Dear Policymaker, Child Advocate, and Friend,

Welcome to the January 2021 edition of All About Kids: Factsheets about Georgia’s Children. Throughout this book, you will find an array of data and research on topics across the spectrum of child policy. Our goal is to provide you with one easy-to-use reference guide that you can refer to as you develop and contribute to the policies affecting children in our state.

While this book is fairly comprehensive, we are constantly learning new information and developing new factsheets to help ground policy discussions in data. That’s why we include a pocket in the back of this book where you can add new documents as we create them.

At Voices for Georgia’s Children and Georgia Statewide Afterschool Network, we recognize children’s needs are interconnected. By focusing on the “whole child,” we identify how different policies affect children on multiple levels. We hope you agree that the best way to figure out how to help our children and youth is to assess relevant data and work with those who have expertise in the various fields affecting our children. Children make up about 30 percent of our population, but 100 percent of our future.

Thank you for all you do for the children and youth of our state (and for the rest of us too!).

Most sincerely,

Erica, Katie, Polly and Melissa

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Acknowledgements

Voices for Georgia’s Children would like to thank the Governor’s Office, the Georgia General Assembly, and state agency leadership, all of whom have committed years of hard work to ensure that Georgia’s children are healthy and safe. Voices would also like to express gratitude to all those who helped in the development of these factsheets by sharing their data, perspectives, expertise, and time.

About Voices for Georgia’s Children

Voices for Georgia’s Children believes every child can thrive when given the opportunity. Through research and analysis, public education, and convening and engaging with decision-makers, we advance laws, policies, and actions that improve the lives of children – particularly those furthest from opportunity. Our work is framed in a holistic “whole child” perspective that allows us to identify how different policies impact children and propose solutions that benefit children on multiple levels.

For more information, visit georgiavoices.org.

About Georgia Statewide Afterschool Network

The Georgia Statewide Afterschool Network (GSAN) is a public-private collaborative that envisions a day when all communities in Georgia have the resources to provide exceptional afterschool programming. Our mission is to advance, connect, and support quality afterschool programs to promote the success of children and youth throughout Georgia.

For more information, visit afterschoolga.org.
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Two-Generation “2Gen” Approach

2Gen: An Overview

The Two-Generation (2Gen) approach to policy and programs disrupts generational cycles of poverty and poor outcomes by taking the whole family into account - focusing on the needs of the entire family, rather than on children or parents separately.\(^1\) Any policy, program, or service for parents or children, including those for early care and education, health, child welfare, and juvenile justice, can use a 2Gen approach.

2Gen policies address multiple areas that allow the whole family to change and thrive.

Economic Impact of 2Gen Approaches

21% of Georgia’s children are in families living in poverty,\(^2\) with Black and Latino children being 3 times as likely to live in poverty compared to their White peers.\(^3\) A $3,000 increase in a parents’ income when their child is young is associated with a 17% increase in their child’s future earnings.\(^4\) Children with college savings between $1 and $499 are 3 times more likely to go to college and 4 times more likely to graduate.\(^3\)

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\(^1\)Household income below 100% of the federal poverty level. See HHS Poverty Guidelines for more info.

www.georgiavoices.org
2Gen Models in Georgia*

Department of Early Care and Learning (DECAL)

DECAL’s Childcare and Parent Services (CAPS) program:  

- Provides access to high-quality and affordable early learning for families with low incomes
- Helps young learners achieve school readiness for greater academic gains in the long-term
- Assists families in achieving stability and self-sufficiency by providing financial support for childcare

DECAL also supports select technical colleges with Two-Generation Innovation Grants, which connect children from low-income families with quality early learning and helps their parents receive the training and education they need for well-paying jobs.

Department of Juvenile Justice

The Department of Juvenile Justice’s (DJJ) multi-organization Parenthood Project strives to enhance relationships between youth committed to secure placement who are parents and their children. Parenthood Project includes:

- Network of Trust School Health Program

The Network of Trust school health program in Albany works with pregnant teens and young mothers to:

- Promote healthy moms and babies
- Increase mother’s self-esteem
- Increase rates of school attendance and graduation

The Network of Trust also works to decrease the rate of child abuse.

*This is not a comprehensive list of 2Gen models in Georgia. Other examples include Home Visiting, Child Care Access Means Parents in School (CCAMPIS), The Boost Program: Making College Possible, and Nana grants.

Sources available here: https://tinyurl.com/TwoGenApproach
A child’s early years are critical for later health and development. Missing key milestones during this crucial period may indicate developmental delays. It is critical to know what to expect during the early stages of a child’s development, since early detection and intervention can help kids stay on track. Between birth and age 5, a child’s brain develops more than at any other time in life.

95% of brain growth happens before kindergarten.

THE FIRST YEAR OF LIFE

**0-3 months**
- Begins to smile
- Holds head up and pushes up when lying down
- Learns to briefly calm self (e.g., bring hand to mouth and suck on hand)

**3-6 months**
- Copies movements and sounds
- Begins to babble
- Rolls from stomach to back

**6-9 months**
- Shows curiosity for items out of reach
- Begins to sit with support
- Plays peek-a-boo
- Knows familiar faces

**9 months to 1 year**
- Attaches to familiar caregivers
- Crawls and pulls to stand
- Uses simple gestures (e.g., shakes head, waves)
- Responds to simple spoken requests

Visit www.georgiavoices.org
Building Blocks of Brain Development

1-2 years²
- Plays simple pretend
- Points to show something is interesting
- Knows several words

2-3 years²
- Speaks sentences with 2-4 words
- Begins to run
- Finds objects that are hidden
- Follows instructions with 2-3 steps

3-4 years²
- Cooperates with other children
- Dresses self
- Sings songs or poems from memory
- Plays roles (e.g., mom and dad)

Sources available here: https://tinyurl.com/BrainBuildingBlocks
The Economics of Early Care in Georgia

Quality early care is critical to Georgia’s economy – it generates jobs and revenue, while equipping kids with the tools they need to be the workforce of tomorrow.

**Early Care in Georgia’s Economy**

$2.5 + $2.2 = $4.7 BILLION BILLION BILLION

The early care industry generates $2.5 billion in annual earnings and $2.2 billion in additional economic activity. This translates into a $4.7 billion annual investment in Georgia’s economy.\(^1\)

Every $1 spent in the early care and education industry...

Generates one additional dollar in short term positive economic activity.\(^3\)

By 2022, the child care industry is expected to be one of the 20 fastest growing industries in Georgia.\(^5\)

**Investing in Early Care Creates Jobs**

Georgia’s early care industry employs approximately 67,500 people who work in a variety of jobs, including:\(^2\)

- Teachers
- Administrators
- Kitchen Staff
- Office Staff
- Drivers

Additionally, every 100 jobs in early care generates an additional 26 jobs in other industries.

**Early Care Supports Georgia’s Parents**

68% of Georgia’s children under the age of six have parents in the labor force.\(^4\)

Parents with children enrolled in Early Care Programs have been shown to:\(^6\)

- Miss fewer days at work
- Earn more income to support the family
- Stay employed at higher rates

$24 billion per year supported by the availability of child care.\(^7\)

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Early Care Brightens Our Children’s Futures

How Early Care Benefits Children

- School Readiness
- Behavioral and Social Development
- Health and Well-being

These benefits lead to:

- Lower retention rates
- Lower likelihood of repeating a grade
- Reduced dependency on public welfare systems
- Lower involvement in the criminal justice system
- Improved long-term health

All of which reduce public spending in the long run.

For every $1 spent on expanding early learning initiatives...

$7 to $12 is returned in benefits to society, about half of which comes from increased earning for children when they grow up.

Early Care Creates the Workforce of Tomorrow

Quality early care has been shown to increase:

- Reading proficiency in third grade
- High school graduation rates
- College attendance

Therefore better preparing Georgia’s youngest learners for the jobs of tomorrow.

Why should Georgia invest in its youngest learners?

Investments made at the start of a child’s life accumulate throughout their entire lives.

Young children under the age of eight have the greatest capacity for change. Interventions are often more effective at this age and can have lasting impacts for years to come.

Early education gives young children skills they continue to build on throughout the continuum of their education.

Sources available here: https://tinyurl.com/EconomicsofEarlyCare
Quality Early Learning in Georgia

Quality early care and learning is essential to the growth and development of Georgia’s youngest learners. Multiple studies have shown how quality impacts outcomes for young children in their early years and well beyond.

**WHAT IS QUALITY?**

Elements of quality early care should:

- Have low child-teacher ratios
- Implement individualized instruction
- Engage and support families
- Promote proper physical, social, and emotional development
- Support academic growth particularly in language and literacy
- Ensure a clean and safe environment
- Provide supports for dual-language learners
- Employ qualified and well-trained teachers
- Support academic growth particularly in language and literacy

**QUALITY INITIATIVES IN GEORGIA**

**Georgia Early Learning and Development Standards**

The Georgia Early Learning and Development Standards (GELDS) are a set of high-quality, research-based, appropriate, attainable standards that are flexible enough to support individual rates of development, approaches to learning, and cultural context for children from birth to age five. The GELDS promote quality learning experiences for children and address the question, “What should children from birth to age five know and be able to do?”

The GELDS are aligned with the Georgia Standards of Excellence (GSE) for K-12, as well as the Head Start Early Learning Outcomes Framework, and the Work Sampling System.

The GELDS are a continuum of skills, behaviors, and concepts that children develop throughout this time of life, divided by age group, into these five domains:

**Early Education Community Partnerships Team**

The DECAL Early Education Community Partnerships Team supports, sustains, and expands the impactful work across Georgia’s Race to the Top Early Learning Challenge Grant—Early Education Empowerment Zones (E3Zs).

DECAL is continuing its investment in community outreach and engagement through the Early Education Community Partnerships (EECP) Team. This team is composed of six Community Coordinators assigned to each DECAL administrative region of the state. These Community Coordinators share information about DECAL resources and collaborate with community organizations to improve learning outcomes for young children.

The EECP Team also engages with local stakeholders to coordinate the delivery of available services for young children and their families, with priority given to efforts that expand access to high-quality care through Georgia’s Quality Rated Child Care system. Specific efforts led by regional Community Coordinators include working with community stakeholders to align systems for children ages birth to 8, fostering public awareness of early education services, serving as a local resource and referral for all DECAL programs and services, and convening regional birth-to-eight teams and child care engagement networks.

[www.georgiavoices.org](http://www.georgiavoices.org)
Quality Rated is a voluntary tiered quality rating and improvement system for early and school-age care programs administered by DECAL. Quality Rated is meant to assess, improve, and communicate the level of quality of a child care program.

To become Quality Rated, programs must score well on portfolios with self-reported information and classroom observations conducted by trained assessors. Star rated programs receive packages with training, materials, and equipment.

Quality Rated is a three-star rating system that awards programs a star rating based on standards.

Benefits for Parents and Families

Quality Rated is an independent, trustworthy resource that helps families find high-quality child care and Pre-K programs.

Parents can use the FREE, online search tool to access information about specific programming, including safety and inspection reports, teacher credentials, and ages served. To find Quality Rated programs, visit www.QualityRated.org.

Benefits to Georgia

Regardless of their rating, all programs that participate are committed to improving the quality of their program by going above and beyond Georgia’s licensing standards. At a community and state level, Quality Rated creates a shared understanding of quality learning and a commitment to achieving it. Due to the pandemic, DECAL has extended its 2020 goal that all eligible CAPS providers must be star rated by December 31, 2020, to at least December 31, 2021.5

Of the 4,579 state licensed and monitored child care programs, more than 2,400 are Quality Rated.6

Percentage of Licensed Programs that are Quality Rated per County

Star Rating Statewide Count

786 ★
1,191 ★★
428 ★★★
Childcare and Parent Services

Childcare and Parent Services: An Overview

The Childcare and Parent Services (CAPS) program offers low-income families subsidies to pay for quality child care, afterschool and summer programs for children up to age 12 and for children up to age 17 with special needs.\(^1\) CAPS is federally funded through the Child Care and Development Fund (CCDF) and is administered by the Department of Early Care and Learning (DECAL).\(^2\) In 2019, Georgia received more than $236 million in federal child care subsidy funds.

The purpose of CAPS is to:\(^3\)

1. Provide access to high-quality and affordable early learning, afterschool and summer environments for low-income families.
2. Increase positive school readiness outcomes.
3. Assist families in achieving and maintaining self-sufficiency by providing financial supports for child care costs.

**CAPS POPULATION BY RACE/ETHNICITY, COMPARED TO GA CHILD POPULATION**

In Georgia, people of color are twice as likely to live in poverty than White people. Children of color represent 56% of Georgia’s child population; yet 78% of children in the CAPS program.

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Child Population</th>
<th>CAPS Population</th>
<th>Poverty Rate by Race/Ethnicity</th>
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<tbody>
<tr>
<td>White</td>
<td>44%</td>
<td>70%</td>
<td>4%</td>
</tr>
<tr>
<td>Black</td>
<td>15%</td>
<td>2%</td>
<td>15%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>8%</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td>Other Race</td>
<td>6%</td>
<td>2%</td>
<td>10%</td>
</tr>
<tr>
<td>Unreported</td>
<td>8%</td>
<td>70%</td>
<td>22%</td>
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**WHO IS ELIGIBLE FOR CAPS?**

To qualify for entry into the CAPS program, family income must not exceed 50% of the state median income.\(^8\)

For example, a family of four cannot initially make more than **$38,103** a year, and can continue to receive a CAPS scholarship until their income reaches **$64,776.**\(^10\)

To qualify for the Very Low Income priority group:

A family of four cannot make more than **$13,100** a year.\(^2\)

www.georgiavoices.org

**PRIORITY GROUP ELIGIBILITY**

Because CAPS scholarships are limited, children in the following situations are given priority:\(^7\)

- Child Protective Services
- Custody of the Division of Family and Children Services
- Domestic violence situations
- Disability status
- Enrolled in Georgia’s Pre-K Program
- Participating in or transitioning from TANF
- Experienced a natural disaster
- Lack fixed, regular and adequate housing
- Very Low Income as defined by CAPS
- Grandparents raising grandchildren
- Minor parents
- Need to protect

(e.g., family with substantiated Child Protective Services case closed within last 12 months, caregiver other than biological or adoptive parents has taken over full-time care of child)
Parents who receive CAPS must complete 24 hours per week of approved activities to stay eligible for the CAPS scholarship.\textsuperscript{11}

Approved activities can include:\textsuperscript{12}

- **Employment**
  Paid employment or volunteering at Head Start or Early Head Start facilities

- **Education**
  Participation in middle or high school, GED programs, vocational training programs, associate degree and bachelor’s degree programs\textsuperscript{*}

- **Job Search**
  Parents who lose their job or stop attending state-approved training or education programs may be authorized for up to 13 weeks of job search.\textsuperscript{**}

\textsuperscript{*}For parents enrolled with the Technical College System of Georgia (TCSG): every credit hour equals two hours towards the required 24 hours per week of approved activities. For example, if a parent is enrolled in a class that counts as 3 credit hours with TCSG, they earn 6 credit hours per week towards the required 24.\textsuperscript{13}

\textsuperscript{**}Parents who meet eligibility requirements for certain priority groups may be authorized with job search as their state-approved activity for the entire 12-month eligibility period.\textsuperscript{14}

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**CHANGES TO THE CHILD CARE DEVELOPMENT FUND FOR 2019-2021**

Georgia received an extra $\textbf{93 million}$ in Child Care Development Fund funds for FY 2019-2021.

As of September 17, 2018, parent fees were significantly reduced, not to exceed $\textbf{7\%}$ of family income.\textsuperscript{15}

Due to the coronavirus pandemic, DECAL has revised its 2020 goal that all eligible CAPS providers must be star rated by December 31, 2020 to at least December 31, 2021.\textsuperscript{16}

Sources available here: [https://tinyurl.com/CAPSinGA](https://tinyurl.com/CAPSinGA)
Georgia’s Pre-K Program

Georgia’s Pre-K Program is a voluntary, free program available to all of Georgia’s four-year-olds regardless of parental income. More than 1.6 million Georgia students have been served by Georgia Pre-K since it began in 1992. The program continues to be nationally recognized for its success.

80,328 kids were enrolled in Georgia Pre-K during the 2019-2020 school year.

**BY THE NUMBERS**

- 3,855 Pre-K classes operate in 159 counties at 1,829 locations.
- 45% are located in a public school system.
- 55% are located in private centers.
- Georgia is one of only eight states and D.C. that provides high-quality care to more than 50% of 4-year-olds.
- 40% of Georgia’s 4-year-olds are not currently enrolled. At the end of the 2019-2020 school year, there were 4,303 kids on the waitlist.

**GEORGIA PRE-K IMPROVES OUTCOMES**

In 2011, the Georgia General Assembly began a multi-year evaluation led by the Frank Porter Graham Child Development Institute. The study has found that children enrolled in the Georgia Pre-K Program:

- Are more prepared for kindergarten compared to four-year-old’s who did not attend a Georgia Pre-K program.
- Sustain gains made in Pre-K through kindergarten and first grade.

Children in Georgia Pre-K showed significant growth across all learning domains, including:

- Math Skills
- Language & Literacy Skills
- Social-emotional Skills

These gains happened for all students, regardless of gender and income differences, and are sustained through the end of first grade.
About Georgia Pre-K

Administered by Georgia Department of Early Care and Learning.

Funding Georgia Pre-K

For the 80,328 children enrolled in the 2019-2020 school year

$378 MILLION

Georgia Lottery dollars were allocated to Georgia Pre-K in 2020.

$4,539 was spent per child

In 2016, the Georgia General Assembly approved a $34 million increase for Pre-K salaries. Despite recent increases, Pre-K salaries are lower than similar professions. Assistant teachers make $15,873/year. The average salary for lead teachers for the 2018 school year was:

4-year degree $31,638

4-year degree & certified $40,338

Master’s Degree $44,338

Research shows a significant factor in an early childhood teacher’s decision to leave the profession is low pay.

High turnover rates have been linked to lower program quality and shown to negatively impact a child’s social and emotional development and relationships between teachers, children and parents.

Sources available here: https://tinyurl.com/GeorgiaPreK
School Readiness in Georgia

Children entering kindergarten with school readiness skills are more likely to experience academic success and better lifetime well-being than their peers.1

What is School Readiness?

A child’s readiness for school includes:2

Detection and appropriate care for potential physical or mental disabilities
Emerging social and interpersonal skills
Evident early literacy and language skills
Possession of a general knowledge about the world

School readiness is influenced by a child’s development, family, community, schools, and the services they have access to. Children from low-income families, whose parents did not graduate high school, or do not speak English at home are less likely to have readiness skills.3 Children’s environmental exposures, such as health, financial strain, conflict, and neighborhood safety, impact their future opportunities – including school readiness and grade promotion.4 Multiple studies of pre-k programs, including Georgia’s Pre-K, show that participation in pre-k can greatly improve school readiness skills, particularly in high-risk populations.5

Georgia’s Commitment to School Readiness

Georgia Department of Early Care and Learning, Bright from the Start (DECAL) runs several programs to increase early readiness skills so students can enter kindergarten ready to learn, including:

**Georgia’s Pre-K Program**

More than 1.6 million Georgia students have been served by Georgia’s Pre-K program since it began in 1992.4 Evaluations have found that children enrolled in the Georgia Pre-K program:2

- Are more prepared for kindergarten compared to four-year-olds in other forms of care.
- Have increased cognitive development and improved educational outcomes in later grades.

Children in Georgia’s Pre-K program showed significant growth across all learning domains, including:6

- Math skills
- Language and literacy skills
- Social-emotional skills

Dual language learners in Georgia’s Pre-K program showed growth across all skills in English and most skills in Spanish.2

**Summer Transition Programs**

DECAL offers both Rising Kindergarten and Rising Pre-K Summer Transition programs as additional supports for high-risk students, including:10

- 175 classes
- 131 program sites

**Fast Facts**11 12

- 6-week intensive summer program
- Child’s family must be at or below 85% of the state median income
- A transition coach is in each class to help families
- Low student-to-teacher ratio

Sources available here: https://tinyurl.com/GASchoolReadiness
Georgia’s Summer Transition Program

Georgia Department of Early Care and Learning, Bright from the Start’s Rising Pre-K and Rising Kindergarten Summer Transition Programs are intensive six-week academic programs to support high-risk children to prepare them for Pre-K and kindergarten.

**Rising Kindergarten (Rising K) Summer Transition Program**

Rising K Summer Transition Program supports children registered to enter kindergarten in the following year.

The program is open to kids who meet one of the following criteria:

1. Did not participate in Georgia’s Pre-K Program or Head Start during the prior school year
2. Attend a Georgia Pre-K or Head Start program but has been identified as needing additional academic support before entering kindergarten (i.e. teacher recommendation, WSO data)
3. Are in one of the following priority groups:
   - Is a Dual Language Learner (e.g., home language is a language other than English)
   - Is in foster care
   - Is homeless as defined by McKinney-Vento Homeless Assistance Act (child’s family is without permanent housing)
   - Has an Individual Education Program (IEP)

<table>
<thead>
<tr>
<th>Rising Kindergarten Summer Transition Program</th>
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<tr>
<td>1,431 children at 94 locations in 26 counties which operate 129 classes</td>
</tr>
<tr>
<td>10% are located in a public school system</td>
</tr>
<tr>
<td>90% are located in private centers</td>
</tr>
</tbody>
</table>

**Rising K Program has:**

- Maximum of 16 kids per classroom
- A lead and assistant teacher per class
- Full day program
- Provides/assists in coordinating care before and after school as needed through CAPS

**Transition Coach**

Summer transition program requires a half-time transition coach for every class, who is responsible for:

- Actively seeking out students who would benefit from the program and meet the enrollment requirements
- Working with families to collect eligibility documentation
- Facilitating at least one family or parent engagement activity per week based on parents’ needs
- Connecting families with community resources
- Planning kindergarten transition activities

www.georgiavoices.org
Research from the Frank Porter Graham Child Development Institute indicated that:

Spanish-speaking DLLs are less likely than their peers to enroll in early care, directly affecting school readiness skills. Both the English and Spanish language skills of participating children increased during the program. The program helped children become more comfortable with school routines and increased independence. While children made significant gains, a meaningful gap remained between DLLs and their peers.

### Rising Pre-K Summer Transition Program

<table>
<thead>
<tr>
<th>Children</th>
<th>Locations</th>
<th>Counties</th>
<th>Classes</th>
<th>Public School</th>
<th>Private Centers</th>
</tr>
</thead>
<tbody>
<tr>
<td>502</td>
<td>37</td>
<td>13</td>
<td>46</td>
<td>7%</td>
<td>93%</td>
</tr>
</tbody>
</table>

Although similar to the Rising K program, the Rising Pre-K program differs in the following ways:

1. Spanish-speaking DLLs are less likely than their peers to enroll in early care, directly affecting school readiness skills.
2. Both the English and Spanish language skills of participating children increased during the program.
3. The program helped children become more comfortable with school routines and increased independence.
4. While children made significant gains, a meaningful gap remained between DLLs and their peers.

### In 2020, the Rising K and Pre-K Summer Transition Programs combined offered:

The total budget* for both of the 2019 Summer Transition Programs was:

- **175 classes** at **131 program sites**
- **$3.4 MILLION**
  - Approximately **$1,788** being spent **PER CHILD**

*Due to the COVID-19 pandemic, many STP providers chose not to operate their class/classes during the Summer 2020.

Sources available here: [https://tinyurl.com/GASummerTransition](https://tinyurl.com/GASummerTransition)
Research shows Farm to School initiatives improve children’s health and nutrition. Most of these programs start in K-12 schools, but children can be reached earlier with Farm to Early Care and Education (FTECE).

