999	61.0	59.2	74.4	3,721
	2000	57.8	56.1	68.5	3,535
National	2000	60.8	57.8	78.1	

Source: Michigan Department of Community Health 2000

\* Death rates are per 100,000 population

Similar findings emerge in analysis of Michigan and national heart disease death rates. As Table 2 illustrates, Michigan rates per 100,000 population are lower than national rates over 1997-2000 period (Anderson 2002). However, the Making the Grade on Women's Health study Michigan ranks 38<sup>th</sup> best out of 51 for heart disease death rate (National Women's Law Center 2000). When we compare the heart disease death rates to the national heart disease death rates for females for the year 2000 (Table 2) by race, we see that Michigan white females have death rates lower than the comparable national death rate per 100,000 population, but the black female population in the state has a much higher death rate than the comparable national rate (Anderson 2002).

**Table 2. Michigan and National Heart Disease Death Rates**

<b>Heart Disease</b>	<b>Year</b>	<b>Female Death Rate*</b>	<b>White Female Death Rate</b>	<b>Black Female Death Rate</b>
Michigan	1997	240.6	231.4	309.7
	1998	241.0	232.3	301.0
	1999	233.0	223.4	304.7
	2000	236.5	226.8	310.8
National	2000	260.2	278.3	220.1

Source: National Vital Statistics Report, Vol. 50, No. 16, September 16, 2002

**POLICY, PROGRAMS AND FUNDING**

At the time this report was written, Michigan had no policy that specifically addressed the issue of CVD. However there were programs in place to help.

The state of Michigan's 1997 to 2000 programs focused on helping people adopt healthy lifestyles and behaviors. Central to this was the statewide Cardiovascular Disease Prevention—Worksite and Community Health Promotion (WCHP) program (this is not exclusive to women). This program provided a variety of activities in both worksite and community settings, which were designed to reduce the behavioral risk factors that lead to CVD. WCHP program services were provided by local public health jurisdictions and over 200 private vendors throughout the state. Services included: cardiovascular disease risk screenings and educational programs targeted at the major behavioral risk factors for CVD, namely high blood pressure and high cholesterol, smoking, overweight and obesity, nutrition, and physical activity. Other services include community awareness activities, media campaigns, and community health events.

Most of the state of Michigan's funding for cardiovascular disease was filtered through the WCHP program to local health departments and private vendors. The local health departments and private vendors were responsible for outreach programs to their local communities. In 2000 approximately \$4 million was appropriated to this program. This is the same amount that was earmarked for the program in the FY 1996-1997 budget.

Michigan's cardiovascular programs, the major component of which was WCHP, were funded from three sources: Healthy Michigan Funds, Healthy Michigan Initiative, and federal preventative block grant allocations. However in 2001, this program was eliminated by the Executive Order of the governor.

## **RECOMMENDATIONS**

In 1998 Congress provided the Centers for Disease Control and Prevention funds to begin national, state-based CVD prevention programs. These programs work to ensure that every state health department has the capacity, commitment and resources to carry out a cardiovascular health promotion and disease prevention and control program. This program is in 28 states, but Michigan is not a funded state. When the program began, the CDC provided guidelines for which states could apply but the state of Michigan did not qualify under the original guidelines. The CDC reopened the program for applications several years ago. Although the State of Michigan qualified to apply, it did not receive funding.

Restoring and increasing funding to the state's CVD programs is important to the public health of Michigan's residents. As women become aware of the risk factors for CVD and its deadly impact, both black and white women will be able to make changes that affect them and their families. Funding needs to be focused on researching why a disparity exists between men and women and towards specifically addressing lowering the incidence and death rates for minority women. The disparity reveals much about how the health needs of black females in the state of Michigan are not being met and how this action has dire consequences for these women.

## **BREAST AND CERVICAL CANCER**

### **OVERVIEW**

Cancer, very basically, is a group of diseases characterized by uncontrolled growth and spread of abnormal cells. Although we know that cancer rates increase with exposure to carcinogens and are linked to certain lifestyle practices and hereditary factors we still do not know how carcinogens cause cancer and why there is so much individual differences in response to the disease and its treatments. Breast cancer and cervical cancer are cancers that are essentially female cancers (American Cancer Society 2000).

Breast cancer is the cancer with the most cases, but only second in leading cancer deaths for women in the United States (American Cancer Society, 2000). One in eight women will develop breast cancer during her lifetime (National Cancer Institute 2002). When we examine statistics more closely one notices that there are racial/ethnic differences both in incidence and mortality rates. African-American females tend to have a lower incidence rate than Caucasian women, but a higher death rate. This fact has been argued to be a result of African-American women not receiving regular screenings and that their cancer is at a later stage when they are screened (Ghafoor et al. 2002). Finding breast cancer as early as possible greatly improves the likelihood that treatment will be successful (American Cancer Society 2003a).

Cervical cancer is a cancer with one of the most significant decreases in cancer deaths in the past 30 years. It is the 10<sup>th</sup> leading cancer for number of cases for females in the United States, but it does not rank in the top ten for cancer deaths. Cervical cancer is unique in that we have been able to closely connect sexual behavior and sexually transmitted diseases to the development of cervical cancer. Although the Pap smear test is the only test or procedure that can detect cervical cancer, this test is a regular part of gynecological exams and this regularity accounts for the large decrease in death rates for

cervical cancer (American Cancer Society 2002b). The incidence rate for African-American women is just under twice that of white women (SEER 2003a) and African-American women are over 50 percent more likely to die of cervical cancer (SEER 2003b). Like breast cancer, this is often argued to be because African American women do not get the screening that white women get and thus receive a diagnosis of cervical cancer at a later stage.

Since Pap smears can be performed at a woman's family physician or OB's office, it is no surprise that the statistics for cervical cancer screening are much higher than the statistics for breast cancer screening. Even given this fact we are still seeing a small difference between richer and poorer women and Pap smear rates, which do not seem to be mirrored in the different ethnic groups (National Center for Chronic Disease and Health Promotion 1997, 1998, 1999, 2000).

Most cervical cancers develop over a relatively long period of time through a series of gradual, well-defined pre-cancerous lesions (American Cancer Society 2003b). During this process, abnormal tissue can be detected easily by a Pap smear and then removed by a clinician. Cervical cancer is different from breast cancer in that experts believe that virtually all cervical cancer deaths could be prevented by a combination of safe sex practices, routine Pap smears, and appropriate follow-up of abnormal screening results (American Cancer Society 2003c).

### **CLINICAL GUIDELINES FOR BREAST AND CERVICAL CANCER**

According to The American College of Obstetricians and Gynecologists (ACOG), for many women it is their obstetrician-gynecologist who is the only provider who imparts their regular health care. Because this is the case ACOG recognizes that obstetrician-gynecologists should be able to provide cancer evaluation and counseling. The Committee on Gynecologic Practice of ACOG recommends that every woman undergo examination of the pelvis and breast annually, beginning at age 18 years or earlier if she is sexually active. This committee, considering the recommendations of major nationally recognized experts, suggests these cancer-screening guidelines (American College of Obstetricians and Gynecologists 2001).

**Table 3. ACOG Screening Guidelines**

<b>Cancer</b>	<b>Guidelines</b>
Breast	Mammography should be performed every 1-2 years for women 40-49 years of age and then annually thereafter.
Cervical	All women who are or have been sexually active or who have reached 18 years of age should undergo an annual Pap test and pelvic examination. After a woman has had three or more consecutive, satisfactory, annual cytologic examinations with normal findings, the Pap test may be performed less frequently on a low-risk woman at the discretion of her physician.

Source: American College of Obstetricians and Gynecologists 2001

New cervical cytology technologies have been introduced in recent years; one of the most important is a fluid-based cytology ThinPrep. In August 1998 ACOG's

Committee Opinion acknowledged that the quality of the ThinPrep smear was better than the conventional smear in that it contained less mucus and debris and had fewer cell clumps that could compromise diagnosis, but it should not be considered a standard of care.

Central to ACOG's position on cervical and breast cancer is education and patient involvement. But ACOG also recommends more research in understanding some of the medical questions concerning these diseases. For instance, there are many questions that have not been answered concerning the link between HPV, or human papillomavirus, and cervical cancer. These questions therefore make it difficult to determine what exactly the public health response to HPV should be. ACOG acknowledges that many questions need to be answered by research into the connection between cervical cancer and HPV to determine public health responses to HPV. For this reason ACOG recommends more funding for research, and increased funding for programs to increase patient and provider awareness and to assess and improve the effectiveness of behavioral interventions. Research, as ACOG makes clear, is necessary to the treatment of either of these diseases in that health officials and policymakers must understand the disease in order to treat it effectively and to work to eliminate it (American College of Obstetricians and Gynecologists 2001).

### **RISK FACTORS, INCIDENCE AND MORTALITY**

The cancer statistics for breast and cervical cancer in Michigan largely parallel national statistics. According to the Making the Grade study, the State of Michigan is in the top ten for both Pap smears screening and mammograms. Michigan ranks number four out of fifty-one for Pap smear screening and ranks ten out of fifty-one for mammograms (National Women's Law Center 2000). For both cervical and breast cancer, screening is the only way to detect their presence.

### **BREAST CANCER RISK FACTORS AND SCREENING**

As women grow older, their risk for breast cancer increases. Other risk factors include obesity or having a family history of breast cancer. The risk of breast cancer is higher in women with a first degree relative (daughter, mother or sister) who developed the disease when young (pre-menopausal). For those women who start menstruating early or who have a late natural or surgical menopause, the risk of breast cancer is increased (American Cancer Society 2002a). As mentioned above screening is the only way to detect the presence of these cancers.

As Table 4 illustrates, some 64 percent of Michigan women have had at least one mammogram. Past age 65 years, over 92 percent of Michigan women have had at least one mammogram. Table 5 shows that there are few racial differences in percentage of Michigan women who have had at least one mammogram. Few differences emerge from the analysis by income in Table 6 (National Center for Chronic Disease and Health Promotion 2000).

**Table 4. Percent of Women in Michigan Who Have Ever Had a Mammogram by Age**

<b>Breast Cancer Screening MICHIGAN</b>	<b>Women all ages</b>	<b>Women age 40-49</b>	<b>Women age 50-59</b>	<b>Women age 60-64</b>	<b>Women age 65+</b>
1997	62.3	86.6	91.1	91.4	89.0
1998	61.8	84.7	92.4	94.2	90.3
1999	63.6	80.0	94.9	97.8	92.2
2000	64.2	86.9	94.4	95.7	92.1

Source: National Center for Chronic Disease and Health Promotion 1997, 1998, 1999, and 2000

**Table 5. Percent of Women in Michigan That Ever Had a Mammogram by Race**

<b>Breast Cancer Screening MICHIGAN</b>	<b>White Females</b>	<b>Black Females</b>	<b>Hispanic Females</b>
1997	63.2	59.8	65.5
1998	62.7	57.4	70.6
1999	64.0	62.6	62.9
2000	65.5	64.8	53.6

Source: National Center for Chronic Disease and Health Promotion 1997, 1998, 1999, and 2000

**Table 6. Percent of Women in Michigan Who Ever Had a Mammogram by Income**

<b>Breast Cancer Screening MICHIGAN</b>	<b>Income of less than \$15,000</b>	<b>Income of \$15,000-\$24,999</b>	<b>Income of \$25,000-\$34,999</b>	<b>Income of \$35,000-\$49,999</b>	<b>Income of over \$50,000</b>
1997	61.5	59.6	60.3	51.0	69.3
1998	63.7	57.0	54.9	64.7	63.1
1999	65.6	60.0	61.3	61.7	60.9
2000	62.6	62.3	67.0	58.5	64.3

Source: National Center for Chronic Disease and Health Promotion 1997, 1998, 1999, and 2000

### **CERVICAL CANCER RISK FACTORS AND SCREENING**

Cervical cancer is unlike breast cancer in that individual behavior plays a significant role in the incidence of cervical cancer. A women's risk of becoming infected with HPV (human papillomavirus), the main risk factor for cervical cancer, is increased when women have intercourse at an early age, have numerous sexual partners, and have unprotected sexual contact at an early age. It could be argued that preventative programs are a necessary part of lowering the incidence and death rates. For cervical cancer this would mean providing sexual education to young girls before they are sexually active (American Cancer Society 2002).