**TOP REASONS PROVIDERS CHOOSE TO PARTICIPATE IN FTECE**

- Teach children where food comes from and how it is grown
- Improve child health
- Provide children with experiential learning

**STRATEGIES THAT WORK**

- Parent education and engagement
- Meal planning and preparation
- Curriculum where kids touch and taste food
- Gardening with kids
- Fruit and vegetable boxes for home consumption

**FTECE SUPPORTS**

**Increase:**

- Fruit and vegetable consumption, some of which may increase vitamin A, C, and E intake
- Healthy food consumption at home
- Willingness to try new foods
- Motor skills
- Life skills, social skills, and self-esteem
- Physical activity

**Decrease:**

- Diet-related diseases among children
- Consumption of unhealthy foods and sodas
- Food waste

**Agriculture and Georgia’s Economy**

Farm to Early Care and Education can have a significant positive impact on the state’s economy.

- Agriculture is the #1 industry in Georgia.
- That’s approximately $76 BILLION contributed to the state’s economy.
- In 2017, there were 399,200 agriculture jobs in Georgia.
- In 2017, farms covered 9.95 million acres in Georgia.
- That’s 1 in 7 Georgians.
- That’s 25% of all the land in Georgia.
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Demand for Afterschool in Georgia

- 327,853 or 18% of Georgia's school-aged children participated in afterschool programs in 2020.
- But more children would enroll if a program was available in their community.
- 633,481 or 42% of Georgia's school-aged children participated in afterschool programs in 2020.
- That's a 16% increase in the demand for afterschool programs since 2004.
- 33% of children in afterschool are from low-income households.
- 238,265 of Georgia's children are alone and unsupervised between the hours of 3pm and 6pm.

The Top Three Roadblocks to Afterschool Program Participation:

- Programs are too expensive: 55%
- No safe way to get their child to and from programs: 52%
- Lack of available programs: 35%

Percentage of parents reporting they did not enroll their child in an afterschool program because of these reasons.
### WHY WE NEED MORE PROGRAMS

**19%** of juvenile violent crimes occur during school days between: 3pm and 7pm

**45%** of students attending 90 days or more at a 21st CCLC afterschool program improved math and reading test scores

**90%** of students in a 4-year afterschool program graduated high school

**25%** fewer absences for students who are in afterschool programs for two years

### WHAT PARENTS SAY

**70%** of Georgia parents say that afterschool programs help parents keep their jobs

**94%** of Georgia parents are satisfied with their child’s afterschool program

**79%** of Georgia parents agree that afterschool programs provide working parents peace of mind

**87%** of Georgia parents report their child’s afterschool program provides a safe environment

### CONTACT US

For more information on afterschool in Georgia go to [www.afterschoolga.org](http://www.afterschoolga.org)

### REFERENCES:

Support for Afterschool in Georgia

**Georgia Parent Satisfaction with Afterschool Programs**

**Overall**
- 2004: 82%
- 2009: 87%
- 2014: 90%
- 2020: 94%

**Safe Environment**
- 2009: 73%
- 2014: 89%
- 2020: 87%

**Georgia Parents Report a Range of Benefits of Afterschool Programs**

- 91% Interacting with peers and building social skills
- 70% Building life skills
- 71% Engaging in STEM or computer science learning opportunities
- 79% Peace of mind for working parents
- 83% Receiving healthy snacks and meals

**Support Extends Beyond Just Parents Who are Served by Afterschool Programs**

- 86% of parents in Georgia support public funding for afterschool programs

- 77% parents agreed nationally that Congress should provide additional funding for afterschool programs to operate during virtual school days due to the COVID-19 pandemic

**Contact Us**
For more information on afterschool in Georgia go to [www.afterschoolga.org](http://www.afterschoolga.org)

**References:**
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The Landscape of Afterschool in Georgia

The Georgia Department of Education (GaDOE) and the Georgia Division of Family and Children Services (DFCS) FUND 513 afterschool and youth development programs across the state.

These programs serve nearly 56,000 young people each year—ranging from Pre-K to high school.

Number of funded programs per county

- 0
- 1-5
- 6-10
- 11-15
- 16-20
- 21+

66 counties are served by more than 1 program but 57 of 159 counties do not have any state funded programs.

For more information, visit GSAN’s Website: www.afterschoolga.org

Sources:
2. Georgia Department of Education, FY21 21st CCLC Sites Open Records Request Oct 1, 2020
3. Georgia Department of Human Services, Division of Family and Children Services, Email Communications October 2020.
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The 21st Century Community Learning Centers (CCLC) Program is the only federal funding stream dedicated to afterschool, before school, and summer learning.

In 2020, Georgia awarded over $41 MILLION for 21st CCLC programming.

Out of the 239 program sites that serve Georgia’s children:

- 57% are located in schools
- 40% are located in community based organizations
- 3% are located in institutions of higher education

177 of the programs operate over the summer.

66% of 21st CCLC sites are in urban areas.

34% of 21st CCLC sites are in rural areas.

89% of students served by 21st CCLC are eligible for free or reduced lunch.

Demographics of students served by 21st CCLC in Georgia:

<table>
<thead>
<tr>
<th>AGE</th>
<th>Number</th>
<th>Racial Makeup</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elementary</td>
<td>16,972</td>
<td>55% Black, 14% Hispanic, 26% Asian, 5% Other/Not Reported</td>
</tr>
<tr>
<td>Middle</td>
<td>6,630</td>
<td>17% Black, 14% Hispanic, 26% Asian, 5% Other/Not Reported</td>
</tr>
<tr>
<td>High</td>
<td>2,917</td>
<td>1% Black, 14% Hispanic, 26% Asian, 5% Other/Not Reported</td>
</tr>
</tbody>
</table>

*Data only available for 47% of students.
Georgia’s 21st CCLC programs offer students the equivalent of at least 45 additional school days.

21st CCLC programs attempt to enroll students who previously did not meet state standards.

9 out of 10 children who participated in 21st CCLC in Georgia increased homework completion.

8 out of 10 children who participated in 21st CCLC in Georgia improved classroom behavior.

96% of parents are satisfied with their child’s 21st CCLC program.

89% of children are satisfied with their 21st CCLC program.

For more information, visit GSAN’s website: www.afterschoolga.org

To learn more about Georgia’s 21st CCLC program please visit www.gadoe.org.

SOURCES
2. Georgia Department of Education, FY21 21st CCLC Sites Open Records Request Oct 1, 2020
3. Georgia Department of Education, FY21 21st CCLC Student Demographics Data Collection Request Oct 20, 2020
 Georgia's afterschool and youth development programs provide thousands of youth – from kindergarten through high school – with a safe and enriching place to go after the school day ends. High quality afterschool programs keep Georgia's young people on track to succeed in school, careers, and life – but what does high quality mean?

**WHAT IS QUALITY:**

** HIGH QUALITY AFTERSCHOOL AND SUMMER LEARNING PROGRAMS:**

- have flexible, well-rounded daily schedules with activities that are well organized, appropriate, and allow for learning new skills
- build upon what young people are learning during the school day
- are safe and clean and reflect the needs and interests of all youth
- nurture positive relationships and promote a respectful environment
- provide opportunities for physical activity and to practice healthy habits
- need great staff and volunteers and should support their growth and development
- have a clear mission, defined goals, and good financial management
- need to always be improving – data collection and analysis is key
- engage families and communities in the program

**WHY DOES QUALITY MATTER:**

** THE ABCS: ATTENDANCE BEHAVIOR AND COURSEWORK**

Participation in high quality afterschool programs can increase attendance, improve behavior and raise student achievement

** CLOSING THE ACHIEVEMENT GAP**

For low-income students who consistently participated in high-quality afterschool programs from kindergarten through fifth grade, the achievement gap in math scores between those students and their high-income peers was eliminated by fifth grade

** BETTER HEALTH**

One Georgia study shows that the prevalence of obesity decreased for children participating in afterschool programs compared to those who did not participate

** CONFIDENCE AND SELF-EFFICACY**

Students in afterschool programs develop better work habits, have more self-efficacy in the classroom and have better attitudes about school

** PRODUCTIVE PARENTS**

Parents report that they have less stress, fewer unscheduled absences and more productive work time when their children are enrolled in afterschool programs

**MINIMIZING RISKS**

The hours between 3:00 p.m. and 6:00 p.m. on school days are the most likely periods for juvenile crime and experimentation with drugs, alcohol, cigarettes and sex
**WHERE IS GEORGIA HEADING:**

**GEORGIA AFTERSCHOOL & YOUTH DEVELOPMENT (ASYD) QUALITY STANDARDS**

The Georgia ASYD Quality Standards is a collaborative project that is funded and endorsed by the Georgia Division of Family and Children Services, the Georgia Department of Education, the Georgia Department of Public Health and the Governor’s Office for Children and Families. These standards are research-based best practice guidelines that delineate the critical components of high quality youth development programs. When adopted by afterschool and youth development programs, the standards can be used as a framework for the design and implementation of high quality programs for youth from elementary through high school.

**GEORGIA AFTERSCHOOL & YOUTH DEVELOPMENT (ASYD) CONFERENCE**

The bi-annual Georgia ASYD Conference, hosted by the Georgia Division of Family and Children Services, the Georgia Department of Education, and the Georgia Department of Public Health, is an opportunity for afterschool programs across the state to come together. Through interactive workshops, afterschool professionals can learn best practices in positive youth development and organizational practices, network with their peers, and better understand how to utilize the Georgia ASYD Quality Standards.

For more information on the Georgia ASYD Quality Standards and Conference go to [www.georgiaasyd.org](http://www.georgiaasyd.org)

**QUALITY RATED SCHOOL AGE PROGRAM**

The Georgia Department of Early Care and Learning’s Quality Rated is a voluntary quality improvement system for child care and afterschool programs to achieve higher levels of quality. Afterschool programs have a specially tailored process to complete Quality Rated that reflects the population they serve.

Quality Rated can support afterschool programs with technical assistance, free training, minigrants, bonus packages for receiving a star rating, and marketing materials.

For more information on Quality Rated go to [www.qualityrated.org](http://www.qualityrated.org)

CONTACT US | For more information on afterschool in Georgia go to [www.afterschoolga.org](http://www.afterschoolga.org)
The ASYD Quality Standards are based on research from a variety of fields including education, child development and psychology, organizational psychology, business management and public health. Each standard aims to encourage positive short-term and long-term outcomes in youth based on best practices found through this research.

EVIDENCE-BASED, RESEARCH-DRIVEN:

The ASYD Quality Standards are based on research from a variety of fields including education, child development and psychology, organizational psychology, business management and public health.

Georgia joins 32 other states, including Arkansas, Florida, Nebraska and Indiana, which already have quality standards for their afterschool programs.

SELF-ASSESSMENT, NOT PUNISHMENT:

Programs can utilize this as a tool for quality awareness and improvement, facilitating important conversations and setting goals among staff.

A TOOL FOR CONTINUOUS IMPROVEMENT:

Studies show that programs that use a continuous quality improvement system are likely to see improvements in the quality of instruction delivered by staff members and even retention levels of short-term staff.

DESIGNED ESPECIALLY FOR PROGRAMS THAT:

• Serve children and youth between ages 5 and 18
• Serve youth who attend regularly and over a long period of time
• Are well-established
• Offer youth a range of enriching experiences
The Standards Promote Education, Families and Health

SUPPORTING EDUCATORS AND STUDENT LEARNING

- Keep open and frequent lines of communication between program staff and school faculty
- Utilize and base activities on Georgia state academic standards
- Offer hands-on activities that further engage students in content from the school day
- Incorporate homework help and tutoring
- Teach students skills that will help them become academically successful, such as time management and teamwork

STRENGTHENING FAMILY PARTNERSHIPS

- Hold orientations for families to learn about the program
- Encourage families to visit and observe the program
- Share positive information and constructive feedback with families regularly through written notes, phone calls and face-to-face conversations
- Ask families for feedback about how to improve the program

ENCOURAGING HEALTHY LIFESTYLES

- Prevent bullying and harassment
- Teach healthy eating and cooking choices and offer healthy snacks
- Incorporate physical activity
- Communicate with and provide resources to families about health

FOR MORE INFORMATION:
Visit the Georgia ASYD Website: www.georgiaasyd.org
Visit GSAN’s Website: www.afterschoolga.org
Afterschool Supports Healthy Lifestyles


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<tbody>
<tr>
<td>OVERWEIGHT</td>
<td>OBESE</td>
<td>MALES WERE OBESE</td>
</tr>
<tr>
<td>14%</td>
<td>18.4%</td>
<td>19.7%</td>
</tr>
</tbody>
</table>

523,470 of Georgia’s children were food insecure – lacking reliable and regular access to food.

Hungry children are likely to have:
- Lower grades
- Higher rates of absenteeism and tardiness
- Higher chances of repeating a grade

Youth lack physical activity opportunities:
- 46.1% of middle and 33.6% of high school students attend daily physical education classes.
- 64.1% live near a park or playground area.
- 35.5% of high school students spend three or more hours a day playing video games or using a computer.

Impact of Afterschool

Afterschool and summer learning programs are critical partners in supporting the health of Georgia’s youth by providing access to nutritious foods, keeping kids physically active, and promoting healthy habits.

GEORGIA PARENTS IN 2014

- 79% said their child’s afterschool program offers beverages, snacks, and/or meals
- 80% said their child’s afterschool program offers opportunities for physical activity

Meals Served in 2017

- 116,328 youth served daily by Child and Adult Care Food Program (CACFP)
- 195,233 youth served daily by Summer Nutrition Programs

Youth who actively participate in high quality afterschool programs show less prevalence of obesity when compared to their non-participating peers.

Afterschool provides opportunities for:
- Snacks and meals
- Nutrition education
- Additional time for physical activity
- Safe space and materials
- Structured activities
- Adult support
- Team sports leading to:
  - conflict resolution skills
  - decreased stress
  - improved communication

Regular physical activity and healthy eating leads to:
- Strong bones and muscles
- Improved cardiorespiratory fitness
- Reduced symptoms of anxiety and depression
- Decreased likelihood of serious health conditions as an adult (heart disease, Type II diabetes, and cancer)
- Higher academic achievement
- Improved classroom behavior
- Improvement in indicators of cognitive skills (concentration, memory, and verbal skills)

For references, go to www.afterschoolga.org/afterschool-issues.
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Afterschool Builds Georgia’s STEM Workforce

STEM careers in Georgia are expected to grow 13% by 2027.1

Georgia students performing at or above the National Assessment of Education Proficiency in math and science (2015-2017): 2

35% of 4th graders vs. 31% of 8th graders

INEQUITIES IN OPPORTUNITIES LEAD TO RACIAL ACHIEVEMENT GAPS IN GEORGIA

4th Grade Math

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>0%</th>
<th>10%</th>
<th>20%</th>
<th>30%</th>
<th>40%</th>
<th>50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>23%</td>
<td>44%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>14%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
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</tbody>
</table>

8th Grade Math

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>0%</th>
<th>10%</th>
<th>20%</th>
<th>30%</th>
<th>40%</th>
<th>50%</th>
<th>60%</th>
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<tbody>
<tr>
<td>White</td>
<td>25%</td>
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<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>18%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Proficiency Percentages in Georgia Math Assessments in 2017 3

Historical inequities in educational opportunities, systemic barriers, and significantly fewer opportunities have resulted in unequal outcomes and continue to prevent a significant number of Georgians from reaching their full potential.4, 5

Impact of Afterschool

Afterschool and summer learning programs are helping close the opportunity gap - which often results in a skills gap - by offering additional time and opportunities for students to experience hands-on STEM learning.

NATIONAL STEM OUTCOMES

Survey of 1600 youth from 160 programs 6

73% Students that have a more positive STEM identity (strongest indicator of pursuing a STEM career)

Afterschool program serving 25,000 youth 7

80% Students that reported the program was the most important source of support for pursuing a career

97% Students that said it taught them to set high goals and expectations of themselves.

National program 8

70% Students that pursued post-secondary education and careers in STEM fields.

Afterschool provides opportunities for: 9

- Enriching STEM activities such as computer science, coding, and robotics
- Critical foundational skills
- Communication skills
- Working collaboratively
- Fostering confidence
- Exposure to career pathways

Regular participation leads to: 10, 11

- Significant gains in math achievement
- Positive results in reading achievement
- Increase in STEM knowledge and skills
- Higher chances of graduation
- Higher chances of pursuing a STEM career

For references, go to www.afterschoolga.org/afterschool-issues.
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Afterschool Improves Literacy in Georgia

6 out of 10 children (58%) completing third grade in Georgia were not prepared to meet the literacy challenges of the next grade level (2019)

This leads to a cycle of low literacy
- Struggle with learning and fall behind
- Discipline problems
- Perform poorly in 8th grade math
- Higher chances of becoming teen parents
- Higher chances of dropping out of high school
- More likely to spend time in prison
- Struggle with unemployment
- Poor health & shorter life expectancy

1 million Georgia adults have low literacy and earn 30% less than adults with a HS diploma

Costs the state $1.26 billion in social services and lost tax revenue annually

72% chance of being at lowest reading level for children with parents with low literacy levels

National Assessment of Educational Progress (NAEP) Reading (2017)

SUMMER IS CRUCIAL

2-3 months reading skills loss for low income children
2/3 of the achievement gap in reading between low and middle income children by 9th grade due to summer learning loss

Impact of Afterschool

Afterschool and summer learning programs provide students with the additional supports they need to help build a strong foundation in literacy, including reading, writing and critical thinking skills.

7 out of 10 parents report that their children's programs provide opportunities for reading or writing and homework assistance

21st Century Community Learning Centers (CCLC) are federally funded afterschool and summer learning programs that offer opportunities to youth across Georgia.

Afterschool provides opportunities for:
- Project based learning opportunities
- Strong literacy foundation
- Group activities
- Peer-to-peer learning
- Critical thinking skills
- Communications skills

Regular attendance lead to:
- Significant gains in reading skills
- Improved grades
- Improved attendance
- Improved attitude towards school
- Higher chances of graduation

For references, go to www.afterschoolga.org/afterschool-issues.
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The 2017-2018 National Survey of Children’s Health: 24% of Georgia’s youth aged 3 – 17 years had one or more mental, emotional, developmental, or behavioral problem.¹

High Quality Afterschool and Summer Learning Programs

- Provide supportive environments & incorporate healthy habits into routine²
- Promote positive behavioral factors like positive decision-making skills, self-control, and self-awareness⁶
- Offer protective factors that improve youth outcomes & mitigate the effects of risk factors³, ⁴
- Provide opportunities to learn from mentors⁷
- Help overcome Adverse Childhood Experiences & reduce chances of developing substance use disorders⁵
- Lead to improved work habits and classroom behavior, gains in reading and math, and increased school attendance and graduation rates⁸, ⁹

These programs are an ideal opportunity to foster positive behavioral health, which increase a child’s sense of well-being, supports healthy relationships, and enables children to achieve their full academic potential.¹⁰,¹¹

Spring 2019 Behavioral Health Round Table Discussions

Georgia Statewide Afterschool Network hosted 5 Behavioral Health round table discussions with 37 Afterschool & Summer Learning providers to identify strategies, tools, and resources to address program challenges in supporting youth’s behavioral health needs.

What We Heard

Behavioral Health Issues Observed
- Attention seeking behavior
- Defiant behavior and testing boundaries
- Physical and verbal altercations

Obstacles to Supporting Youth
- Lack of behavioral health knowledge, understanding, and training
- Program capacity stretched too thin
- Lack of access to a list of referral services and organizations

Resources Needed
- Training and professional development
- Education and awareness
- Vetted master list of services, partners and referral organizations

Successful Strategies
- Raise awareness and knowledge
- Include families in services and intervention methods
- Offering youth choice, nurturing relationships, supportive age appropriate environments, and enriching activities

For references, go to www.afterschoolga.org/afterschool-issues/
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How Medicaid and PeachCare Money Work

**Georgia Dollars:**
$3,511,632,198

**Total Amount:**
$10,908,082,625

**Federal Match:**
$7,397,301,151

---

**Fee for Service**
State pays providers directly per service
(DCH manages physical health care/costs, DBHDD manages behavioral health care/costs)

- **CHILDREN SERVED:**
  Primarily children that are blind or disabled, including those enrolled in Katie Beckett

- **AGES SERVED:**
  Blind, disabled: ALL
  Katie Beckett: 0 until 19

- **KEY REQUIREMENTS:**
  Disability, income limits

---

**Georgia Families 360° Managed Care**
State pays Care Management Organization (CMO) per member per month to manage care/costs

- **CHILDREN SERVED:**
  Children in foster care, receiving adoption assistance, and in some juvenile justice programs

- **AGES SERVED:**
  Foster Care: 0 until 26
  Adoption Assistance: 0 until 18
  Juvenile Justice: While in state custody

- **KEY REQUIREMENTS:**
  In foster care or receiving adoption assistance, juvenile justice eligible while in state custody in certain programs

---

**Georgia Families Managed Care**
State pays CMOs per month to manage care/costs

- **CHILDREN SERVED:**
  Children under age 19 with income limits per the chart below as well as newborns born to mothers enrolled in any Medicaid program

- **AGES SERVED:**
  0 until 19
  Newborns: 0 until 13 months

---

**Medicaid Income Limits**

<table>
<thead>
<tr>
<th>AGE</th>
<th>FPL</th>
<th>INCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 until 1</td>
<td>210%</td>
<td>$55,020</td>
</tr>
<tr>
<td>1 until 6</td>
<td>154%</td>
<td>$40,348</td>
</tr>
<tr>
<td>6 until 18</td>
<td>138%</td>
<td>$36,156</td>
</tr>
</tbody>
</table>

**PeachCare Income Limits**

<table>
<thead>
<tr>
<th>AGE</th>
<th>FPL</th>
<th>INCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 until 18</td>
<td>247%</td>
<td>$64,714</td>
</tr>
</tbody>
</table>
## The Facts About Medicaid and PeachCare

### Medicaid

**1,136,131 children served**

**What is it?**
Medicaid is a jointly funded, Federal-State medical assistance program for low-income individuals and families.

**How is it funded?**
Medicaid is financed through a combination of federal and state funds. The federal dollars vary year to year based on facts like the per capita income. Georgia’s federal financial participation matching rate for Medicaid is 67.03% for the Federal Fiscal Year 2021.

**Who does it cover?**
It covers children, pregnant women, the aged, blind, and/or disabled people. All Georgia Medicaid beneficiaries must be citizens or legal residents for 5 years.

**What does it cover?**
In Georgia, Medicaid covers primary, preventive, specialty, dental, and vision care. In addition, the insurance covers hospitalization, emergency room visits, prescription medications, mental health care, and non-emergency medical transportation.

### PeachCare for Kids

**Georgia’s Children’s Health Insurance Program (CHIP)**

**136,393 children served**

**What is it?**
CHIP is a federal assistance program that helps states provide insurance for low-income children whose families make too much to allow them to qualify for Medicaid coverage, but make too little to provide the insurance on their own.

**How is it funded?**
Federal matching funds are available to subsidize more than 75 percent of the benefit cost less premiums with the remaining percentage coming from the state. The percentage of federal matching funds is adjusted annually. Georgia’s enhanced federal financial participation matching rate for CHIP is 76.92% for the Federal Fiscal Year 2021.

**Who does it cover?**
In Georgia, CHIP covers children of families earning at or below 247% of the federal poverty level (FPL) -- that’s at or below $64,714 for a family of four.

**What does it cover?**
In Georgia, CHIP covers primary, preventive, specialty, dental, and vision care. In addition, the insurance covers hospitalization, emergency room visits, prescription medications, and mental health care.

Sources available here: [https://tinyurl.com/MedicaidPeachCareMoney](https://tinyurl.com/MedicaidPeachCareMoney)
Two Ways to Get (and Keep) Kids Covered

Georgia has 197,000 kids who lack health insurance. That makes us 4th highest in the number of uninsured kids in the nation.¹

TWO THINGS GEORGIA CAN DO TO INSURE MORE KIDS

Guarantee Medicaid/PeachCare for Kids (PeachCare) enrollment for children for 12 continuous months. This prevents kids from losing coverage due to temporary surges in family income, such as seasonal overtime.

Use SNAP (Supplemental Nutrition Assistance Program) eligibility data to automatically enroll eligible children in Medicaid/PeachCare, since children who are eligible for SNAP are also eligible for Medicaid. This would allow tens of thousands of Georgia’s children to gain coverage while reducing the administrative burden on the state to collect and review previously verified data.