If all women had pelvic exams and Pap tests regularly, most precancerous conditions would be detected and treated before cancer develops. That way, most invasive cancers could be prevented. Any invasive cancer that does occur would likely be found at an early, curable stage. For this reason regular screening is essential to lowering incidence and mortality rates for cervical cancer.

Tables 7-10 provide information on use of Pap smears by Michigan women. Nearly 95 percent of Michigan women of all ages have had at least one Pap smear (Table 7); over three-fourths have had a Pap smear in the past year (Table 8). Very little difference emerges by race (Table 9) or income (Table 10).

**Table 7. Percent of Women in Michigan Who Have Ever Had Pap Smear**

<b>Cervical Cancer Screenings</b>	<b>% of Michigan Women that have ever had a Pap smear</b>
1997	94.7
1998	95.5
1999	94.7
2000	94.5

Source: National Center for Chronic Disease and Health Promotion 1997, 1998, 1999, and 2000

**Table 8. Percent of Women in Michigan Who Have Had Pap Smears and Time Intervals**

<b>Cervical Cancer Screening Michigan</b>	<b>Past Year</b>	<b>Past 2 Years</b>	<b>Past 3 Years</b>	<b>Past 5 Years</b>	<b>5+ Years</b>
1997	70.2	13.8	4.1	3.2	8.7
1998	69.6	15.2	5.3	3.1	6.8
1999	70.9	13.7	3.3	2.8	9.2
2000	75.5	11.3	3.4	3.2	6.7

Source: National Center for Chronic Disease and Health Promotion 1997, 1998, 1999, and 2000

**Table 9. Percent of Women in Michigan Who Have Ever Had a Pap Smear by Race**

<b>Cervical Cancer Screening Michigan</b>	<b>White Females</b>	<b>Black Females</b>	<b>Hispanic Females</b>
1997	95.2	94.0	91.1
1998	95.8	96.0	97.3
1999	95.2	94.2	93.8
2000	94.7	94.0	98.7

Source: National Center for Chronic Disease and Health Promotion 1997, 1998, 1999, and 2000

**Table 10. Percent of Women in Michigan Who Have Ever Had a Pap Smear by Income**

<b>Cervical Cancer Screening Michigan</b>	<b>Income of less than \$15,00</b>	<b>Income of \$15,000-\$25,999</b>	<b>Income of \$30,000-\$34,999</b>	<b>Income of \$35,000-\$49,999</b>	<b>Income of over \$50,000</b>
1997	89.4	94.3	95.3	96.1	97.4
1998	91.0	93.8	95.4	97.5	98.4
1999	94.6	93.4	98.4	92.9	97.4
2000	90.6	92.8	97.4	96.6	95.6

Source: National Center for Chronic Disease and Health Promotion 1997, 1998, 1999, and 2000

### **POLICIES, PROGRAMS AND FUNDING**

Central to the state of Michigan's breast and cervical cancer programs and funding is a multi-year grant from the CDC. The Department of Community Health has been able to fund a statewide cancer control program with CDC funds. Since 1991 Michigan has implemented its comprehensive Breast and Cervical Cancer Control Program (BCCCP) that is coordinated by local public health agencies. This control program is mostly aimed at providing cancer screenings for low-income women in the state, but the program is also concerned with cancer education for all women (Michigan Department of Community Health 2003).

Women eligible for the BCCCP include those with no health insurance; women insured, but unable to meet their deductible or whose insurance does not cover clinical breast exam, pelvic exam, Pap test, or mammogram; women at or below 250 percent of the federal poverty guidelines; and women ages 40 to 64 years. Those who meet these eligibility requirements receive a Pap test, pelvic exam, clinical breast exam and annual mammogram. The services are available through over 500 BCCCP contracted providers throughout the state (Michigan Department of Community Health 2003).

The BCCCP relies heavily on partnerships with community organizations, businesses, and agencies across Michigan to help educate the women of Michigan concerning the importance of breast and cervical cancer screening. The BCCCP partnerships with organizations that serve minorities and other hard to reach populations are particularly fundamental since these groups are frequently underserved (Michigan Department of Community Health 2003).

One of the central organizations that the BCCCP works with is the American Cancer Society, Great Lakes Division. American Cancer Society staff and volunteers help raise breast and cervical cancer awareness among the public and also help recruit eligible women into the BCCCP. Other partnerships include churches, retailers, restaurants, beauty parlors, grocery stores, and government agencies to name just a few. Activities are often highlighted during the month of October, which is National Breast Cancer Awareness Month (Michigan Department of Community Health 2003).

BCCCP services are coordinated through many local health departments across Michigan as well as the Karmanos Cancer Institute in Detroit. These services rely on the cooperation and participation of physicians, hospitals, and other health care organizations in their communities to assure that all necessary follow-up services are provided. Local agencies are required to provide or arrange for basic screening services, such as clinical

breast exams, screening mammograms, pelvic exams, Pap smears, and patient education. According to the BCCCP some local agencies are delivering these basic services through their existing or expanded department staff. Others are providing the basic services through subcontracts with community providers. Local agencies usually contract with radiology facilities to provide mammography services to enrolled women, as well as with clinical laboratories to analyze Pap smears. The federal grant also requires an extensive patient data and tracking system be used to ensure appropriate follow-up of abnormalities and encouragement of routine re-screening. Coordination of this tracking system is the responsibility of the local agency. The program depends on having arrangements with community medical providers who agree to provide diagnostic and treatment services to all women in the program who need it, regardless of insurance status or ability to pay. If there are no arrangements then the screenings cannot be provided (Michigan Department of Community Health 2003).

Other programs and funding in the state of Michigan for breast and cervical cancer supplement the BCCCP. Healthy Michigan Funds have contributed \$5.2 million to various cancer initiatives, including diagnostic tests for low income women, mammograms for women aged 40-49 years, and medical campaigns directed at men and women concerning prostate and breast cancer. This money comes from the cigarette tax increase in 1994. In the 1998 budget the Michigan Legislature added \$750,000 from tobacco tax revenues to the cancer control program to support education and early detection. In 1999 the Secretary of State's office teamed up with the Karmanos Cancer Institute in Detroit to distribute cancer screening information in the 27 Secretary of State branch offices in Wayne County. This was an essential move on the part of the State of Michigan because although the BCCCP can be linked to a drop in deaths due to breast cancer among white women, we are not seeing this same drop in the African-American community. Statistics also show that African-American women have a higher death rate for cervical cancer. This program points out many positive steps that Michigan could make: the Department of Community Health working with other state departments to reach citizens, going outside of the medical environment to the community, and targeting minorities specifically. Table 11 shows Michigan BCCCP programs in place from 1997 to 2000.

The women least likely to take advantage of screening procedures, such as mammography and Pap smears, are racial and ethnic minorities, those who did not graduate from high school, and those living at or below the poverty level (Michigan Secretary of State 1999). In 1999 the state appropriated \$100,000 to the Asian Women's Program which targeted the medically underserved Asian-American Women ages 40-64 years residing in Oakland, Wayne and Washtenaw counties. This money was to be used to recruit underserved Asian-American women into the Michigan BCCCP. No funds were allocated to this program in 2001. This was also an important program for the state to fund, but emphasizes clearly what Michigan's main failure is concerning breast and cervical cancer—there is no stable funding allocated to this problem.

**Table 11. Michigan's Breast and Cervical Cancer Programs**

Year	Programs	Continuing or New Program	Money Source	Money Targeted
1997	Since 1991, the Michigan Department of Community Health has implemented a comprehensive breast and cervical cancer program (BCCCP), through a multi-year grant from the U.S. Centers for Disease Control and Prevention.	Continuing	U.S. Centers for Disease Control and Prevention	\$5.2 million for a 5 year time period
	Michigan Cancer Consortium Initiative is a public-private partnership formed to achieve top priority cancer control objectives for Michigan	Continuing	Public/Private Organizations	Not available
1998	Cancer Control Program: Money targeted to support additional education and early detection of breast, cervical, and prostate cancer.  May Mother's Day Mammogram Campaign. Free Pamphlets provided at Rite-Aids throughout Michigan. Toll Free Number for BCCCP listed.	New	Tobacco Tax Revenues  MDCH and Rite Aid	\$750,000
1999	Secretary of State Offices in Wayne County distributes cancer-screening information to uninsured and underinsured women.	New	Secretary of State and Karmanos Cancer Institute in Detroit and MDCH	CDC money and funding for Wayne State overseen by Karmanos Cancer Institute
2000	Asian Women's Program: Recruit medically underserved Asian American women into Michigan BCCCP.	New	Healthy Michigan Funds	\$100,00

## **RECOMMENDATIONS**

Mammography statistics for the state of Michigan reveal that a large segment of Michigan women are not receiving mammograms. Although we do not see large differences in the percentage of women in different racial and income groups who receive mammograms, more can be done to bring these statistics up across the board and to reduce deaths from breast and cervical cancer. The recommendations can be summarized as follows:

- 1) removal of barriers for the screening and follow-up service;
- 2) advancement of research, especially with the goal of understanding who is (and is not) receiving age-appropriate breast cancer screening and why;
- 3) improved education and awareness from the public and providers. The State of Michigan has Breast Awareness Month every October, but this program should not be a one-month program. All year women need to be informed of the importance of receiving breast cancer screening; and
- 4) more effective collaborations with community-based organizations, health care plans, providers, businesses and the media.

## **VIOLENCE AGAINST WOMEN**

### **OVERVIEW**

Violence against women incorporates intimate partner violence, sexual violence by any perpetrator, and violence committed by acquaintances and strangers. Violence against women is a substantial public health problem; however, the nature of violence against women does not lend itself to the collection of statistics. Most violence against women is unreported and undisclosed for a wide range of social and economical reasons. Data collection is further complicated by inconsistencies in the terms and definitions used to gather information about relevant acts (Saltzman 1999).

On the federal level, the CDC has begun to develop monitoring systems that provide numbers for how often family and intimate violence occurs, who faces the greatest risks, and whether the problem is improving or worsening over time at both the national and local levels. In 1996, the Family and Intimate Violence Prevention Team within the CDC convened a working group of experts to develop a set of data elements and a glossary of terms and uniform definitions needed for the surveillance of intimate partner violence. There are currently three CDC funded states that are pilot testing and evaluating the data elements and definitions: Massachusetts, Rhode Island, and Michigan. The Michigan Department of Public Health (MDPH), Domestic Violence Prevention Unit was awarded a cooperative agreement to establish the Michigan Prevention of Violence Against Women Program (National Center for Injury Prevention and Control 2003).