BENEFITS TO CHILDREN’S HEALTH INSURANCE COVERAGE

- Children receive the check-ups needed to identify developmental delays or conditions that can become life-threatening when left untreated
- Children with chronic conditions, such as asthma or ADHD, have the medications they need
- Children receive routine health care, which can prevent a health care crisis
- Doctors receive reimbursement for services provided, supporting financial stability

HEALTH INSURANCE COVERAGE DISPARITIES IN GEORGIA

Latino children are almost 3x as likely to lack health insurance as White children in Georgia.
How are Georgia’s Children Covered?

Most children in Georgia who have health insurance are covered through their parent’s employer-sponsored insurance or through Medicaid or PeachCare, public coverage offered by the state.

<table>
<thead>
<tr>
<th>PUBLIC</th>
<th>PRIVATE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEDICAID</strong></td>
<td><strong>EMPLOYER-SPONSORED INSURANCE</strong></td>
</tr>
<tr>
<td><img src="https://tinyurl.com/2WaysToGet-KidsCovered" alt="Image" /></td>
<td><img src="https://tinyurl.com/2WaysToGet-KidsCovered" alt="Image" /></td>
</tr>
<tr>
<td>1,136,131</td>
<td>1,211,700</td>
</tr>
<tr>
<td>average enrollment of children in Medicaid in 2019²</td>
<td></td>
</tr>
<tr>
<td><strong>PEACHCARE FOR KIDS</strong></td>
<td><strong>INDIVIDUAL/SMALL GROUP MARKETPLACE</strong></td>
</tr>
<tr>
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<tr>
<td>136,393</td>
<td>109,700</td>
</tr>
<tr>
<td>average enrollment of children in PeachCare in 2019³</td>
<td></td>
</tr>
<tr>
<td>*Created in 1998, PeachCare for Kids is the name of Georgia’s State Children’s Health Insurance Program.</td>
<td></td>
</tr>
</tbody>
</table>

**UNINSURED**

![Image](https://tinyurl.com/2WaysToGet-KidsCovered)

197,000

Georgia children do not have health insurance

= approximately 50,000 kids

Sources available here: [https://tinyurl.com/2WaysToGet-KidsCovered](https://tinyurl.com/2WaysToGet-KidsCovered)
Benefits of School-Based Health Centers

School-Based Health Centers (SBHCs) place critically needed health-related services directly in schools to reduce access to barriers for children, families, and school personnel.1

**SBHC**
- Offers primary care services through a staffed primary care provider (e.g., nurse practitioner or physician assistant)2

**Comprehensive SBHC**
- Offers primary care, behavioral health and other expanded services, including health education, dental, and vision services3

SBHCs can quickly become self-sustaining when start-up funds are available. Currently, 17 of 49 states, and the District of Columbia, have allocated state-run funds for administering SBHS grants.

SBHCs have grown from two to 52 since 2013.4 During the 2020 legislative session, the General Assembly allocated funding to support the development of another SBHC in Irwin County.5

### THE NEED FOR SCHOOL-BASED HEALTH CENTERS

- **197,000** children in Georgia are currently uninsured6
- **41%** of children 3-17 struggle to, or are not able to, access needed mental health treatment and counseling8
- **28%** of counties don’t have a licensed social worker or psychologist6
- **146,000** children in Georgia stay home sick more than 6 days a year9
- Georgia’s rank in access to mental health care, resources, and insurance. Access is generally worse for rural communities10
- Georgia’s current rank in overall child well-being11

### THE BENEFITS OF SCHOOL-BASED HEALTH CENTERS

**Increased:**
- Access to primary, oral, and behavioral health care
- Use of mental health and substance abuse services
- Access to the flu vaccination

**Decreased:**
- Emergency room use and hospitalization for children with asthma
- Prescription drug use

**Increased:**
- Attendance and GPA for students utilizing mental health services

**Decreased:**
- Drop out rates and school discipline referrals
- Faculty and staff absences due to illness

**Decreased:**
- Emergency room use and hospitalizations
- Pharmacy and transportation costs
- Time away from work for parents
- Pediatric health care for Medicaid, PeachCare, and private insurers

More information can be found at www.georgiavoices.org.
REV. 11/2020

SUCCESS IN GEORGIA

Whitefoord SBHC

50% reduction in average cost per child to Medicaid for children with SBHC access

62% reduction in annual expense per Medicaid-covered child

Offers primary care, oral health, and behavioral health, and maintained available services throughout the community rezoning process

Turner SBHC

More than 200 patient visits a month, on average

First in the country to initiate Hallways to Health, a program to address childhood obesity, student emotional health, and school staff wellness

Received a state grant to:
• Increase study physical activity
• Reduce barriers to healthy lunches for teachers

Offers primary care, oral health, and behavioral health

Tiger Creek SBHC

More than 300 patient visits a month, on average

Open to the entire community, including adults

Offers primary care and oral health

Screens and refers for mental health

More than 65,000 children, families, and school personnel currently benefit from services at 52 SBHCs in Georgia.

Funding for SBHCs

17 states have an ongoing funding mechanism to support SBHCs.

Philanthropic partners provide another funding opportunity for SBHCs.

Current SBHC grants in Georgia:
• NIH Grant to study the impact and benefits of SBHCs in suburban and rural areas of Georgia
• PARTNERS for Equity in Child and Adolescent Health: allocates planning grants to communities in Georgia. 46 have been awarded since 2010.

RECOMMENDATIONS TO STRENGTHEN SBHCS

• Increase state funding to Federal Qualified Health Centers to support the development and expansion of school-based health services throughout the state, especially in high-need, rural areas.

• Strengthen coordination and collaboration among state agencies to increase comprehensive school-based mental health programs and reduce stigma.

• Support existing efforts to create a School-Based Health Technical Assistance Hub under the Rural Health Innovation Center to facilitate communication between healthcare and education entities and coordinate investments to improve outcomes in rural communities.

Sources available here: https://tinyurl.com/BenefitofSBHC
School-Based Telehealth in Georgia

A school-based telehealth (SBTH) program uses telecommunications technology to connect children in need of acute or specialty care services to a healthcare provider at a distant site.\(^1\)

**THE NEED FOR SCHOOL-BASED TELEHEALTH**

More than **170,000** children in Georgia stay home sick more than 6 days a year.\(^2\)

**63** counties do not have a pediatrican.\(^1\)

**109,000** children live in households that do not own a vehicle.\(^4\)

**BENEFITS OF SCHOOL-BASED TELEHEALTH**

- Increased children and families’ access to health education, especially for the management of chronic health conditions (i.e. diabetes and asthma)\(^3, 6\)
- Reduced barriers to healthcare in rural communities\(^2, 8\)
- Reduced student absenteeism due to illness\(^2\)

**BARRIERS TO IMPLEMENTATION**

- Engaging and sustaining relationships with healthcare providers or specialists
- Insufficient training or staff capacity
- Lack of continuity in care
- Lack of oversight and access to technical assistance
- Low program enrollment due to parental concerns about privacy and lack of understanding about telehealth

**SCHOOL-BASED TELEHEALTH MODELS**\(^*\)

- **Private Providers**
- **Provider Network**
- **FQHC/Local Hospital**
- **FQHC/Local Hospital**

![Infographics for School-Based Telehealth Models]

**Likelihood of Success**

\(^*\)all models require equipment valued at a minimum of $10,000

www.georgiavoices.org
RECOMMENDATIONS* FOR SUCCESSFUL SCHOOL-BASED TELEHEALTH PROGRAMS

FOR POLICYMAKERS
• Establish a governing entity for telehealth delivery that has authority to ensure quality, streamline school access to qualified telehealth providers and develop and encourage best practices.
• Increase opportunities for telehealth programs to be implemented within a comprehensive health system, including state funding for comprehensive school-based programs throughout the state.
• (Medicaid) Expand health care locations able to conduct presumptive eligibility to include SBHCs or SBTH programs.

FOR DISTRICTS OR SCHOOLS
• If possible, develop a school-based telehealth program within an existing or planned school-based health center.
• Engage and enlist the support of key stakeholders before planning begins.
• Allocate time and resources to continuously market the program and recruit and enroll students.
• Ensure an adequate number of trained personnel to provide services and manage the program’s administrative components.
• Ensure all children, regardless of insurance status, are served through the SBTH program.

*for an in-depth look at these recommendations, refer to https://tinyurl.com/SBTHinGAReport

GLOSSARY OF TERMS

Federally Qualified Health Center (FQHC)
A Federally Qualified Health Center is an outpatient clinic that qualifies for specific reimbursements under Medicare and Medicaid. Health centers provide a comprehensive set of health services including primary care, behavioral health, chronic disease management, preventive care, and other specialty, enabling, and ancillary services, which may include radiology, laboratory services, dental, transportation, translation, and social services.

School-Based Health Centers (SBHCs)
School-Based Health Centers place critically needed services like medical, behavioral, dental, and vision care directly in schools to reduce access barriers for children, families, and school personnel.

Telehealth
Telehealth refers to a broad scope of remote healthcare services, including nonclinical services, such as provider training, administrative meetings, and continuing medical education, in addition to clinical services.

Telemedicine
Telemedicine involves the use of electronic communications and software to provide clinical services to patients without an in-person visit

Sources available here: https://tinyurl.com/SBTHinGA
Healthcare Coverage for Parents and Caregivers

The impact of parents’ health on their child is lifelong and severe. It can have a long-lasting impact on cognitive ability and socio-emotional development, and can significantly deteriorate a family’s financial situation. However, nearly one in five Georgia adults with child dependents, or 371,100 people, lack healthcare coverage.1

**HOW GEORGIA PARENTS AND CAREGIVERS ARE (OR ARE NOT) COVERED**

- **Medicaid**
- **Uninsured**
- **Military** (2%)
- **Medicare** (1%)
- **Employer-sponsored insurance**

**COVERAGE SUBSIDIES AVAILABLE FOR GEORGIA PARENTS AND CAREGIVERS**

- **Medicaid**
  - Parent/Caretaker Medicaid is for people with child dependents whose incomes are 35% of the federal poverty level, or $9,170/year for a family of four. This is the only way for parents/guardians to receive Medicaid if they are not pregnant, aged, blind, or disabled.**
  - **Supplemental Security Income (SSI)** is available for adults with certain disabilities.

- **Subsidized Coverage on the Individual/Small Group Marketplace**
  - Subsidies are available on a sliding scale on healthcare.gov for parents/guardians who make between $26,200/year and $104,800/year for a family of four. The average marketplace premium in Georgia is $463/month.4

- **Employer-Sponsored Coverage**
  - In Georgia, less than half of private-sector employers offer employer-sponsored coverage, but most people who have employer-sponsored coverage make more than 400% FPL, or $104,800/year for a family of four.3
  - Fewer than 15% of people who make less than 100% FPL have employer-sponsored coverage.

**EXTENDED MEDICAID COVERAGE FOR NEW MOMS**

In 2020, Georgia extended coverage for new moms under Right from the Start Medicaid for Pregnant Women from two months postpartum to up to six months. This extension will improve the health of both mother and baby. Georgia’s pregnancy-related death rate is one of the highest in the nation and Black women are 2.7x more likely to die from pregnancy-related complications than White women.

**HEALTHCARE COVERAGE DISPARITIES**

- 32% of Hispanic or Latino adults are uninsured 5
- 46% of unemployed adults are uninsured 6
- 24% of working adults with incomes less than 138% FPL ($36,156 for a family of four) are uninsured 7

Sources available here: https://tinyurl.com/HealthcareCoverageGA

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1. [www.georgiavoices.org](http://www.georgiavoices.org)
2. [HOW GEORGIA PARENTS AND CAREGIVERS ARE (OR ARE NOT) COVERED](http://www.georgiavoices.org)
3. [Employer-Sponsored Coverage](http://www.georgiavoices.org)
4. [Subsidized Coverage on the Individual/Small Group Marketplace](http://www.georgiavoices.org)
5. [Medicaid](http://www.georgiavoices.org)
6. [Coverage Subsidies Available for Georgia Parents and Caregivers](http://www.georgiavoices.org)
7. [Extended Medicaid Coverage for New Moms](http://www.georgiavoices.org)
8. [Healthcare Coverage Disparities](http://www.georgiavoices.org)
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Access to Dental Care in Georgia

Poor oral health is one of the leading causes of school absenteeism in Georgia.¹

**ORAL HEALTH DISPARITIES IN GEORGIA**

Untreated tooth decay is **50% more common** in children in families with low-income compared to children in families with higher income.³

Hispanic children have a higher prevalence of tooth decay compared to non-Hispanic children.⁴

Children in rural communities have a higher prevalence (60%) of tooth decay compared to children in urban communities (48%).⁵

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**MAJOR CHALLENGES FACING KIDS AND DENTISTS**

**Availability of Care**

<table>
<thead>
<tr>
<th>Dentists</th>
<th>Hygienists</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 per 2,064 Georgians⁶</td>
<td>1 per 1,656 Georgians⁷</td>
</tr>
</tbody>
</table>

Georgia has **180** dental care shortage areas.¹

**Public v. Private Insurance**

On average, Medicaid and PeachCare beneficiaries have to travel **15 more miles** for dental care than their non-Medicaid peers.²

Medicaid reimburses **47.4%** of fees charged. Private insurance reimburses about **80%** of fees charged.¹⁰

**28%** of Georgia dentists accepted public insurance (Medicaid or PeachCare) in 2017.¹¹

Medicaid patients are required by federal law to have access to translation services arranged and paid for by the provider.¹² ¹³ ¹⁴

**38%** of dental schools in the U.S. report that students were not adequately prepared to manage Limited English Proficient patients.¹⁵

---

**20.3%** of children in Georgia did not have a dental check-up in the last 12 months.²

That’s more than **420,000** children.

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www.georgiavoices.org
BENEFITS OF IMPROVED DENTAL HEALTH

IMPROVED HEALTH OUTCOMES

Routine dental care is linked to:
- Improved eating and speaking
- Improved diabetes outcomes
- Reduced dental pain
- Improved pregnancy outcomes, including fewer low birthweight babies

COST SAVINGS FOR KIDS, FAMILIES, AND THE STATE

- Reduction of future dental visits and related costs
- Reduction in emergency department visits for non-traumatic dental problems

IMPROVED EDUCATION AND LIFE OUTCOMES

- Improved attendance
- Improved academic performance
- Improved self-esteem and employability
- Reduced pain and suffering

POLICY RECOMMENDATIONS

Increase dental workforce in shortage areas by:
- Educating and raising awareness about the ability of dental hygienists to practice in settings such as schools and nursing homes.

Incentivize and increase Medicaid acceptance rates among dentists by:
- Increasing Medicaid reimbursement rates for dental services like exams, cleanings, fluoride, sealants, and treatments of caries.
- Reducing administrative barriers that hinder dentists from accepting Medicaid.

Increase access to dental services in schools by:
- Leveraging comprehensive school-based health services as a vehicle for providing dental care.

Sources: https://tinyurl.com/AccessstoDentalCare
Childhood Illnesses in Georgia

ALARMING STATISTICS
Within the last three years, Georgia has fallen under the national average in childhood vaccinations - now ranking last in the country on the percentage of children ages 19-35 months who are immunized. More than 16% of 2-year-olds in Georgia lacked the recommended immunizations in 2017. When a child is not up-to-date on their immunizations, they are at risk for life-threatening diseases that were once rare or eliminated in the United States. Well-child visits are essential to staying up to date with childhood vaccines, as well as tracking developmental milestones and discussing your child’s health concerns.

PERTUSSIS
Commonly known as Whooping Cough
Known for uncontrollable, violent coughing which makes it difficult to breathe
Highly contagious and sometimes deadly for children of all ages
Most deaths are infants under 3 months

181
cases of pertussis in Georgia in 2018

1980s
saw a dramatic increase in the number of diagnosed pertussis cases

15,662
cases of pertussis in nationwide outbreak in 2019

MEASLES
Known for a rash of small, raised red spots that begins on the face and spreads down the body
Very contagious; can be contracted through airborne particles, which can stay active for up to two hours in the air or on objects
In 2017, the U.S. reported 1,282 measles cases, the greatest number of cases since 1992

17
states had confirmed outbreaks of measles, including Georgia in 2019

2000
the year measles was declared eliminated in the United States

MUMPS
Known for swelling in the salivary glands
Outbreaks typically occur in close-contact settings, such as schools or college campuses
Complications can include hearing loss, inflammation of the brain, pancreas, and spinal membranes

125
confirmed cases in Georgia in 2018, up from 17 in 2016

20%
of infected individuals show no symptoms, but can infect others

99%
drop in cases of mumps since the introduction of the vaccine in 1967

Sources available here: www.tinyurl.com/ChildhoodIllnessesinGA
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A study of more than 95,000 children found that the measles-mumps-rubella (MMR) vaccine did not increase a child’s risk of autism. Since 2003, 9 studies from the Centers for Disease Control (CDC) confirmed the mercury-based ingredient thimerosal is not linked to autism. The CDC stresses vaccines are safe, necessary to save lives, and there is no link between vaccines and autism.

Despite evidence of vaccines being safe and effective, some parents are choosing not to vaccinate their children. When children are not vaccinated, they are at risk of life-threatening diseases including diseases that were once rare or completely eradicated.

Vaccines and Vaccine Safety

Vaccines save lives! Vaccines build immunity to a disease by imitating an infection which causes the body to create antibodies and defensive white blood cells. The defensive white blood cells remain in the body and fight the disease if the body encounters it in the future.

Vaccines protect against 25+ serious and often life-threatening diseases in the U.S.

Vaccines protect

- Newborns
- People with Cancer/Weakened Immune Systems
- Transplant Patients

VACCINES ARE SAFE

- Side effects are minimal (e.g. slight discomfort and redness for short time).
- Serious side effects such as allergic reactions are extremely rare.
- Benefits of vaccines significantly outweigh any risks.

SO WHAT’S THE CONCERN?

- Despite evidence of vaccines being safe and effective, some parents are choosing not to vaccinate their children.
- When children are not vaccinated, they are at risk of life-threatening diseases including diseases that were once rare or completely eradicated.

VACCINES DO NOT CAUSE AUTISM

Since 2003, 9 studies from the Centers for Disease Control (CDC) confirmed the mercury-based ingredient thimerosal is not linked to autism. The CDC stresses vaccines are safe, necessary to save lives, and there is no link between vaccines and autism.

A study of more than 95,000 children found that the measles-mumps-rubella (MMR) vaccine did not increase a child’s risk of autism.

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Because vaccines **WORK!**
Many of these diseases have been wiped out or are very rare, thanks to vaccines!

<table>
<thead>
<tr>
<th><strong>VACCINE-PREVENTABLE ILLNESSES</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Polio</strong></td>
</tr>
<tr>
<td>- Poliovirus spreads from person to person via contact with an infected person’s feces; a less common spread can occur through sneezing or coughing.</td>
</tr>
<tr>
<td>- Lives in infected individual’s throat and intestines but can enter the brain and spinal cord and result in paralysis or death.</td>
</tr>
<tr>
<td>- Vaccine developed 1955.</td>
</tr>
<tr>
<td>- Some common ways to contract poliovirus are through contaminated food and unsanitary water.</td>
</tr>
</tbody>
</table>

| **Tetanus**                         |
| - Serious disease caused by a bacterium, called Clostridium tetani, that produce toxins. |
| - Some common ways to contract the bacteria that causes tetanus are through contaminated wounds and burns. |
| - Causes muscle stiffness and spasms, paralysis, and breathing problems. |
| - Treatment usually requires hospitalization. |
| - Vaccine first introduced in late 1940s. |
| - Tetanus has an approximately 11% fatality rate, and an even higher fatality rate among unvaccinated persons at 22%. |

| **Influenza**                       |
| - Respiratory illness caused by a virus. |
| - Every year since 2010, between 12,000 and 48,000 children under the age of 18 have been hospitalized by the flu. |
| - Vaccine licensed for all civilians in the U.S. during 1945. |

| **Hepatitis A**                    |
| - Liver infection caused by hepatitis A virus. |
| - Can be contracted from contaminated food, drinks, stool or sexual contact. |
| - Vaccine developed in 1995. |

| **Hepatitis B**                    |
| - Liver infection caused by the hepatitis B virus. |
| - Spread when blood and other bodily fluids of an infected person enter an uninfected person. |
| - Vaccine first became commercially available in 1981 in the U.S. |
| - Some common ways to contract the hepatitis B virus are through sexual contact, mother to child during pregnancy, sharing needles, and needle sticks. |

| **Rubella**                        |
| - Spreads through sneezing and coughing. |
| - Especially dangerous to pregnant women and fetuses. |
| - Vaccine first available in 1969. |

| **Hib**                            |
| - Haemophilus influenzae type b is a bacteria that infects the lining of the brain. |
| - Harms the immune system and causes brain damage and hearing loss and is sometimes fatal. |
| - Prior to vaccine development, Hib was the leading cause of bacterial meningitis for children under age five. |
| - Can cause severe infections of the lining of the brain and spinal cord (meningitis) and the bloodstream. |
| - Vaccine first licensed in 1987. |

| **Measles**                        |
| - Very contagious and can be contracted through airborne particles. The virus can stay active for up to 2 hours in the air or on objects. |
| - Especially serious for young children. |
| - Vaccine licensed in the U.S. in 1967. |

| **Pertussis**                      |
| - Highly contagious and sometimes deadly for infants. |
| - Known for uncontrollable, violent coughing which makes it difficult to breathe. |
| - Vaccine developed in 1930s and used widely by the mid-1940s. |

| **Pneumococcal Disease**           |
| - Bacterial disease that results in ear and sinus infections, pneumonia and sometimes meningitis. |
| - Especially dangerous for children and can affect the brain and spinal cord. |
| - Vaccine first used in U.S. in 1977. |

| **Rotavirus**                      |
| - Spread through hand-to-mouth contact. |
| - Symptoms include severe diarrhea and vomiting which can lead to severe dehydration requiring hospitalization. |
| - Vaccine was approved by the FDA in 2006 and a second was introduced in 2008. |

<p>| <strong>Mumps</strong>                          |
| - Contagious disease that cannot be treated. |
| - Symptoms include salivary gland swelling, fever and aches and fatigue. |
| - Vaccine licensed in the U.S. in 1967. |</p>
<table>
<thead>
<tr>
<th>Disease</th>
<th>Description</th>
</tr>
</thead>
</table>
| Chickenpox         | • Can be serious or even deadly for infants, adults and immunosuppressed
• Symptoms include itchy rash, blisters, and fever
• Vaccine first licensed for use in the U.S. in 1995 |
| Diphtheria         | • Can cause difficulty breathing and lead to heart failure, paralysis or even death
• Vaccine introduced in 1920s
• Most commonly spread from person to person through coughing or sneezing |
| Shingles           | • Painful skin rash on the face or body caused by the same virus that causes chickenpox: varicella-zoster
• Long-term nerve pain is one of the most common complications of shingles
• Healthy adults 50 years or older should get two doses, separated by 2 to 6 months |
| Human Papillomavirus | • Spread primarily through skin to skin contact (e.g., sexual contact, cut, abrasion, or small tear in skin)
• Most infections go away on their own, some can cause certain types of cancer in both men and women
• Children can receive the vaccine (administered in two doses) around ages 11-12, or around 15 (administered in three doses)
• Nearly all men and women will get HPV at some point in their lives |
| Tuberculosis       | • A bacteria spread through the air (cough, speak, sing) from one person to another
• Symptoms can include a cough lasting three weeks or longer, chest pain, and coughing up blood
• Can be detected through two tests: a blood test or a skin test |
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Benefits of Physical Education

Physical activity is crucial for a person’s well-being. Schools play a vital role in providing the opportunity for physical activity, with both recess and physical education (P.E.) classes.

WHERE GEORGIA STANDS

16.2% of Georgia’s youth ages 10-17 are overweight\(^1\) (see definition below)

13.8% of Georgia’s youth ages 10-17 are obese\(^2\) (see definition below)

RECOMMENDATIONS ON PHYSICAL ACTIVITY

The U.S. Department of Health and Human Services recommends children and adolescents aged 6 to 17 years have 60 minutes or more of physical activity each day.\(^3\)

Approximately 1 in 4 middle and high school students do not meet the recommended 60 minutes of physical activity.\(^4\)

Physical education benefits students by:

- Increasing their level of physical activity\(^2\)
- Improving grades and standardized test scores\(^2\)
- Helping stay on-task in the classroom\(^2\)

<table>
<thead>
<tr>
<th>Terms to Know</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body Mass Index (BMI)(^8)</td>
<td>Found by dividing a person’s weight in kilograms by the square height in meters. For children, weight status is determined by using age- and sex-specific percentile for BMI</td>
</tr>
<tr>
<td>Overweight(^2)</td>
<td>A BMI at or above the 85th percentile but below the 95th percentile</td>
</tr>
<tr>
<td>Obese(^10)</td>
<td>A BMI above the 95th percentile</td>
</tr>
<tr>
<td>Physical Education (P.E.)</td>
<td>A course to help students develop health-related fitness, physical competence, cognitive understanding, and positive attitudes toward physical activity</td>
</tr>
<tr>
<td>Contact Hour</td>
<td>A measure representing an hour of scheduled instruction given to students</td>
</tr>
</tbody>
</table>

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 PHYSICAL EDUCATION IN GEORGIA

<table>
<thead>
<tr>
<th>Grades</th>
<th>P.E. Requirement</th>
</tr>
</thead>
</table>
| K-5    | Minimum of 90 contact hours of instruction at each grade level in health and P.E.  
| 6-12   | Schools must provide a P.E. class, but students are not required to enroll. However, to graduate, students must have one semester of P.E. (.5 credit) and one semester of health (.5 credit) at some point in grades 9-12. |

The Georgia Performance Standards for Physical Education are based on the National Physical Education Standards developed by the National Association for Sport and Physical Education (NASPE). The Standards reflect what a physically educated student should know and be able to do at each grade level (K-12). Six standards, with accompanying elements, are provided for each grade level.  

Children and adolescents should do 60 minutes or more of physical activity daily. As part of their daily physical activity, they should engage in vigorous activity on at least three days per week. Additionally, preschoolers should be physically active throughout the day.

Our children should be guaranteed:

1. A minimum of three hours per week of physical education, distinct from health class, throughout the school year for all grade levels (K-12).
2. A minimum of 30 minutes of recess per day for grade levels K through 8.
3. Participation in recess and physical education classes that cannot be withheld for punitive reasons, such as discipline and/or poor academic performance.

Sources: http://tinyurl.com/BenefitsofPE
Benefits of Recess and Physical Activity

Research overwhelmingly shows that recess and physical activity have a positive impact across multiple domains.¹

**Recess and unstructured physical activity can lead to:**

**LEARNING AND ACADEMIC PERFORMANCE**

- **Higher grades** for students performing below grade level²
- **Higher recall rate** of vocabulary words (compared to those without recess)³
- **6%** Increase in standardized test scores for schools that build physical activity into lessons⁵
- A 2013-2015 study of Cobb County elementary and middle schools students found that maintained or improved fitness was associated with higher academic performance in:⁶
  - Math
  - Reading
  - Science

**SOCIAL AND EMOTIONAL DEVELOPMENT**

- **Increases brain development** in areas associated with attention, information processing, storage, retrieval, coping, and positive affect²
- **Increases opportunity** for development of social, intrapersonal, and communication skills¹⁰

**CLASSROOM ENGAGEMENT AND PRODUCTIVITY**

- **Increase in on-task behaviors**²
- **Decrease inappropriate behaviors**, such as distracting other students⁸

**PHYSICAL ACTIVITY AND FITNESS**

- **Nearly one-third** of Georgia’s children aged 10-17 were overweight or obese in 2018¹¹
- Recess provides a critical opportunity to boost physical activity among children¹²
- **Increases opportunity** for development of cognitive and motor skills¹³

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Sources available here: https://tinyurl.com/BenefitsofRecess

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¹ Reference 1
² Reference 2
³ Reference 3
⁴ Reference 4
⁵ Reference 5
⁶ Reference 6
⁷ Reference 7
⁸ Reference 8
⁹ Reference 9
¹⁰ Reference 10
¹¹ Reference 11
¹² Reference 12
¹³ Reference 13
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Youth E-cigarette and Tobacco Use in Georgia

E-cigarettes are electronic devices that heat a liquid and produce an aerosol or mix of small particles in the air for people to inhale. E-cigarette aerosol usually contains nicotine, flavorings and other chemicals.

**FACTS ABOUT TOBACCO AND E-CIGARETTE USE**

Using nicotine in adolescence can harm the parts of the brain that control attention, learning, mood, and impulse control.¹

Young people who use e-cigarettes and smokeless tobacco (chew or dip) are more likely to smoke cigarettes in the future.²

E-cigarettes are known by many different names. They are sometimes called “e-cigs,” “e-hookahs,” “mods,” “vape pens,” “vapes,” “carts,” “tank systems,” and “nicotine electronic delivery systems.”³ ⁴

Using an e-cigarette is sometimes called vaping or JUULLing.⁵

JUUL is a brand of e-cigarette. A single JUUL pod (the liquid nicotine refill) contains as much nicotine as a pack of 20 regular cigarettes.⁶

Nearly 80% say a friend or family member is the reason why they started to vape.²

**NATIONAL TRENDS**

**5.3 million**
6th to 12 grade students used e-cigarettes in 2019, up from 3.6 million in 2018.⁸

**1 in 10**
middle school students reported in 2019 that they used e-cigarettes within the past 30 days.²

More than **1 in every 4** high school students reported they used e-cigarettes in the past 30 days.¹⁰

**27.5%**
5.8% of high school students reported in 2019 that they smoked cigarettes in the past 30 days.¹¹

**GEORGIA TRENDS**

**1 in 4**
Georgia high school students reported that they had ever used e-cigarettes.¹²

Among Georgia high school students:

- **3.4%** were daily e-cigarette smokers.¹³
- **12.7%** say they have smoked e-cigarettes within the past 30 days.¹⁴

White students are **2.5 times** as likely to have smoked within the last 30 days compared to Black students.¹⁵

4% of Georgia’s high school students smoked cigarettes in the past 30 days.¹⁶

E-cigarettes are more popular among Georgia high school youth than other types of tobacco and have inspired more overall youth tobacco use as well.

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69,189 Georgia students reported that they have smoked a cigarette in the past.

**High School Students’ Perceptions**

- **One in four** believes e-cigarettes were more acceptable in society than cigarettes.  
- **Almost a third** reported that they believed e-cigarettes were less harmful than cigarettes.  
- **26.6%** reported that they believed e-cigarettes are less addictive than cigarettes.  
- **40%** believe that there is little to no risk in smoking one or more packs of cigarettes a day.

**How Youth Are Acquiring and Using E-Cigarettes and Tobacco**

- **84%** are purchasing e-cigarettes at a gas station or convenience store.
- **32%** of high school students report using alcohol, drugs, tobacco, or drugs at home, school, friend’s house, or in a car.

**Key Policy Changes and Recommendations**

1. Georgia’s General Assembly passed legislation that will apply a 7% excise tax to vape products and raises the legal smoking age from 18 to 21.
2. To combat youth access to cigarettes, raise the tobacco tax from 37 cents to the national average of $1.81.

Sources available here: [https://tinyurl.com/ECigarettesandTobacco](https://tinyurl.com/ECigarettesandTobacco)
Federal Child Food Programs in Georgia

When given access to adequate nutrition, the impact is clear: children are healthier and perform better in school. However, children who are not provided adequate, healthy food often perform poorly in school and are more likely to experience mental health problems. These children are also at greater risks for health issues later in life, like diabetes, high blood pressure, hypertension, heart disease, arthritis, and some types of cancer.

### CHILD HUNGER IN GEORGIA

Food insecurity affects **405,380** of Georgia’s children under the age of 18.

<table>
<thead>
<tr>
<th>PROGRAMS DESIGNED TO SUPPORT HEALTHY AND ADEQUATE CHILD NUTRITION</th>
<th>Description</th>
<th>Children Impacted in Georgia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CACFP</strong>&lt;br&gt;Child and Adult Care Food Program</td>
<td>Reimburses for nutritious meals. Child care programs, afterschool care programs, child care homes, emergency shelters, and adult care centers can be CACFP eligible.</td>
<td>153,933 average daily attendance</td>
</tr>
<tr>
<td><strong>NSLP</strong>&lt;br&gt;National School Lunch Program</td>
<td>Provides nutritionally balanced, free or reduced-cost (based on a sliding scale) free lunches to children in public and nonprofit private schools, and residential child care institutions.</td>
<td>1,174,602 total participation</td>
</tr>
<tr>
<td><strong>SBP</strong>&lt;br&gt;School Breakfast Program</td>
<td>Provides cash subsidies to public or non-profit private schools and residential child care institutions to provide meals that meet federal nutrition requirements. Meals are provided to eligible children for free or at a reduced cost.</td>
<td>649,674 total participation</td>
</tr>
<tr>
<td><strong>NSLP/SBP</strong>&lt;br&gt;Seamless Summer Option</td>
<td>Provides the same meal service that is available during the regular school year to hungry kids in the community during the summer. This program is provided through either the NSLP or SBP.</td>
<td>101,394 average daily participation</td>
</tr>
<tr>
<td><strong>SFSP</strong>&lt;br&gt;Summer Food Service Program</td>
<td>Reimburses for healthy meals and snacks served to children from low-income areas during summer months when school is not in session.</td>
<td>80,055 average daily attendance</td>
</tr>
<tr>
<td><strong>SMP</strong>&lt;br&gt;Special Milk Program</td>
<td>Provides milk in schools, childcare institutions and other eligible organizations which do not participate in other federal meal service programs. It is also available to children in half-day pre-kindergarten and kindergarten programs where school meal programs are not available.</td>
<td>69,492 half-pints served</td>
</tr>
<tr>
<td><strong>SNAP</strong>&lt;br&gt;Supplemental Nutrition Assistance Program</td>
<td>Provides a nutrition-designated electronic benefit card to supplement food budgets of individuals or families with low-income.</td>
<td>327,000 households with children</td>
</tr>
<tr>
<td><strong>WIC</strong>&lt;br&gt;Women, Infants, and Children</td>
<td>Provides supplemental food assistance, health care referrals, and nutrition education for low-income pregnant, postpartum, and breastfeeding women, infants, and children up to age five.</td>
<td>202,914 total participation</td>
</tr>
</tbody>
</table>

All data represents average daily participation for FY 2019 except for SNAP and NSLP/SSO data. SNAP data is from FY 2018 and represents the number of households with children receiving SNAP. NSLP/SSO data is from 2017.

Sources available here: www.tinyurl.com/ChildFoodPrograms
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Learning Disabilities in Children

The symptoms of learning disabilities are a diverse set of characteristics which affect development and achievement. All children can exhibit some of these symptoms at some point in their development. A person with a learning disability has a variety of these symptoms, which do not disappear as they grow older. However, with interventions these symptoms can be mitigated.

### SPECIFIC LEARNING DISABILITIES (SLD)

Specific Learning Disabilities affect the understanding or use of language, written or spoken.

**Nearly 35%**

of Georgia students receiving special education have a SLD.

Some of the most frequently displayed symptoms of a learning disability include:

- Short attention span
- Poor memory
- Inability to discriminate between letters, numerals, or sounds
- Difficulty with hand-eye coordination
- Sensory difficulties

### MOST COMMON LEARNING DISABILITIES THAT AFFECT LEARNING

- **Dyslexia**: affects reading, spelling, comprehension, writing, and recall
- **Dyscalculia**: poor comprehension of math symbols and numbers
- **Dysgraphia**: difficulty with writing, spacing, spelling, and composition
- **Attention Deficit/Hyperactivity Disorder (ADHD)**: an ongoing pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development
- **Visual Perceptual/Visual Motor Deficit**: a person may miss subtle differences in shapes or letters. They may also experience difficulty holding writing instruments or poor hand-eye coordination
- **Auditory Processing Disorder**: a person does not recognize subtle differences in sounds in words and difficulty blocking out background sound or determining a sound's origin

The most common disability areas served by the Georgia Department of Education’s Special Education Services and Supports are Specific Learning Disability, other health impairments, Speech Language Impairment, Significantly Developmentally Delayed, and Autism.

79,730 children across Georgia’s 200+ school districts have been diagnosed with a SLD.

Learning disabilities and intelligence are NOT related.

Early screening and intervention positively impacts a child’s development and success in the classroom.

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Dyslexia

Dyslexia is a language-based learning disability which results in difficulties with specific language skills including reading, writing, and pronouncing words. It is classified as a SLD under the Individuals with Disabilities Education Act. It can affect:

- speech and language
- reading comprehension and word recognition
- spelling and word substitutions
- social and emotional development

POLICY RECOMMENDATIONS

- Screen for potential language deficiencies prior to age six (e.g., remembering letters of the alphabet or rhyming).
- Provide training for ALL new teachers through the schools of education, relating to identifying dyslexia/reading problems and knowing how to teach students reading skills.
- Embrace the Cox Campus’ “Read Right from the Start” program that provides instruction to existing teachers on how to teach reading.
- Work with the new Sandra Dunagan Deal Center for Early Language and Literacy to ensure that the dyslexia piloted legislation from 2019 is well-implemented and well-evaluated.
- Expand early screening by building the expertise of educators and healthcare professionals to detect the early signs of a learning disability.
- Empower students and families to prepare students for a transition to postsecondary education or employment, address socio-emotional learning, increase access and build capacity for learning institutions, and invest in research.
- Cultivate and create informed educators to create supportive classrooms, partner to eliminate discipline disparities, expand research on youth involvement in the justice system.

Sources available here: www.tinyurl.com/LearningDisabilitiesinGA
Georgia’s Crisis in Child and Adolescent Behavioral Health

THE PROBLEM:
41% of children ages 3-17 struggle to or are not able to access needed mental health treatment and counseling.¹

Behavioral health is at the core of the majority of the problems we see in education, juvenile justice, and child welfare. And the challenges don’t stop there - they continue into adulthood.

**Georgia’s counties²**

- 78 counties do not have a licensed psychologist
- 53 counties do not have a licensed social worker
- 45 counties do not have a licensed psychologist OR a licensed social worker

Schools often serve as the primary point of access to behavioral health services and supports.³

<table>
<thead>
<tr>
<th>Social Workers</th>
<th>School Psychologists</th>
<th>School Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CURRENTLY:</strong></td>
<td><strong>CURRENTLY:</strong></td>
<td><strong>CURRENTLY:</strong></td>
</tr>
<tr>
<td>1 FOR EVERY</td>
<td>1 FOR EVERY</td>
<td>1 FOR EVERY</td>
</tr>
<tr>
<td>2,475 STUDENTS</td>
<td>2,475 STUDENTS</td>
<td>1,088 STUDENTS</td>
</tr>
<tr>
<td><strong>NEEDED:</strong></td>
<td><strong>NEEDED:</strong></td>
<td><strong>NEEDED:</strong></td>
</tr>
<tr>
<td>1 FOR EVERY</td>
<td>1 FOR EVERY</td>
<td>1 FOR EVERY</td>
</tr>
<tr>
<td>250 STUDENTS</td>
<td>700 STUDENTS</td>
<td>750 STUDENTS</td>
</tr>
</tbody>
</table>

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WHY WE NEED BEHAVIORAL HEALTH SERVICES

Untreated behavioral health illness in children and adolescents can lead to:¹² ¹³ ¹⁴

<table>
<thead>
<tr>
<th>Drug and alcohol abuse</th>
<th>Violent or self-destructive behavior</th>
<th>Low educational attainment</th>
<th>Much lower rates of employment in adulthood</th>
</tr>
</thead>
</table>

WHAT WE NEED:

1. All children and adolescents have access to behavioral health services.
2. Schools are equipped to meet the need early and effectively.
3. Georgia has the workforce to help children and adolescents with behavioral health needs.
4. Collaboration in normalizing behavioral health services to combat the stigma around addressing mental health needs.
5. Promotion of the Free Your Feels campaign to encourage youth to explore their real feelings and share them fearlessly.

WHAT NEXT?

We need to fully implement Georgia’s comprehensive three-year System of Care State Plan for child and adolescent health and support the work of Behavioral Health Innovation and Reform Commission to develop policy which can improve children’s behavioral health outcomes.

Sources available here: https://tinyurl.com/CrisisinBehavioralHealth
Snapshot of Health and Behavioral Health Services and Supports in Schools and Afterschool Settings

Please note that some services and supports are only available in a certain school district or school and are not countywide.

Counties shaded in: Black - have at least one school taking part in the Georgia Apex Program (school-based mental health services)  Grey - no schools participating in the Georgia Apex Program

Symbols below indicate a county with:

- Limited on-site health services
- Comprehensive SBHCs (includes behavioral health services)
- Project Aware
- Telehealth services
- Limited on-site behavioral health services
- Medical Mobile Unit - DeKalb and Chatham’s Medical Mobile Units serve 4 schools
- DBHDD Substance Abuse Clubhouses
- DBHDD Mental Health Resiliency Clubhouses
- Schools trained in Positive Behavioral Interventions and Supports
- School districts using the Georgia Partnership for Telehealth network

Georgia Department of Education (GaDOE) and Regional Educational Service Agencies (RESAs) coordinated 1,095 Mental Health Awareness Trainings (MHAT) for more than 25,000 educators and school staff, including:

- Trauma 101
- Brain Development 101
- Trauma and the Brain 201
- Trauma II: Recognizing and Managing Secondary Traumatic Stress

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**SCHOOL-BASED ACCESS**

**Georgia Apex Program**
Increases school-based behavioral health capacity through Community Service Boards (CSBs) and several private providers. Both develop partnerships with local schools to provide behavioral health services. Funding: DBHDD state funds.

**Project Aware**
Builds capacity of state and local educational agencies to increase awareness of mental and substance abuse issues through student screenings and school staff trainings. Grantees will assist in developing a statewide framework to provide training to school and community professionals to identify students with mental health needs and connect youth and families to community resources.

**Youth Mental Health First Aid**
Provides individuals who interact with youth with skills for helping an adolescent who is experiencing a mental health or addiction challenge or is in crisis.

**Sources of Strength**
Targets strengthening multiple sources of support, changing social norms and school culture. The program is designed promote help seeking behavior and encourage connections between peers and adults.

**School-Based Health Centers (SBHCs)**
Improve childrens’ access to health services. 34 SBHCs provide mental and behavioral health services through on-site services in partnership with community providers. Funding: Foundation grants for start-up costs, insurance billing for sustainability.

**Positive Behavior Interventions and Supports (PBIS)**
Facilitates positive school climate and timely identification of behavioral health needs for students. A network of 1100+ schools and programs representing 50% of Georgia local educational agencies continue implementation with fidelity. Funding: DOE state funds PBIS specialists in each Regional Educational Service Agency.

**TELEMEDICINE & TELEHEALTH**

**School-based Telehealth (SBTH)**
Provides children and families with access to needed primary, acute, and specialty care on a school campus through telecommunication technologies.

**Georgia Partnership for Telehealth (GPTH)**
116 schools have telehealth equipment to be used for behavioral health services through the GPTH network. Funding: GPTH grant; school budget for staff time; Medicaid.

**OUT-OF-SCHOOL TIME**

**Clubhouses**
Mental Health Resiliency Club Houses: 13 clubhouses statewide, supported by DBHDD, to provide supportive services, e.g., educational, social, and employment support geared to engage youth and assist them in managing behaviors and symptoms.

DBHDD supports three prevention clubhouses that were designed to provide prevention services to high-risk youth ages 12-17 to address challenges they face in their communities. They are located in Norcross, LaGrange, and Dawson, Georgia.

Sources available here: https://tinyurl.com/SBHCServicesSupport
School-Based Mental Health Programs: How They Work and Succeed

School-based mental health programs increase much-needed access to mental health support by eliminating barriers to care such as transportation, provider availability and proximity, and cost.

THE NEED FOR SCHOOL-BASED MENTAL HEALTH

Nearly 80,000 students in 6th through 12th grade reported having seriously considered attempting suicide.¹

2 in 5 children have trouble accessing the mental health treatment they need.²

1 in 6 children aged 2 to 8 years old has a diagnosed mental, behavioral, or developmental disorder.³

CHALLENGES PROVIDERS EXPERIENCE

- Limited qualified workforce who will accept the salary (lower than other jobs in the field)
- Clinician burnout (i.e. from heavy caseloads and secondary trauma)
- Blurred roles in schools and extra demands on clinicians’ time (hindering billable time, which is important for program sustainability)
- Lack of transportation for afterschool and summer services
- Stigma around mental health treatment
- Limited parental involvement

FACTORS THAT BOOST PROGRAM SUCCESS

- Using both insurance billing and grant funding (This allows programs to be comprehensive, providing interventions in all three tiers.)
- School buy-in

RESOURCES

Read Voices’ full report, Supporting Children’s Mental Health in Georgia Schools: How Three School-Based Mental Health Providers Serve Students

Read Georgia Statewide Afterschool Network’s report, Behavioral Health Needs in Afterschool & Summer Time: Equipping Programs to Support Georgia’s Youth

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MULTITIERED SYSTEM OF SUPPORTS

Comprehensive school-based mental health increases the chance that teachers and clinicians will identify students with untreated mental health needs and avoid misdiagnoses. Students who appear to have a mental health disorder but are actually experiencing another challenge (e.g., family instability, severe hunger, trouble with vision) are more likely to be properly tested.

Recommendations

**State Agencies and Leadership**
- Extend telemedicine reimbursement provisions to support increasing access (including summer services) and family engagement (Providers need to be reimbursed to continue to provide telemedicine, as we recommend in the next section.)
- Streamline Medicaid eligibility determination policy and practices to reduce the number of insured children (Georgia’s high rate of uninsured children, most of whom are eligible for Medicaid or PeachCare, puts a great strain on the financial sustainability of community providers.)
- Regularly share school-based mental health program outcomes annually
- Support integrated school-based health (physical and mental health)
- Reimburse school-based mental health services consistently
- Simplify/streamline insurance billing
- Explore reasonable alternatives to the state salary schedule such that state behavioral health professionals are competitive in their field
- Consider mobilizing school counselors, school psychologists, and school social workers to provide therapeutic services

**Providers**
- Increase peer-to-peer support opportunities for youth and families (e.g., sources of strength program, establishing family federation chapters)
- Support clinicians to ease the burden and prevent burnout (e.g., secondary trauma supports, billing programs to minimize administrative burdens)
- Promote free clinical supervision toward licensure and incentives, like federal loan forgiveness
- Partner with afterschool and summer learning programs
- Partner with Regional Education Service Agencies (RESAs), School Climate Specialists, and school Positive Behavioral Interventions and Supports (PBIS) coordinators
- Continue to use telehealth to enhance access to services

**Schools**
- Work with providers to submit community plans to draw down federal funding (e.g., HRSA grants)
- Leverage district and school-level funds to support program costs
- Include providers in school meetings and groups (e.g., staff meetings, student support teams) and leverage providers for teacher trainings and professional development

Sources: [https://tinyurl.com/SBMHFactsheetRefs](https://tinyurl.com/SBMHFactsheetRefs)
Voices for Georgia’s Children conducted an analysis of Georgia’s child and adolescent behavioral health workforce* in order to improve the preparation, practice, and support of the workforce. The following represent key findings and recommendations from that analysis.