The program goals are to: (1) establish an ongoing surveillance system of Violence Against Women (VAW); (2) evaluate the usefulness of the surveillance system for assessing VAW; (3) establish a broadly representative advisory structure to address issues related to VAW; (4) assess and define the MDPH's capacity and role in addressing VAW; (5) develop, implement, and evaluate four multifaceted community level programs to prevent VAW; and (6) prepare and broadly disseminate replication guidelines describing

all aspects of the VAW program in Michigan (National Center for Injury Prevention and Control 2003).

The Family and Intimate Violence Prevention Team, in conjunction with the National Institute of Justice, supported the *National Violence Against Women Survey*. This was a national phone survey of 8,000 men and 8,000 women conducted between November 1995 and May 1996. The survey compares women and men's experiences on violent victimization, as well as providing empirical data on the prevalence and incidence of rape, physical assault, and stalking (Tjaden 1998). Also, the Bureau of Justice Statistics conducts the *National Crime Victimization Survey* from an ongoing nationally representative sample of households in the United States. The last update was completed in 1998.

Within the state of Michigan, there is no organization or department charged with the collection of data related to the incidence or prevalence of violence against women. Police data indicate some of the females who have died as a result of homicide at the hands of an intimate partner. However, these relationships are not always able to be determined by the police or are left unreported. Data on nonfatal cases of assault are even less accessible. In 1996, the Michigan Department of Community Health conducted an extensive survey regarding violence in the lives of Michigan women. Between April 1996 and July 1996, 1,848 telephone interviews of women between the ages of 18 and 69 years were conducted regarding male to female violence among randomly selected households. The *Survey of Violence in the lives of Michigan Women* (Largo et al, 1996) found that one out of five, or 21 percent, of Michigan women with current partners reported sustaining some type of violence in that relationship. This was the only time such data collection has been undertaken in Michigan. These numbers are very similar to national survey results. Findings from the *National Violence Against Women Survey* show that physical assault is widespread among American women. Some 0.3 percent of surveyed women reported being raped in the 12 months preceding the survey. Based on U.S census estimates of the number of women aged 18 years and older in the country, an estimated 302,091 out of 100,697,000 were forcibly raped by an intimate partner in the 12 months preceding the survey (Tjaden 1998). This means approximately one in five American women were physically assaulted.

There is an urgent need for data regarding violence against women to be collected and coordinated between agencies and departments to provide a better understanding of who is at risk and how these women can be helped. In this review of violence against Michigan women, data were collected from as many sources as could be identified as related to violence. It must be noted that the completeness of data provided varies among the contacted agencies.

## **CLINICAL GUIDELINES REGARDING DOMESTIC VIOLENCE**

In December of 1999, the American College of Obstetricians and Gynecologists (ACOG) developed an educational bulletin regarding domestic violence. This was intended as an educational tool presenting current and relevant information, and was not to be construed as establishing a standard of treatment or detailing an exclusive course of treatment. The ACOG recognizes that domestic or intimate partner violence is a widespread problem that disproportionately affects women. Further, it crosses all racial,

ethnic, religious, educational, and socioeconomic lines. It is a progressive phenomenon that has both physical and psychological components that often occur in a predictable cycle that includes tension building, battering, and a honeymoon phase where the batterer may make excuses apologize and promise never to do it again. The College also recognizes that the true extent of the violence is difficult to ascertain. Similar to what was found in Michigan, studies have resulted in inconsistent findings as a result of variations in definitions, sample populations, and the methods of survey and data collection. However, it is known that domestic violence is a major cause of injury among women. These injuries are most often severe, repetitive, and most commonly found in the head, face, breast, and abdominal areas (American College of Obstetricians and Gynecologists 2001). Abused women may also have chronic headaches, chronic pelvic pain, sleep and appetite disturbances, sexual dysfunction, abdominal complaints, palpitations, and chronic vaginitis as a result of the stress of an ongoing abusive relationship. The mental health symptoms associated with domestic violence include depression, feelings of inadequacy, self-blame, substance abuse, mood and anxiety disorders, and suicide attempts (American College of Obstetricians and Gynecologists 2001).

**CRIME REPORTING**

Statistics were obtained and computed from the Michigan State Police Reports from 1997 to 2000 and relevant databases from the Michigan State Police Information Center. The crimes of murder, rape, aggravated assault, and domestic violence were examined.

Murder is defined as the willful killing of one human being by another. Offenses are the unlawful acts reported to a law enforcement agency. Victims are the injured party of the offense (Michigan Uniform Crime Report 2000).

**Table 12. Murder and Offenses Against Women in Michigan**

<b>MURDER</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>
Number of Offenses	721	716	675	669
Number of Victims	721	716	675	669
Number of Women Victims	176	183	160	170
Number of Women Victims Over 18 Years	150	148	144	147

Source: Michigan Uniform Crime Report 1997, 1998, 1999, and 2000

As indicated in Table 12, the number of women victims for the years 1997 to 2000 remained more or less constant over the 1997 to 2000 time period. Table 13 was constructed to demonstrate the characteristics of the women who have been murdered in Michigan. These women were predominantly black and between the ages of 26 and 35 years of age. The vast majority of offenders were males who were known by the victim. Between 1997 and 2000, an increasing number of murders in Michigan were committed by intimate partners of the victim (Michigan Uniform Crime Report 1997, 1998, 1999, 2000).

**Table 13. Characteristics of Women Murder Victims**

	1997	1998	1999	2000
Number of Female Victims (18 years and older)	150	148	144	147
Number of White Victims*	60	58	65	69
Number of Black Victims*	84	85	72	74
Number of Asian/ Pacific Islander* Victims	0	2	1	1
Number of American Indian/ Alaskan Native Victims*	0	1	1	0
Number of Victims of Unknown Race*	6	2	5	3
Victims 18-25 Years	32	36	27	30
Victims 26-35 Years	46	38	43	41
Victims 36-45 Years	30	34	29	42
Victims 46-55 Years	11	13	17	15
Victims 56-65 Years	12	7	8	6
Victims 66 and older	11	15	13	8
Victims of unknown age	8	5	7	5
Number of known Offenders	150	148	144	147
Number of Male Offenders	137	138	137	141
Number of Female Offenders	13	10	7	6

\*White, Black, Asian/Pacific Islander, American Indian/ Alaskan Native, and Unknown Race are the only categories for victim race used by the Michigan Incident Crime Reporting System. There is another category used to specify victim ethnicity, which includes Hispanic, Not Hispanic, and Unknown. Virtually all of the entries for victim ethnicity were “unknown,” and therefore this category was not deemed useful and was not included along with the above racial data.

Source: Michigan Uniform Crime Report 1997, 1998, 1999, and 2000

Table 14 shows that over the 1997 to 2000 period, around 70 percent of the murders with known causes are by intimate and acquaintance relationships (Michigan Uniform Crime Report 1997, 1998, 1999, 2000).

**Table 14. Victim Relationship to Offender: Percent of Known Cause Murders in Michigan 1997-2000\***

Victim Status	1997	1998	1999	2000
% of known cause murders accounted for by intimate relationships	30.4	26.9	43.4	43.8
% of known cause murders accounted for by acquaintance relationships	40.2	47.4	26.5	25.8
% of known cause murders accounted for by intimate and acquaintance relationships	70.7	74.3	69.9	69.7

\*The category of “intimate” encompasses the State Police designations of wife, common law wife, ex-wife, girlfriend and one instance of a female homosexual relationship. The category of “other known to victim” includes the State police designations of friend, neighbor, other family, in-law, sister, or daughter. Other categories, including unknown, mother, stranger, and acquaintance, are the same as those designated by the State Police.

Source: Michigan Uniform Crime Report 1997, 1998, 1999, and 2000



## **RAPE**

Rape is the carnal knowledge of a person, forcibly and against that person's will, or where the victim is incapable of giving consent because of his/her temporary or permanent mental or physical incapacity. Rape classification includes assault to rape and attempted rape, and only those offenses where the victim and offender are of the opposite sex. Other types of penetration not included. Offenses are the unlawful acts reported to a law enforcement agency. Victims are the injured party of the offense (Michigan Uniform Crime Report 2000).

**Table 15. Reported Rape**

<b>RAPE</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>
Number of Offenses	4,493	5,279	4,695	4,971
Number of Known Victims	Not listed	3,372	3,106	3,629
Number of Women Victims	Not listed	3,206	2,977	3,530
Number of Victims of Unknown Sex	Not listed	14	11	0

Source: Michigan Uniform Crime Report 1997-2000

## **AGGRAVATED ASSAULT**

Aggravated Assault is the unlawful attack by one person upon another for the purpose of inflicting severe or aggravated bodily injury. This type of assault is usually accompanied by the use of a weapon or by means likely to produce death or great bodily harm. Offenses are unlawful acts reported to the law enforcement agency. Victims are the injured party of the offense. As indicated in Table 16, women victims make up around 40 percent of total aggravated assault victims in Michigan from 1997 to 2000 (Michigan Uniform Crime Report 1997, 1998, 1999, 2000).

**Table 16. Aggravated Assault**

<b>AGGRAVATED ASSAULT</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>
Number of Offenses	33,688	40,073	35,386	35,001
Number of Victims	Not listed	18,807	14,718	18,092
Number of Women Victims	Not listed	7,986	5,725	7,165
Number of Victims of Unknown Sex	Not listed	213	208	92

Source: Michigan Uniform Crime Report 1997, 1998, 1999, and 2000

## **DOMESTIC VIOLENCE**

Domestic violence is physical abuse committed by a spouse, a former spouse, boyfriend or girlfriend, person living in the same household, or a cohabitant upon another person. Offenses are the unlawful acts reported to a law enforcement agency. Offenders are the individuals perpetrating the crime. Victims are the injured party of the offense. Table 17, indicates the number of victims of domestic violence for the years 1997-2000. Women are the most likely to suffer domestic violence, making up over three-fourths of the victims of domestic violence (Michigan Uniform Crime Report 1997, 1998, 1999, 2000).

**Table 17. Domestic Violence**

<b>DOMESTIC VIOLENCE</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>
Number of Offenses	Not listed	Not listed	Not listed	45,676
Number of Victims	44,138	47,499	41,822	46,711
Number of Women Victims	34,839	37,592	33,291	35,846
Number of Victims of Unknown Sex	45	174	149	996
Number of Offenders	Not listed	Not listed	Not listed	44,903
Number of Male Offenders	Not listed	Not listed	Not listed	35,618

Source: Michigan Uniform Crime Report 1997, 1998, 1999, and 2000

Further relationships between women victims and other variables for rape, aggravated assault, and domestic violence are impossible to analyze because of the way the information from each agency is reported and summarized. All law enforcement agencies within the State of Michigan are required to report to the Michigan Uniform Crime (URC) Reporting Program or the Michigan Incident Crime Reporting (MICR) System. URC is a summary submission of crime information, which makes the tracing of particular demographic information impossible. MIRC is an incident-based reporting system in which data are collected on each single crime occurrence and demographics of a particular sub-group are obtainable. Although the state encourages all agencies to report to MICR, the number of agencies reporting on this system is neither substantial nor complete. The state has not mandated MIRC reporting or discontinued use of the URC system since they fear the larger state agencies would fail to continue reporting, and there are no state ramifications for agencies that do not report. Additional data are available for homicide through the Supplemental Homicide Report that is filed in conjunction with the URC report for homicides and provides circumstance and demographic data. The Michigan State Police Reports were generated by computer in 1997, and were changed to a more detailed format in 1998. Reporting of the data has not changed between 1998 and 2000; however, the format of the book has changed on the basis of decisions made by the Michigan Criminal Justice Information Center regarding publication.

## **PROGRAMS AND FUNDING**

Programs and funding for domestic prevention in Michigan are primarily housed in two agencies: the Family Independence Agency (FIA) and the Department of Community Health, Division of Chronic Disease and Injury Control and Violence Prevention. FIA programs include

- Domestic violence prevention treatment
- STOP violence against women
- Transitional Supportive Housing Projects
- Comprehensive Domestic Violence Grant Services
- Rape Prevention and Services Program
- Michigan Coalition against Domestic and Sexual Violence

Programs implemented by Department of Community Health (DCH) include:

- Community Violence Prevention Partnership Grants
- Anti-Violence Community Coalition Support Grants
- Specialized Grants

In addition, the DCH Violence Prevention section supports a network of community violence prevention coalitions, partnership grants and program interventions.

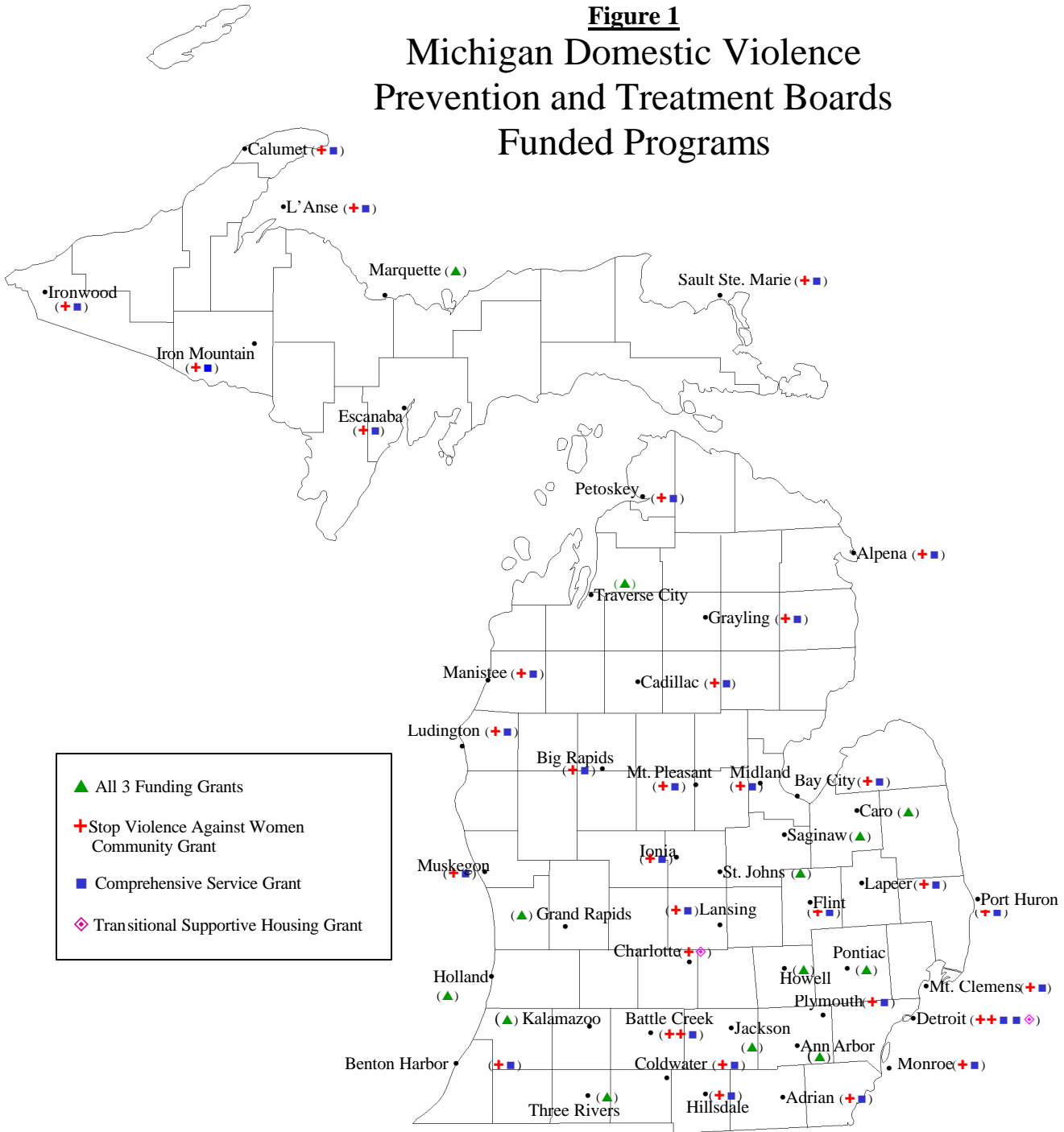
## **MICHIGAN DOMESTIC VIOLENCE PREVENTION AND TREATMENT BOARD**

The Michigan Domestic Violence Prevention and Treatment Board (MDVPTB) is a division of the FIA with the mission of eliminating domestic violence in Michigan. The board administers state and federal funding for domestic violence shelters and advocacy services, develops and recommends policy, and develops and provides technical assistance and training. The seven member board is comprised of a cross-section of the professionals concerned with the crime of domestic violence. Members are appointed by the governor with the advice and consent of the senate. FIA staff assists the board in carrying out their charge. The MDVPTB is mandated to provide funding to community-based agencies for domestic violence prevention and treatment, develop standards for operation of victim service programs, provide technical assistance to service providers, conduct research to identify means of domestic violence prevention and treatment, assist the state police in setting up a reporting system for law enforcement agencies, and carry out educational efforts targeted to both the public and relevant professionals.

MDVPTB grants and general activities are supported through a variety of federal and state funding sources. State (GF-GP) funds support comprehensive domestic violence contracts and a variety of board activities. The Federal Family Violence Prevention and Services Act Grant provide additional funding for the comprehensive domestic violence contracts. Services designed to address the special needs of survivors in rural areas, such as access, lack of service availability, and transportation, are supported by the Rural Domestic Violence and Child Victimization Enforcement grant. The Temporary Assistance to Needy Families Block Grant is used to provide transitional supportive housing, comprehensive services, and rape prevention. Centers for Disease Control supports the Rape Prevention and Services comprehensive service grants through the Violence Against Women Act.

The Michigan Domestic Violence Prevention and Treatment Board provides funding through grants to 46 nonprofit community based agencies that assist victims of domestic violence and their dependent children. Figure 1 provides information on the locations of the funded grant projects. Table 18 provides information submitted to MDVPTB from its funded organizations for 1997-2000.

**Figure 1**  
**Michigan Domestic Violence**  
**Prevention and Treatment Boards**  
**Funded Programs**



From the Michigan Domestic Violence Prevention and Treatment Board's Grantee Lists  
 Note: Particular year(s) of grant funding between 1997 and 2000 not provided by MDVPTB.

**Table 18. Domestic Violence Prevention and Treatment Board Yearly Activity Report**

	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2000*</b>
Nights of Shelter for Women	87, 990	90, 522	96, 349	69, 887
Shelter Arrangements Made for Women	1, 040	1, 641	2, 093	1, 521
Shelter Denied due to Capacity	3, 240	2, 621	3,188	2, 710
Shelter Denied Other	1, 917	2, 616	2,062	1, 502.1
Unduplicated Women Residents	9, 337	6, 017	6, 013	4, 594
Unduplicated Women Non-Residents	16, 302	16, 285	16, 497	11, 643
Information and Referral Calls	59, 632	55, 593	66, 791	58, 370
Crisis Calls	61, 693	59, 416	52, 224	39, 000
Individual Counseling Units	N/A	424,952	436,385.5	344, 246
Group Counseling Units	92, 759	118,114	125,976	75, 549

\* 2000 only included the months of January through September of the year 2000, as this was all that was released by the MDVPTB.

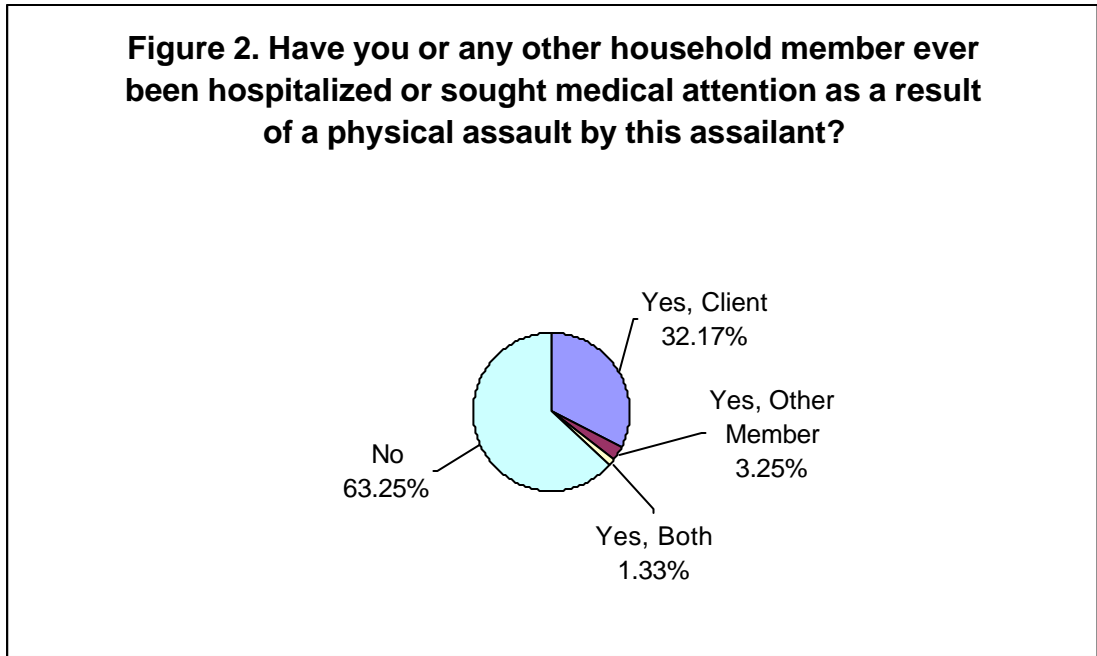
Source: Family Independence Agency 1997, 1998, 1999, and 2000a

Table 18 illustrates the scope of the services of shelters for domestic violence victims. In 1999, for example, some 6,013 women sought shelter according to the MDVPTB reports (Family Independence Agency 1999).<sup>2</sup>