<table>
<thead>
<tr>
<th>FINDINGS</th>
<th>RECOMMENDATIONS</th>
<th>KEY PARTNERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Education and Training</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Georgia lacks a strategic, integrated and formal approach to education, training, and licensure:</td>
<td>Pilot a training program that ensures the workforce has a path from degree to licensure with relevant evidenced-based therapy training</td>
<td>State Agency-University Partnerships</td>
</tr>
<tr>
<td>• Lack of sufficient opportunities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Lack of system connectivity</td>
<td>Expand residency and post-degree certification opportunities</td>
<td></td>
</tr>
<tr>
<td>• Difficult path to licensure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Graduates lack certain skills, training, and confidence in:</td>
<td>Streamline trauma training of existing workforce and child serving systems</td>
<td>State Agency-University Partnerships</td>
</tr>
<tr>
<td>• Evidence-based therapies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Administrative skills</td>
<td>Offer scholarships or sponsor cohorts of practitioners to be trained in targeted therapies and obtain CEUs</td>
<td></td>
</tr>
<tr>
<td><strong>Scope and Practice Environment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Georgia does not collect demographic information on who is practicing and where</td>
<td>Implement a Minimum Data Set Survey (MDSS) to collect data on the workforce at licensure renewal</td>
<td>Secretary of State; Georgia Board of Health Care Workforce; State Legislature; Georgia Composite Board of Professional Counselors; Social Workers; and Marriage &amp; Family Therapists</td>
</tr>
<tr>
<td>• Report geographic and demographic data collected in the MDSS annually (e.g. map the distribution of the workforce)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inconsistent and low Medicaid reimbursement rates</td>
<td>Explore evidence-based reimbursement rates to ensure consistent reimbursement rates across practice settings</td>
<td>State Agencies; State Agency-University Partnerships; Governor’s Office; and State Legislature</td>
</tr>
<tr>
<td>Lack of coordination between crisis care and follow-up care</td>
<td>Improve integration of Georgia’s Crisis and Access Line (GCAL) with the systems that provide follow up care (e.g., care coordination services within Care Management Organizations)</td>
<td>GCAL; State Agencies</td>
</tr>
<tr>
<td>Advanced Practice Nurses (APRNs) in Georgia have a more limited scope of practice than in comparable states</td>
<td>Research expanding the authorization of Psychiatric Nurses to fully leverage their education, training, and capabilities</td>
<td>State Legislature; State Agencies; Medical Composite Board; Nursing associations &amp; degree programs</td>
</tr>
<tr>
<td>Lack of clarity about license reciprocity with other states</td>
<td>Create a publicly available list of licensure reciprocity standards and the states from which Georgia accepts licenses for incoming professionals (particularly helpful to support military spouses)</td>
<td>State Legislature; Professional Licensing Boards</td>
</tr>
<tr>
<td><strong>Support</strong></td>
<td>Expand loan reimbursement programs to include additional mental health professionals</td>
<td>State Agencies; State Legislature; Governor’s Office</td>
</tr>
<tr>
<td>Limited loan reimbursement programs available for all provider types, and providers struggle to enroll in those that exist</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*The analysis covered core behavioral health providers including psychiatrists, pediatricians, psychologists, psychiatric nurses, social workers, marriage and family therapists, and professional counselors.

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Youth Suicide in Georgia

Suicide was the second leading cause of death for Georgia children aged 10-17 in 2018.

GEORGIA YOUTH SUICIDES, AGES 5-17
Source: Georgia Bureau of Investigation, Child Fatality Review Unit

BREAKDOWN OF 2018 YOUTH SUICIDE DATA
Source: Georgia Bureau of Investigation, Child Fatality Review Unit

GEORGIA STUDENT HEALTH SURVEY
Source: Georgia Department of Education

In 2019:
- 108,494 students reported having seriously considered harming themselves
- 61,978 students reported having harmed themselves

The number of children in Georgia who visited emergency rooms for reasons related to suicide doubled between 2008 and 2018.

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These signs may mean that someone is at risk for suicide. Risk is greater if the behavior is new, or has increased, and if it seems related to a painful event, loss, or change. Risk is also greater with the presence of multiple warning signs.1

- Talking about wanting to die or kill oneself
- Seeking or having lethal means, such as firearms or medication, to kill oneself
- Talking about feeling hopeless or having no reason to live
- Talking about feeling trapped or being in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated; behaving recklessly
- Sleeping too little or too much
- Withdrawing or feeling isolated
- Displaying extreme mood swings
- Putting affairs in order or saying goodbye
- Sudden cheerful mood after depression
- Losing interest in enjoyable things
- Difficulty dealing with life issues

### PROTECTIVE FACTORS TO PREVENT SUICIDE

According to the Centers for Disease Control and Prevention, protective factors buffer individuals from suicidal thoughts and behaviors.2

- Ongoing quality healthcare for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support
- Family and community support and connection
- Development of strong skills for non-violent conflict resolution and problem solving
- Cultural and religious believes that discourage suicide and support instincts for self-preservation

<table>
<thead>
<tr>
<th>Comprehensive Prevention Strategies</th>
<th>Example Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify and assist persons at risk</td>
<td>Gatekeeper training, suicide screening, teaching warning signs, referral to professional help</td>
</tr>
<tr>
<td>Increase help-seeking</td>
<td>Self-help tools and outreach campaigns</td>
</tr>
<tr>
<td>Ensure access to effective treatment</td>
<td>Safety planning, evidenced-based treatment, and reducing financial, cultural, and logistical barriers to care</td>
</tr>
<tr>
<td>Support safe care transitions and organizational linkages</td>
<td>Formal referral protocols, interagency agreements, cross-training, follow-up contacts, rapid referrals, and patient and family education</td>
</tr>
<tr>
<td>Respond effectively to individuals in crisis</td>
<td>Mobile crisis teams, walk-in crisis clinics, hospital-based psychiatric emergency services, and peer-support programs</td>
</tr>
<tr>
<td>Provide immediate and long-term post-vention</td>
<td>Protocols to respond effectively and compassionately after a suicide, supports for people bereaved by suicide</td>
</tr>
<tr>
<td>Reduce access to means of suicide</td>
<td>Educate families, distributing gun safety locks, changing medication packaging, and installing barriers on bridges</td>
</tr>
<tr>
<td>Enhance life skills and resilience</td>
<td>Skills training, mobile apps, and self-help materials</td>
</tr>
<tr>
<td>Promote social connectedness and support</td>
<td>Social programs for specific population groups</td>
</tr>
</tbody>
</table>

Source: Suicide Prevention Resource Center
### Youth Substance Use and Non-Substance Disorders

**Substance Use Disorder¹**
Recurrent use of substances that causes clinically and functionally significant impairment and failure to meet major responsibilities

**Non-Substance Disorder²**
Behavioral addictions that lead to significant psychosocial and functional impairments

#### SUBSTANCES USED BY YOUTH

<table>
<thead>
<tr>
<th>Substance</th>
<th>Type of Drug</th>
<th>Physical Form</th>
<th>Consumption</th>
<th>Impact on Health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alcohol</strong></td>
<td>Depressant</td>
<td>Liquid</td>
<td>In beverages</td>
<td>Impaired brain functioning; increased risk of cancer; weakened immune system; decreased heart health and functioning; damage to the liver and other organs; and increased risky behaviors² ³</td>
</tr>
<tr>
<td><strong>Cocaine</strong></td>
<td>Stimulant</td>
<td>Fine, white powder</td>
<td>Snorted, smoked, or injected</td>
<td>Impaired brain functioning; decreased appetite; damage to nose, intestines, and bowels; increased alertness, insomnia, anxiety, and erratic behavior; increase risk for heart issues; and increased risk for infectious diseases² ⁴</td>
</tr>
<tr>
<td><strong>Marijuana</strong>*</td>
<td>Psychoactive</td>
<td>Greenish, gray mixture of dried, shredded leaves, stems, seeds, flowers; or resin</td>
<td>Smoked or eaten</td>
<td>Decreased coordination and reaction time; hallucinations, anxiety, panic attacks and psychosis; problems with mental health, learning, and memory; and damage to the respiratory system² ⁵ ⁶</td>
</tr>
<tr>
<td><strong>Opioids</strong></td>
<td>Pain relievers, depressants, and stimulants</td>
<td>Tablet, capsule, or liquid</td>
<td>Swallowed or injected</td>
<td>Drowsiness, nausea, constipation, and confusion; slowed breathing and death; and increased risk of infectious diseases² ¹⁰</td>
</tr>
<tr>
<td><strong>Tobacco</strong></td>
<td>Stimulant</td>
<td>Cigarettes, cigars, bidis, hookahs, snuff, or chew</td>
<td>Smoked, snorted, chewed, or vaporized</td>
<td>Increased blood pressure, breathing, and heart rate; greatly increased risk for cancer; and increased risk for chronic bronchitis, emphysema, heart disease, cataracts, and pneumonia¹¹ ¹²</td>
</tr>
</tbody>
</table>

---

* Legislation passed in 2017 and 2018 that expanded the conditions for which cannabis oil can be prescribed to include post-traumatic stress disorder, intractable pain, Tourette’s syndrome, Autism Spectrum Disorder, Epidermolysis bullosa, Alzheimer’s disease, Human immunodeficiency syndrome, Autoimmune disease and Peripheral neuropathy.

[www.georgiavoices.org](http://www.georgiavoices.org)
**Non-Substance Disorders**

**Pathological Gambling**
- **Description**: A formally recognized and treatable addiction to regulated and non-regulated gambling and betting that causes significant problems in a child’s life.
- **Impact on Health**: Loss of means to protect well-being (e.g., money, school materials, food, etc.); stress and guilt associated with loss and debt; damaged relationships; and increased risk for mental health disorders, crime, substance use, and risky behaviors.

**Problematic Internet Use**
- **Description**: Encompasses gambling, internet enabled sexual behavior, online gaming, and excessive internet use (more than 35 hours/week) that causes youth to neglect other areas of life important to healthy development and functioning (e.g., spending time with friends and family, sleeping, and doing school work).
- **Impact on Health**: Decrease in offline social activities; changes in health habits (e.g., sleep, eating, and physical activity); and increased likelihood of developing depression.

---

**FACTS ON YOUTH SUBSTANCE USE**

- **Alcohol, marijuana, and tobacco** are the most commonly used substances among adolescents. More than **36,000** high school students reported using marijuana in the last 30 days.

- Georgia has the **5th highest** marijuana possession arrest rate in the nation and a Black person is **3 times more likely** to be arrested for possession than a White person.

---

**GEORGIA HIGH SCHOOL STUDENT USE OF SUBSTANCES WITHIN THE LAST MONTH**

<table>
<thead>
<tr>
<th>Substance</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>11%</td>
</tr>
<tr>
<td>e-Cigarette (Vaping)</td>
<td>10%</td>
</tr>
<tr>
<td>Marijuana</td>
<td>9%</td>
</tr>
<tr>
<td>Cigarettes</td>
<td>4%</td>
</tr>
<tr>
<td>Pain Relievers</td>
<td>4%</td>
</tr>
</tbody>
</table>

The Georgia Student Health Survey is offered annually. “The last month” refers to the month prior to the students completing the survey. This measure is used to assess alcohol and drug use among youth and can be compared to national data from the Youth Risk Behavior Surveillance System (YRBSS).

Sources available here: [https://tinyurl.com/YouthSubstanceUseGA](https://tinyurl.com/YouthSubstanceUseGA)
Opioid Use in Georgia

WHAT ARE OPIOIDS?\(^1\)
Opioids are a class of drugs that act in the nervous system to produce feelings of pleasure and pain relief. They can be generally classified into three categories:\(^2\)

<table>
<thead>
<tr>
<th>Prescription Opioids</th>
<th>Fentanyl</th>
<th>Heroin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can be prescribed by doctors to treat moderate to severe pain, but can have serious risks and side effects.</td>
<td>Fentanyl is a synthetic opioid pain reliever. It is many times more powerful than other opioids and is approved for treating severe pain, typically advanced cancer pain.</td>
<td>Heroin is an illegal opioid.</td>
</tr>
<tr>
<td>Common types are:  • oxycodone (OxyContin)  • hydrocodone (Vicodin)  • morphine  • methadone</td>
<td>Illegally made and distributed fentanyl has been on the rise in several states.</td>
<td>Heroin use has increased across the U.S. among men and women, most age groups, and all income levels.</td>
</tr>
</tbody>
</table>

Addiction (termed substance dependence by the American Psychiatric Association) is defined as a brain disease that leads to compulsive substance use despite harmful consequences.\(^3\)

**NEONATAL ABSTINENCE SYNDROME**

Neonatal Abstinence Syndrome (NAS) is a set of clinical withdrawal signs and symptoms present in a newborn infant who was exposed to illegal or prescription drugs while in the mother’s womb.\(^4\)

The long-term effects of NAS may include learning disabilities and delayed motor skills.\(^5\)

762 confirmed cases of NAS in Georgia in 2017.\(^4\)

$16,225 the average hospital charge for an infant with withdrawal symptoms.\(^2\)

More than one in three infants with NAS were born to mothers 25-29 years of age.\(^8\)

Infants with non-Hispanic White mothers had nearly twice the cases of NAS as infants with non-Hispanic Black mothers.

In 2020, nearly 20,000 middle school and high school students reported taking a prescription drug painkiller, within the last 30 days, that was not prescribed for them.\(^10\)

www.georgiavoices.org
Opioid-involved overdoses accounted for 4,858 emergency room visits and 2,174 hospitalizations.\(^{17}\)

### OPIOID DEATHS IN GEORGIA

From 2010 and 2019, the number of opioid-involved overdose deaths increased by 78% in Georgia, from 514 to 913 deaths.\(^{11}\) In fact, in 2014, Georgia saw more deaths related to drug overdose than from motor vehicle crashes.\(^{12}\)

<table>
<thead>
<tr>
<th>Year</th>
<th>Opioid Deaths</th>
<th>Motor Vehicle Crashes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>1223</td>
<td>1070</td>
</tr>
<tr>
<td>2011</td>
<td>1248</td>
<td>1070</td>
</tr>
<tr>
<td>2012</td>
<td>1177</td>
<td>1059</td>
</tr>
<tr>
<td>2013</td>
<td>1223</td>
<td>1125</td>
</tr>
<tr>
<td>2014</td>
<td>1219</td>
<td>1307</td>
</tr>
<tr>
<td>2015</td>
<td>1345</td>
<td>1556</td>
</tr>
<tr>
<td>2016</td>
<td>1307</td>
<td>1540</td>
</tr>
<tr>
<td>2017</td>
<td>1537</td>
<td>1504</td>
</tr>
<tr>
<td>2018</td>
<td>1404</td>
<td></td>
</tr>
</tbody>
</table>

Opioid-involved overdoses accounted for 4,858 emergency room visits and 2,174 hospitalizations.\(^{17}\)

### GEORGIA’S RESPONSE

- Georgia’s opioid-focused legislation and prevention efforts have led to an improvement in the state’s nationwide opioid overdose deaths ranking, dropping from 11th to 42nd.\(^{18}\)
- In 2017, Georgia developed a standing order allowing pharmacists across the state to dispense naloxone/narcan, an opioid overdose reversal drug.\(^{19}\)
- The Opioid and Substance Misuse Unit is implementing a sustainable, collaborative and multi-disciplinary approach, by forming eight workgroups and one supporting committee on Multi-cultural Inclusion: Prevention Education; Maternal Substance Use; Data and Surveillance, Prescription Drug Monitoring Program, Treatment and Recovery; and Control and Enforcement; Harm Reduction and Hospice. Each workgroup outlined strategic next steps for the state.\(^{20}\)
- The General Assembly passed legislation to establish the Department of Community Health as an oversight agency for drug treatment and rehabilitation programs, which will ensure that policies and procedures are standardized.\(^{21}\)
- In 2014, the General Assembly passed House Bill 965, the Georgia 911 Medical Amnesty Law, which provides protection for the people who seek medical assistance for someone who is experiencing a drug or alcohol-related overdose. The bill also increased access to naloxone/narcan to family members. Non-profit organizations like the Atlanta Harm Reduction Coalition (AHRC) and the Georgia Overdose Prevention Project raise funds to offset the cost of naloxone/narcan.\(^{22}\) For more information or overdose prevention training, contact AHRC at 404-817-9994 or TA@ahrc-atl.org.\(^{23}\)
- The Criminal Justice Coordinating Council (CJCC) received funding from the Office of Juvenile Justice and Delinquency Prevention (OJJDP) to create the Georgia Opioid Affected Youth Initiative competitive grant opportunity. The grant supports public government entities, non-profit and for-profit organizations in:
  - improving youth opioid misuse and overdose surveillance,
  - tracking of naloxone dissemination and use, and
  - facilitating opioid overdose prevention training among school faculty and staff; and connecting, creating or expanding treatment and recovery support services for youth involved in the Department of Juvenile Justice.\(^{24}\)

Sources: available here: [https://tinyurl.com/OpioidUseinGA](https://tinyurl.com/OpioidUseinGA)
Autism and Autism Spectrum Disorder (ASD) are used interchangeably to describe a group of complex disorders of brain development that impact how people communicate, interact, and behave. Behaviors associated with ASD can be evident in children prior to two years old, however most signs and symptoms begin to appear between 2-3 years old.

The most recent edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM-5) is the primary tool for diagnosis of ASD. In order for a child to be diagnosed with ASD, the DSM-5 requires that they demonstrate a combination of:

**Persistent deficits in social communications and interactions:**
- Social-emotional reciprocity
- Nonverbal communicative behaviors used for social interaction
- Developing, maintaining, and understanding relationships

**Restricted and repetitive patterns of behaviors, interests, and activities:**
- Repetitive motor movements, use of objects, or speech
- Insistence on sameness; inflexible adherence to routines
- Highly restricted, abnormally intense, and fixated interests
- Hyper- or hyporeactivity to sensory input; unusual interest in sensory aspect of environment

**Prevalence of ASD in Georgia**

91,914 children in Georgia, ages 3-17, are diagnosed with autism.

Factors related to apparent increase in prevalence:
- Improved diagnosis criteria
- Environmental influences, such as parental age at conception, prematurity, and birth weight
- Increased awareness and earlier screenings

**Behavior Analysts in Georgia**

<table>
<thead>
<tr>
<th>Certification</th>
<th>Statewide Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctoral (BCBA)</td>
<td>60</td>
</tr>
<tr>
<td>Master’s/Graduate (BCBA)</td>
<td>679</td>
</tr>
<tr>
<td>Bachelor’s (BCaBA)</td>
<td>43</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>782</strong></td>
</tr>
</tbody>
</table>

BCBA: Board Certified Behavior Analyst
BCaBA: Board Certified Assistant Behavior Analyst

Sources available here: [https://tinyurl.com/AutisminGA](https://tinyurl.com/AutisminGA)
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Babies Can’t Wait

Babies Can’t Wait (BCW) is Georgia’s evidence-based, community-centered early intervention program that provides screening, treatment, and support services for certain infants and toddlers (from birth to age 3) with disabilities and developmental delays.

A child’s brain develops extremely rapidly from birth to age three. **This is a critical window of opportunity to detect and address developmental delays before they become significant barriers to healthy development.** BCW staff work with physicians to identify children showing signs of certain degrees of developmental delays so that needed supports can be provided early on – and long-term development challenges can be prevented or mitigated.

**WHO QUALIFIES FOR SERVICES?**

BCW serves children 0-36 months who have a documented developmental delay or chronic health condition that leads to developmental delays.

A free developmental evaluation is given to families to determine eligibility for services and supports under the program.

Services provide support and resources to assist family members/caregivers to enhance children’s learning and development in the child’s natural environment (e.g., home or community setting).

Anyone can refer a child to Babies Can’t Wait³

Parents
Childcare Providers
Doctors

**HOW THE PROGRAM IS FUNDED**

**babies can’t wait** is funded by state and federal dollars, and housed within

**Georgia Department of Public Health**

**HOW SERVICES ARE PAID FOR**

First, services are billed to the child’s health insurance (where applicable and with parent permission)

A sliding fee is determined based on income and family size

Services are then paid for by the BCW program as payor of last resort, if needed

**CHILDREN SERVED BY BABIES CAN’T WAIT**

Approximately 19,000 children are served** every year in Georgia

The number of children that are referred and eligible is increasing each year¹

It’s likely that more children are in need of services than BCW can currently serve, given existing constraints

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¹ According to the Georgia Department of Public Health, children must score 2 standard deviations from the mean in one area of development, or 1.5 standard deviations in two areas of development on one of the approved standardized eligibility test tools. If a child does not show a documented delay per the test results, the team can determine eligibility based on informed clinical opinion.

² All children received Service Coordination or case management services to guide them through the program and to assist in developing the Individualized Family Service Plan (IFSP). Should a child need additional services determined by the IFSP team, it is added to the plan and coordinated by the Service Coordinator.

³ www.georgiavoices.org
RECOMMENDATIONS TO STRENGTHEN THE BABIES CAN’T WAIT PROGRAM

• Assess and address staff retention issues.
• Prioritize coordination and follow-up coordination/communication between referral source (e.g. physician) and program staff.
• Recruit providers to serve in all districts at numbers that meet the demand for services.
• Leverage telehealth for providing services to parents/caregivers where possible.
• Continue to explore whether there are early intervention services provided by the state which could be billed to Medicaid and/or private insurance (e.g. provider-to-provider consultations to coordinate services). If feasible, this would allow greater flexibility for IDEA Part C grant funds to support case management.

Babies Can’t Wait is a federally regulated program under the Individuals with Disabilities Education Act, specifically, Part C of the law. The program is to be a statewide, coordinated, multidisciplinary inter-agency system that provides early intervention services for infants and toddlers, and coordinates developmental, educational, and community supports for those children. However, eligibility criteria may vary state to state.
"Free Your Feels" is a youth mental health awareness campaign encouraging Georgia's young people to explore their **real feelings** and share them **fearlessly**.

**Why are we doing this?**

Prior to the coronavirus pandemic, data shows that our kids were already facing a mental health crisis for years – one that is now exacerbated by these uncertain times. Anxiety, depression, trauma, and suicidal ideation affect an extraordinary number of the 2.5 million kids in our state. According to the 2018-2019 Georgia Department of Education student health survey:

- Nearly half of all middle and high school students surveyed reported feeling depressed.
- More than 61,000 reported intentionally harming themselves.
- Nearly 40,000 said they had attempted suicide, and another 78,000 kids reported having seriously considered it.

**Also, in Georgia:**

- Suicide is the **second** leading cause of death in children ages 10 to 18.
- Roughly **one-third** of the youth under the supervision of the Georgia Department of Juvenile Justice qualify for a PTSD, trauma, or stress diagnosis.

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**Who are we trying to reach?**

**ADULTS CARING FOR YOUTH**

Supporting educators, parents, faith leaders, childcare providers, etc. in their support of youth.

**TEENS**

Teen-developed content to be delivered peer-to-peer.

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**What are the goals of the campaign?**

**SPEAK**

We want to empower youth to speak out and express their real feelings,

**LISTEN**

To encourage adults and peers to check-in with each other and listen judgment-free,

**CONNECT**

And to connect everyone to resources for further guidance or help.

---

**What can I do?**

**PARTICIPATE ON SOCIAL MEDIA! SHARE RESOURCES!**

The goal is to reach as many youth and adults as possible. The Free Your Feels website houses a collection of resources from different organizations and agencies, including ready-to-use editable graphics to easily promote and share messaging.

[www.freeyourfeels.org](http://www.freeyourfeels.org)
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Adverse Childhood Experiences (ACEs), or early negative experiences, can lead to negative impacts later in life, such as poor mental and physical health, lower academic achievements, and substance abuse. In the research discussed here, ACEs refer to these eight experiences:

- Emotional abuse
- Physical abuse
- Sexual abuse
- Incarceration of a parent
- Mental illness in a household member
- Substance abuse within the household
- Violence between parents
- Separated or divorced parents

ACEs - along with experiencing community violence, racism, and other negative life events - can cause high levels of stress, or toxic stress, which can also have long-term effects on a child’s development.

PREVALENCE OF ACEs IN GEORGIA

Nearly 3 in 5 surveyed Georgians reported having experienced at least one ACE. In 2016 and 2018, Georgia collected data from adults about ACEs they experienced as children, documenting the prevalence of the above eight types of ACEs. (Other types of ACEs not included in this research are experiencing neglect and having a family member attempt or die by suicide.)