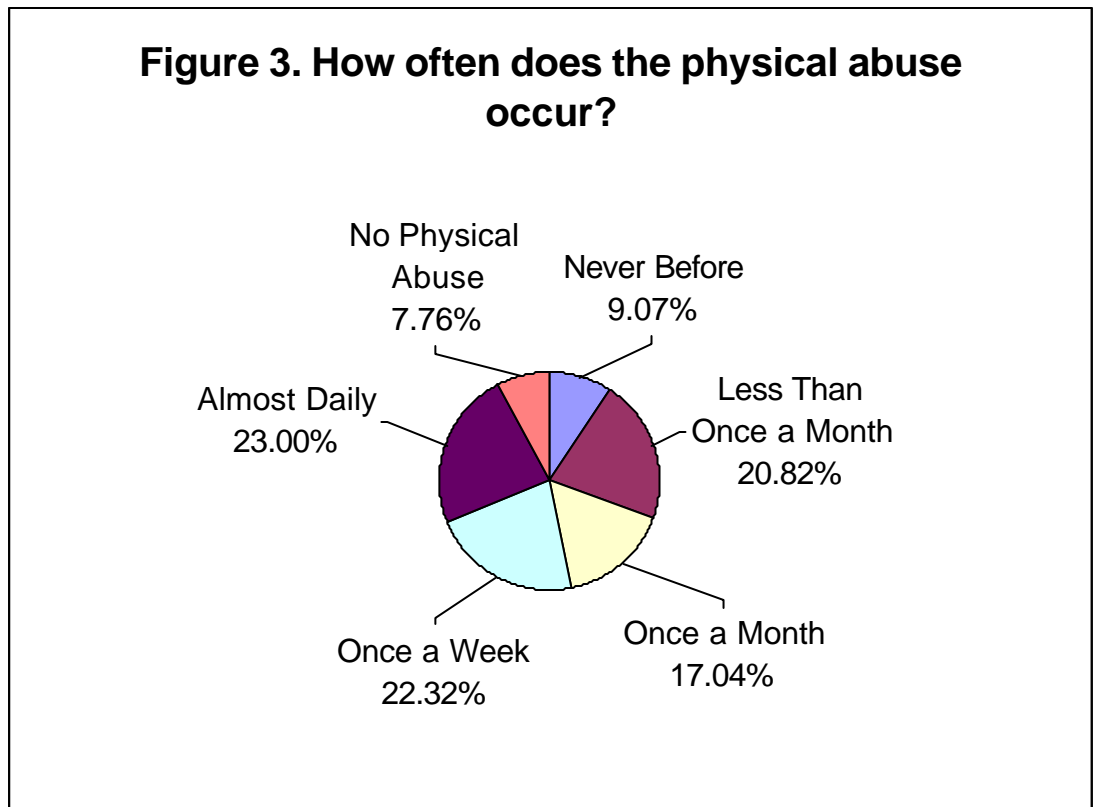
Further information about the actual clients served was only made available for the year 2000 by the MDVPTB. The average client age was 32 years. Over 99 percent of the clients served were women. The majority of clients were self-identified as White (58 percent), followed by Black (34 percent), and then Hispanic, mixed decent, Native American, and Asian. The majority of clients came to the shelters with children (57 percent). The assailant of the client was most often a spouse (34 percent), followed by partner (22 percent), and then dating relationship (15 percent). In 40 percent of cases, the assailant had threatened to kill the client, and in 15 percent of cases the assailant had threatened to kill both the client and significant others. Assailants were found to check up on the client and control the clients through such means as listening to phone calls, calling repeatedly, and checking the mileage on the car (Family Independence Agency 2000b).

According to the Michigan Family Independence Agency's *Domestic Violence Prevention and Treatment Client Information Report* for fiscal year 2000, nearly two-thirds of the victims had been hospitalized or sought medical attention as a result of the physical

assault (Figure 2). Almost one-fourth of the victims reported abuse almost daily (Figure 3) (Family Independence Agency 2000b).



Source: Family Independent Agency 2000b



Source: Family Independent Agency 2000b

## **MDVPTB PROGRAMS**

Among MDVPTB funded programs are the STOP Violence Against Women Community Grant, Transitional Supportive Housing Projects, and Comprehensive Domestic Violence Grant Services. Each is briefly described in this section.

STOP Violence Against Women Community Grant: This program is designed to strengthen local criminal justice system responses by using the experience of all types of persons within the system to develop a comprehensive set of strategies to deal with the problems of violent crimes against women. Some 45 local and four statewide contracts are awarded. Services providers must submit a plan that addresses the problems of domestic violence, sexual assault, and/or stalking in all the counties of their geographic service area. The plan must also show collaboration between prosecution, law enforcement, and victim services. For each community, the prosecutor and at least one law enforcement agency needs to have participated in the planning and/or implementation process. The federal STOP Violence Against Women program requires communities to show how it will allocate at least 25 percent of the grant to law enforcement, 25 percent to prosecution, and 25 percent to victim services programs. The remaining 25 percent may be spent in any way that the group deems appropriate within the federal grant guidelines. Only five percent of the STOP grant money may be allocated to administrative costs. Grants that are made to nonprofit, non-governmental victim service agencies do not require a local match of funds. Grants made to all other types of agencies require a 25 percent non-federal, local match. The federal funds received in the STOP Grant must be used to supplement, not supplant, existing funds. The MDVPTB has created the Violence Against Women Training Institute to provide training initiatives and to serve as the Board's liaison to the State STOP training partners. The institute also takes on many Family Independence Agency training initiatives as well as the coordination and oversight of a number of task forces and committees (Family Independence Agency 2003a).

Funds for this program are awarded through the Department of Justice, Office of Justice Programs, and the Violence Against Women Office. The Funds were awarded to the Family Independence Agency, and the Family Independence Agency has designated the MDVPTB as the lead agency to receive these funds. The funds are distributed to local projects via a formula that places 70% weight on population and 30% weight on geographic service area size. No agency receives less than \$30,000 (Family Independence Agency 2003a). In 2000 funding for the program was \$4.2 million.

Transitional Supportive Housing Projects: The Board supports 15 transitional Supportive Housing Projects across the state which are awarded through a competitive bid process. Transitional Supportive Housing grantees must, at a minimum, provide the following services: transitional supportive housing, counseling, networking, advocacy, and parenting and children's services. Transitional supportive housing entails safe, decent, single-family housing coupled with case managed support services that assist eligible domestic violence survivors and their dependent children. The program must provide safe, affordable, permanent housing for these persons within 24 months. Employment service assistance is available to eligible survivors to help with meeting the employment related activities required by the Family Independence Agency. Possible services include career development, literacy courses, and GED programs. Individual counseling, group counseling, and networking programs are available to survivors as well.

The advocacy services of the program work with community services and individuals for the survivor's welfare as well as systems change when necessary. They are in place to increase the survivor's access to community resources and supports including legal needs, financial assistance, utility payments, security deposits, and transportation needs. Active assistance with parenting and children's services are also available. The expectation is that grantees of this money will forge a comprehensive, coordinated housing and service delivery system provided with sensitivity to the special needs of survivors of domestic violence (Family Independence Agency 2003b).

Transitional Supportive Housing funds are supported by the federal Temporary Assistance for Needy Families (TANF) grant. Awards range from approximately \$100,000 to \$300,000.

Comprehensive Domestic Violence Grant Services: A total of 45 nonprofit domestic violence programs provide services under these contracts in all of Michigan's 83 counties. These services include: emergency shelter, 24-hour crisis hotlines, crisis counseling, individual counseling, group counseling, and support services. Emergency housing is provided to victims of domestic violence and their dependent children using the grantee's shelter facilities or safe homes that have been recruited and trained by the grantee. Adequate food, clothing and personal hygiene products are supplied as needed while in the emergency housing. When the grantee's shelter facility is full, the shelters are responsible for the arrangement of alternative housing in other community shelters or motels. Grantees provide for a hotline that is answered by trained staff that enables victims and other concerned individuals to receive crisis counseling, information, and referrals. Crisis, support, and group counseling is also available to resident and non-resident survivors (Family Independence Agency 2003c).

Support services include health care advocacy with referrals to hospitals, physicians, dentists, and other care providers. Information and legal assistance is also offered along with referrals to legal and criminal justice agencies for those who are pursuing legal avenues. These clients will also be supported by the grantees through accompaniment to law enforcement agencies, attorneys and prosecutor's offices, and court. Grantees are also responsible for providing the transportation necessary to reach shelter, appointments with prosecutors, lawyers, caseworkers, counselors, and health care providers. Housing assistance and resources along with financial assistance for living expenses are provided. Childcare is provided for on site sessions along with referrals to day care providers and help with children's protective services. Grantees also work toward systems change including, but not limited to the areas of law enforcement, hospitals, mental health, criminal justice, courts, schools, universities, batterer's intervention treatment agencies, community service organizations, substance abuse services, and the faith community (Family Independence Agency 2003c).

Federal Family Violence Grant funding is used for the Comprehensive Services Grants. In 2001, that funding totaled \$2.4 million. The MDVPTB receives approximately 3 percent of the funds available nationwide. The federal intent is primarily to support direct service programs with an emphasis on reaching under-served populations.

### **Rape Prevention and Services Program**

The MDVPTB also funds 26 rape prevention and services programs. across Michigan to provide comprehensive services to sexual assault survivors. Services include



emergency crisis intervention, individual and group counseling, advocacy in working with medical, legal, and criminal justice systems, and public awareness activities. Educational projects provide education and training to domestic and sexual violence workers, FIA staff, law enforcement officers, prosecutors, child welfare workers, attorneys, physicians, medical workers, and others (Family Independence Agency 2003d).

Funding for the Rape Prevention and Services Grants comes from the Centers for Disease Control and the Violence Against Women Act. The grants to programs are for \$35,000 annually. Some 23 of these agencies provide domestic violence services as well.

### **Monitoring**

The MDVPTB is legislatively mandated to monitor programs and services. MDVPTB Peer Monitoring teams monitor 15 programs each year using Quality Assurance Monitoring Standards. The Quality Assurance Monitoring Standards provide an overview of the mandatory and best practices standards as determined by the MDVPTB. Programs must be in compliance with these standards prior to funding.

### **MICHIGAN COALITION AGAINST DOMESTIC AND SEXUAL VIOLENCE**

The Michigan Coalition Against Domestic and Sexual Violence (MCADSV) is dedicated to the empowerment of all the state's survivors of domestic and sexual violence. Its mission is to develop and promote efforts aimed at the elimination of all domestic and sexual violence in Michigan. MCADSV promotes public awareness, and provides leadership advocacy, training and technical assistance on a statewide level on issues regarding domestic violence and sexual assault. The organization participates in collaborative efforts to promote social change with local, state, and national organizations. It provides a forum for the exchange and development of skills and information regarding the community's response to domestic and sexual violence. The goal of MCADSV is to ensure the delivery of quality services to victims of sexual assault and domestic violence.

The MCADSV provides technical training to hundreds of advocates, concerned individuals, and allied professionals, as well as whole organizations on a local, state, and national level. MCADSV also provides management assistance and consultation to all membership programs and director's training and a mentorship program for new Executive directors. MCADSV is involved in many public policy issues on many levels and provides significant advocacy-based public policy leadership through participation in numerous statewide initiatives. These areas include legislative, criminal justice, prosecuting attorneys, welfare reform, law enforcement, gubernatorial, community health and confidentiality workgroups and committees. MCADSV promotes public awareness through a publication detailing recently introduced and passed legislation regarding domestic and sexual violence, *The Public Policy Update*, which is distributed two times each year.

While this is a non-profit organization, MCADVS has taken on a major share of technical training and management assistance for community service delivery organizations throughout the state, as well as a large role in lobbying for victims. It is crucial in the communication between communities, victims, and the legislature. However, funding, while increasing for the years being examined, is unstable which means the services provided for the state by MCADVS are not guaranteed. There is also little accountability that can be exerted in this quasi-governmental structure.

## **STATE OF MICHIGAN DEPARTMENT OF COMMUNITY HEALTH**

### **Division of Chronic Disease and Injury Control, Violence Prevention Section**

The focus of this agency is to reduce violence in Michigan by establishing a network of community-based primary prevention programs, policies, and activities. The Violence Prevention Section supports a network of community violence prevention coalitions, partnership grants, and program interventions. Overall this section provides over \$1 million in grants for local programs.