ACEs Among Adults 18 Years and Older, Georgia Behavioral Risk Factor Surveillance System, 2018

<table>
<thead>
<tr>
<th>ACE</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incarceration</td>
<td>9.5%</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>13%</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>15%</td>
</tr>
<tr>
<td>Physical Abuse</td>
<td>16%</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>19%</td>
</tr>
<tr>
<td>Emotional Abuse</td>
<td>25%</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>26%</td>
</tr>
<tr>
<td>Divorce</td>
<td>33%</td>
</tr>
</tbody>
</table>

DATA ON DISPARITIES

While the likelihood of having four or more ACEs did not vary significantly by race or ethnicity in Georgia, White respondents were about 8 times as likely to have experienced no ACEs as Black respondents, according to 2016 BRFSS data.
POLICY RECOMMENDATIONS

These recommendations build protective factors around families. In order to adequately tackle ACEs and toxic stress, an adequate support system for each child should be at the center of any child policy platform.

Early Care and Learning
• Create an environment where the effects of toxic stress are buffered with appropriate supports to help children adapt and enhance cognitive and social development

Early Intervention
• Increase access to health care and home visiting support to promote healthy development and provide early diagnoses, appropriate care, and intervention when problems emerge

Parental Health
• Address parental mental and behavioral health to minimize, or even prevent a child’s exposure to traumatic environments

Afterschool and Summer Learning Programs
• Increase funding and prevalence for quality afterschool and summer learning programs like the Boys and Girls Clubs and YMCAs to increase access and ensure affordability

Foster Youth Care
• Maximize implementation of the federal Family First Prevention Services Act
• Develop procedures that enable continuity of behavioral health and primary care while youth are in foster care and after they’re transitioning out of the system

Juvenile Justice and School Discipline
• Provide environments that are safe and services that do not increase the level of trauma that youth and families experience
• Train Public Safety Officers who engage with children in child development and trauma awareness

Workforce and Systems Development
• Train caregivers and child-serving professionals on the effects of trauma and stress on children and youth to ensure they respond appropriately to behaviors and initiate effective interventions

Nutrition
• Increase funding for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

IMPACT OF ACEs
Children with ACEs are at increased risk of negative outcomes in multiple areas of their lives:

• Poor health, including mental health
• Substance abuse
• Depression
• Risky behavior
• Difficulty concentrating or making decisions
• Poor academic achievement
• Employment problems

Sources available here: https://tinyurl.com/ACEsChildhoodStress
The Family First Prevention Services Act (FFPSA) changes the child welfare system by allowing states to use federal funds under Title IV of the Social Security Act to support families and prevent foster care placements. Georgia plans to implement FFPSA by September 30, 2021. There are two main components of the act:

1) optional foster care prevention services and programs
2) required changes to congregate care

### Foster Care Prevention Services and Programs

<table>
<thead>
<tr>
<th>WHO IS ELIGIBLE?</th>
<th>SERVICES AND PROGRAMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children who are candidates for foster care, but who can safely remain at home</td>
<td>Mental health services</td>
</tr>
<tr>
<td>Children in foster care who are pregnant or parenting</td>
<td>Substance abuse prevention and treatment services</td>
</tr>
<tr>
<td>Parents or kin caregivers of the children</td>
<td>In-home parenting programs</td>
</tr>
<tr>
<td>Eligibility is <strong>not</strong> dependent on family income</td>
<td></td>
</tr>
</tbody>
</table>

For more details on who is eligible for these services and programs, see the definition for candidacy on [Blueprint for Family First](https://www.georgiavoices.org).

### How does a state obtain funding for services or programs?

- State must maintain a written prevention plan for each eligible child and collect data on programs and services administered.
- Services or programs must be *trauma-informed and evidence-based*.
- Services or programs must be based on promising, supported, or well-supported practices.

Half of the cost of prevention services, training, and related administrative tasks can be covered by Title IV-E funds.

If Georgia postpones the effective date of congregate care changes, it must also delay requesting prevention funds until the same date.
Congregate Care

Starting September 30, 2021, FFPSA limits foster care payments for group homes for up to two weeks only. Children will have to be placed in foster homes for all placements longer than two weeks UNLESS the child is placed in one of the following:

- A Qualified Residential Treatment Program (QRTP).
- A setting specializing in providing prenatal, postpartum, or parenting supports for youth.
- If a child is 18, a supervised setting in which child is living independently.

Qualified Residential Treatment Programs

QRTPs must meet the following requirements:

- Use a trauma-informed treatment model
- Have a registered or licensed nursing and clinical staff onsite
- Facilitate family outreach and participation
- Document family integration into the treatment process
- Provide discharge planning and family-based supports for at least 6 months after discharge

Be licensed and accredited by one of the following:
- Commission on Accreditation of Rehabilitation Facilities
- Joint Commission on Accreditation of Healthcare Organizations
- Council on Accreditation
- Other nonprofit accrediting organization approved by the Secretary

Sources available at: https://tinyurl.com/FFPSAinGA

Rev. 12/2020
The Federal Foster Care Program, also called Title IV-E, helps provide safe and stable out-of-home care for children until they are able to safely return home, placed permanently with adoptive families or placed in other planned arrangements.1

In FY 2021, the Department of Human Services received $93,803,752 and the Department of Juvenile Justice received $3,223,757 of federal funding for Title IV-E.2

Funding activities include:
- Monthly maintenance payments for daily care and supervision of eligible children3
- Administrative costs to manage the program at the state level4
- Training of staff and foster care providers5
- Title IV-E Child Welfare Education Program provides stipends for competitively selected MSW and BSW senior students to prepare them for competent professional child welfare practice

12,392 kids are in Georgia’s foster care system6

**TOP REASONS A CHILD IS IN FOSTER CARE**

- Neglect (47%)
- Caregiver Drug Abuse (44%)
- Inadequate Housing (22%)
- Incarceration (11%)
- Physical Abuse (10%)

**FAMILY FIRST PREVENTION SERVICES ACT**8

The Family First Prevention Services Act reformed Title IV-E to fund prevention services to families who are at risk of entering the child welfare system.

The changes will help keep children safely with their families and avoid the traumatic experience of entering foster care, emphasizes the importance of children growing up in families, and helps ensure children are placed in the least restrictive, most family-like setting appropriate to their needs.

**New Prevention Activities** include:

- 12 months of mental health services and substance abuse treatment
- In-home parent skill-based programs
- Mandatory prevention plan for a child to remain safely at home
- No time limit for family reunification
- Trauma-informed services

*Must be an approved Title IV-E Prevention Services Clearinghouse activity.

Sources available here: https://tinyurl.com/TitleIVEinGA
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State Agency Programs That Protect Child Well-being and Safety

Preventing a child’s removal from the home requires a comprehensive approach that targets multiple layers of a child’s surroundings and engages multiple state agencies.¹

1. **Mandated Reporters of Child Abuse**
   Most state agencies have employees or service contracts with people that are mandated reporters. For certain sectors, mandated reporter training is made available. Georgia Code (O.C.G.A § 19-7-5) states that the following positions are mandated reporters of child abuse, and thus play a vital role in protecting children: physicians; hospital or medical personnel; dentists; registered professional nurses or licensed practical nurses; professional and school guidance counselors, social workers, or marriage and family therapists; school teachers and administrators; school social workers and psychologists; child welfare agency personnel; law enforcement personnel; and more.

2. **Reasons a Child is Removed from Home**
   A child is removed from his or her home and placed in foster care for a variety of reasons, and often for more than one reason, including (but not limited to):²
   - Neglect* (47%)
   - Parental alcohol/drug abuse (44%)
   - Inadequate housing (22%)
   - Incarceration (11%)
   - Physical abuse (10%)
   - Child behavior (10%)

   * Neglect is defined as failure to provide adequate food, shelter, clothing, medical care, education, or supervision, or failure to meet emotional or psychological needs (GA Code § 15-11-2 [2018])

3. **Mandated Reporters of Child Abuse**
   Most state agencies have employees or service contracts with people that are mandated reporters. For certain sectors, mandated reporter training is made available. Georgia Code (O.C.G.A § 19-7-5) states that the following positions are mandated reporters of child abuse, and thus play a vital role in protecting children: physicians; hospital or medical personnel; dentists; registered professional nurses or licensed practical nurses; professional and school guidance counselors, social workers, or marriage and family therapists; school teachers and administrators; school social workers and psychologists; child welfare agency personnel; law enforcement personnel; and more.

www.georgiavoices.org
Georgia’s Strategies to Prevent Child Abuse and Neglect

The State Child Abuse and Neglect Prevention Plan, “A Vision for Child Well-being in Georgia”, outlines specific collective objectives designed to support children and families, prevent child abuse and neglect, and strategies to do so. These include:

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Examples of Strategies to Achieve Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase family economic stability</td>
<td>• Expand access to safe, affordable housing&lt;br&gt;• Expand access to secondary education and non-traditional programs, like technical colleges</td>
</tr>
<tr>
<td>Increase family resiliency</td>
<td>• Expand access to evidence-based afterschool and summer programs&lt;br&gt;• Increase access to evidence-based parenting skills support</td>
</tr>
<tr>
<td>Increase access to early childhood care and education</td>
<td>• Expand access to childcare, incentivizing childcare business in underserved areas and expanding Childcare and Parent Services</td>
</tr>
<tr>
<td>Increase family mental health</td>
<td>• Expand accountability courts with an emphasis on access to behavioral health treatment for all families&lt;br&gt;• Increase access to community-based behavioral health services for low-income families</td>
</tr>
<tr>
<td>Increase family physical health</td>
<td>• Expand access to affordable health insurance coverage for all Georgians&lt;br&gt;• Promote evidence-based sexual health education and pregnancy prevention for youth</td>
</tr>
<tr>
<td>Increase community knowledge and awareness of the societal factors that contribute to child abuse and neglect</td>
<td>• Ensure medical professionals are educated on recognizing child abuse and trauma-informed care&lt;br&gt;• Expand local collaborations and advocacy across sectors, including government, non-profits, faith organizations, and businesses</td>
</tr>
</tbody>
</table>

Prevention By the Numbers**

Below is a snapshot of state agency programs that provide primary, secondary, and/or tertiary prevention.*** These are funded through a combination of federal, state, and local sources.

<table>
<thead>
<tr>
<th>State Agency Program</th>
<th>Number of Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Georgia Bureau of Investigation</td>
<td>2</td>
</tr>
<tr>
<td>Georgia Accountability Court Program</td>
<td>2</td>
</tr>
<tr>
<td>Division of Family and Children Services</td>
<td>4</td>
</tr>
<tr>
<td>Department of Public Health</td>
<td>3</td>
</tr>
<tr>
<td>Department of Labor</td>
<td>1</td>
</tr>
<tr>
<td>Department of Juvenile Justice</td>
<td>9</td>
</tr>
<tr>
<td>Department of Human Services</td>
<td>2</td>
</tr>
<tr>
<td>Department of Education</td>
<td>5</td>
</tr>
<tr>
<td>Department of Early Care and Learning</td>
<td>8</td>
</tr>
<tr>
<td>Department of Community Health</td>
<td>3</td>
</tr>
<tr>
<td>Department of Community Affairs</td>
<td>4</td>
</tr>
<tr>
<td>Department of Behavioral Health and Developmental Disabilities</td>
<td>3</td>
</tr>
<tr>
<td>Criminal Justice Coordinating Council</td>
<td>2</td>
</tr>
</tbody>
</table>

**This is not an exhaustive list of state agency programs that support child well-being.

***Some of these programs may serve to prevent child abuse and neglect on multiple tiers; we have categorized each as the base level tier for the purposes of the visual.

Sources available here: https://tinyurl.com/ChildProtectionAgencies
Brain development is impacted by both our genetics and our experiences. As children grow, their brains develop basic functions first (e.g. breathing) before progressing to more sophisticated functions (e.g. complex thought).1

### HEALTHY BRAIN DEVELOPMENT

#### Early Brain Development
- Before and after birth, neurons are created and form connections.2
- The brainstem and midbrain fully develop first, governing functions necessary for life like heart rate, breathing, eating, and sleeping.2

#### Young Child Brain Development
- Formation of synapses occur at a high rate.4
- Higher function brain regions (governing emotion, language, and abstract thought) grow rapidly in the first three years.5
- By age two, a child has formed 100 trillion synapses.4
- Synapses are eliminated as experiences deem them unnecessary (i.e. pruning).2
- By age 3, a child’s brain is nearly 90 percent of its adult size.8

#### Adolescent Brain Development
- Prior to puberty, there is a growth spurt in the areas of the brain governing planning, impulse control, and reasoning.9
- While these areas develop, teenagers can act impulsively, make poor decisions, and take increased risks (all normal behaviors for this stage).10
- More pruning and myelination occurs in the teenage years.11
- Limbic system grows and transforms.12

### COMMON TERMS

- **Amygdala** - brain’s emotional reaction center associated with behavioral function and survival instincts (e.g. fight or flight)13
- **Neuron** - a unique type of cell found in the brain and body that is specialized to process and transmit information14
- **Brain stem** - one of the four major parts of the brain. It monitors basic, vital functions such as heartbeat, body temperature, and digestion. The brain stem is the first part of the brain to develop.15
- **Midbrain** - the part of the brain that regulates auditory and visual processing, motor control, arousal, and alertness16
- **Synapse** - the site between neurons where the transmission of messages occurs17
- **Pruning** - the selective elimination or “weeding out” of non-essential synapses based on a child’s specific experiences.18
- **Myelination** - the strengthening of necessary connections between neurons19
- **Limbic System** - a network of brain structures that governs emotions and memory20

### OTHER FACTORS IMPACTING DEVELOPMENT

#### Responding to Stress

- **Positive Stress** - moderate, brief, and generally normal part of life21
- **Tolerable Stress** - more severe and long-lasting difficulties; can be damaging unless the stress is time-limited and buffered by relationships with adults that help the child adapt22
- **Toxic Stress** - strong, frequent, and prolonged activation of body’s stress response system that disrupts healthy development23

#### Sensitive Periods

Windows of time in development when certain parts of the brain may be more susceptible to certain experience (e.g. strong attachments to caregivers formed during infancy)24

#### Memories

Systems of neurons that have been repeated and strengthened25

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FUNCTIONS OF THE DIFFERENT PARTS OF THE BRAIN

- Prefrontal Cortex: regulation
- Amygdala: fear
- Frontal Lobe: executive functions and developmental milestones
- Limbic System: brain reward system
- Temporal Lobe: social interactions

EFFECTS OF MALTREATMENT

On Behavior, Social, and Emotional Functioning
- Permanent fear response to certain triggers, even when they pose no actual threat
- Fear response is automatically triggered without conscious thought
- Destabilization of emotion and stress regulation
- Diminished executive functions like memory, attention, impulse control, etc.
- Delayed developmental milestones
- Decreased response to positive feedback or rewards
- Social interactions made more difficult

CONFIRMED CHILD VICTIMS OF MALTREATMENT IN GEORGIA, BY AGE

POLICY AND PRACTICE CONSIDERATIONS

Prevention and early intervention remain the most effective methods for minimizing the effect of maltreatment on development. Other promising trends include:

- Trauma informed care and evidence-based practices
- Family-centered practice and case planning, including parent-child interaction therapy
- Individualized services for children and families
- Child advocacy centers offering interviews, assessments, and services in a child-friendly environment
- The promotion of evidence-based practices
Homelessness and Children in Georgia

Homeless children and youth are defined as individuals who lack a fixed, regular, and adequate nighttime residence.

More than **40,000**

Georgia students were homeless in 2019.²

Being homeless doesn’t always mean sleeping outside. Of the students who reported experiencing homelessness, 71% said they were staying with extended family or friends.²

Georgia has a growing population of students experiencing homelessness. These students are more likely to:
- be suspended
- miss school
- fall far behind in reading and math

**COVID-19 AND HOMELESSNESS IN GEORGIA**

The COVID-19 related recession has increased housing insecurity in Georgia, which directly impacts children. As of Oct. 2020, **more than one in five** Georgia families with children were late on their rent or mortgage payment, according to the U.S. Census Household Pulse Survey.³

**DISPARITIES IN THE MAKEUP OF HOMELESS STUDENTS**

Black students make up a disproportionate amount of Georgia’s homeless student population.

**RISK FACTORS AND CAUSES OF CHILD AND YOUTH HOMELESSNESS**

**Economic Problems**
- Child and family poverty
- Employment issues
- Lack of health insurance
- Lack of affordable housing

**Family Problems**
- Abuse/neglect and trauma
- Single or youth parents
- Mental illness
- Substance abuse

**System Involvement**
- Involvement with foster care or the juvenile justice system
- Transitioning out of foster care and residential or institutional facilities

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The district’s McKinney-Vento program engages parents, school staff, and community partners through the Bartow “Give A Kid A Chance” program. It provides back to school supplies; haircuts; hearing, vision, and dental screenings; books; and other resources to McKinney-Vento students.

Atlanta Public Schools has partnered with the Atlanta Housing Authority (AHA) to provide 50 housing vouchers to children and families that are identified as homeless based on the McKinney-Vento definition of homelessness.

The district’s Homeless Liaison worked closely with Family Connection, as well as 20 community agencies and numerous community volunteers, to provide school supplies, food, and hygiene products as well as informational resources to approximately 400 McKinney-Vento students.

In 2018, the Georgia Department of Education subgranted more than $2.2 million in 43 school districts.

**POLICY RECOMMENDATIONS**

- Increase public awareness of the scope and impact of homelessness on children and families.
- Improve program design and service delivery to meet unique needs of homeless children and families.
- Inform state and local policies and plans to address the needs of homeless children and families.
  - Increase the availability and equitable distribution of quality and affordable housing.
  - Support policies, including rent subsidies, which protect families and children from unsafe housing, hardship, baseless evictions, and unjustified fees and penalties.
  - Identify and disseminate successful models of interagency coordination across child welfare, homelessness, and housing networks.
  - Improve access to educational opportunities that will ensure success for children and youth who are homeless.
  - Prevent youth who age out of foster care and unaccompanied youth from becoming homeless.
  - Collect data on housing status to increase knowledge of the scope of homelessness.
Child Sexual Abuse

Child sexual abuse is the exploitation of a child for the sexual gratification of an adult or caregiver. Sexual abuse includes:

**Touching Offenses:**
- Fondling
- Sodomy
- Rape
- Intercourse
- Masturbation

**Non-touching Offenses:**
- Child Pornography
- Indecent Exposure

Approximately **1 in 10** children is sexually abused by the time they turn 18.

**Who are the Perpetrators?**

People who sexually abuse children look just like everyone else. Abusers can be neighbors, religious leaders, teachers, family members, or anyone who interacts with children.

90% of children know their abuser

**One-third** are abused by family members.

**DID YOU KNOW?**

- Gay individuals are **not more** likely to sexually abuse children than straight individuals. In fact, most men who abuse boys self-identify as straight.
- There is **no research** that says a transgender person is more likely to sexually abuse children than someone who is not transgender.
- Although men are consistently shown to commit the majority of child sexual abuse, **women are also abusers.**
- In 2018, Georgia mandated age-appropriate sexual abuse and assault awareness education for all students K-9.

The majority of children who are sexually abused **DO NOT** tell anyone about it. Many children are afraid of getting in trouble, worried about what people will think of them, or simply do not understand what is happening to them.
Victims of Child Sexual Abuse

Children and youth who are more at risk of being sexually abused:\(^{11}\)

- Females
- Youth with physical, emotional or cognitive disabilities
- Children living in single parent households
- Lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth

Children who have been sexually abused are more likely to:\(^{12}\)

- Show physical aggression
- Experience behavioral health problems
- Attempt suicide
- Become delinquent
- Perform poorly in school
- Abuse alcohol or other drugs
- Become pregnant

Labeling Youth as Sexual Predators

Juveniles represent one-fourth of all sex offenders and one-third of known offenders against other juveniles.\(^{13}\)

40-80% of juvenile sex offenders have themselves been victims of sexual abuse. These children are often responding to their own trauma.\(^{14}\)

Juvenile sex offenders are unlikely to commit another sex offense later in life.\(^{15}\) Studies universally confirm that juvenile sex offense recidivism is relatively low with an estimated rate of 7%.\(^{14}\) In addition, interventions for juvenile sex offenders have shown to be a particularly effective.\(^{17}\)

How Can I Help?

1. Encourage community members to learn how they can prevent child sexual abuse. For example, consider taking a Darkness to Light Stewards of Children training. Learn more at www.d2l.org.

2. Educate adults, youth, and children about the harm caused by treating others as sexual objects.

3. Develop relationships with your local, state and federal representatives, and educate them about child sexual abuse and exploitation.

If you suspect that a child is being abused, call the Division of Family and Children Services at 1-855-GACHILD immediately to report.

Sources available here: https://tinyurl.com/GAChildSexualAbuse

Rev. 12/2020
New parents may need support to strengthen their families as they transition to parenthood. Evidence-Based Home Visiting, under the Georgia Department of Public Health, gives at-risk pregnant women, new moms, and families with children 0-5 years old the skills they need to raise healthy children.¹

**GOALS OF HOME VISITING PROGRAMS**

- Increase healthy pregnancies
- Improve child health and development
- Improve parenting skills
- Strengthen family connectedness

In 2018, more than 19,300 home visits were conducted for nearly 1,500 Georgia families.²

**WHO IS ELIGIBLE FOR HOME VISITING?**

To be eligible, parents must be in need of ongoing support and meet some of the following criteria:

- Low-income
- First-time parent
- Younger than 21 years old
- Lack employment or stable housing
- Low educational attainment
- Lacking access to prenatal care
- Experienced child abuse or neglect
- History of, or ongoing, substance abuse or mental health challenges
- Is receiving or has received special education services
- Has veteran or active military members in the family

**WHO RECEIVES THESE SERVICES?**

- **26** the average age of primary caregivers upon enrollment
- More than **70%** of parents served by the Georgia Home Visiting Program were **low-income** in 2018.
- More than **1 in 10** parents were **teen parents**.
- **25%** of services were provided in a **language other than English** in 2018.

[www.georgiavoices.org](http://www.georgiavoices.org)
Evidence-Based Home Visiting Model | Strategy/Objective
--- | ---
Early Head Start - Home Visiting | Promotes healthy prenatal outcomes, infant/toddler development, and strengthening families
Healthy Families Georgia | Enhances early, nurturing relationships between children and their parents/caregivers
Nurse-Family Partnership | Promotes healthy pregnancies for first-time mothers, and encourages healthy attachment and parenting choices
Parents as Teachers | Focuses on parenting knowledge, attitudes, and behaviors; promotes family well-being and healthy child development
Childhood Lead Poisoning

Lead is a heavy metal found in the earth’s crust that does not break down in the environment.¹ When someone inhales or swallows lead, they can suffer serious health consequences, up to and including death.²

**WHAT IS CHILDHOOD LEAD POISONING?**

Childhood lead poisoning is defined by the presence of 5 or more micrograms per deciliter or more of lead within the body.³ Children under age 6 are at the greatest risk of lead poisoning.

**DISPARITIES ON LEAD EXPOSURE**

According to 2019 Georgia Department of Health data, childhood lead poisoning is more prevalent in Asian, Black, and Multiracial children than White children.

In 2019, 118,351 of Georgia’s children were screened for lead poisoning. Of those, **2,331 children** had lead poisoning.⁶

All children enrolled in Medicaid or PeachCare for Kids are supposed to be tested for lead poisoning at age 12 months, 24 months, and – if they haven’t yet been tested – between 36 and 72 months. Enrolled children and their families are also offered certain related screening services, like a lead risk assessment questionnaire, at six and nine months of age.

**EFFECTS OF LEAD POISONING ON CHILDREN**

Children’s bodies absorb lead more easily, affecting brain and other physical development, like in organs and the nervous system.² Even low levels of lead can result in:

- Speech, language, and behavioral problems
- Learning disabilities and Attention Deficit Disorder
- Lower IQ
- Nervous system damage

**DID YOU KNOW?**

Higher levels of lead - also called elevated blood lead levels - can cause coma, convulsions, mental retardation, seizures, and death. Elevated blood lead levels can require expensive medical treatment and exacerbate health conditions like asthma.⁸

[www.georgiavoices.org](http://www.georgiavoices.org)
WHAT TO DO IF YOUR CHILD HAS LEAD POISONING

1. Make a plan with your child’s doctor.
2. Find the lead in your home using a licensed lead inspector.
3. Clean up lead dust.
4. Eat foods high in calcium, iron, and vitamin C. These vitamins and minerals help keep lead out of the body.