Community Violence Prevention Partnership Grants: These grants are intended to fund the organization of a community violence prevention partnership and to support the partnership in active prevention programming in the community. These grants are potentially available for five years (new applicants) and for four years (applicants that currently have a coalition grant) depending on the availability of funds. Approximately \$75,000 is available to fund up to three Community Violence Prevention Partnership awards. The grant requires communities to match funds in order to show that they will eventually be able to work on their own (Michigan Department of Community Health 2001).

Anti-Violence Community Coalition Support Grants: These grants provide funding for coalitions not currently funded by the Michigan Department of Community Health. The coalition model engages all sectors of a community in a uniform, community-wide prevention effort to identify key problems and take advantage of opportunities as well as the best use of resources. Those receiving funds from this grant are expected to establish a new or enhance an existing advisory/coordinating group to address violence issues related to the community, to ensure community input in violence prevention and reduction activities, and to generate community support for violence prevention activities. The coalitions selected will also conduct an inventory of existing data sources and prevention programs that address violence in the targeted community. Further, the coalition will be responsible for providing a plan for reviewing existing community violence prevention policies, including but not limited to, those for law enforcement, schools, and government. The plan developed by the coalition should include developing written recommendations based upon the reviews and a process for implementing changes based on the recommendations (Michigan Department of Community Health 2001).

Approximately \$200,000 is available to fund roughly ten two-year anti-violence community coalition projects. Awards approximate \$20,000 for each 12-month budget period. At the end of the two years, all organizations that received awards will be able to compete for an additional three years of funding. Michigan Department of Community Health funds that are awarded to coalitions beyond the initial two-year period will be

subject to match funding requirements (Michigan Department of Community Health 2001).

Specialized Grants: These grants go for projects or on-going activities that contact the Department for specific assistance. Applicants can apply for either a Partnership grant or a Community Coalition Support grant. Organizations that are currently in the first or second year of a Coalition Support Grant can choose to enter the competition for a more comprehensive Partnership Grant. If the coalition competes and does not receive a Partnership Grant, the coalition must continue the activities identified in the initial coalition plan. The proposals that meet the guidelines set forth in the instructions will be rated by a review panel in accordance with established review criteria (Michigan Department of Community Health 2001).

Eligible applicants are local health departments; other local governmental and judicial agencies; non-profit community-based organizations; federally recognized Indian tribal governments, Indian tribes or Indian tribal organizations; sheriff or police departments; local state police posts; intermediate school districts; hospitals; universities; colleges; churches or other religious community organizations, local domestic violence programs; local sexual assault programs; and other non-profit entities with a demonstrated capacity for working with high-risk populations (Michigan Department of Community Health 2001).

The Department of Community Health Violence Prevention Section also supports a network of rape and sexual assault primary prevention programs. It has federal grant monies for rape prevention and domestic shelters provided to health departments and earmarked for violence prevention. A portion of the money is turned over to the Family Independence Agency for service provision. There are 19 total primary rape prevention programs, with one-fourth of the funds going to middle school and high school aged youth as stipulated in the grant.

Further, state surveillance activities have been undertaken thanks to funding from the Centers for Disease Control. Through a competitive process to address family and intimate partner violence, Michigan, Rhode Island, and Massachusetts were awarded cooperative agreements. The surveillance system of intimate partner violence in Michigan has two primary data sources: emergency departments and prosecuting attorneys' offices.

Historically the system includes only non-fatal cases, but program staff is developing a process for including intimate partner violence homicides. Each source/component is being developed to allow the Violence Against Women Prevention Program to characterize and monitor intimate partner violence on a statewide basis. This type of system is needed in Michigan because there is no single source that can provide useful information on this major health issue (Saltzman et al. 1999).

The Department of Community Health Violence Prevention Section also collects data and creates publications to inform and focus interest where there is a continued unmet need. The Sexual Assault Surveillance System project is a major database for information related to violence against women. This project is conducted by the Violence and International Injury Prevention Program at Michigan State University with funding from the Michigan Department of Community Health Violence Prevention Section. The system was developed to estimate the magnitude of sexual assault in the State, determine populations at risk, identify trends, document the distribution and spread of sexual assault, and evaluate control strategies and prevention programs. During the summer of

1997, the Sexual Assault Surveillance System team began identifying and compiling existing data sources for inclusion in the Surveillance System (Sexual Assault Surveillance System 2003).

There are several reports and surveys available from the Michigan Department of Community Health Violence Prevention Section specific to violence against women:

--*An Analysis of Michigan Data Sources Relevant to Intimate Partner Violence* (Largo 1997), analyzes a wide variety of state-level data sources that potentially could be incorporated into an intimate partner violence surveillance system. It includes descriptions of fully operational systems regarding what data related to intimate partner violence is collected, how, who, and if could link the data to other data sources. The systems were also evaluated in terms of their reporting rate, data accuracy, representativeness, and timeliness.

--*Violence in the Lives of Michigan Women: Results of a Statewide Survey* (Largo et al. 1999), presents the initial findings from an extensive telephone survey of Michigan women conducted between April 1996 and July 1996. The women were a representative sample ranging in age from 18-69 years and regarded violence in their lives as perpetrated by men. A total of 1,848 women completed the survey, which was conducted to improve the state's knowledge regarding the prevalence and characteristics of this type of violence. A public use dataset from this survey is available for research.

## **ADULT PROTECTIVE SERVICES**

A discussion of violence against women would not be complete without dealing with violence within the aging population. The National Center on Elder Abuse (NCEA) conducted the *National Elder Abuse Incidence Study* in 1997 based on a sample of 20 out of approximately 3,000 counties in the country. Michigan had both a metro county, Bay County, and a non-metro county, Presque Isle County, selected as part of the sample for this study. The study revealed that elderly persons in domestic settings were being increasingly abused and neglected. The other conclusions concluded that female elders were abused at a higher rate than males in all categories of abuse, even after accounting for their larger proportion of the aging population. Males were found to be the most frequent perpetrators of abandonment, physical abuse, emotional abuse, and financial/material exploitation. Only in cases of neglect were women more frequent perpetrators. White elders were the victims of the most types of maltreatment; however, this figure was consistent with their percent of the total elder population. Black elders were over-represented and Hispanic and other racial/ethnic groups were under-represented among victims of all types of maltreatment. Most importantly, this study documented the existence of a very large unidentified and unreported stratum of elder abuse. Results of the *National Elder Abuse Incidence Study* estimate that for every abused elder reported to and substantiated by Adult Protective Services there are five additional abused elders that have not been reported (National Center on Elder Abuse, 1998).

In Michigan, elder abuse also seems to reflect this increase. According to the Office of Adult Services within Adult Protective Services, there were slightly more than 2,600 open cases in January of 1997, which had increased to 3,264 active cases by October of 1998. The data from Adult Protective Services Demographic Trends shows that the type of harm most commonly seen by Adult Protective Services is neglect, followed by self-

neglect, abuse, and exploitation. The perpetrators of the adult mistreatment in Michigan are most likely to be an unrelated caregiver, followed by an “other” relative, child, and least frequently a spouse. It also notes that health care providers, concerned citizens, and social welfare providers account for two out of three referral sources. Physicians and educators together accounted for less than one in 20 reports. Adult Protective Services Client Characteristics could not be obtained for the state as a whole because of the nature of the independent county reporting and database information (Adult Protective Services 2001).

## **LEGISLATION AND POLICY**

In addition to the legislation passed by the Michigan Legislature, the executive branch has been active in developing policy for the state. Two gubernatorial appointed task forces have addressed the issue of domestic violence. In July of 1997, Governor John Engler established a statewide Task Force on Batterer Intervention Standards. This task force was charged with developing statewide standards for programs that provide services to the court-ordered perpetrators of domestic violence. It was also charged with making recommendations for improving the courts’ response to domestic violence. The finalized recommendations, released in June of 1998, provide guidelines for ethical and accountable intervention systems to better protect victims and other family members. They also provide a framework for the use of batterer intervention as a part of the continuum of a coordinated community response to criminal behavior. The standards establish what shall be used as the minimum level of respectful, humane, consistent, and appropriate intervention for persons convicted of domestic violence. Standards are also used to give batterers increased access to appropriate intervention services to reinforce that their violent behavior is unacceptable, while assisting judges as well as others to identify the batterer intervention services that are reliable, predictable, and responsive sources of intervention. These standards detail exactly what is expected at intake of an individual, throughout ongoing lethality evaluation, acceptable curriculum and intervention methods, contra-indicated modalities, completion for discharge, participants’ rights, and duration, among other details of service. All judges are encouraged to order offenders to complete programs that meet the minimum standards set forth by the task force for the State of Michigan (Governors Task Force on Batterer Intervention Standards 1998).

The idea for a second task force, the Domestic Violence Homicide Prevention Task Force, began in 1999 when media reported 41 homicides in Michigan as a result of domestic violence. Governor Engler then established the Homicide Prevention Task Force in October of 2000. The results were released in April of 2001. The mission of the task force was to stop homicides resulting from domestic violence, and the task force recognized that the only way to end such homicides was to end domestic violence (Michigan Domestic Violence Homicide Prevention Task Force 2003). The conclusions from the task force included:

- the awareness that the entire public needed to be educated and made aware that domestic violence was not a private matter, but rather a crime;
- concern that victims of domestic violence are often unable to gain protection through the courts;

- no accurate or uniform system for reporting and standardizing data collection for domestic violence crimes and homicides currently exists; and,
- a standardized method of domestic violence prevention training is needed to better prepare the judiciary and law enforcement for responding to victims' needs (Michigan Domestic Violence Homicide Prevention Task Force 2001).

Using their findings as a guide, the Michigan Domestic Violence Homicide Prevention Task Force recommended changes in the areas of public awareness and education, victim protections throughout judicial proceedings, creation of uniform standards for reporting and tracking crimes and offenders, and enhanced domestic violence prevention training for judges and law enforcement. Other recommendations were made to deal with challenges to social service and medical providers, as well as community organizations (Michigan Domestic Violence Homicide Prevention Task Force 2001).

The task force recommended that the MDVPTB serve as the coordinating organization and develop a state website featuring resources and others to provide statistics and information on domestic violence. The MDVPTB was encouraged to create and implement domestic violence prevention and awareness curricula for students. MDVPTB was also directed to develop a plan to oversee and monitor batterer intervention programs (Michigan Domestic Violence Homicide Prevention Task Force 2001). The task force also recommended that:

- “current and former dating relationship” be included in the definition of domestic relationships;
- specific guidelines be provided for the expeditious processing of domestic violence cases;
- court records be sealed to protect the security of victims in both criminal and civil cases;
- state and county death review teams for domestic violence homicides be authorized;
- a standardized data collection of domestic violence homicides through a central database will be used to create more uniform standards for reporting and tracking;
- law enforcement agencies complete a standard report form, as created by the Michigan State Police, for all crimes which involve a domestic relationship. Law enforcement will also be called upon to use the Michigan Information Crime Reporting System (MICR), rather than the uniform Crime Reporting (UCR) System;
- sanctions for failing to report be instituted, domestic violence training be enhanced and encouraged for all judges, probation officers, Friend of the Court, and other court personnel;
- to help social service and medical providers, the Michigan State Medical Society in coordination with the MDVPTB work to develop a domestic violence response resource guide for emergency room physicians and nurses for dissemination in communities;
- multidisciplinary workgroups be convened by the MDVPTB to study and make recommendations regarding mandatory reporting of domestic violence as well as addressing health care screening for domestic violence; and

--local domestic violence service providers, coordinating councils, and the Michigan Coalition Against Domestic and Sexual Violence be supported through active volunteers and financial support. Domestic violence experts should be invited to provide education and awareness programs at local religious institutions, civic groups, youth groups, schools, and community organizations (Michigan Domestic Violence Homicide Prevention Task Force 2001).

## **RECOMMENDATIONS**

State of Michigan Family Independence Agency and Department of Community Health have a number of programs to help domestic violence victims as well as to create awareness and gather community support. However, as the task force report clearly pointed out, improvements can be made to deal with these deficiencies:

**Data Collection:** At an aggregate level, there is no collection, coordination, or accessibility to statistical data regarding domestic violence. This makes it impossible to examine the scope, severity, or characteristics surrounding violence against women. It is clear that homicide data related to domestic violence has been targeted for future developments in collection efforts; however, this is incomplete.

**Co-ordination of reports from all agencies:** Efforts should be made to coordinate reporting from all possible agencies and service providers across the state. There are many suggested practices that have failed to be institutionalized at a state level and other practices, especially surrounding reporting, that have been encouraged but have no penalties attached to ensure compliance.

**Focus on implementation:** Improvements also need to be made in order to implement changes rather than indefinitely continue discussions regarding mandated screening and reporting of suspected abuse. Analysis of service providers needs to ensure that services will be available to every woman in need of protection and assistance if she is a victim of domestic violence in Michigan. This will require improved coordination and cooperation among agencies.

## **OVERALL RECOMMENDATIONS**

Across the three areas affecting women included in this analysis—cardiovascular disease, breast and cervical cancer, and violence against women—Michigan is making progress, but more can be done. Future activities across the three areas fall in three broad areas: more resources generally, more recognition of barriers that prevent some women for using resources and programs now available, improved community-based approaches.

**1) Allocation of funds:** More state funds would help deconstruct the barriers to screening and follow-up services and would educate providers and the public about the need for screening. This should be done for all women, but most essentially for those women most likely not to get routine screening: racial and ethnic minorities, those who did not graduate from high school, those living at or below the poverty level, and women in rural and urban areas for whom access to routine health care services is problematic. Although the BCCCP screens and conducts follows-up on about 2,000 women a year, many women eligible for its services do not know of the service and therefore do not get the advantages of these early screenings.

**2) Increased accessibility and responsiveness of the health care system:** Michigan fails to address other barriers besides race, age, and income level that may prevent women from seeking screening services, these include: fear of cancer diagnosis, transportation, and child care issues. These are difficult but extremely important impediments to current and future programs.

**3) Encouraging Community Based Participatory Approach:** Using a community development model to increase sustained funding for policies that influence health care access, women's health care delivery, women health research and ultimately women's health outcomes will not mean an abandonment of the one-on-one service delivery system. It is recognition that the one-on-one service delivery model has limitations. This model often excludes a substantial portion of women that are most in need of care, positions women to have little power or participation in decision-making and is fraught with hurdles of complex payment systems and delivery structures which often limit access to services (Williams et al. 2002). For example, traditional methods of CVD prevention such as screenings and counseling have failed to reach significant numbers of Black women who have a 1.3 higher rate of dying of heart disease than all women in Michigan. Moreover, the one on one service delivery system doesn't consider the decisions that women make to seek or not to seek health care services, and fails to recognize that these are decisions that are made in the context of other priorities, availability of resources and role demand in women's lives (Leslie 1992, Mays et al. 1994, Mays et al. 1996).

As the State and other agencies consider ways to formulate women's health policy it is imperative to keep in mind that women are not monolithic. Women are diverse economically and culturally, which affects their access to health care and their experiences within the health care system, which in turn greatly impacts outcomes. Involving various women's advocacy and interests groups will enhance the balance necessary to serve all women. Including women's health advocacy and interest groups as partners in public policy making is another approach to transforming the context within which health care policy is formulated and implemented (Weisman 1998).

The State of Michigan has the opportunity to continue to assist in creating healthier communities. An increased emphasis on health education and preventive care is necessary. However, we are cautioned that health promotion and disease prevention programs should not be developed under the assumption that individuals have total control over factors that influence their health (Airhihenbuwa and Lowe 1994). Often there is a propensity to believe that given the right information and perhaps the right circumstances, individuals would be willing and able to change their health conditions. Eliminating disparities among women will require more than information. Collaboration between medicine, public health and community is essential to develop the necessary capacity and to make substantial improvements in health outcomes (Williams et al. in press).

Funding female-focused community-based participatory research in selected health areas greatly affecting large numbers of women is yet another strategy that can be employed by the state. This approach recognizes that women have been neglected in all types of research for decades. Funding community-based participatory research, however, is practical. It is research that translates into better policy and service delivery practices.



Creating a partnership between community and universities to address health disparity issues among women is progressive, it builds capacity and it expands public resources. In addition, it would allow women who are at risk for an illness to work with researcher in the context of a “real setting” – the community. This would also foster innovative policy and service delivery. With limited resources and women living longer the State of Michigan will have to include various communities of women as it sets policy and designs programs for its female residents, understanding that some of the state’s most acclaimed models of excellence are those that included partnerships with its residents.

## REFERENCES

Adult Protective Services. 2001. Domestic Violence Prevention and Treatment Client Information Report Summary (FY 2000).

Airhihenbuwa, C.O. Lowe, AG. 1994. Improving the Health Status of African Americans: In the Handbook of Black American Health: The Mosaic of Conditions, Issues, Policies and Prospects. (Ed.) Ivor Lensworth Livingston. Green Wood Press, Westport, CT.

American Cancer Society. 2000. Cancer Facts and Figures: 2000. Atlanta: American Cancer Society. Available at: <http://www.cancer.org/downloads/STT/F&F00.pdf>.

American Cancer Society. 2002a. Breast Cancer Facts and Figures 2001-2002. Available at: <http://www.cancer.org/downloads/STT/BrCaFF2001.pdf>.

American Cancer Society. 2002b. Cancer Facts and Figures: 2002. Atlanta: American Cancer Society. Available at:  
<http://www.cancer.org/downloads/STT/CancerFacts&Figures2002TM.pdf>.

American Cancer Society. 2003a. Breast Cancer Reference Information. Available at: [http://www.cancer.org/docroot/CRI/content/CRI\\_2\\_4\\_3X\\_Can\\_breast\\_cancer\\_be\\_found\\_early\\_5.asp?sitearea=](http://www.cancer.org/docroot/CRI/content/CRI_2_4_3X_Can_breast_cancer_be_found_early_5.asp?sitearea=) .

American Cancer Society. 2003b. What is Cervical Cancer? Available at: [http://www.cancer.org/docroot/CRI/content/CRI\\_2\\_4\\_1X\\_What\\_is\\_cervical\\_cancer\\_8.asp](http://www.cancer.org/docroot/CRI/content/CRI_2_4_1X_What_is_cervical_cancer_8.asp).

American Cancer Society. 2003c. Can Cervical Cancer be Prevented? Available at: [http://www.cancer.org/docroot/CRI/content/CRI\\_2\\_4\\_2X\\_Can\\_cervical\\_cancer\\_be\\_prevented\\_8.asp](http://www.cancer.org/docroot/CRI/content/CRI_2_4_2X_Can_cervical_cancer_be_prevented_8.asp).

American College of Obstetricians and Gynecologists. 1997. Routine Cancer Screening. ACOG opinion, no. 185. Washington, D.C.

American College of Obstetricians and Gynecologists. 2001 Compendium. Pages 231-237. ACOG: Washington, DC.

American Heart Association. 2000. Know Heart and Stroke Survey. Available at: <http://women.americanheart.org/stroke/survey.html>.

American Heart Association. 2003a. Statistical Fact Sheet: Women and Cardiovascular Diseases. Available at: <http://www.americanheart.org/downloadable/heart/1045753419565FS10WM03.pdf>.

American Heart Association. 2003b. Statistical Fact Sheet: African Americans and Cardiovascular Diseases. Available at:  
<http://www.americanheart.org/downloadable/heart/1046238221277FS01AF03.pdf>.

American Osteopathic Association. Fact Sheet -- Menopause. Revised October 2001. Available at: <http://www.aoa-net.org/Consumers/WomensHealth/post1001.pdf>.

Anderson, Robert. National Vital Statistics Reports. Vol. 50, No. 16. Centers for Disease Control. September 2002. Available at:  
[http://www.cdc.gov/nchs/data/nvsr/nvsr50/nvsr50\\_16.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr50/nvsr50_16.pdf).

Asch, Steven M., Eve A. Kerr, Pablo Lapuerta, Anandi Law, and Elizabeth A. McGlynn. A New Approach for Measuring Quality of Care for Women with Hypertension. Archives of Internal Medicine, Vol. 161, No. 10: 1329-1335. May 2001.

Bureau of the Census. 2001. Census 2000 Summary File 1 (Michigan) 100-Percent Data, prepared by the U.S. Census Bureau. Available at:  
[http://factfinder.census.gov/servlet/DTGeoSearchByListServlet?ds\\_name= DEC\\_2000\\_S F1\\_U&\\_lang= en&\\_ts= 73834063490](http://factfinder.census.gov/servlet/DTGeoSearchByListServlet?ds_name= DEC_2000_S F1_U&_lang= en&_ts= 73834063490).

Family Independence Agency: Domestic Violence Prevention and Treatment. 1997. Monthly/Quarterly Activity Report.

\_\_\_\_\_. 1998. Monthly/Quarterly Activity Report.

\_\_\_\_\_. 1999. Monthly/Quarterly Activity Report.

\_\_\_\_\_. 2000a. Monthly/Quarterly Activity Report.

Family Independence Agency: Domestic Violence Prevention and Treatment. 2000b. Client Information Report Summary (FY 2000).

Family Independence Agency. 2003a. Domestic Violence STOP Grants. Last Accessed: June 2003. Available at: [http://www.michigan.gov/fia/0,1607,7-124-5460\\_7261\\_7272-15062--,00.html](http://www.michigan.gov/fia/0,1607,7-124-5460_7261_7272-15062--,00.html).

Family Independence Agency. 2003b. Transitional Supportive Housing Grants. Last Accessed: June 2003. Available at: [http://www.michigan.gov/fia/0,1607,7-124-5460\\_7261\\_7272-15066--,00.html](http://www.michigan.gov/fia/0,1607,7-124-5460_7261_7272-15066--,00.html).

Family Independence Agency. 2003c. Domestic Violence Shelter and Support Services Grants. Last Accessed: June 2003. Available at: [http://www.michigan.gov/fia/0,1607,7-124-5460\\_7261\\_7272-15058--,00.html](http://www.michigan.gov/fia/0,1607,7-124-5460_7261_7272-15058--,00.html).

Family Independence Agency. 2003d. Rape Prevention and Services. Last Accessed: June 2003. Available at: [http://www.michigan.gov/fia/0,1607,7-124-5460\\_7261\\_7272-37866--,00.html](http://www.michigan.gov/fia/0,1607,7-124-5460_7261_7272-37866--,00.html).

Ghafoor, A., A. Jemal, V. Cokkinides, et al. Cancer Statistics for African Americans. *CA A Cancer Journal for Clinicians*. 2002; 52(8):326-341.