PROTECT YOUR FAMILY

1. Have your child tested
2. Get your home checked for lead hazards
3. Test your water
4. Clean regularly
5. Remove shoes or wipe off soil before entering house

In herbal or folk remedies
Greta and azarcon, which are traditional Hispanic medicines, as well as other traditional medicines from India, China, Bhutan and others can contain lead.

Certain Mexican candies
Candies containing tamarind have lead.

Small metal objects
Which can be swallowed by children.

Paint
Generally, the older the home or childcare facility, the more likely it is to have lead-based paint. While the use of lead in residential paints was banned in 1978, lead is present in many homes and childcare facilities built prior to that date.

Small metal objects
Which can be swallowed by children.

PROTECT YOUR FAMILY

1. Make a plan with your child’s doctor.
2. Find the lead in your home using a licensed lead inspector.
3. Clean up lead dust.
4. Eat foods high in calcium, iron, and vitamin C. These vitamins and minerals help keep lead out of the body.

REPORTING LEAD HAZARDS IN YOUR HOME

Landlords and home sellers are required to provide information on any known lead-based painting hazards in homes built before 1978.

Sellers must provide a 10-day period for the buyer to test the home for lead.
Swimming Pool Safety

Drowning is the second leading cause of unintentional death for children ages 1-17 years old in Georgia.¹ There were 32 drowning deaths among children in that age group in 2019.² There were 235 emergency room visits in 2019 for drowning and submersion.³ While the biggest drowning threat for children is unexpected, unsupervised access to water, thousands of children are treated in the emergency room every year for water-related injuries.

### ER-Treated Pool/Spa Non-fatal Injuries in the U.S.⁴

<table>
<thead>
<tr>
<th>Year</th>
<th>Estimated ER-Treated Injuries</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Younger than 5</td>
</tr>
<tr>
<td>Average</td>
<td>4,700</td>
</tr>
<tr>
<td>2017</td>
<td>5,300</td>
</tr>
<tr>
<td>2016</td>
<td>4,200</td>
</tr>
<tr>
<td>2015</td>
<td>4,600</td>
</tr>
</tbody>
</table>


In addition to adult supervision, fences, drains, and clean water are critical to pool safety.

### PUBLIC POOL BARRIERS⁶

Per Georgia law:
- All outdoor swimming pools and spas shall have a barrier (e.g., fence, safety cover, wall, building wall, or a combination) which completely surrounds or covers the pool or spa, and obstructs access.
- Top of the barrier should be at least 4 feet high.
- Pedestrian access gates should be self-closing and self-latching; other gates should have a self-latching device.

### PUBLIC POOL DRAINS⁸

Per Georgia law:
- Suction outlets must have been tested and meet approved standards.
- The main drain must be visible through the water from the pool edge.
- All drain covers and grates must meet appropriate standards.

### CLEAN WATER

The Georgia Department of Public Health (DPH) is the state agency that ensures public swimming pools are clean, healthy and safe. Pool inspections are critical to maintaining healthy water quality in public swimming pools.

DPH mandates that children, 3 years and younger, and those not potty trained, wear a swim diaper.²

Swim diapers are not leak proof. Diarrhea-causing germs may be delayed from leaking into the water for a few minutes, but these germs still contaminate the water.⁸

Toddlers, between the age of 1 and 4, are most likely to drown in swimming pools.
WHY POOL INSPECTIONS ARE IMPORTANT

Germs that cause water illnesses can be spread in recreational settings when swallowing water that has been contaminated with fecal matter. Appropriate levels of disinfectants kill most germs within minutes, but some can survive for days.

<table>
<thead>
<tr>
<th>Germ</th>
<th>Symptoms Can Include</th>
<th>Time It Takes to Kill or Inactivate Germs in Chlorinated Water</th>
</tr>
</thead>
<tbody>
<tr>
<td>E.coli O157:H7 Bacterium</td>
<td>Watery or bloody diarrhea, fever, abdominal cramps, nausea, vomiting, and kidney failure</td>
<td>Less than 1 minute</td>
</tr>
<tr>
<td>Hepatitis A virus</td>
<td>Fever, fatigue, loss of appetite, nausea, vomiting, abdominal pain, dark urine, diarrhea, clay-colored stool, joint pain, jaundice</td>
<td>About 16 minutes</td>
</tr>
<tr>
<td>Giardia Parasite</td>
<td>Diarrhea, gas, greasy stools that tend to float, stomach or abdominal cramps, upset stomach or nausea/vomiting, dehydration (loss of fluids)</td>
<td>About 45 minutes</td>
</tr>
<tr>
<td>Crypto Parasite</td>
<td>Watery diarrhea, stomach cramps or pain, dehydration, nausea, vomiting, fever, weight loss</td>
<td>About 10.6 days</td>
</tr>
</tbody>
</table>

* 1 part per million (ppm) free chlorine at pH 7.5 or less and a temperature of 77°F (25°C) or higher. Source: CDC

SWIMMING POOLS IN GEORGIA

The Georgia Department of Public Health (DPH) is the state agency that ensures public swimming pools are clean, healthy and safe. To ensure minimum standards are met, DPH regularly inspects public swimming pools. Public swimming pools must have:

- A clearly labeled emergency shutoff valve
- A trained operator perform a minimum of 2 weekly visits and document conditions
- Regular collection of water samples to test

DPH’s 7 PREVENTION STEPS FOR HEALTHY AND SAFE SWIMMING

- Closely supervise children in the water.
- Don’t swim when you have diarrhea.
- Shower before you enter the pool.
- Don’t swallow the water you swim in.
- Do not pee in the water and always report fecal matter.
- Don’t swim if pool drain covers are missing, broken, or can’t clearly be seen.
- Report hazards to your local health department or environmental health office.
Juvenile Justice Update

In 2012, then-Governor Nathan Deal reappointed the Special Council on Criminal Justice Reform. He asked members to study Georgia’s juvenile justice system and craft recommendations to improve public safety and reduce costs. These recommendations and resulting legislation reorganized, revised, and modernized Title 15, Chapter 11 of the Official Code of Georgia Annotated, a section of our law known as the Juvenile Code.

SIGNS OF PROGRESS FROM 2013 TO 2018

45% reduction in short-term secure confinement

40% reduction in secure detention

22% reduction in overall commitments to DJJ

According to DJJ, Regional Youth Detention Centers (RYDCs) provide temporary, secure care and supervision to youth who have been charged with offenses or who have been adjudicated delinquent and are awaiting placement. Youth Development Campuses (YDCs) provide secure care, supervision, and treatment services to youth committed to DJJ custody for the short and long-term.

In 2019:
- 324 youth were in non-residential community settings, like psychiatric residential treatment facilities
- More than 9,000 youth were under DJJ supervision in community, at-home settings (e.g., probation, electronic ankle monitoring devices)

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OVERVIEW OF GEORGIA’S JUVENILE JUSTICE PROGRAMS

<table>
<thead>
<tr>
<th>Program</th>
<th>Administered by</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>JJIG</td>
<td>Juvenile Justice Incentive Grants</td>
<td>To maximize the impact on public investment on public safety by reducing the number of out-of-home placements of youth through the use of evidence-based programs.</td>
</tr>
<tr>
<td></td>
<td>Criminal Justice Coordinating Council</td>
<td></td>
</tr>
<tr>
<td>CSG</td>
<td>Community Service Grant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Department of Juvenile Justice</td>
<td></td>
</tr>
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</table>

FUNDING OF JJIG AND CSG

<table>
<thead>
<tr>
<th></th>
<th>Initial*</th>
<th>FY17</th>
</tr>
</thead>
<tbody>
<tr>
<td>JJIG</td>
<td>State</td>
<td>$5 million</td>
</tr>
<tr>
<td></td>
<td>Federal</td>
<td>$1 million</td>
</tr>
<tr>
<td>CSG</td>
<td>State</td>
<td>$1.6 million</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td><strong>$7.6 million</strong></td>
</tr>
</tbody>
</table>

Cost Savings of JJIG and CSG

- Cost per year for out-of-home placement: $90,000
- Number of youth diverted in FY19 with a successful outcome: 1,374
- Avoided cost of detaining youth in FY19 due to diversion: $123.6 million

*JJIG was initially funded in 2013 and CSG in 2014

IMPLEMENTATION OF JJIG AND CSG

Between JJIG and CSG, all of Georgia’s counties are eligible to receive evidence-based services.

- These grants provide funding and technical support for juvenile courts to deliver evidence-based treatment programming for juvenile offenders in their home communities.
- 70% of youth served through JJIG and CSG were in FY19 were Black. Black youth made up 54% of juvenile arrests in 2018.1

More than 10,000 youth have received evidence-based services through JJIG or CSG from FY14 to FY19.3

JJIG and CSG OUTCOMES IN GEORGIA

- **Out-of-Home Placements**
  - 56% JJIG
  - 43% CSG
  - Reduction in out-of-home placements in 2019*1 compared with FY12 baseline

- **Program Completion**
  - 70% JJIG
  - 74% CSG
  - Successful completion rate in 2019 for youth in JJIG and CSG programs

- **School Engagement**
  - 94% JJIG
  - 92% CSG
  - Youth who were actively enrolled in or had completed school in 2019

In FY19, JJIG served 1,350 and CSG served 614 at-risk youth across Georgia.

Cost per year for out-of-home placement: $90,000

Number of youth diverted in FY19 with a successful outcome: 1,374

Avoided cost of detaining youth in FY19 due to diversion: $123.6 million

*2019 data is used to present a full picture of both CSG and JJIG effectiveness.

HOT OFF THE PRESS: FY2020 JJIG Outcomes Data

- 1,051 youth were served in FY20
- 71% overall successful program completion rate
- 67% reduction in out-of-home placements compared to 2012 baseline
- 95% enrolled in or completed an education program
GOALS OF GEORGIA’S 2013 JUVENILE JUSTICE REFORM

The goals of the Juvenile Justice Reform Act of 2013 were for juvenile courts and DJJ to improve public safety and decrease costs by preserving and strengthening family relationships in order to allow each child to live in safety and security.

Policies and practices include:

- Increased use of evidence-based programs
- Treating youth in the community rather than in secure facilities
- Juvenile Justice Incentive Grant Program, which aims to reduce recidivism

DJJ Mission Statement: Adopted in 2020, the Georgia Department of Juvenile Justice transforms young lives by providing evidence-based rehabilitative treatment services and supervision, strengthening the well-being of youth and families, and fostering safe communities.¹
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A "Child in Need of Services" under Georgia law means a child who is in need of care, guidance, counseling, structure, supervision, treatment, or rehabilitation AND meets one of the following criteria:

• Habitually truant from school
• Habitually disobedient of the reasonable commands of his or her parent/guardian/legal custodian
• Runaway
• Committed an offense applicable only to a child
• Wanders or loiters about the streets, highway, or any public place, between the hours of 12:00 A.M and 5:00 A.M.
• Disobeys the terms of supervision contained in a court order which has been directed to such child, who has been adjudicated a CHINS
• Patronized any bar where alcoholic beverages are being sold, unaccompanied by his or her parent/guardian/legal custodian, or who possesses alcoholic beverages
• Committed a delinquent act and is in need of supervision but not in need of treatment or rehabilitation

The passage of the comprehensive Juvenile Justice Reform Act of 2013 updated Georgia’s forty-year-old juvenile justice statute, resulting in improved responses to young offenders. To date, this thoughtful and data-driven approach has reduced recidivism, saved taxpayer dollars, improved public safety and helped misbehaving youth get back on track to success.

Included in this factsheet are two diagrams illustrating pathways for Children in Need of Services (CHINS), Delinquency Process, and a short glossary of juvenile justice terminology.
Continued Custody Hearing (continued)

**PLACEMENT**

- There is probable cause that the child committed a status offense or is in need of services. The court must decide to place in **least restrictive custody**.
- There is no probable cause.
- Released to Parents/Guardian or Legal Custodian

**NEXT STEPS**

- Order a CHINS Petition and schedule an adjudication hearing.
- Refer to a community-based risk reduction program

**If youth is held in state custody:**
- the petition must be filed within 5 days of Continued Custody Hearing

**If youth is held with parent/guardian/legal custodian OR never taken into custody:**
- the petition must be filed within 30 days of Continued Custody Hearing

**Court Issues Summons**
- This goes to the child, parent/guardian/legal guardian, DFCS or other public agencies or necessary parties. The summons requires the person to come to court for the adjudication to participate in the hearing.

**Adjudication Hearing**

**Disposition Hearing**
- Within 3 months (and every 6 months until the disposition is complete)

**Review Hearing**
- The court must periodically review the case as long as the disposition order is in effect

**Sources:** [https://tinyurl.com/JJRoadmap](https://tinyurl.com/JJRoadmap)
Georgia Juvenile Justice Process

Complaint
- Citizen of Law Enforcement Investigation

Temporary Detention or Released to Parents/Guardians

Detention/Probable Cause Hearing
- Must be held within 72 hours if detained or 48 hours if no arrest warrant.
- Youth have the same right to bail as adults.

Petition Filed
- By anyone with knowledge of facts. Within 72 hours if detained or, if not detained, within 30 days of receipt of complaint.

Adjudication
- If detained, must be within 10 days of when petition is filed or within 60 days if not detained. Court finds whether allegations in petition are sure beyond a reasonable doubt.

Predisposition Investigation
- Court may schedule a disposition on a later date to allow time to investigate appropriate placements or outcomes.

Disposition Hearing
- If youth is detained, no more than 30 days after adjudication. Judge decides outcome of case.

Dismissal
- Charges dismissed.

Informal Adjustment
- Diversion to alternative programs. Probation officer may monitor child. Discretion to proceed to adjudication is retained until program completion.

Dismissal
- Charges dismissed.

Dismissal
- Charges dismissed.

90 Day Short Term Placement
- Judge may order a stay in a YDC for up to 90 days.

Commitment to DJJ
- For up to two years. DJJ has discretion on placement.

Probation
- Child remains with parent/guardians at home. Probation officer assigned to supervise while in community.

Restitution/Fines
- Court may determine amount.

Other
- Mandatory school attendance or completion, community service, counseling, suspension, or prohibit issuance of driver’s licence.

Post-Disposition
- A child has the right to appeal case. Upon motion of DJJ and after a hearing, the court may extend DJJ custody for up to two years.

Superior Court Jurisdiction
- Prosecutorial Discretion
- No Juvenile Court Jurisdiction
  - Juveniles 13-17 who have committed certain violent felonies including murder, rape, armed robbery with a firearm, aggravated child molestation, aggravated sodomy, aggravated sexual battery and voluntary manslaughter.

Criminal Proceedings in Superior Court
- Trial as adult.

Transfer Hearing
- A juvenile court hearing to consider transfer of the proceedings if the child is over 13 and the crime is punishable by death or life imprisonment.
Definitions

Adjudication Hearing: Fact-finding proceeding to determine whether the facts alleged in the petition or other pleadings are true. This is the juvenile court equivalent to a trial in civil cases. Standard of proof is clear and convincing evidence in dependency, CHINS (Children in Need of Services) and TPR (Termination of Parental Rights) proceedings; standard is beyond a reasonable doubt in delinquency proceedings.

Case Plan: Document developed in a dependency case by DFCS, in conjunction with parents/guardian/legal custodians and child (when appropriate), which states the reasons a child is brought into protective custody and the exact steps which must be taken by everyone involved to alleviate the conditions of dependency and allow the parent to provide a safe and stable home for the child.

Community-based risk reduction program: Programming that allows a youth adjudicated with a delinquent offense to remain in their home community and receive cognitive behavioral treatment to reduce their risk of recidivating in the future. These are also used in CHINS cases as well during custody hearings. (O.C.G.A. 11-14-414).

Detention Assessment Instrument (DAI): A standardized and validated tool, required prior to detention, that measures the youth’s risk to reoffend and risk to flee before court proceedings occur. The DAI was implemented in 2000 to provide greater structure and consistency, focus the use of detention resources on high risk youth, reduce inappropriate detention by identifying youth who can be safely released, and establish a basis for DJJ to monitor detention assessment operations. The DAI is completed by DJJ staff at the time a youth is arrested or picked up by law enforcement.

Disposition Hearing: Proceeding to determine what placement is best suited to the protection and physical, mental, and moral welfare of a child adjudicated dependent, delinquent, or “child in need of services.”

Guardian ad litem: Officer of the court who is appointed to represent the best interest of the child in abuse and neglect proceedings, custody proceedings, and sometimes in delinquency or unruly proceedings. May be an attorney or layperson. Often referred to as “G.A.L.”

Informal Adjustment: An informal adjustment is given by a judge as an alternative to a formal petition in juvenile court. If conditions are met, the Judge is able to informally adjust and erase the case from the youth’s record.

Least Restrictive Custody: The level of custody which safeguards the child’s best interests and protect the community (i.e. release to parent, foster care, other court-approved placement that is not secure, or secure residential facility).

Nonsecure Facility: Nonsecure residential facilities are community residential facilities that provide 24-hour care in a residential setting that are not hardware secured. These nonsecure community residential programs include group homes, emergency shelters, wilderness/outdoor therapeutic programs, and other placements that provide 24-hour care in a residential setting.

Post-Disposition: Treatment that is received after the case has been disposed of.

Predisposition Investigation: A predisposition investigation, or PDI, is ordered by the court to get more information from a youth and family in order to determine what services or assistance is needed to help a youth move forward and stay out of the juvenile justice system.

Probation: Probation is the release from detention, subject to a period of good behavior under supervision.

Prosecutorial Discretion: Prosecutorial discretion is the authority of an agency or officer to decide what charges to bring and how to pursue each case.

Secure Facility: Secure facility is defined as a hardware secure residential institution operated by or on behalf of DJJ and shall include a youth development center or a regional youth detention center.

Transfer Hearing: A hearing in juvenile court to determine whether jurisdiction over a juvenile case should remain in juvenile court or be transferred to adult court. In Georgia, these are commonly referred to as “440 cases” which encompass the most serious offenses such as murder rape, aggravated assault, etc.

Regional Youth Detention Center (RYDC): Regional Youth Detention Centers provide temporary, secure care and supervision to youth who have been charged with offenses or who have been adjudicated delinquent and are awaiting placement. In addition, youth who have been committed to the custody of DJJ are sometimes placed in an RYDC while awaiting treatment in a community program or a long-term facility.

Youth Development Campus (YDC): A Youth Development Campus provides secure care, supervision and treatment services to youth who have been committed to Department of Juvenile Justice custody for short- and long-term programs. Every YDC provides education, vocational programming, health and mental health treatment, food services, resident counseling, substance abuse treatment/counseling and family visitation.

Sources available at: https://tinyurl.com/JJRoadmapGA

Rev. 12/2018
Raising the Age in Georgia

Georgia is one of only three states (along with Texas and Wisconsin) that processes all 17-year-olds as adults in the criminal justice system, sending them to adult court rather than through the juvenile justice system.¹

In recent years, several states have raised the maximum age of juvenile court jurisdiction from 17 up to 18 (or older) to reflect the growing body of research which shows that brain development at age 17 is at a fundamentally different stage than that of an adult.

In 2018, 6,661 17-year-olds were arrested in Georgia.² Only 5% of these arrests were for violent crimes.³ 123 counties in Georgia had fewer than 50 arrests of 17-year-olds in 2018.⁴

Even if Georgia raises the age to 18, youth as young as 13 with certain violent felonies may still be tried as adults. Such crimes include murder, rape, armed robbery committed with a firearm, aggravated child molestation, aggravated sodomy, aggravated sexual battery, and voluntary manslaughter.

IMPROVING PUBLIC SAFETY THROUGH EVIDENCE-BASED PROGRAMS

Data shows lower level offenders, when confined with higher level offenders, emerge from incarceration more inclined to conduct criminal activity.⁵ Evidence-based alternatives to detention have been proven to reduce the likelihood of criminal activity.⁶ Georgia has already taken steps to improve public safety. To date, Georgia has seen a 40% reduction in juvenile incarceration since 2013.²
Juvenile court is preparing juveniles for adulthood recognizing that they are still children.

Georgia’s Juvenile Justice Incentive Grants (JJIG) and Community Services Grants fund the delivery of six evidence-based programs proven effective for juveniles: Functional Family Therapy, Thinking for a Change, Aggression Replacement Training, Multisystemic Therapy, Seven Challenges, and Brief Strategic Family Therapy. Together the two grants make these therapies available to juvenile court jurisdictions encompassing 98% of Georgia’s youth.

The juvenile justice system makes use of:

- Mental health treatment/substance abuse counselors
- Evidence-based programs that aid in social skills development, cognitive restructuring, problem-solving skills, and crisis management
- Career development and job readiness training
- Education opportunities

Juvenile court is preparing juveniles for adulthood recognizing that they are still children.

Georgia’s Juvenile Justice Incentive Grants (JJIG) and Community Services Grants fund the delivery of six evidence-based programs proven effective for juveniles: Functional Family Therapy, Thinking for a Change, Aggression Replacement Training, Multisystemic Therapy, Seven Challenges, and Brief Strategic Family Therapy. Together the two grants make these therapies available to juvenile court jurisdictions encompassing 98% of Georgia’s youth.

JJIG served 1,350 youth at moderate or high risk to reoffend in 2019, and 94% served by JJIG were actively enrolled or had completed high school.

56% resulting in a reduction in out-of-home placements in JJIG-participating counties.

70% successfully completed their evidence-based programs.

The Georgia Department of Juvenile Justice (DJJ) is the 181st school district in the state. Georgia Preparatory Academy is the middle and high school within the DJJ school system with 30 campuses across the state in detention and transitional centers. Additionally, Pathways to Success is an adult education program that offers GED instruction and testing. The Connections Graduate Program focuses on re-entry, work skills development, and post secondary options.
• Nationally, youth are 36 times more likely to commit suicide in an adult facility than a juvenile facility.16

• In 2019, the average daily caseload of youth in Georgia receiving mental health services was 1,252.17

• From 2014-2018, more than 8,000 youth have received individual or group therapy through evidence-based models delivered by the Georgia juvenile justice system.18

**FAST FACTS**

17-year-olds are still in the adolescent phase of brain development, where their executive functioning skills are not yet fully developed. Executive function allows for self-control, regulating emotions, and understanding different points of view.19

Studies show that, when compared to adults, 17-year-olds are:20
• less capable of impulse control
• less able to regulate their emotions
• less able to consider the consequences of their actions
• more easily influenced by their environment
• more likely to change course if given the right support

![Brain Development of a 17-Year-Old](image)

Offending rates typically peak during teenage years and decline in the early 20s.21

The U.S. Supreme Court* finds adolescents are more capable of change than adults and should be given the opportunity to rehabilitate.22

*Graham v. Florida (2010)
**ECONOMIC IMPACT OF RAISING THE AGE**
States that have recently raised the age have experienced no or minimal cost increases while lowering arrest and detention rates.

**CONNECTICUT**
Raised the age in 2007

**In the first year, Connecticut:**
- Saved $2 million
- Decreased reliance on confinement

**After 10 years:**
- The number of new juvenile cases decreased by 40%
- The two-year rearrest rate of children on probation declined by nearly 8%.

**NORTH CAROLINA**
Raise the age law effective in December 2019

16 and 17-year-olds will now go into the juvenile court system

Reduced reliance on detention facilities, generating cost savings to put toward increased youth population

**RAISING THE AGE EFFECT ON JUVENILE ARRESTS**

Connecticut, Illinois, and Massachusetts have seen significant drops in juvenile arrests after raising the age up to 18.

<table>
<thead>
<tr>
<th>State</th>
<th>Violent Crime</th>
<th>Property Crime</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td>-10%</td>
<td>-8%</td>
</tr>
<tr>
<td>Connecticut</td>
<td>-10%</td>
<td>-8%</td>
</tr>
<tr>
<td>Illinois</td>
<td>-10%</td>
<td>-8%</td>
</tr>
<tr>
<td>Nat’l Avg.</td>
<td>-10%</td>
<td>-8%</td>
</tr>
</tbody>
</table>

Sources available here: [https://tinyurl.com/RaisetheAgeGA](https://tinyurl.com/RaisetheAgeGA)
What is a gang?
Georgia law states a “criminal street gang” is any organization, association, or group of three or more persons who engage in criminal gang activity (e.g., rape, racketeering, criminal trespass, or any offense that involves violence, use of a weapon, or possession of a weapon, among others).