Governors Task Force on Batterer Intervention Standards. 1998. Batterer Intervention Standards for the State of Michigan. Lansing, Michigan. Available at: [http://www.biscmi.org/aboutus/docs/michigan\\_standards\\_final.pdf](http://www.biscmi.org/aboutus/docs/michigan_standards_final.pdf).

Grundy, Scott M., Richard Pasternak, Philip Greenland, Sidney Smith, Jr., Valentin Fuster. American Heart Association and American College of Cardiology Scientific Statement: Assessment of Cardiovascular Risk by Use of Multiple-Risk-Factor Assessment Equations. *Journal of American College of Cardiology* 1999; 34: 1348-59.

Largo, Thomas W. 1997. An Analysis of Michigan Data Sources Relevant to Intimate Partner Violence. Michigan Department of Community Health.

Largo, Thomas W., Patricia K. Smith, John C. Thrush, Nancy McCrohan, Ann Rafferty, Jan Christensen. Violence in the Lives of Michigan Women: Results of a Statewide Survey. Michigan Department of Community Health, 1999.

Leslie, J. 1992. Women Lives and Women's Health Using Social Science Research to Promote Better Health for Women. New York Washington DC Population Council International Center for Research on Women.

Mays, V.M., Beckman, L.J., Oranchak, E., Harper, B. 1994. Perceived Support for Help Seeking of Black Heterosexual and Homosexuality Activities of Women Alcoholics. *Psychology of Addict Behavior*: 8(4).

Mays, V.M., C.S. Howard-Caldwell, J.S. Jackson. 1996. Mental Health Symptoms and Services Utilization Patterns of African American Women in the United States in H.W. Neighbors & J.S. Jackson, eds. *Mental Health in Black America*. Newbury Park CA: Sage Publications.

Michigan Department of Community Health. Age-Adjusted Stroke Death Rates by Race and Sex for Michigan Residents, 1980-2001. Last updated: October 2000. Available at: <http://www.mdch.state.mi.us/pha/osr/deaths/Strokeidx.asp>.

Michigan Department of Community Health. 2001. Request for Proposals for (1) Community Violence Prevention Partnership Grants and (2) Community Coalition Support Grants).

Michigan Department of Community Health. Michigan Community Health Information: Preventable Hospitalizations. Last updated: March 2002. Available at: <http://www.mdch.state.mi.us/pha/osr/chi/hosp/frame.html>.

Michigan Department of Community Health. Breast and Cervical Cancer Control Program. Last Accessed: June 2003. Available at: [http://www.michigan.gov/mdch/0,1607,7-132-2940\\_2955-13487--,00.html#what](http://www.michigan.gov/mdch/0,1607,7-132-2940_2955-13487--,00.html#what).

Michigan Domestic Violence Homicide Prevention Task Force. 2001. Final Report and Recommendations of the Michigan Domestic Violence Homicide Prevention Task Force.

Michigan Domestic Violence Homicide Prevention Task Force. 2003. About the Domestic Violence Homicide Prevention Task Force. Last Accessed: June 2003. Available at: [http://www.michigan.gov/emi/0,1303,7-102-112\\_219\\_240-2351--CI,00.html](http://www.michigan.gov/emi/0,1303,7-102-112_219_240-2351--CI,00.html).

Michigan Secretary of State. 1999. SOS to Provide Cancer Screening Information. Available at: [http://www.michigan.gov/minewswire/0,1607,7-136-3452-47650--M\\_1999\\_3,00.html](http://www.michigan.gov/minewswire/0,1607,7-136-3452-47650--M_1999_3,00.html).

Michigan Stroke Initiative. 2003 Fact Sheets on CVD and Stroke. Available at: <http://www.msu.edu/unit/epi/msi/cvd.htm>.

Michigan State Police Criminal Justice Information Center. 1997. 1997 Uniform Crime Report. Lansing, Michigan. Available at: [http://www.michigan.gov/documents/UCR1997\\_17580\\_7.pdf](http://www.michigan.gov/documents/UCR1997_17580_7.pdf)

\_\_\_\_\_. 1998. 1998 Uniform Crime Report. Lansing, Michigan. Available at: [http://www.michigan.gov/documents/UCR1998\\_17579\\_7.pdf](http://www.michigan.gov/documents/UCR1998_17579_7.pdf).

\_\_\_\_\_. 1999. 1999 Uniform Crime Report. Lansing, Michigan. Available at: [http://www.michigan.gov/documents/UCR1999\\_17577\\_7.pdf](http://www.michigan.gov/documents/UCR1999_17577_7.pdf).

\_\_\_\_\_. 2000. 2000 Uniform Crime Report. Lansing, Michigan. Available at: [http://www.michigan.gov/msp/0,1607,7-123-1645\\_3501\\_4621-26742--,00.html](http://www.michigan.gov/msp/0,1607,7-123-1645_3501_4621-26742--,00.html).

National Center for Chronic Disease Prevention and Health Promotion. 1997. Behavioral Risk Factor Surveillance System Prevalence Data: Michigan -- 1997 Women's Health. Available at: <http://apps.nccd.cdc.gov/brfss/page.asp?cat= WH&yr= 1997&state= MI#WH>.

\_\_\_\_\_. 1998. Behavioral Risk Factor Surveillance System Prevalence Data: Michigan -- 1998 Women's Health. Available at: <http://apps.nccd.cdc.gov/brfss/page.asp?cat= WH&yr= 1997&state= MI#WH>.

\_\_\_\_\_. 1999. Behavioral Risk Factor Surveillance System Prevalence Data: Michigan -- 1999 Women's Health. Available at:  
<http://apps.nccd.cdc.gov/brfss/page.asp?cat= WH&yr= 1997&state= MI#WH>.

\_\_\_\_\_. 2000. Behavioral Risk Factor Surveillance System Prevalence Data: Michigan -- 2000 Women's Health. Available at:  
<http://apps.nccd.cdc.gov/brfss/page.asp?cat= WH&yr= 1997&state= MI#WH>.

National Center for Injury Prevention and Control. State Health Department Project Summaries: Michigan Department of Public Health. Last Reviewed: February 2003. Available at: <http://www.cdc.gov/ncipc/dvp/fivp/page6.htm>.

National Center on Elder Abuse. National Elder Abuse Incidence Study. U.S. Department of Health and Human Services. September 1998.

National Women's Law Center. Making the Grade on Women's Health National State-By-State Report Card. FOCUS on Health & Leadership for Women Center for Clinical Epidemiology and Biostatistics University of Pennsylvania School of Medicine. August 2000. Available at: [http://www.nwlc.org/display.cfm?section= health#\(Women's Health Report Card 2000\)](http://www.nwlc.org/display.cfm?section= health#(Women's Health Report Card 2000)).

National Cancer Institute. 2002. Cancer Facts: Lifetime Probability of Breast Cancer in American Women. Available at: [http://cis.nci.nih.gov/fact/5\\_6.htm](http://cis.nci.nih.gov/fact/5_6.htm).

Saltzman, L.E., J.L. Fanslow, P.M. McMahon, G.A. Shelley. 1999. Intimate Partner Violence Surveillance: Uniform definitions and recommended data elements, Version 1.0. Atlanta (GA): National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Schulman K., Berlin J., Harless W., et al. The effect of race and sex on physicians' recommendations for cardiac catheterization. *New England Journal of Medicine* 1999.

Sexual Assault Surveillance System. What is Surveillance? Last accessed: June 2003). Available at: <http://vip.msu.edu/sass/surveillance.html>.

Surveillance, Epidemiology, and End Results (SEER) Program ([www.seer.cancer.gov](http://www.seer.cancer.gov)) SEER\*Stat Database: Incidence - SEER 9 Regs Public-Use, Nov 2002 Sub (1973-2000), National Cancer Institute, DCCPS, Surveillance Research Program, Cancer Statistics Branch, released April 2003a, based on the November 2002 submission.

Surveillance, Epidemiology, and End Results (SEER) Program ([www.seer.cancer.gov](http://www.seer.cancer.gov)) SEER\*Stat Database: Mortality - All COD, Public-Use With State, Total U.S. (1969-2000), National Cancer Institute, DCCPS, Surveillance Research Program, Cancer Statistics Branch, released April 2003b. Underlying mortality data provided by NCHS ([www.cdc.gov/nchs](http://www.cdc.gov/nchs)).

State of Michigan, Family Independence Agency. Domestic Violence Prevention and Treatment Client Information Report (FY 2000).

Tjaden, Patricia and Nancy Thoennes. 1998. Prevalence, Incidence, and Consequences of Violence Against Women: Findings From the National Violence Against Women Survey. National Institute of Justice and Centers for Disease Control and Prevention. Available at: <http://ncjrs.org/pdffiles/172837.pdf>.

Weisman, Carol S. 1998. Women's Health Care Activist Traditions and Institutional Change. The Johns Hopkins Press. Baltimore MD.

Williams, K.P. 1998. An Analysis of Community Development Approaches to Cardiovascular Disease Prevention Projects for African Americans. Dissertation, Michigan State University.

Williams K.P., Sheppard, V. Hurst, R. Capacity Building: A Strategy to Help Narrow the Health Disparity Gap Among Black Women. Center for Research on African American Women Journal, February 2002.

## NOTES

---

<sup>1</sup> The Michigan Department of Community Health notes for the death rate and number of deaths are classified in accordance with the Tenth revision of the International Classifications of Diseases (ICD-10), a coding structure developed by the World Health Organization. This revision has been used, according to the MDCH, to classify deaths occurring on or after January 1, 1999.

<sup>2</sup> The reports include only services provided for domestic violence clients. Shelter nights for women include the number of nights the agency provided shelter or the money for shelter. A night is counted for any adult woman, being over 18 years of age and not a dependent of anyone else seeking shelter, arriving in the shelter before midnight and leaving after 1:00 AM. Shelter arranged for women is the number of persons for whom shelter was arranged, but not paid for, either by using another community program or by arranging shelter elsewhere. Shelter denial due to capacity is the number of denials for shelter made because there were no empty beds, and shelter denial for other refers to denials that were made for any other reason, but does not count denials that were not domestic violence clients. The unduplicated rows indicate the number of unduplicated women, either resident or non-resident, that were served by the agency. If a client was carried forward to another reporting month or held over from a previous month, they were not recounted for these sections. The information and referral calls are the number of calls received that are not a crisis call but in which support or education related to domestic violence takes place. Individual counseling refers to the number of domestic violence counseling units that take place on a one on one, face-to-face basis. One unit equal fifteen minutes of goal oriented counseling. Group counseling is the number of units of counseling time spent in a group of three to fifteen people. One unit equals fifteen minutes of time regardless of the number of attendees.



Copies of the MSU Applied Public Policy Research Program reports are available in Adobe Portable Document Format (PDF) online at [www.ippsr.msu.edu/Applied Research](http://www.ippsr.msu.edu/Applied%20Research).

**IPPSR**  
*Institute for Public Policy & Social Research*

Institute for Public Policy  
& Social Research  
Michigan State University  
321 Berkey Hall  
East Lansing, MI 48824-1111  
Telephone: 517/355-6672  
Facsimile: 517/432-1544  
Website: [www.ippsr.msu.edu](http://www.ippsr.msu.edu)

IPPSR is the nonpartisan public policy network at Michigan State University. The Institute is dedicated to connecting legislators, scholars, and practitioners through applied research, policy forums, and political leadership instruction.