A gang can be established by a common name or identifying signs, symbols, tattoos, graffiti, attire, or other distinguishing characteristics.

What is youth violence?
Youth violence is the intentional use of force or power by 10- to 24-year-olds to threaten or harm others. Committing youth violence increases the risk for:

- Academic challenges and school drop-out
- Substance use
- Depression
- Suicide
- Behavioral and mental health difficulties

Most youth who commit violence, including through gangs, lack positive supports from parents, schools, peers, and their community.

RISK FACTORS
Risk factors for youth violence and gang membership include:
- Child abuse and neglect
- Academic problems or school discipline issues
- Lacking parental involvement
- Poverty
- Aggressive, violent, or delinquent behavior
- Alcohol or drug use
- Mental health problems
- Exposure to violence outside the home, including racial prejudice
- Parent criminality and/or parent-child separation

The more risk factors a young person experiences, the greater their chance of committing youth violence, including through gang membership. The more protective factors a youth is exposed to, the lower their chances of committing youth violence or gang involvement.

PROTECTIVE FACTORS
Protective factors against youth violence and gang membership include:
- Parental involvement
- Family support system
- Coping and interpersonal skills
- Positive social connections
- Peer support
- Academic achievement
- Reducing alcohol and drug use

Given this, prevention strategies are aimed at increasing these crucial supports in a youth’s life: security, connectedness, and safety.
MULTI-TIERED SYSTEM OF SUPPORTS FOR GANG AND YOUTH VIOLENCE PREVENTION AND INTERVENTION

**STRATEGY**

**APPROACH**

**SOME GEORGIA OPTIONS**

Promote family environments that support healthy development

- Early childhood home visitation
- Parenting skill and family relationship programs

DPH and DFCS home visiting and parental skill-building, DJJ’s Parenthood Project, and Strengthening Families Georgia

Provide quality education early in life

- Preschool enrichment with family engagement

Georgia Pre-K, Head Start, CAPS, and Quality Rated Child Care

Strengthen youth’s skills

- Universal school-based programs

Georgia Apex Program, Youth Mental Health First Aid and Teen Mental Health First Aid (tMHFA), Positive Behavioral Interventions and Supports, and comprehensive school-based health centers

Wrapping children who are at risk of becoming gang-involved with an array of supportive services

- Cognitive behavioral treatment

Cobb County Juvenile Court R.I.S.I.N.G. Program diverts participants from the juvenile justice system by offering a specialty court that has been developed based on an accountability court structure.

Connect youth to caring adults and activities

- Mentoring programs
- Afterschool programs

Boys and Girls Club, 21st Century Community Learning Centers, DBHDD’s Resiliency Support Clubhouses, DFCS’s Afterschool Care Program, YMCAs, and 4-H

Create protective community environments

- Modify the physical and social environment
- Reduce exposure to community-level risks
- Street outreach and community norm change

Community-oriented policing, afterschool programs and community centers like the @PromiseCenter, Front Porch Community Resource Center, Juvenile Detention Alternatives Initiative, norms change programs like CureViolence (happening in some Southwest Atlanta neighborhoods)

Intervene to lessen harms and prevent future risk

- Treatment to lessen the harms of violence exposures
- Treatment to prevent problem behavior and further involvement in violence
- Hospital-community partnerships

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT); DJJ’s evidence-based programs for cognitive restructuring, problem-solving, and crisis management; DJJ’s Georgia Preparatory Academy, Pathways to Succeed, and Connections Graduate Programs, offering educational and vocational opportunities; and mental health and substance abuse treatment through DJJ

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**MULTI-TIERED SYSTEM OF SUPPORTS FOR GANG AND YOUTH VIOLENCE PREVENTION AND INTERVENTION**

**Tier One:** Targeted enforcement and prosecution through a gang accountability court. May account for 4-8% of offenders.

**Tier Two:** Intensive treatment, like group therapy, family therapy, mentoring, and cognitive-behavioral therapy.³

**Tier Three:** Less intensive levels of the same interventions as used for Tier Two.

**Tier Four:** Primary prevention strategies, like school-based, mentoring, and afterschool programs.⁴
RECOMMENDATIONS

PREVENTION

- Expand trauma-informed training to all school faculty and staff (including school resource officers), afterschool and youth development professionals.
- Ensure that all school resource officers receive training on developmentally appropriate responses, and that school personnel receive training regarding appropriate use of school resource officers.
- Expand federal and state funding to afterschool and summer learning programs to increase access and ensure affordability.
- Increase the number of mental health and social work professionals in schools.
- Expand and create positive engagement initiatives between public safety personnel and the communities they serve.
- Ensure that school codes of conduct are data-reliant, trauma-informed, and free of inadvertent bias, and developed in coordination with local child-serving stakeholders (such as child psychologists, social workers, juvenile courts).

INTERVENTION

- Strengthen partnerships between community-based afterschool programs, school districts, juvenile courts, and other community partners to align services for young people, perhaps through Local Interagency Planning Teams or truancy prevention programs.
- Create incentive grants for afterschool programs to use trauma-informed practices and evidence-based programs to build protective factors.
- Promote the use of mentoring programs in communities (e.g. partner with local chambers of commerce, rotary clubs, chapters of 100 Black Men, Big Brothers Big Sisters, or other civically focused organizations).
- Increase employment apprenticeships.
- Use restorative and, when necessary, evidence-based therapeutic responses to behavior which threatens the safety of himself or others.
- Continue funding evidence-based interventions for children at high or medium risk to reoffend through the Juvenile Justice Incentive Grant Program and Community Services Grants Program.
- Improve technical assistance and develop a reliable funding mechanism for all juvenile courts’ Children in Need of Services (CHINS) programs.
- Expand the jurisdiction of juvenile courts to encompass children under 18.
- Eliminate provisions that automatically transfer (without juvenile court approval) certain youth to adult courts.
- Improve staff and youth safety by require all DJJ staff be trauma informed and responsive.

RESTORATION

- Raise the maximum age of juvenile court jurisdiction up to 18.
- Increase access to evidence-based practices for mental and behavioral health in schools.
- Increase access to educational and work remediation.
- Expand and develop effective juvenile gang accountability courts, including wraparound services that support the youth and the youth’s family.
WHAT CAN AFTERSCHOOL PROVIDE?

- Trauma-informed practices to help kids overcome trauma and adverse experiences and reduce their chance to develop substance use disorders and other health conditions.
- Safe, supervised environments to explore new interests and build confidence in their abilities.
- Quality relationships with caring and supportive mentors.
- Opportunities for positive peer interaction like how to reach consensus and work collaboratively.
- Academic instruction for remediation, enrichment, or enhancement.
- Problem-solving and critical thinking skills through interactive learning experiences.

AFTERSCHOOL OUTCOMES

Regular participation in high quality afterschool programs leads to a reduction in crime and juvenile delinquency:

- Decrease in number of arrests and gang activity.
- Decrease in drug, tobacco, marijuana, and alcohol use.
- Decrease in likelihood of selling drugs.
- Decreased reports of misconduct in school and disciplinary incidents, including aggression, noncompliance, and conduct problems.
- Decreased likelihood of dropping out of school.

Regular participation in high quality afterschool programs leads to improved behavior and decision-making skills:

- Gain self-control and confidence.
- Develop strong social skills.
- Build healthy relationships with adults and peers.
- Improved school day attendance.
- Improved work habits and classroom behavior.
- Gains in reading and math.
- Increased graduation rates.

Sources available here: https://tinyurl.com/GangsYouthViolence
THE JUVENILE DETENTION ALTERNATIVES INITIATIVE: AN OVERVIEW

History

The Juvenile Detention Alternatives Initiatives (JDAI) was developed by the Annie E. Casey Foundation in December of 1992. It was developed in response to the growing number of youth being held in secure detention across the country for non-violent acts. It currently operates in 40 states, including Georgia, and is housed within the Council of Juvenile Court Judges.¹

Purpose

To help jurisdictions reduce their reliance on secure detention while ensuring public safety through the establishment of more effective and efficient systems that accomplish the purposes of juvenile detention.²

Objectives

- To eliminate the inappropriate or unnecessary use of secure detention
- To minimize failures to appear and incidents of delinquent behavior
- To improve conditions in secure detention facilities
- To redirect public finances from building new facility capacity to responsible alternative strategies
- To reduce racial, ethnic, and gender disparities

Collaboration between major juvenile justice agencies, governmental entities, and community organizations
- Use of accurate data to diagnose the system’s problems and identify real solutions
- Objective admissions criteria and instruments to replace subjective decisions that inappropriately place children in custody
- Alternatives to detention to increase the options available for arrested youth
- Case processing reforms to speed up the flow of cases so that youth don’t languish in detention
- Reducing the use of secure confinement for “special” cases like technical probation violations
- Deliberate commitment to reducing racial disparities by eliminating biases and ensuring a level playing field
- Improving conditions of confinement through routine inspections

HISTORY OF JDAI IN GEORGIA

In 2015, a state-level committee was established by Governor Nathan Deal and the Georgia Criminal Justice Reform Council to improve the delivery of juvenile justice services and expand JDAI efforts throughout Georgia. The committee, called the State Steering Committee for JDAI, consists of juvenile court judges and representatives from stakeholder organizations. While some communities instituted JDAI as far back as 2003, statewide rollout of JDAI began in 2016 after an initial phase of assessment.³
IMPLEMENTATION OF THE JDAI IN GEORGIA

Currently, six counties in Georgia are JDAI sites and all have completed JDAI Readiness Assessments. As of 2017, one additional county has completed JDAI Readiness Assessments.4

Currently, six counties in Georgia are JDAI sites and all have completed JDAI Readiness Assessments. As of 2017, one additional county has completed JDAI Readiness Assessments.4

<table>
<thead>
<tr>
<th>Completed County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fulton</td>
</tr>
<tr>
<td>Clayton</td>
</tr>
<tr>
<td>Rockdale</td>
</tr>
<tr>
<td>Athens-Clarke</td>
</tr>
<tr>
<td>Newton</td>
</tr>
<tr>
<td>Glynn</td>
</tr>
<tr>
<td>Chatham</td>
</tr>
</tbody>
</table>

**Trend**

- Reduced reliance on juvenile detention
- Reduced commitments to state custody
- Reduced juvenile crime
- Remaining challenges with racial equity and overrepresentation of youth of color

**JDAI NATIONWIDE OUTCOMES**

As of 2016, there were 197 JDAI sites in the United States, representing 300 local jurisdictions and 10 million youth ages 10 to 17. Recent data gathered from these sites suggests the following trends for JDAI-involved areas:

<table>
<thead>
<tr>
<th>Trend</th>
<th>Indicator</th>
<th>Pre-JDAI Baseline</th>
<th>2016 Data</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced reliance on juvenile detention</td>
<td>Average Daily Population (ADP)</td>
<td>8,780</td>
<td>4,967</td>
<td>-43%</td>
</tr>
<tr>
<td></td>
<td>Annual Admissions</td>
<td>188,948</td>
<td>95,939</td>
<td>-49%</td>
</tr>
<tr>
<td>Reduced commitments to state custody</td>
<td>State Commitments</td>
<td>17,457</td>
<td>7,432</td>
<td>-57%</td>
</tr>
<tr>
<td>Reduced juvenile crime</td>
<td>Felony Petitions</td>
<td>79,391</td>
<td>48,770</td>
<td>-39%</td>
</tr>
<tr>
<td></td>
<td>Delinquency Petitions</td>
<td>42,562</td>
<td>29,770</td>
<td>-31%</td>
</tr>
<tr>
<td>Remaining challenges with racial equity and</td>
<td>Percent of ADP that are youth</td>
<td>75%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>overrepresentation of youth of color</td>
<td>of color</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percent of annual admissions</td>
<td>70%</td>
<td>76%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>that are youth of color</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percent of state commitments</td>
<td>70%</td>
<td>83%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>that are youth of color</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Sources available here: [https://tinyurl.com/JDAIGA](https://tinyurl.com/JDAIGA)
Positive Behavioral Interventions and Supports

What is Positive Behavioral Interventions and Supports?

Positive Behavioral Interventions and Supports, or PBIS, is an evidence-based, data-driven framework proven to reduce disciplinary incidents, increase the sense of safety, and support improved academic outcomes in schools.\(^1\)

PBIS schools apply a multi-tiered approach to prevention, using disciplinary data and principles of behavior analysis to develop schoolwide, targeted, and individualized interventions and supports to improve school climate for all students.

PBIS vs. Non-PBIS Disciplinary Outcomes in Georgia’s Middle Schools

PBIS vs. Non-PBIS Disciplinary Outcomes in Georgia’s High Schools

In PBIS schools, 11,746 fewer students were assigned out-of-school suspension in 2018 than in 2014.\(^3\)

Sources available here: https://tinyurl.com/PBISinGA

Rev. 11/2020
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State Agency Salaries for Child-Serving Workers

Child-serving state agency workers help Georgia’s children and families get support for their most basic needs.

Child-Serving Agency Entry-Level Salaries

- **$40,000**
- **$35,000**
- **$30,000**
- **$25,000**
- **$20,000**
- **$15,000**
- **$10,000**
- **$5,000**
- **$0**

**DFCS Child Welfare Worker**

**DECAL Pre-K Teacher (with a 4-year degree)**

**DPH Registered Nurse**

**DBHDD Licensed Clinician (e.g. LPC, LCSW)**

**DFCS Food Stamps and Family Medicaid Worker**

**DBHDD Associate-Level Clinician (e.g. LAPC, LMSW)**

**DJJ Corrections Officer**

**DJJ Probations Specialist**

**DBHDD Associate-Level Clinician (e.g. LAPC, LMSW)**

**DPH Registered Nurse**

Georgia Department of Behavioral Health and Developmental Disabilities

Clinicians and social workers at Community Service Boards, which are safety net mental health providers based in communities, provide direct services to youth in the community and sometimes in schools. These services include individual, group, and family therapy.

**Associate-level Clinician (e.g. LAPC, LMSW)**

Base-Level Salaries (as of 2019): $29,400

**Licenced Clinician (e.g. LPC, LCSW)**

Base-Level Salaries (as of 2019): $32,418

www.georgiavoices.org
Georgia Division of Family and Children Services (DFCS)

Child Welfare
Child welfare workers provide investigative and comprehensive case management for children experiencing abuse or neglect. They assess safety concerns, identify physical, educational, and behavioral needs of the child, parents, and foster parents, and ensure these needs are addressed.

Social Services Specialist I, Entry Level  
$35,388
Social Services Specialist II, Mid Level  
$38,927
Social Services Specialist III, Advanced Level  
$42,101
Social Services Specialist, Supervisor  
$47,101

Office of Family Independence
Office of Family Independence workers process SNAP/Food Stamp and Family Medicaid cases. They determine applicant eligibility and process applications.

Economic Support 1 (One Program)  
$27,000
Economic Support 2 (Two Programs)  
$29,000
Economic Support 3 (Three Programs)  
$34,000
Economic Support Supervisor  
$36,000

Georgia Department of Early Care and Learning
Georgia Pre-K teachers teach 4- and 5-year-old children, 5 days a week, 180 days per year. The school-day is 6.5 hours, and sometimes longer to provide before- and after-school care.

Pre-K Teacher, 4-year degree  
$31,638
Pre-K Teacher, 4-year degree & Certified  
$40,338
Pre-K Teacher, Master’s degree  
$44,338

Georgia Department of Juvenile Justice (DJJ)
DJJ staff are responsible for youth under DJJ supervision, both in detention facilities and on probation in communities.

Juvenile Corrections Officer I, Entry Level  
$27,690
Juvenile Probation Specialist, Entry Level  
$29,399
Probation Officer I, Entry Level  
$29,690

Georgia Department of Public Health (DPH)
DPH Registered Nurses provide nursing care, including for populations with special needs during natural disasters and emergencies.

Registered Nurse, Entry Level  
$47,101
Registered Nurse, Working Level  
$51,812
Registered Nurse, Advanced Level  
$58,547
Registered Nurse, Supervisor  
$66,158

Sources available here: www.tinyurl.com/GASalariesChildWorkers
In State Fiscal Year 2021, federal funds will go to nine state agencies serving Georgia’s children:

<table>
<thead>
<tr>
<th>STATE AGENCY</th>
<th>SFY 2021 BUDGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>DCH Department of Community Health</td>
<td>$8,608,318,309</td>
</tr>
<tr>
<td>DHS Department of Human Services</td>
<td>$1,030,469,086</td>
</tr>
<tr>
<td>DPH Department of Public Health</td>
<td>$395,951,809</td>
</tr>
<tr>
<td>DBHDD Department of Behavioral Health &amp; Developmental Disabilities</td>
<td>$149,263,138</td>
</tr>
<tr>
<td>DECAL Department of Early Care and Learning</td>
<td>$391,102,499</td>
</tr>
<tr>
<td>DOE Department of Education</td>
<td>$2,096,148,714</td>
</tr>
<tr>
<td>CJCC Criminal Justice Coordinating Council</td>
<td>$94,263,997</td>
</tr>
<tr>
<td>DOD Department of Defense</td>
<td>$60,985,963</td>
</tr>
<tr>
<td>DJJ Department of Juvenile Justice</td>
<td>$6,425,565</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$12,832,929,080</td>
</tr>
</tbody>
</table>

*Reported budget totals do not include Federal COVID-19 relief funds.*

---

Federal Funding by Policy Area

- **79.4% Health and Human Services**
  - DBHDD Department of Community Health
  - Department of Human Services
  - Department of Public Health

- **1.3% Public Safety**
  - Criminal Justice Coordinating Council
  - Department of Defense
  - Department of Juvenile Justice

- **19.4% Education**
  - Department of Early Care and Learning
  - Department of Education
# STATE PROGRAMS RECEIVING FEDERAL FUNDING

## Health and Human Services

<table>
<thead>
<tr>
<th>Agency</th>
<th>Programs/Grants</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>DBHDD</td>
<td>Community Mental Health Services Block Grant, Medical Assistance Program (Medicaid), Sub. Abuse Prevention and Treatment Block Grant</td>
<td>$ 10,184,002,342</td>
</tr>
<tr>
<td>DCH</td>
<td>Medicaid Assistance Program (Medicaid), State Children’s Insurance Program</td>
<td></td>
</tr>
<tr>
<td>DHS</td>
<td>Medicaid Assistance Program (Medicaid), Social Services Block Grant, Temporary Assistance for Needy Families, CAPTA, Child Care and SNAP</td>
<td></td>
</tr>
<tr>
<td>DPH</td>
<td>Infants and Toddlers with Disabilities Grant, Maternal and Child Health Services Block Grant, Temporary Assistance for Needy Families</td>
<td></td>
</tr>
</tbody>
</table>

## Public Safety

<table>
<thead>
<tr>
<th>Agency</th>
<th>Programs/Grants</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>CJCC</td>
<td>Temporary Assistance for Needy Families, Family Violence Prevention and Services Act, Edward Byrne Memorial Justice Assistance Grant, Residential Substance Abuse Treatment for Prisoners, Paul Coverdell Forensic Science Improvement Grants*</td>
<td>$ 161,675,525</td>
</tr>
<tr>
<td>DOD</td>
<td>STARBASE, National Guard Youth Challenge and Job Challenge, United States Department of Agriculture</td>
<td></td>
</tr>
<tr>
<td>DJJ</td>
<td>Education, National School Lunch Program, Re-Entry/2nd Chance, Residential Substance Abuse Treatment, Title IV-E: Foster Care</td>
<td></td>
</tr>
</tbody>
</table>

*denotes grants that do not benefit children but contribute to the total federal funds received

## Education

<table>
<thead>
<tr>
<th>Agency</th>
<th>Programs/Grants</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>DECAL</td>
<td>Child and Adult Care Food Program, Child Care and Development Block Grant, Child Care Development Fund, Head Start, National School Lunch Program</td>
<td>$ 2,487,251,213</td>
</tr>
</tbody>
</table>

*Some grants/programs benefit populations other than children

Sources available here: [https://tinyurl.com/FederalDollarsinGA](https://tinyurl.com/FederalDollarsinGA)
2020 Federal Poverty Guidelines

The U.S. Federal Poverty Guidelines determine financial eligibility for certain federal programs. The poverty guidelines are designated by the year in which they are issued (i.e. guidelines issued in January 2020 are designated the 2020 poverty guidelines).  

### 2020 Federal Poverty Guidelines

<table>
<thead>
<tr>
<th>Family/Household Size</th>
<th>100%</th>
<th>200%</th>
<th>400%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 person</td>
<td>$12,760</td>
<td>$25,520</td>
<td>$51,040</td>
</tr>
<tr>
<td>2 people</td>
<td>$17,240</td>
<td>$34,480</td>
<td>$68,960</td>
</tr>
<tr>
<td>3 people</td>
<td>$21,720</td>
<td>$43,440</td>
<td>$86,880</td>
</tr>
<tr>
<td>4 people</td>
<td>$26,200</td>
<td>$52,400</td>
<td>$104,800</td>
</tr>
</tbody>
</table>

Federal Poverty Guidelines are published every January by the U.S. Department of Health and Human Services.

www.georgiavoices.org
### Federal and State Program Eligibility Based on Federal Poverty Guidelines

Certain federal programs use the federal poverty guidelines to determine eligibility. The following chart details specific programs and the maximum yearly income a family of 4 can earn to remain eligible.

<table>
<thead>
<tr>
<th>Program</th>
<th>Maximum Yearly Income (Family of 4)</th>
<th>Maximum % of Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childcare and Parent Services - Low Income Priority Group</td>
<td>$26,200</td>
<td>100%</td>
</tr>
<tr>
<td>Supplemental Nutrition Assistance Program</td>
<td>$34,060</td>
<td>130%</td>
</tr>
<tr>
<td>Pregnancy Medicaid</td>
<td>$57,640</td>
<td>220%</td>
</tr>
<tr>
<td>Women, Infants, Children</td>
<td>$48,470</td>
<td>185%</td>
</tr>
<tr>
<td>Medicaid (Children up to 1 year)</td>
<td>$55,020</td>
<td>210%</td>
</tr>
<tr>
<td>Medicaid (Children ages 1-5)</td>
<td>$40,348</td>
<td>154%</td>
</tr>
<tr>
<td>Medicaid (Children ages 6-18)</td>
<td>$36,156</td>
<td>138%</td>
</tr>
<tr>
<td>PeachCare (Children 0-18)</td>
<td>$64,714</td>
<td>247%</td>
</tr>
<tr>
<td>Marketplace (Health Insurance) Premium Tax Credit</td>
<td>$104,800</td>
<td>400%</td>
</tr>
</tbody>
</table>

### Federal and State Program Definitions

**Childcare and Parent Services (CAPS):** The Childcare and Parent Services (CAPS) program offers low-income families subsidies to pay for quality child care, afterschool and summer programs for children up to age 12 and for children up to age 17 with special needs. [See Voices’ CAPS factsheet for more details](#).

**Marketplace (Health Insurance) Premium Tax Credit:** Individuals and families with incomes at 100 – 400% FPL who purchase health insurance through the Health Insurance Marketplace, can receive federal premium tax credits to reduce their monthly insurance premium payments.

**Medicaid:** Medicaid in the U.S. is a joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid also offers benefits not normally covered by Medicare, like nursing home care and personal care services. [See Voices’ How Medicaid and PeachCare Money Work factsheet for more details](#).

**Peachcare for Kids™:** PeachCare for Kids™ is a comprehensive health care program for uninsured children (under age 19) living in Georgia, whose parents earn too much to qualify for Medicaid, but not enough to pay for private coverage. [See Voices’ How Medicaid and PeachCare Money Work factsheet for more details](#).

**Supplemental Nutrition Assistance Program (SNAP):** SNAP offers nutrition assistance to millions of eligible, low-income individuals and families through electronic benefit cards.

**Women, Infants, Children (WIC):** Women, Infants, and Children provides supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk.